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CAMBODIA

UPDATED SITUATION ANALYSIS OF CHILDREN AND WOMEN IN CAMBODIA

Acronyms

AEC	ASEAN Economic Community
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ASEAN	Association of Southeast Asian Nations
ADB	Asian Development Bank
CARD	Council for Agricultural and Rural Development
CC	Commune Council
CBI	Core Breakthrough Indicators (in Education)
CDB	Commune Database
CDC	Council for the Development of Cambodia
CDHS	Cambodia Demographic and Health Survey
CDPO	Cambodian Disabled People's Organization
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIPS	Cambodia Inter-Censal Population Survey
CLTS	Community-Led Total Sanitation
CMDG	Cambodia Millennium Development Goals
CP	Country Programme
CPAP	Country Programme Action Plan
CRC	Convention on the Rights of the Child
CRUMP	Cambodia Rural-Urban Migration Project
CSES	Cambodia Socio-Economic Survey
CSO	Civil Society Organization
D&D	Decentralization and De-concentration
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
ECCD	Early Childhood Care and Development
ECD	Early Childhood Development
ECE	Early Childhood Education
EMIS	Education Management Information System
ESP	Education Strategic Plan
GDP	Gross Domestic Product
GPI	Gender Parity Index
HC	Health Centre
HEF	Health Equity Fund
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSP3	Health Strategic Plan 2016-2018
HSSP	Health Sector Support Programme
IFA	Iron Folic Acid
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
JMI	Joint Monitoring Indicator
KAP	Knowledge, Attitudes and Practices
LDC	Least Developed Country
LSS	Lower Secondary School
M&E	Monitoring and Evaluation
MAFF	Ministry of Agriculture, Forestry and Fisheries
MCH	Maternal and Child Health

MDG	Millennium Development Goals
MEF	Ministry of Economy and Finance
MIME	Ministry of Industry, Mines and Energy
MoEYS	Ministry of Education, Youth and Sports
MoH	Ministry of Health
MoI	Ministry of Interior
MoJ	Ministry of Justice
MoLVT	Ministry of Labour and Vocational Training
MoP	Ministry of Planning
MoPWT	Ministry of Public Works and Transportation
MoRES	Monitoring Results for Equity Systems
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MoWA	Ministry of Women's Affairs
MoWRAM	Ministry of Water Resources and Meteorology
MPSP	Ministry of Planning Strategic Plan
MRD	Ministry of Rural Development
MTR	Mid-Term Review
NAPA	National Adaptation Plan of Action
NAR	Net Admission Rate
NAttR	Net Attendance Rate
NCDM	National Committee for Disaster Management
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NER	Net Enrolment Rate
NFE	Non-Formal Education
NGO	Non-Government Organization
NIS	National Institute for Statistics
NMR	Neonatal Mortality Rate
NMSP	National Monitoring Support Programme
NSDP	National Strategic Development Plan
NP-SNDD	National Programme on Sub-National Democratic Development
NPWSS	National Policy on Water Supply and Sanitation
NSDP	National Strategic Development Plan
NSPS	National Social Protection Strategy
NSRWSSH	National Strategy on Rural Water Supply, Sanitation and Hygiene
OCHA	Office for the Coordination of Humanitarian Affairs
ODA	Official Development Assistance
PFM	Public Financial Management
PFMRP	Public Financial Management Reform Programme
RGC	Royal Government of Cambodia
RWSSH	Rural Water Supply, Sanitation and Hygiene
SDG	Sustainable Development Goals
STD	Sexually Transmitted Disease
TVET	Technical and Vocational Education and Training
U5MR	Under-five Mortality Rate
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	UN Development Programme
UNFPA	UN Population Fund
UNICEF	UN Children's Fund
WASH	Water, Sanitation and Hygiene
WB	World Bank

Contents

List of tables

List of figures

Executive summary

UNICEF supported the development of this 'light' update of the 2013 Situation Analysis (SitAn) of Children and Women in Cambodia against the backdrop of Cambodia's recent transition towards status of a lower-middle-income country, as well as the global transition towards the Sustainable Development Goals (SDGs).

Both of these changes at national and global levels set the scene for UNICEF's upcoming 2019-23 Country Programme (CP) in partnership with the Royal Government of Cambodia (RGC).

The population profile of the country is one of the youngest in South-East Asia. According to the latest 2017 UN Population Division statistics, the total population increased from 4.4 million in 1950, to about 16 million in 2017 and this is projected to increase to 18.8 million by 2030. In 2017, 31 per cent of the 16 million populace were aged 0-14 years and one fifth aged between 15-24 years.

This young, dynamic and highly mobile population is poised to enter the work force and be a major contributor to economic growth under the right conditions and this provides compelling evidence of a favourable demographic dividend.

Migration is a common phenomenon in Cambodia. The national Inter-Censual Population Survey of 2013 estimated around 4.2 million migrants; of which only 2.5 per cent were cross-border and 8.3 per cent were between 10 and 19 years-old. Migration can pose both opportunities and challenges for migrants and their families, especially children.

Increased household income from wages remitted to home communities from cross-border, as well as rural-urban migrants, is acknowledged to have made a significant contribution to the improvement of lives in home communities.

However, since the majority of parents migrate and leave their young children behind, this has created a parental care role vacuum that vulnerable, old grandparents, who are also in need of care, have to take on.

Overall, Cambodia has achieved remarkable development progress in a comparatively short period and the country is well-poised in the post-2015 era of the SDGs. Progress has been particularly impressive in terms of reducing head-count poverty and under-five mortality rates (U5MR); official figures indicate the country has met the relevant Millennium Development Goal (MDG) targets. Other significant areas of progress include improving maternal health, early childhood development and primary education in rural areas.

However, child mortality in Cambodia remains among the highest in Asia, predominately due to high neonatal mortality, inadequate complementary feeding practices, the poor nutritional

status of women of reproductive age and poor Water, Sanitation and Health (WASH) coverage. Low budget allocation and a lack of effective intervention in the maternal and child health, nutrition and WASH sectors – combined with limited access to, and availability of quality services are some of the factors constraining progress in these areas. Malnutrition is considered the underlying cause of 45 per cent of child deaths and 20 per cent of maternal deaths and this creates an economic loss of one to two per cent of GDP annually. Thirty-two per cent, or approximately 0.5 million, of children under five are stunted.

While net enrollment in primary education increased from 82 per cent in 1997 to 93.5 per cent in 2017, lower secondary completion rates, at 42.7 per cent in 2017, are significantly below the average for lower middle-income countries.

As of 2015, 70 per cent of Cambodia's population (12.3 million people) did not have access to a piped water supply and 58 per cent (9.3 million people) did not have access to improved sanitation. This calls for future policy, programming and budget allocation to adopt a more calculated equity approach.

Quality improvements in social services and targeted interventions for specific socio-economic groups are required to further accelerate progress in reducing neonatal mortality and to further address Cambodia's pressing, unfinished agenda in child survival, development and learning.

Cambodia has also seen increased momentum regarding the introduction of laws to protect children and women. The Inter-Country Adoption Law; the Law on Suppression of Human Trafficking and Sexual Exploitation and its Explanatory Note; the Law on the Protection and Promotion of the Rights of Persons with Disabilities; the Law on Domestic Violence; the Sub-Decree on the Management of Residential Care Institutions (2015); and the Juvenile Justice Law (JJL) are among major achievements.

However, the country still lacks a child protection systems-based approach built on a national vision for protecting children from harm. This includes having a legal framework and a comprehensive child protection law; in addition to defining a unified commune-level service delivery mechanism; improving government agency coordination and collaboration with NGOs; enhancing the human resource base, particularly qualified social workers; and strengthening monitoring and accountability systems.

At the same time, the status of women and children has also been found to be deeply rooted in negative social norms, attitudes and practices. Importantly, social perceptions of childhood continue to vary according to age, gender, wealth, geography, disability and other factors.

Communication for development strategies that can be used to address these attitudes are required to be adopted by RGC and other partners at national and sub-national levels in order to reduce gender gaps in economic participation and opportunity, education attainment, health and survival, protection and political empowerment.

Cambodia is witnessing rapid urbanization and while still predominantly a rural population, projections suggest that by 2030 over a third of the country's population will reside in urban areas. Adequate provision of quality basic services that meet the needs of this growing

urban population will be vital to preventing a deepening of inequities.

The country is also increasingly vulnerable to climate change and this threatens the significant achievements made in poverty reduction and achieving SDGs.
According to the *2017 World Risk Report*, Cambodia is ranked among the top 15 countries in the world that have the highest exposure to extreme natural events which can lead to disaster, with an exposure rating of 27.65 per cent.

Given that women and children tend to be disproportionally affected by the harmful effects of climate change and disasters, it is now crucial to invest in climate change adaptation and social services that are resilient to disruptions caused by natural disasters and other climate-related events.

Children with disabilities are often invisible in mainstream development programming. This is compounded by a lack of quality data on the number of children with disabilities. Therefore, there is a need to enhance interventions for children with disabilities through early detection, inclusive education and social protection to ensure they are not left behind.

As Cambodia transitions from lower middle-income to middle-income country status and in light of decreasing official development assistance, a strengthened budget allocation from national resources to social services is crucial.

Effort is needed to strengthen collaboration and technical support to the ministries of Education, Health, Rural Development and Social Affairs, including their preparation of strong budget proposals.

This intervention includes increased spending on social protection programmes and support to the Ministry of Economy and Finance (MEF) to deliver effective budget allocations.

For example, an increased budget allocation is vital to ensure full implementation of RGC's recently adopted inter-ministerial costed Action Plan to Prevent and Respond to Violence Against Children (VAC).

This situation analysis identifies some of the main causes that are preventing children and women in Cambodia from enjoying their rights, it explains why key duty-bearers are not always able to fulfil their obligations for them to do this and it gives recommendations on how RGC and its partners can advance the development agenda across Cambodia.

Introduction

UNICEF Cambodia is currently implementing a three-year CP in partnership with RGC. This programme is aligned with the current United Nations Development Assistance Framework (UNDAF) (2016-2018) and the National Strategic Development Plan (NDSP) (2014-2018).

CP development was informed by the 2013 SitAn of children and women's issues; the Mid-Term Review (MTR) of the 2011-2015 CP; and findings from the Cambodia Demographic and Health Survey (CDHS) of 2014.

In preparation for the new CP which will begin in 2019, UNICEF Cambodia has undertaken an update of the current SitAn, building on detailed findings of 2013 and strengthening the child-rights, equity, gender and risk aspects of each respective analysis.

This SitAn update uses and collates research, studies and evaluations conducted between 2014 and 2017 to confirm inequities, deprivations and gaps in the fulfilment of children's rights, especially the most disadvantaged, marginalized and excluded, as established by the Convention on the Rights of the Child (CRC) and other key international conventions.

Due to the sheer diversity of issues relevant to child and adolescent rights and sustainable development in Cambodia, there was a need to adopt a focused approach to data usage to keep the scope of the update manageable and to ensure that the narrative remains concise, and squarely focused on the most pressing challenges at hand.

This assessment update also identifies and captures key themes and issues for additional research and deeper collective consideration.

A comprehensive new SitAn will be commissioned in 2020/21, once findings are available from the next census planned in 2019; the next CDHS planned in 2020; and fine-tuning of the MTR of the National Strategic Development Plan (NSDP), which is due to start in 2019, has been completed.

1.1 Methodology and approach

The methodological approach for preparing this SitAn update assessment report is based on steps suggested in UNICEF's Global Guidance on Conducting Situation Analysis of Children's and Women's Rights (2011); UNICEF's Guidance on Conducting Risk-Informed Situation Analysis (2012), which was updated in 2015; the Human Rights-Based Approach to Programming; and the equity-focused key determinants analysis.

A number of formative guiding principles underscore the methodology and approach employed for the development of the 'light' update of this SitAn. These include:

- A critical consideration of inequities, deprivations, risks and gender issues as they relate to children and adolescents and the agenda for sustainable development.
- A rights-based perspective that considers the situation of rights-holders, state obligations and the role of other duty bearers.
- Analysis, where appropriate and applicable, guided by the 10 determinants used by UNICEF to assess barriers and bottlenecks to improved service delivery for children and adolescents.
- A consideration of the challenges and emerging issues faced by children and

adolescents; and an overall focus on advocacy for investments in the wellbeing of children and adolescents and on the sustainable benefits that such investments yield.
- A process to ensure that all information collected is treated with honesty and integrity.

In order to adequately update the SitAn, given the limited budget and time, the consultant in consultation with the country office used a combination of methods to undertake this assessment. These include:

- A desk review, analysis and synthesis of existing data and evidence from the identified list of studies, research and evaluations. Over 70 secondary data sources have been used, thereby ensuring a greater understanding of the state of children's and women's rights in Cambodia. Effort was made to rely on official RGC data and analysis to the best extent possible and this approach informed subsequent key informant consultations.
- Selected key informant consultations/interviews with selected UNICEF Cambodia staff, representatives of RGC, UN and other stakeholders, complemented by limited analysis of the most recent legislation, policies, budgets and expenditure documents availed in conformity with provisions of the CRC and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Interviews were conducted with key partners and UNICEF staff during an in-country mission in October. These views were used particularly to contextualize secondary data.
- Review, interpretation and analysis of relevant, existing risk mapping, (considering hazards, exposure, vulnerability and capacity).
- Socio-demographic trend analysis at the most disaggregated level possible on the basis of micro data sets over the past decade and also future forecasting as appropriate.
- Gender analysis to identify key issues that contribute to gender inequalities.
- Sharing the consolidated assessment update with regional office staff for review and feedback.
- The creation of user-friendly links to detailed analysis and background reports in order to provide interesting and contextual information for the reader. This was achieved through technical support from the country office communications team.

2. National context for children's and women's rights

Demographics – Cambodia's population was estimated at 16 million, according to the UN Population Division (2017)[1]. Population growth has declined steadily from 3.43 per cent in 1990-95 to 1.62 per cent in 2010-15. Annual population growth is projected to fall to 1.08 per cent between 2025 and 2030. Table 1 below compares some general demographic measures between 1990 and 2015.

Table 1: General Demographic Measures: 1990 vs 2015[2]

General Demographic Measures	1990	2015
Population (thousands)	9,009	15,762
Population under 18 years (thousands)		5,854
Population under five years (thousands)	1,726	1,761
Annual growth rate (per cent)	2.2	1.3
Fertility rate (births per woman)	5.6	2.6
Sex ratio (males per 100 females)	93.4	95.2
Density of population (persons per sq-km)	51.0	88.3
Urban population (percentage of total)	15.5	20.7

Population growth varies across Cambodian provinces and this has an effect on the demand for education and for other social services. Growth is highest in border provinces in the north-east, south-east and north-west.

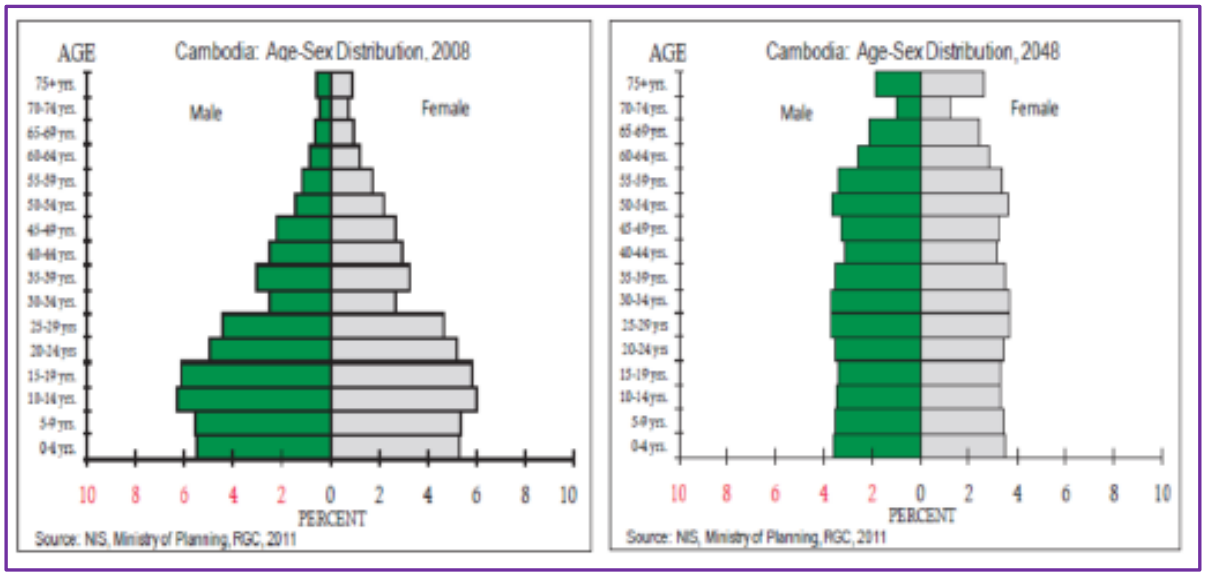
Economically, these areas are a mixture of underdeveloped rural areas, as well as corridors of development associated with tourism and transport arteries to and from neighbouring countries and the capital Phnom Penh. A number of special economic zones exist, such as Snoul district in Kratie province, which can greatly affect population movement.

The population profile of the country is one of the youngest in South-East Asia. According to the UN Population Division's 2017 statistics, the population increased from 4.4 million in 1950, to the estimated figure of 16 million in 2017 and is projected to increase to 18.8 million by 2030[3]. In 2017, 31 per cent of the populace were aged 0-14 years and one fifth were aged between 15-24 years.

As stated in the Executive Summary of this SitAn, this young, dynamic and highly mobile population is set to enter the work force and be a major contributor to economic growth, providing compelling evidence of a potential demographic dividend.

Figure 1: Comparison of Age-Sex Pyramids, 2008 and 2048

[1] United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, Key Findings and Advance Tables. Working Paper No. ESA/P/WP/248.
[2] UNDP 2014/2015.
[3] United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, Key Findings and Advance Tables. Working Paper No. ESA/P/WP/248.



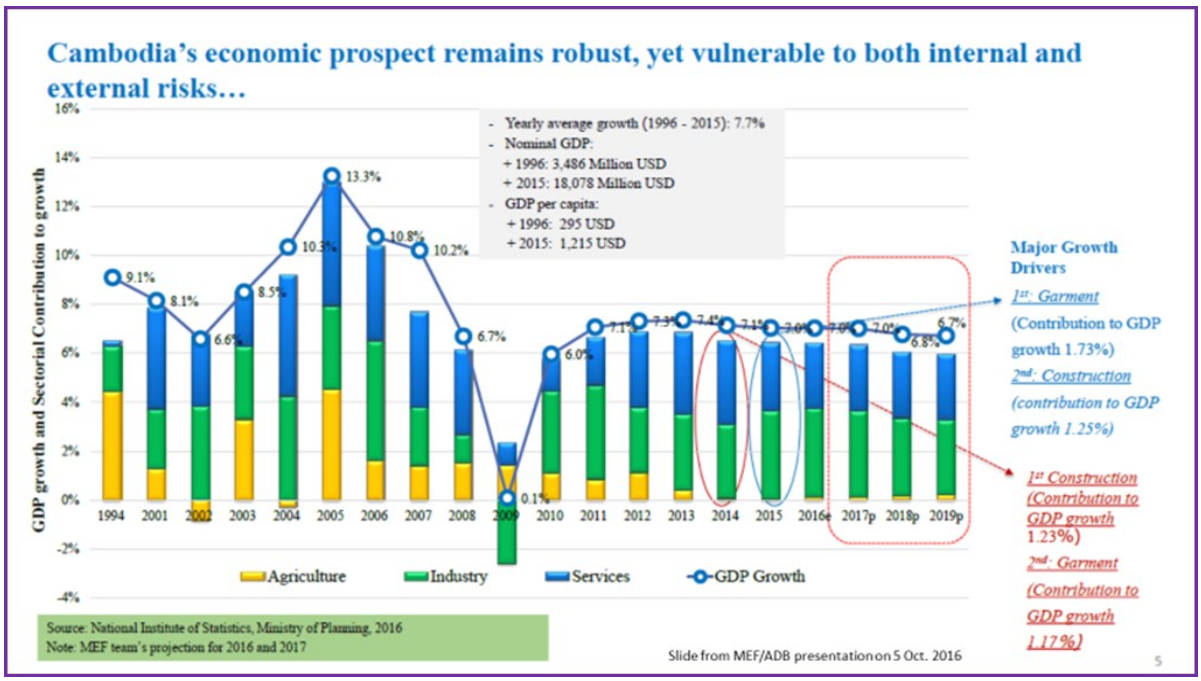
Economy – After two decades of development, Cambodia officially transitioned to lower middle-income status in July 2016. According to a World Bank assessment in 2015, Cambodia was ranked sixth in a classification of countries with the fastest economic growth rate. This economic progress has helped to reduce the country's monetary poverty rate from 53.2% per cent in 2004 to 13.5 per cent in 2014. The Gini Coefficient Index – a measure of the degree of inequality in the distribution of family income in a country – also decreased over the period 2004-2014 (see figure 2 below)[4].

Figure 2: Poverty Reduction Trends and Gini Coefficient Index 2004-2014

Over the past two decades, the annual average economic growth rate was around 7.7 per cent and this is expected to remain stable in the medium-term as shown in figure 3 below.

[4] MoP (2015). Calculation done using Cambodia Socio-Economic Survey (CSES) 2004-2014.

Figure 3: Cambodia's Macroeconomic Trends and Prospects – 1994-2016



The Asian Development Bank (ADB) forecasts[5] an economic growth rate of around 7.1 per cent for 2017/2018, in line with a strong performance in developing countries across Asia and aligned with a recovery in major industrial economies.

The inflation rate was around 3.8 per cent, while the exchange rate was close to 4.037 riels to one US dollar at the time of the publication of this report. The nominal value of Gross Domestic Product (GDP) is estimated and projected at 89.033 billion riels (US$22,200 million) and 99,116 billion riels (US$24,552 million), with GDP per capita reaching US$1,434 and US$1,568 in 2017 and 2018, respectively[6].

Given this positive outlook, together with the expected recovery of the global economy, RGC has set forth its ambitious goal to transform Cambodia from a low-income to a upper-middle income country by 2030 and to a high-income country by 2050.

The national budget deficit declined gradually to three per cent in 2015, due to implementation of the Public Financial Management Reform Programme (PFMRP); the Medium-term Revenue Mobilization Strategy 2014-2018; and enhancement of effective national expenditure procedures.

The balance of payments has been, on average, at a surplus of around three per cent of GDP over recent years and the current account deficit has decreased gradually.
The decline in the poverty rate and the Gini Coefficient Index were accompanied by improvements in the labour market. Private sector growth and economic diversification steadily absorbed labour forces from the agricultural sector into manufacturing industry and

[5] Asian Development Bank Outlook 2017-April 2017.
[6] MEF (2017). 2018 Budget Summary Statement; MEF (2016). Circular on 2017 Budget Law Preparation.

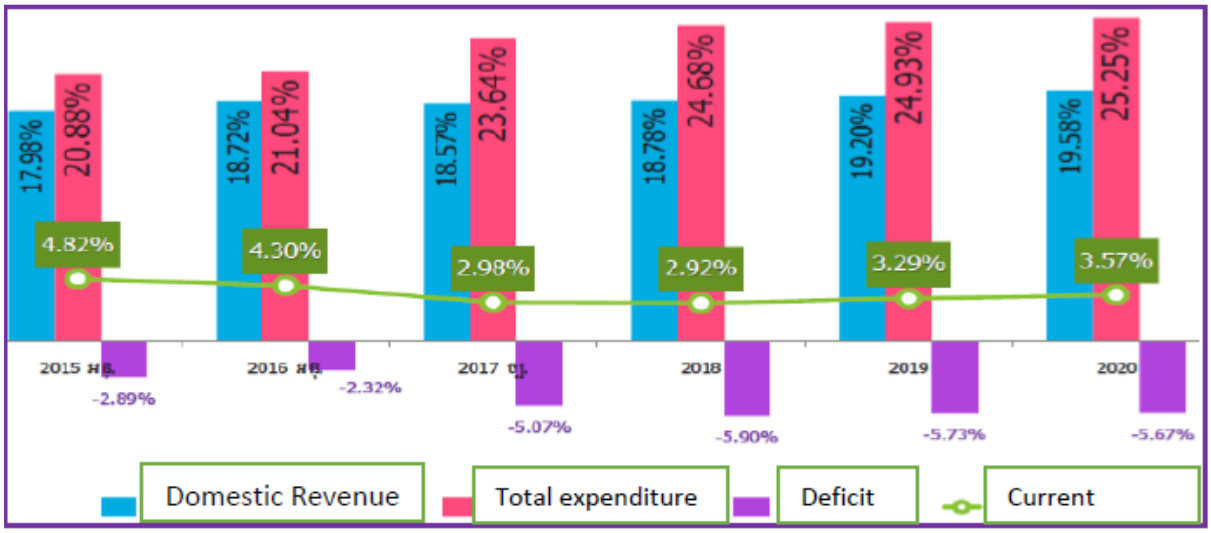
services sectors. A predominant working age population, combined with a low unemployment rate[7] have also driven economic growth[8].

Fiscal space is expanding following stable economic growth and the implementation of the revenue mobilization strategy 2014-2018 through improved tax administration and tax collection. The total government budget expenditure for 2017 and 2018 is US$5,239.5 billion and US$6,037.9 billion, respectively.

With the move from low-income status, RGC is identifying other finance sources including concessional loans, more efficent tax collection and an expanding tax base through the introduction of new taxes and tax rate increases to offset shrinking grants from development partners and an increasing external debt burden of mostly concessional loans.

The budget deficit is projected to expand in the medium-term as RGC faces an increased demand for better quality social services and other effective investments to promote economic growth. See figure 4 below.

Figure 4: Major Trends of Public Finance (in percentage of GDP)

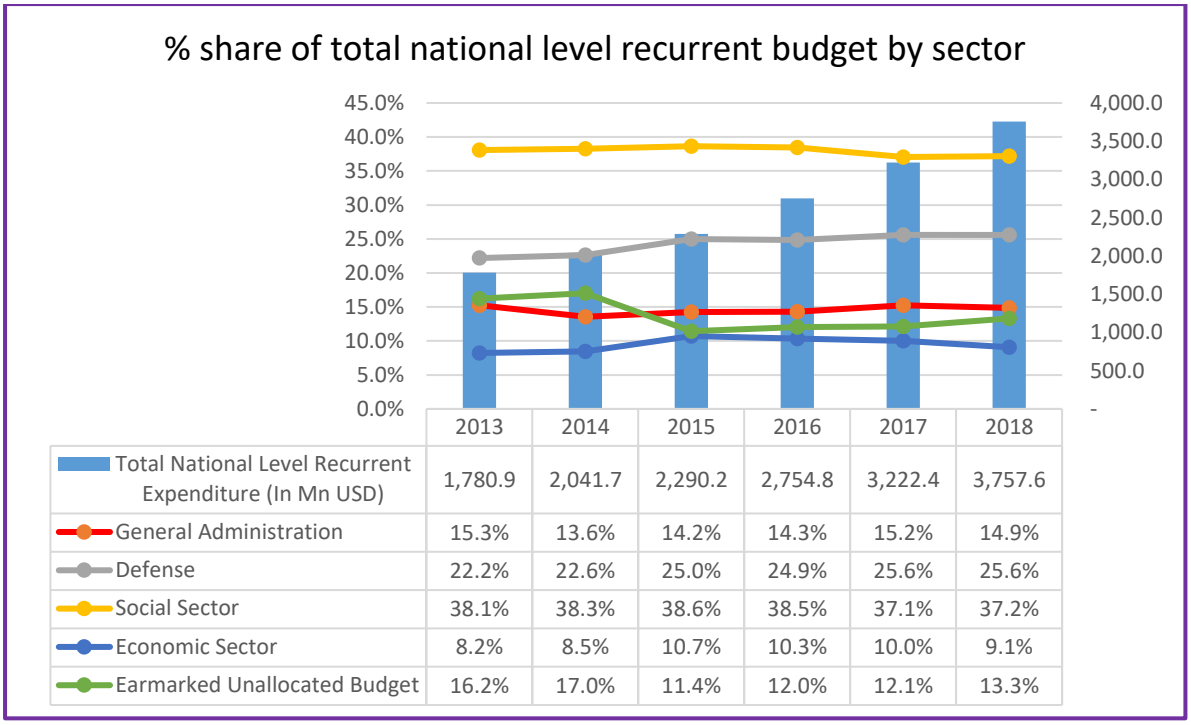


Source: MEF (2017)

In terms of financial allocation, the social sector budget has shrunk over the last five years due to increased defence sector spending. In absolute terms, all sectors have seen their budget increase, however, this is mostly due to an increase in the personnel cost. RGC introduced salary reform in 2013 and the sector with the largest number of personnel has since received the biggest budget increase. Personnel costs have absorbed over 50 per cent of the total national level recurrent budget – leaving less for programmatic interventions.

Figure 5: Percentage Share of Total National Level Recurrent Budget by Sector

[7] Due to the definition of unemployment, the unemployment rate is unreasonably low.
[8] World Bank overview, 2015.



	2013	2014	2015	2016	2017	2018
Total National Level Recurrent Expenditure (In Mn USD)	1,780.9	2,041.7	2,290.2	2,754.8	3,222.4	3,757.6
General Administration	15.3%	13.6%	14.2%	14.3%	15.2%	14.9%
Defense	22.2%	22.6%	25.0%	24.9%	25.6%	25.6%
Social Sector	38.1%	38.3%	38.6%	38.5%	37.1%	37.2%
Economic Sector	8.2%	8.5%	10.7%	10.3%	10.0%	9.1%
Earmarked Unallocated Budget	16.2%	17.0%	11.4%	12.0%	12.1%	13.3%

Significantly, recent economic growth has not benefited all and noteable geographic disparities exist, with monetary poverty rates ranging from around 15 per cent in Phnom Penh, up to 37 per cent in the mostly rural north-east provinces.

Of the estimated 15.58 million population in 2015[9] around 40 per cent lived just above the poverty line and this group were highly vulnerable to small economic changes, natural disasters, or other shocks.

National development agenda – Cambodia's Rectangular Strategy Phase 3 (RS3) for growth, employment, equity and efficiency, effective from 2013 to 2018, lays out RGC's political commitment for socio-economic progress in the medium-term. Phase one was implemented from 2004.

Cambodia over the last 20 years has witnessed a profound change in all aspects of society. It has gone from post-conflict status to a situation where it provides peace-keeping troops to UN missions globally. As noted above, economic growth, while unevenly spread across all sections of society, has been sustained and substantial.

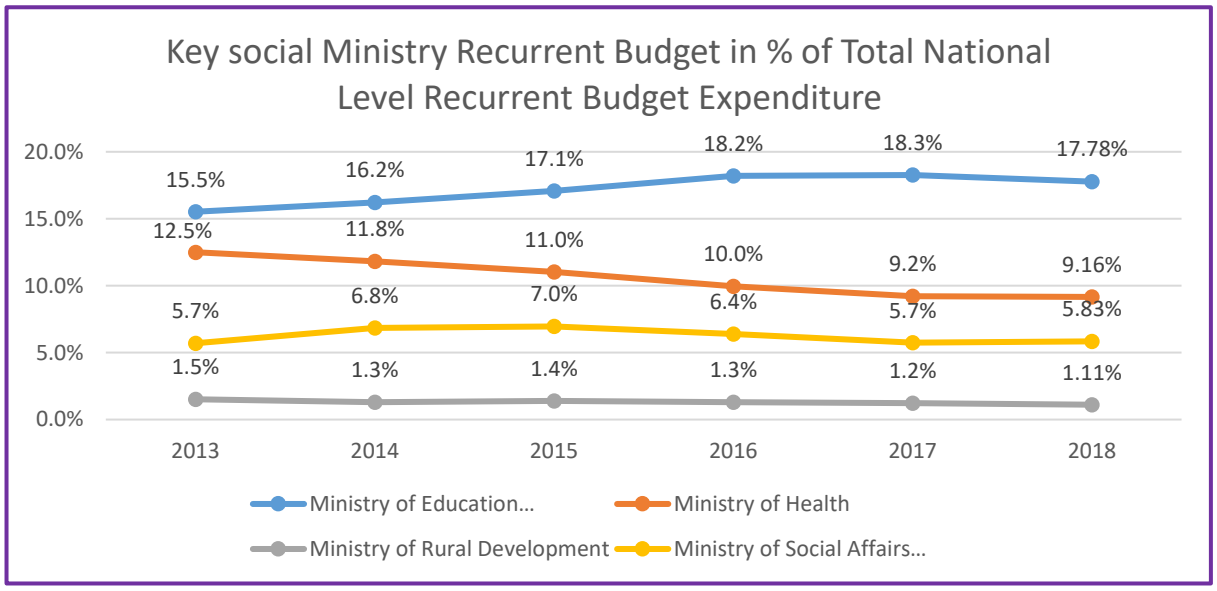
NSDP 2014-2018 carries forward the agenda laid out in RS3; NSDP is the policy document with which all sector policies and plans are required to be aligned. The aim of NSDP is to support the transitioning of Cambodia from a low-income country to a lower-middle-income country, while building the foundations to realize its long-term vision of becoming an upper-middle-income country by 2030 and a high-income country by 2050.
NSDP is based on a planning model of moving from poverty reduction to economic development. The social sector benefits from clear budget allocations. To maintain economic growth, RS3 lays out a number of important challenges and opportunities facing the country,

[9] UN Population Division (2015).

including human resource development and education service delivery.

In particular, the strategy aims to ensure that the country makes the most of the demographic opportunity presented by its substantial young population. One of the RS3 directives states: "... to particularly focus on strengthening the quality and responsiveness to labor market demand and the development of technical skills for youth to increase their job opportunities and to realize in full the potential benefits of Cambodia's demographic dividend as well as to ensure continuity in the country's leadership development for the future".[10]

Figure 6: Percentage Recurrent Budget by Social Sector Ministry



Source: Budget Law 2013-2018, percentage of nominal value.

RGC's budget allocation to social ministries has increased in absolute terms. However, the share of the recurrent budget of the Ministry of Health (MoH) and Ministry of Rural Development (MRD)[11] has decreased over the last five years, from 12.5 per cent in 2013, to 9.2 per cent in 2018.

Given the high out-of-pocket health expenditure (62.3 per cent in 2014)[12], this decreasing share in the health sector suggests the need for a larger budget allocation to cover public health services, particularly for women and children. The Ministry of Education, Youth and Sport's (MoEYS) budget continues to increase its share of total national level recurrent budget due to RGC's prioritization of this sector in budget policy. Nevertheless, the 95 per cent of the annual budget execution rate of the ministry is leaving some of the unspent balance in personnel costs not being able to be reallocated, or spent on other priorities within the sector.
Education and vocational training play an important role in producing much needed human resources to address a skills gap and mismatch[13] in the labour market and to support RGC's industrialization policy and growth strategy implementation.

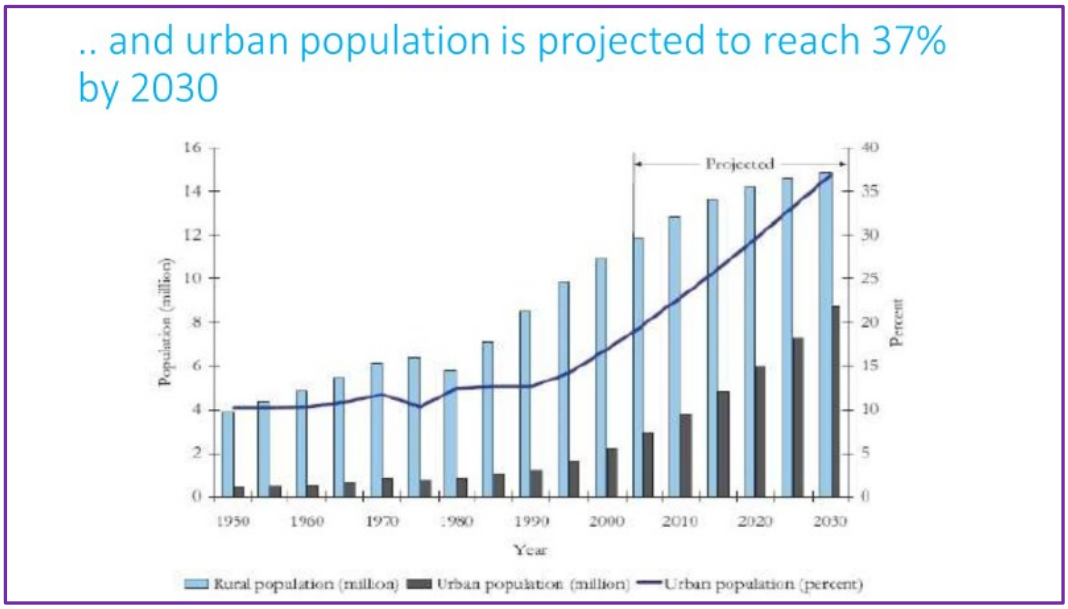
[10] RSP3, 2013, p5.
[11] Rural water supply and sanitation is part of the ministry's rural development budget.
[12] MoH (2016). Estimating Health Expenditure in Cambodia: National Health Account Report (2012-2014 data).
[13] World Bank (2012). Matching aspirations: Skills for Implementing Cambodia's Growth Strategy.

The Law on Administrative Management of the Capitals, Provinces, Municipalities, Districts and Khans, also known as the Organic Law, was envisaged to strengthen the implementation of Decentralization and De-concentration (D&D) policies and also have an impact on social service provision at sub-national levels.

However, there has been slow development of D&D reform. This is due to a poorly functioning accountability framework; a weak check-and-balance mechanism by provincial and district councils; and the slow pace of financial decentralization as Sub-National Authorities (SNA) account for only seven per cent of total budget[14].

Migration – Migration is an important phenomenon in Cambodia. The urban population in Cambodia is expected to double by 2030. Older adolescents (aged 15-19) are increasingly migrating towards urban spheres.

Figure 7: Rural and Urban Migration Trends and Prospects 1950-2030



The recent *Cambodian Rural-Urban Migration Project* (CRUMP) report revealed some rural areas are estimated to have lost four per cent of their population in a year. Females aged 15-24 make up about 31 per cent of migrants, compared to 27 per cent for males. With migration to urban areas and the consequent development of these areas, rural and poor adolescents may face disadvantages in accessing information, education and health services, as well as new risk factors as they move into an urban setting that exposes them to a greater risk of crime, hazardous working conditions and violence.

The movement of people is predominantly rural but the rapid rate of urbanization is quite visible as depicted in Figure 8 below. Between 2008 and 2030, 20 per cent of the population resided in urban areas and 80 per cent in rural areas[15].

[14] Review of UNICEF Cambodia work at sub-national level 2017.
[15] Cambodia Population Census, 2008.

It is projected that the urban population will double by 2030, while the rural population is projected to grow by 14.2 per cent. Increasingly, as young rural females migrate to urban areas in search of employment, an estimated 20 per cent leave their children behind, especially those below 15 years-old.

Figure 8: Rapid Pace of Urbanization between 2003 and 2013 (Phnom Penh)

Source: UNFPA presentation, 2014.

Disaster risk reduction and social cohesion – Cambodia is considered one of the most hazard-prone countries in South-East Asia. The World Risk Report 2017[16] classifies it as the eighth most at-risk country in the world due to a significant exposure to natural hazards and the limited adaptive and coping capacities of its population and of national and local structures to prevent and mitigate the effects of disasters.

According to the International Disaster Database, seasonal hazards such as floods, droughts, storms and epidemics have resulted in over 1,500 deaths and over US$1.5 billion in disaster losses[17], affecting more than 12 million people at different times since the turn of the millennium.

Table 2: Disaster Events and Losses in Cambodia 1996-2014

[16] World Risk Report Analysis and Prospects 2017.
[17] EM-DAT-OFDA/CRED International Disaster Database (quoted from NCDM/ADPC 2014).

Disasters		Number of Events	People Killed	Population Affected	Damage (000 US)
Drought	Drought	5	-	6,550,000	138,000
	average per event		-	1,310,000	27,600
Flood	Flood 1994	1	506	29,000	-
	average per event		506	29,000	-
	Flash flood	1	7	535,904	500
	average per event		7	535,904	500
	General flood	14	1083	12,055,758	1,418,600
	average per event		77	861,125	101,328
	Storm surge/coastal flood	1	-	124,475	-
	average per event		-	124,475	-
Storm	Tropical cyclone	3	44	178,091	10
	average per event		14.7	59,363	3

Source: EM-DAT - OFDA/CRED International Disaster Database (quoted from NCDM/ADPC 2014)

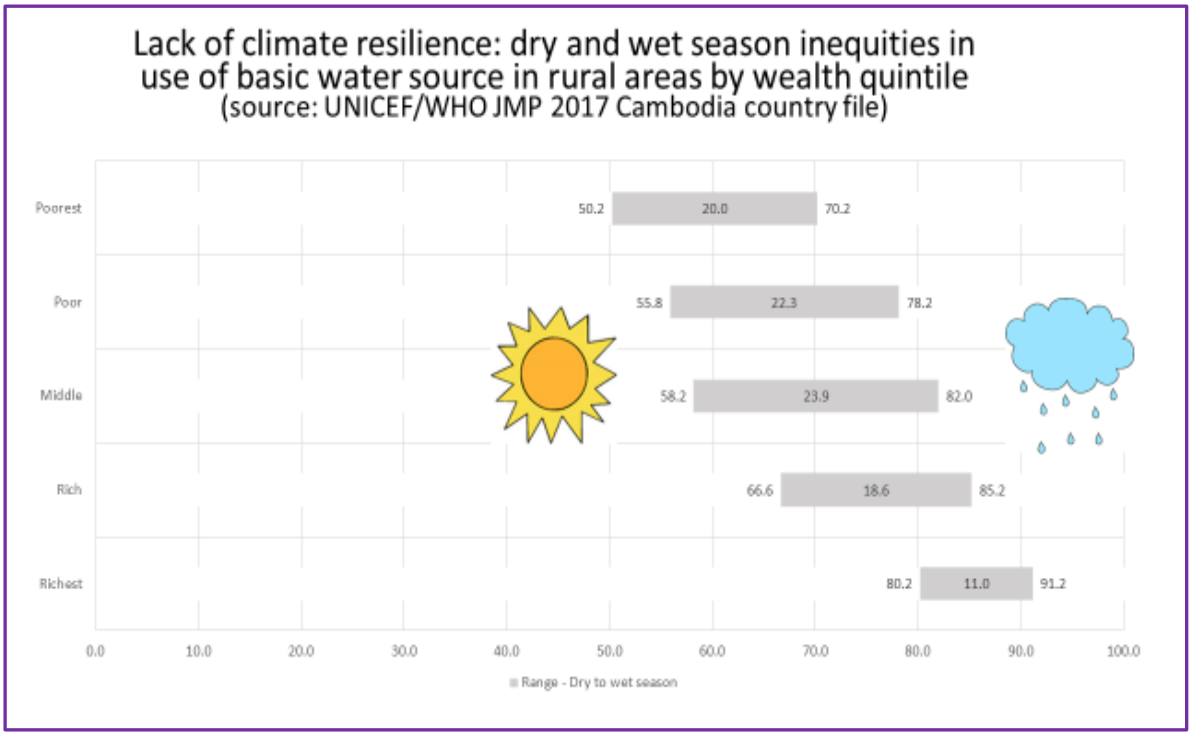
Key environmental issues in Cambodia that interact with natural hazards include: a) poor surface water management practices (further threatened by infrastructure development; i.e. the construction of hydro-power plants along major rivers, within and outside the territory of Cambodia); b) land allocation and (unsustainable) use; c) depletion of forests (including mangrove forests), primarily through logging and concessions for resource extraction, and; d) degradation of soil driven by unsuitable agricultural practices.

Cambodia's protracted civil war and armed conflict resulted in it being one of the world's most heavily mined countries. The leftover mines are an obvious hazard to people and especially children. With over two decades of humanitarian demining, the land-mine threat is now largely concentrated in 21 north-west border districts, according to humanitarian mine clearance organization, Halo Trust Cambodia.

The country receives most of its rainfall from the southwest monsoon, which lasts from mid-May through to the end of November. The dry season starts in December and ends in May. Due to climate change the mean annual temperature is expected to increase between 0.7 °C and 2.7 °C until 2050 and between 1.4 °C and 4.3 °C until 2100. Mean annual rainfall is also predicted to increase from three per cent to 35 per cent (towards the end of the century) with the most significant increase experienced during the wet season.

Cambodia is also increasingly affected by climate change. Observations of the Lower Mekong River Basin over the past 30-to-50 years show an increase in temperature and intensified flood and drought events. UNDP ranks Cambodia among the top 10 countries most vulnerable to climate change since some 80 per cent of the population lives in rural areas with limited knowledge, infrastructure and opportunities and over 70 per cent rely on rain-fed agriculture. With climate change making extreme weather events more frequent and severe, Cambodia's high risk rating for flooding is also of particular concern.

Figure 9: Dry and Wet Season Inequities in Use of Basic Water Sources in Rural Areas by Wealth Quintiles



Disasters of any nature, inspired by natural phenomenon or social triggers, are both a humanitarian and development concern. They are also events that directly impact child survival and development in Cambodia. Disasters such as flooding have historically eroded development gains and diverted scarce resources away from systems and services that can support children's health, nutrition, education, protection and empowerment. Children also usually bear the brunt of disasters due to their special needs and vulnerabilities.

The draft child-centred risk assessment conducted by UNICEF in 2016 found that the highest relative disaster risk for children using a composite of flood, drought and storm were in Kampong Cham/Tboung Khmum provinces.

The main reason was the combination of a high hazard value and an above average vulnerability value. In Phnom Penh, the relative disaster risk for children was among the lowest. For Pailin, Koh Kong, Preah Sihanouk and Kep, the relative disaster risk for children was also low. For Mondul Kiri, the relative vulnerability value was among the highest but because of the very low relative hazard value as per data available, the disaster risk for children was low[18].

Cambodia's national disaster loss database (CamDi) records eight different hazards of flood, drought, fire, storm, lightening, pest outbreak, epidemic, and river bank collapse. The top three events in terms of both frequency and associated impact are floods, droughts and storms.

The international emergency events database, or EM-DAT, shows a similar pattern.

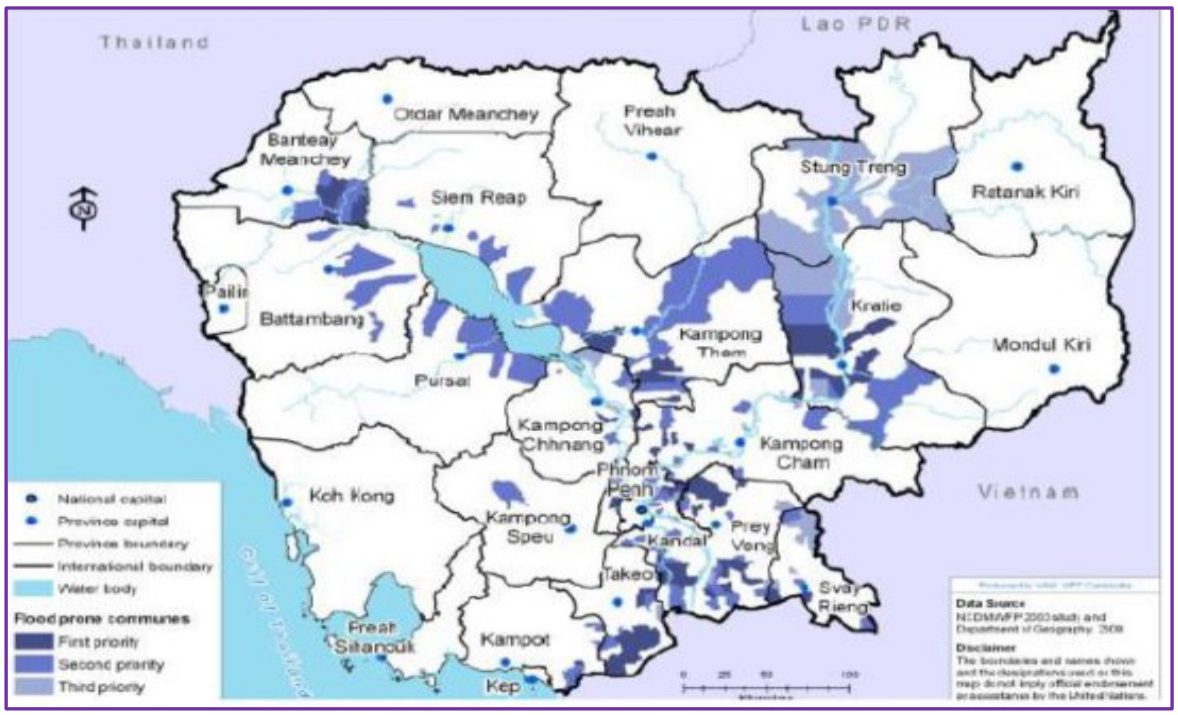
[18] UNICEF Draft Child-Centred Risk Assessment (2016).

Cambodia does not have a significant earthquake hazard. It is below V on the modified Mercalli Scale – a seismic intensity scale used for measuring the intensity of an earthquake – and there is no record of significant damages caused by earthquakes.

About 86 per cent of Cambodia's territory lies within the Mekong and Bassac river basins and the Tonle Sap Lake. Large fluctuations of water levels between dry and wet seasons contribute to the frequent occurrence of floods and droughts in these areas.

For instance, extreme flooding in the Mekong River basin occurred in 1990, 1991, 1994, 2000, 2001, 2011 and 2013[19]. Flooding in river basins is typically gradual and gives populations some lead time to take protective measures, though the overtopping, or failure of dykes can cause more rapid emergencies.

Figure 10: Flood Hazard Map, Cambodia (ADRC, 2014)



Droughts in Cambodia are usually associated with prolonged periods of reduced water availability due to a combination of meteorological (e.g. lower levels of rainfall) and hydrological (e.g., reduced water flow in rivers and streams) conditions.

Shorter periods of dry conditions are not a problem but extended periods are, in particular during the wet season. For instance, a shorter wet season or unusually dry conditions during the wet season exacerbate the lack of rainfall during the dry season and can lead to a fully developed drought. Extreme drought events in Cambodia occurred in 1994, 1997-78, 2001, 2002, 2004, 2005, 2009, 2011, 2012, 2014 and 2015[20].

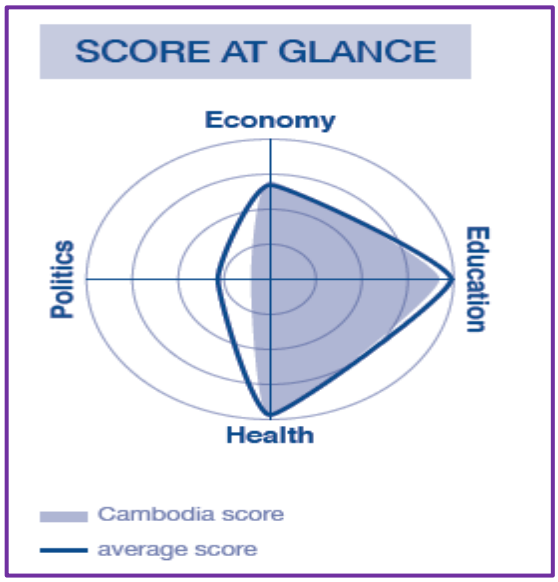
Typhoons strike Cambodia every two-to-five years and normally occur at the end of the rainy season (September/October). Typhoons and tropical depressions typically make landfall in

[19] Asian Development Bank 2016.
[20] Ibid.

other countries in Indochina (e.g., Vietnam). Sometimes they do not weaken over land and produce torrential rainfall and extensive flooding, especially if they coincide with the rainy season. Recent events include *Typhoon Pabuk* in 2009 and *Typhhon Ketsana* in 2011 that triggered significant urban flooding.[21]

Gender equality – According to the 2017 *Global Gender Gap report*, Cambodia is ranked 99 out of 144 world-wide countries with a score of 0.676. Regionally, Cambodia is ranked 11 out of 18 countries, with Timor-Leste (128) coming last in progress towards reducing gender gaps in economic participation and opportunity, education attainment, health and survival and political empowerment[22].

Figure 11: Cambodia Gender Score in 2017 by Dimension



In rural and indigenous communities where there is less access to secondary education, child marriage and adolescent pregnancy are significant concerns[23]. Polygamy supports inequitable power relationships between husbands and wives and while not common still affects three per cent of women in a union. Female-headed households are considerably more common, having increased during the time of the Khmer Rouge when there was significant family separation and male deaths. In 2012, 22 per cent of all Cambodian households were headed by women with a greater proportion of these households being assessed as poor (22.5 per cent), compared to those headed by men (20.1 per cent)[24]. On average, households headed by women were reported to have smaller land holdings than those led by men[25]. In a male-headed household, a woman's lack of decision-making power may limit her ability to challenge decisions, control her own life and manage time and resources.

While maternal mortality declined significantly over the last decade from 472-to-167 deaths per 100,000 live births (2005-2014) it remains significantly in excess of the SDG target of 70 deaths per 100,000 live births[26].

This is despite a majority of mothers (89 per cent) having a skilled attendant at birth and attending a minimum of four antennal visits (76 per cent)[27].
Disability – The concept of disability is not well understood and leads to serious under-reporting. Estimates of the number of Cambodians with a disability vary. According to the 2008 National Census, there were close to 193,000 people with disabilities in Cambodia,

[21] Asian Disaster Reduction Centre 2014.
[22] World Economic Forum: The Global Gender Gap Report 2017 (pages 108 and 109 for Cambodia).
[23] OECD Social Protection System Review of Cambodia – Draft 2017.
[24] Ibid.
[25] Cambodian Demographic and Health Survey (2014).
[26] Ibid.
[27] Ibid.

accounting for 1.4 per cent of the total population.

The 2014 Cambodia Socio-Economic Survey (CSES) identified four per cent of the total population with disabilities, or around 524,000 people. The 2013 Cambodia Inter-Censal Population Survey noted 301,629 persons with disabilities, or 2.1 per cent of the total population – 86 per cent of whom lived in rural areas. The National Population census in 2019 is expected to collect more statistics on disability.

The 2014 CDHS[28] reported a disability prevalence rate of 9.5 per cent (10.4 for women and 8.4 per cent for men) for any level of functioning difficulty and 2.1 per cent for severe functioning difficulty. The prevalence of disability was marginally higher (9.6 per cent) among rural compared with the urban population (8.6 per cent).

The level of functional difficulties among those aged five and older was found to vary substantially across provinces, from two per cent in Mondul Kiri/Ratanak Kiri; to 20 per cent in Battambang/Pailin. These statistics should be interpreted cautiously due to potential underestimates due to the nature of disability questions in CDHS which are not recommended for use with children as they were developed to assess disability in the adult population[29].

Disability prevalence in Cambodia varies highly with age. For any level of functioning difficulty, the prevalence rate ranges from 1.8 per cent for persons aged five to 14 years, to 44.2 per cent for persons aged 60 years-plus. Disability increases dramatically in middle age from 3.5 per cent for persons aged 15-34 years, to 13.2 per cent for those aged 35-59 years.

Persons with disabilities, on average, are approximately double the age of persons without disabilities (54 years compared to 28 years). They are more likely to be female than male (57 compared to 43 per cent) and at a proportion higher than persons without disabilities (51 compared to 49 per cent). Educational achievements are significantly lower for the disabled population. On average, persons with disabilities completed 1.6 years, or one-third less education than persons without disabilities. Persons with disabilities experience a rate of poverty approximately four-to-six per cent higher than persons without disabilities.

The proportion of persons with disabilities that reported being ill or injured in the last thirty days was approximately 2.5 times higher than persons without disabilities (26 compared to 11 per cent). On average, persons with disabilities spent over three times more on health care treatment and associated travel in the past month (US$10.30 compared to US$3.09). A recent study[30]on disability among children between two-to-nine years of age in Cambodia has estimated the prevalence of impairment at 15.6 per cent; disability at 10.1 per cent; and moderate/severe/profound disability at 3.2 per cent. Cognition (5.48 per cent); speech (motor) (2.05 per cent); speech (language) (1.8 per cent); and hearing (2.51 per cent) were the most common disabilities. Children with intellectual disabilities and their families face

[28] Health care utilization of persons with disabilities in Cambodia: An analysis of the Cambodia Demographic Health Survey 2014: Factsheet.
[29] UNICEF, A statistical profile of child protection in Cambodia', 2017 (draft).
[30] Peter Evans, Shaheen Shah, Adam Huebner, Selvaraj Sivasubramaniam, Chhoeurn Vuthy, Kao Sambath, Lucy Haurisa, Yim Borun, 'A Population-based Study on the Prevalence of Impairment and Disability Among Young Cambodian Children', Vol. 25, No. 2, 2014; doi 10.5463/DCID.v25i2.188; www.dcidj.org

significant discrimination, ranging from childish to extremely violent reactions[31].

Women and children living with disability are even more likely to experience exclusion than their non-disabled peers. Consequently, their opportunities and security are further limited. This is the double jeopardy. The most vulnerable of groups consist of those individuals living in poverty. A poor woman or child living with disability may face further exclusion and highly limited opportunities and security. This is the triple jeopardy.

2 Every child has an equitable chance in life

Goal Area 5 within UNICEF's new Strategic Plan 2018-2021 underpins other goal areas by addressing some of the key dimensions of inequity that prevent children from realizing their rights. It supports the achievement of several SDGs, in particular Goals 1, 5 and 10; and supports numerous articles such as 2, 23, 26 and 30 of the CRC.

Much of the deprivation experienced by the most disadvantaged children is a result of living in poverty; their status of being girls or young women; children with disabilities; or children belonging to minorities. Poverty has lifelong consequences for children. Children are two times more likely than adults to be living in poverty and a child living in poverty is also more likely to grow into an adult living in poverty. Gender inequality perpetuates poverty.

2.1 Social policy context

As stated, RGC's vision and aim is to increase the status of Cambodia to become an upper-middle income country by 2030 and a high-income country by 2050[32]. http://www.managementinsider.asia/cambodia-asias-new-tiger/In this context, RGC acknowledges that the social protection system is a major contributor to 'economic growth with equity and inclusiveness'. Being responsible for stable living conditions for its citizens, RGC has defined its long-term vision for the development of the social protection system as such: "The construction of a social protection system based on inclusiveness, effectiveness and financial sustainability as a tool to reduce and prevent poverty, vulnerability and inequality and which will contribute to the development and protection of human resources and stimulate economic growth"[33].

In line with this vision and on the basis of political, macro-economic stability and an improved socio-economic development, RGC is developing a broad national Social Protection Policy Framework 2016-2025 (SPPF) focused on two main pillars of social assistance and social security. The goal of this policy framework is to develop a strategic plan for RGC to ensure income security and reduce the economic and financial vulnerability of its citizens. It will increase people's well-being and solidarity in society and aims at reducing poverty to a maximum extent.
The policy framework aligns, concentrates and improves the existing social protection programmes and schemes and enhances the efficiency, equity, transparency and consistency of the social protection system as a whole.

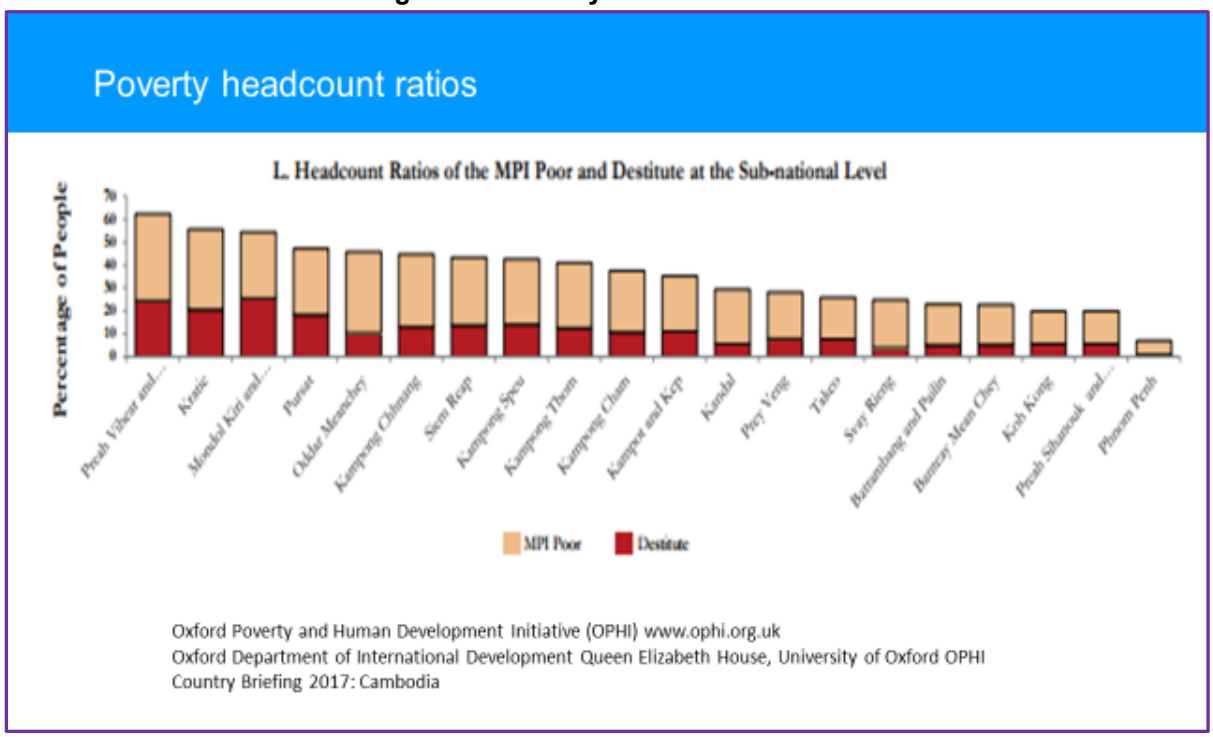
[31] Jennifer Carter, 'Preparing for the Journey: A Cooperative Approach to Service Provision for Children with Intellectual Disabilities in Cambodia'.
[32] World Economic Forum on ASEAN 2017: Cambodia – Asia's New Tiger, Management Insider.
[33] The Royal Government of Cambodia: National Social Protection Policy Framework (2016-2025) .

Depending on the country's level of economic growth, the current coverage, which is still considerably low, is expanded in order to respond to the needs of citizens in all segments. A framework on governance and cross-cutting issues will also be developed to ensure the efficiency of the system and its budgetary implications.

Monetary child poverty – Using 2014 CSES data and looking at children age 0-17 years, 16 per cent of children in Cambodia live below the nationally-defined poverty line. The povery headcount ratio is significantly higher for children compared to the total population or adult population. The mean proportionate poverty gap in the child population indicates poverty intensity. It suggests that, on average, individual poor children fall below the monetary poverty line at a proportion of 0.03 of the poverty line[34].

Additionally, the Palmer study notes the reduction in household living standards is greater for households with a disabled member aged less than 20, compared to households with disabled members aged 20 or older[35].

Figure 12: Poverty Headcount Ratios



A larger share of rural children make up the total poor – 79.1 per cent of poor children in Cambodia live in rural areas, compared to only 20.9 per cent who live in urban areas.
At the zone level, 18.7 per cent of children living in Plateau and Mountainous zones live below the poverty line.
This is only slightly higher than the, on average, 15.6 per cent of children living in the other Plain, Tonle Sap Lake, and Coastal zones who live below the poverty line. Children living in Plain zones make up the largest share of the poor – 42.8 per cent of poor children live in

[34] MODA 2017.
[35] Palmer, M., Williams, J., McPake, B. 2016. The Cost of Disability in a Low-Income Country. The University of Melbourne.

Plain zones; followed by 34.4 per cent of poor children who live in the Tonle Sap Lake area; 15.7 per cent in the Plateau and Mountainous zones; and 7.2 per cent in the Coastal zones.

Male and female children do not show strong differences between their poverty headcount, and rank equally in terms of overall poverty severity. In terms of age group corresponding to those used in the multidimensional child poverty analysis, the youngest children are the worst off in terms of overall poverty. It was determined that 17 per cent of children age 0-4 years live under the poverty line, making up 30.9 per cent of total poor children.

This is followed closely by 16.2 per cent of children age 5-14 years living in monetary poverty, making up 53.6 per cent of the total poor and 13.9 per cent of children age 15-17 years making up 15.5 per cent of the share of child poverty.

2.2 Multidimensional child poverty, vulnerability and social protection

Multidimensional poverty – Multidimensional poverty analysis using Multiple Overlapping Deprivation Analysis (MODA) of children in Cambodia provides both broad and specific insights into the situation of children in the country[36].

The study goes beyond measuring whether children have access to financial resources necessary to obtain essential goods and services. As the monetary poverty analysis[37] revealed, 16.0 per cent of children do not have access to financial resources.

The multidimensional poverty study measures whether children have actual access to essential goods and services, irrespective of their financial resources and whether all their needs are met and their rights are fulfilled simultaneously. MODA used key children indicators mostly available in CDHS 2014 data by different age groups. These indicators were grouped into dimensions of: nutrition, health, early childhood development, education, water, sanitation, housing and information.

The study reveals not only which dimensions of children's well-being is being deprived, but also how this deprivation might be interrelated (overlap) and how to identify the deprived children. The analysis focuses on results by age group of children: ages 0-4 years (0-48 months); ages five-14 years; and 15-17 years in order to be sensitive to the heterogeneous needs of children over their the course of their life.

For all children age 0-17 years-old, the figures show that children living in rural areas have significantly higher deprivation headcount rates across all dimensions compared to those resident in urban areas. The most observant discrepancies can be found in the dimensions for water and sanitation.

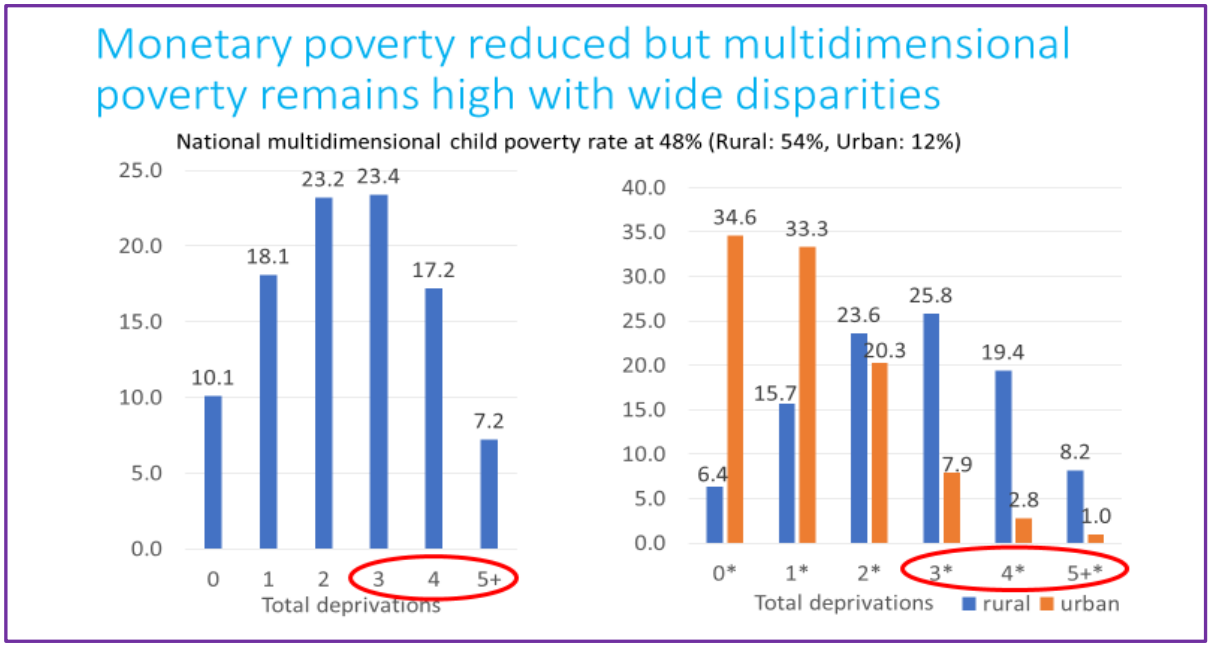
The multiple deprivation analysis showed that the majority of children suffer from more than one deprivation/dimension at a time. Children age 0-to-14 years are most likely to suffer from three deprivations simultaneously (22.4 per cent of children age 0-4 years and 23 per cent of

[36] Note that disability was not included in this study due to a lack of numbers in CDHS 2014.
[37] Monetary poverty is measured using data from the Cambodia Socio-Economic Survey 2014. While this report is being finalized, national poverty working group led by the Ministry of Planning is revising the poverty line which may affect the result of the monetary poverty rate.

children age 5-14 years, respectively). The distribution for children age 15-17 years peaks at 31.7 per cent of children deprived in three dimensions at a time, out of the five studied dimensions.

The north-east region of Cambodia experiences significantly higher deprivation rates than children living in southern or westen regions. Children living in rural areas are, furthermore, far more likely than urban children, to have multiple deprivations. The peak of the multiple deprivations distribution for rural children is at three simultaneously experienced deprivations, while the majority of children resident in urban areas were not deprived in any dimension studied.

Figure 13: Multidimensional Poverty by Location



Additionally, the mother's level of education influences the deprivation distribution of children of all age groups. Children with a mother who attended secondary or higher education levels are less likely to have multiple deprivations than children whose mother has a lower education level. However, MODA was unable to use data to look at whether a child with disabilities may face more deprivations. This gap in information is challenging.

MODA findings show that a child can be deprived in more than one dimension concurrently. For example, a child deprived in nutrition can also be deprived in education, water and sanitation at the same time.

To reduce incidence of multi-dimensional child poverty, multiple and simultaneous interventions are required, complemented by systematic monitoring and evaluation. This means that budget allocation and execution of relevant line ministries should also be prioritized toward addressing the most deprived children in target areas.

2.3 Social protection

The National Social Protection Policy Framework (NSPPF) was developed under the leadership of MEF in 2015 and endorsed by the Council of Ministers in 2017. It brings together all social protection work under one policy document for the first time.

In order to provide for improved social protection, RGC has access to growing financial resources such as increased fiscal capacity and improved tax collection, more rapid economic growth and continued support from international donors.

However, social protection currently receives only a small proportion of current expenditure and the low coverage of social protection among poor households means that the fiscal system can leave them worse off once the burden of a regressive indirect taxation system is taken into account[38].

Cambodia's current social protection system is at an early stage of development. Scholarships and school meals comprise the bulk of social assistance spending (see Learning), which also includes disaster relief and public works programmes. However, there are major gaps in these programmes, none of which operate nationally as they are concentrated in rural areas.

The level of benefits is typically very small and they rely extensively on donor support. School scholarships are financed by MoEYS, while school meals are fully funded by donors. There is no coordination between them and little or no evidence of their effectiveness.

The largest social protection scheme in terms of coverage is the Health Equity Funds (HEF) system which operates nationally and provides access to healthcare and other benefits to at least two million poor and vulnerable individuals. HEF is co-financed by RGC and development partners.

Meanwhile, Technical Vocational Education and Training (TVET) schemes for informal-sector workers are RGC's principal labour-market programme, though coverage is very low given the extremely large informal sector.

Social insurance is also highly fragmented. Workers in the formal private sector have access to employment injury insurance and social health insurance but not to a statutory pension arrangement. Public-sector workers, on the other hand, are entitled to pensions but not to health insurance.

Compounding this challenge is the high level of informality. With over 90 per cent of the workforce operating informally, a social insurance system based on the formal economy excludes the vast majority of workers, leaving them extremely vulnerable to lifecycle shocks and economic downturns. There is also a risk to the financial viability of social protection which must be addressed urgently. Non-contributory pension arrangements for civil servants and the military already absorb a large proportion of the social protection budget and their expenditure is rising fast. Implementing contributions for public servants is an important and urgent first step towards a sustainable pension system that covers the entire workforce, as

[38]VAT is not charged/collected in small businesses/venders where the poor make purchases often. Income tax is only collected in the formal sector. The poor, who are engaged in the informal sector at the same time, therefore do not pay income tax.

envisaged by the SPPF.

3. Every child survives and thrives

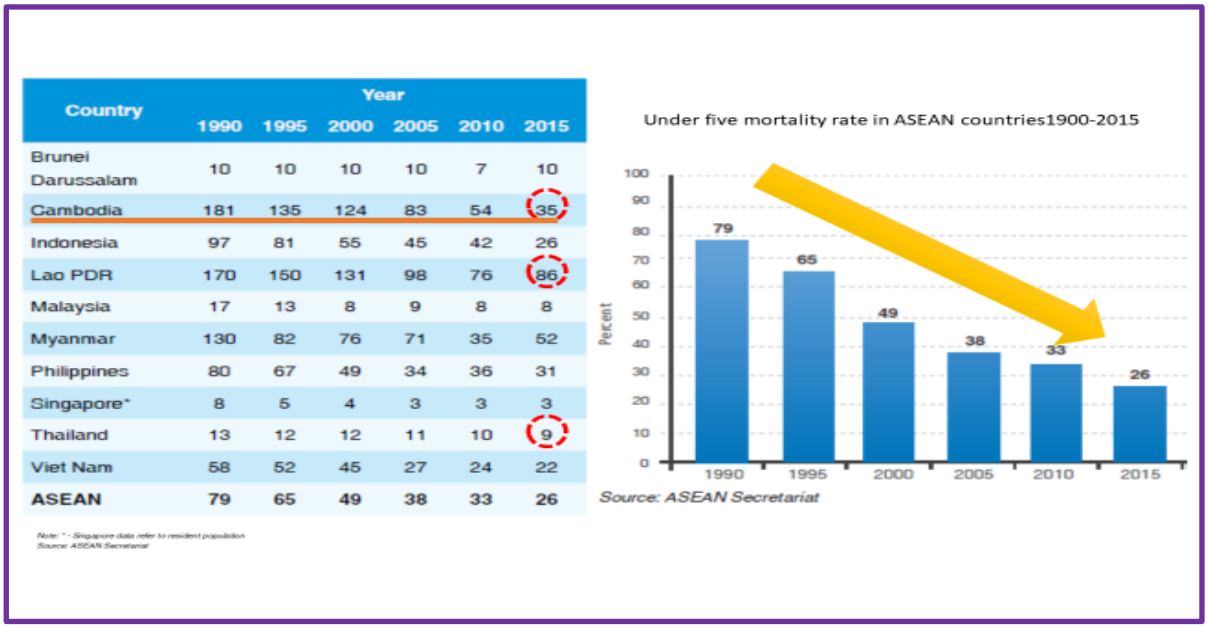
Goal Area 1 within UNICEF's new Strategic Plan 2018-2021 aims to ensure that every child survives and thrives. It supports the achievement of SDGs 2, 3 and 5 in both humanitarian and development contexts; and supports articles 6 and 24 of CRC.

Reduction of neonatal and under-five mortality rates remains a primary target in the achievement of universal health goals, as evident in renewed investments of SDGs.

Various studies attribute declines in mortality to the combined effects of improvements in health care practices and changes in socio-economic factors.

Cambodia's development efforts are reflected in some remarkable health outcomes such as a significant decline in child mortality rates and the early achievement of related MDGs.

Figure 14: Under Five Mortality Rate in ASEAN countries from 1900-2015



Country	Year					
	1990	1995	2000	2005	2010	2015
Brunei Darussalam	10	10	10	10	7	10
Cambodia	181	135	124	83	54	35
Indonesia	97	81	55	45	42	26
Lao PDR	170	150	131	98	76	86
Malaysia	17	13	8	9	8	8
Myanmar	130	82	76	71	35	52
Philippines	80	67	49	34	36	31
Singapore*	8	5	4	3	3	3
Thailand	13	12	12	11	10	9
Viet Nam	58	52	45	27	24	22
ASEAN	79	65	49	38	33	26

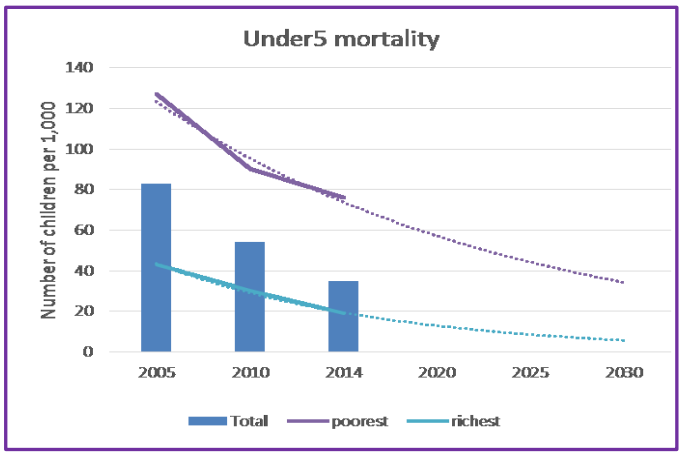
Among the significant achievements of the past 15 years is the reduction in the number of child deaths. According to the 2014 Cambodia Demographic Health Survey, the under-five mortality rate decreased from 124/1,000 live births to 35/1,000 live births; and infant mortality from 95/1,000 live births to 28/1,000 live births[39] between 2000 and 2014.

There are significant geographical differences in under-five mortality, ranging from 18/1,000 in Phnom Penh to 118/1,000 in Preah Vihear and Stung Treng provinces. Neonatal mortality was unchanged at 28/1,000 live births.

[39] Cambodian Demographic and Health Survey (2014)

Secondary analysis highlights the importance of the urban-rural and poor-wealth divides in Neonatal Mortality Rate (NMR) inequities, together with inequities in access to and utilization of quality basic health care interventions. This calls for future policy and programming efforts to be more determined in their equity approach. Two contributing factors to the improved child survival rates were increased immunization coverage, from 67 per cent in 2005, to 73 per cent in 2014.

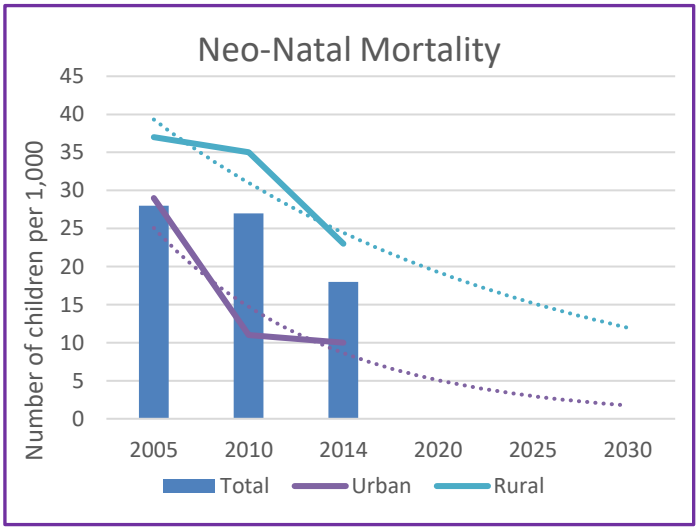
Figure 15: Under Five Mortality in Cambodia



Child mortality - Childhood mortality in Cambodia varies significantly by the socioeconomic characteristics of households and mothers. Mortality in urban areas is consistently lower than in rural areas. For example, infant mortality and under-five mortality in rural areas (42 deaths and 52 deaths per 1,000 live births, respectively) are about three times higher than in urban areas (13 deaths and 18 deaths per 1,000 live births, respectively).

Despite a continued decline in the under five mortality rate, the inequity between the richest and the poorest quintiles remains wide. As noted between 2000 and 2014, there has been a considerable decline in neonatal mortality, which echoes global trends. However, there continues to be pockets of vulnerable groups that are lagging behind. Secondary analysis highlights the importance of the urban-rural and poor-wealth divides in NMR inequities together with inequities in access to and utilization of quality basic health care interventions.

Figure 16: Neonatal Mortality in Cambodia by location

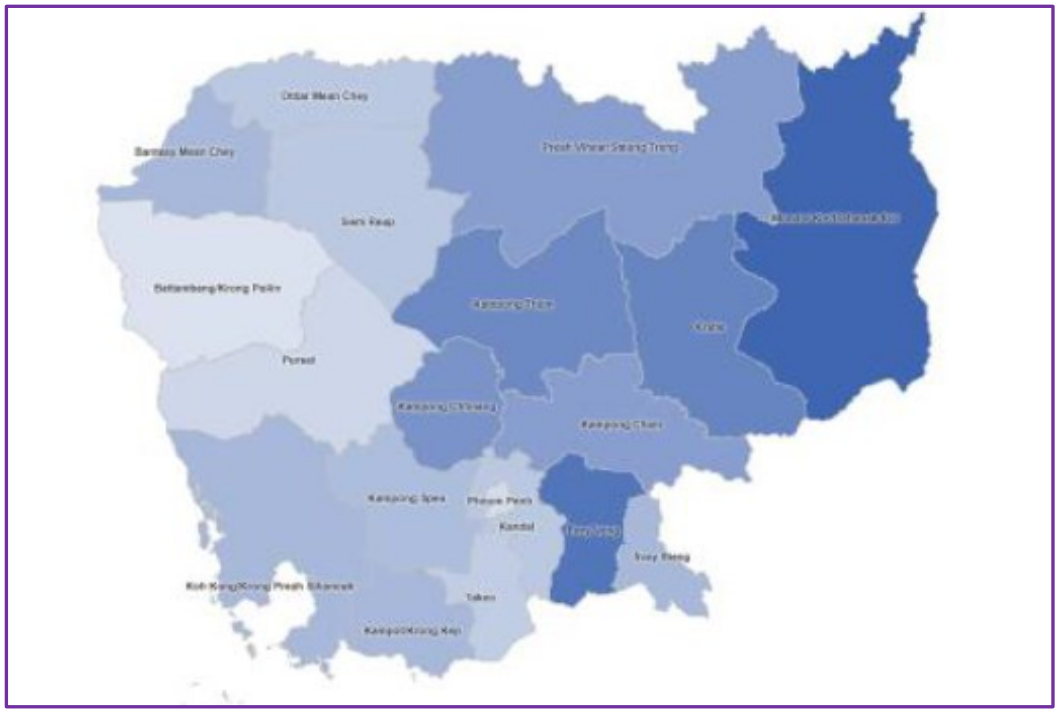


This also calls for future policy and programming efforts to be more calculated in their equity approach. Quality improvements in health services and targeted interventions for specific socio-economic groups will be required to further accelerate progress in reducing neonatal mortality and to address Cambodia's pressing unfinished agenda in health. The urban-rural gap is wider for neonatal mortality, which is five times higher in rural areas than in urban areas.

Differentials in mortality by province are also substantial. Phnom Penh has the lowest rates of both infant mortality (17 deaths per 1,000 live births) and under-five mortality (23 deaths per 1,000 live births). Preah Vihear/Stung Treng and Mondul Kiri/Ratanak Kiri provinces have the highest rates of infant mortality (70 or more deaths per 1,000 live births) and Kratie,

Preah Vihear/Stung Treng and Mondul Kiri/Ratanak Kiri provinces have the highest rates of under-five mortality (79 or more deaths per 1,000 live births)[40].

Figure 17: Cambodia Neonatal Mortality Map by province (based on 2014 DHS data)



Maternal mortality – The dramatically reduced maternal mortality ratio, from 472/100,000 live births in 2000 to 170/100,000 in 2014 is associated with the increased percentage of newborns delivered in health facilities[41].

Financial burden is a critical barrier to use of public health services, with the majority of un-vaccinated children from the poorest wealth quintile and poor pregnant women less likely to complete the full package of maternal care[42].

Additional barriers include the quality of public health services, including weaknesses in WASH in health care facilities and the frequent unavailability of some essential medicines, vaccines and supplies, which continues to depend to a significant extent on development assistance. Overcoming these barriers requires greater decentralized delegation of management, strengthened RGC-donor planning, financing and coordination, technical development of health service providers, more efficient purchasing of essential medicines, as well as sharpened equity approaches to improve access among rural, poor and vulnerable groups.
The lack of regulation of the private health services, enforcement of standards, as well as limited certification and verification procedures for health practitioners has also contributed to the poor quality of health services in the country.

[40] Cambodian Demographic and Health Survey (2014).
[41] Ibid.
[42] Ibid.

In 2016, MoH and MEF jointly issued an inter-ministerial *Prakas* (order) to decentralize and reallocate part of the provincial Department of Health (DoH) budget to provide an operational budget to health centre and referral hospitals throughout the country on a quarterly basis to strengthen quality and equitable access of health services, following programme budget implementation procedure.

In this same year, MoH issued a guideline to all health centres and referral hospitals on expenditure items and procedure to streamline their budget execution and settlement process. Key expenditure items include WASH, emergency and necessary expenses, small repair and equipment, awareness raising and other health service quality strengthening activities.

Cambodia has not achieved the 2015 Cambodia Millennium Development Goal (CMDG) targets for most of its nutrition indicators. For instance, 78.9 per cent of children do not receive a minimum acceptable diet; 23.9 per cent of Cambodian children are underweight; and one-in-every three child is too short for their age, or stunted[43].

Childhood stunting is one of the most significant obstacles to human development and a main target of the 2025 World Health Assembly (WHA) goals with many related activities to be considered, including: i) reducing wasting; ii) reducing anaemia; iii) reducing low birth weight; and iv) increasing appropriate feeding practices during pregnancy and for children under five years of age. It is important to address relevant nutrition and health related issues, as well as WASH in a more comprehensive and integrated way.

Nutrition issues have assumed new prominence in the post-2015 era, with SDG2 focused on ending hunger, achieving food security, improving nutrition and promoting sustainable agriculture. Several other SDGs also refer to nutrition-sensitive interventions, indicating the critical importance of nutrition to the international development framework.

Global evidence shows that adequate nutrition in the first 1,000 days between a woman's pregnancy and a child's second birthday has enormous benefits throughout the life cycle and across generations. Most of the cognitive and physical damage or underdevelopment that happens due to poor nutrition during this sensitive 1,000-day window of opportunity is irreversible[44]. At the same time, obesity levels are rising and this factor will contribute to more widespread diseases such as cancer, heart disease, strokes and diabetes.

SDG 3 focuses on ensuring healthy lives and promoting well-being for all people of all ages – with target 3.8 on Universal Health Care (UHC) an overarching goal for the health sector.

While all SDGs are interlinked and should have a synergistic effect on each other, the goals related to poverty, hunger/food security/nutrition, gender inequality (SDG 5), water, sanitation and climate change (SDG 6) are of particular relevance to the health and nutrition sector. In this regard, working across sectors, as well as in collaboration with various stakeholders including non-state actors, communities and other partners, is crucial for

[43] Economic burden of malnutrition – 2014 Cambodian Demographic Health Survey, Dr Moench Pfanner et al. (2015-UNICEF/CARD/IRD secondary analysis) National Nutrition Report 2016.
[44] Walker SP, Wachs TD, Gardner JM, Lozoff B, Wasserman GA, Pollitt E, Carter JA; International Child Development Steering Group. Child development: risk factors for adverse outcomes in developing countries. *Lancet*. 2007.

attainment of the SDGs.

3.1 Health and nutrition policy context

Reduction of neonatal and under-five mortality rates remains a primary target in the achievement of universal health goals, as evident in renewed investments of SDGs. Various studies attribute declines in mortality to the combined effects of improvements in health care practices and changes in socio-economic factors.

Since the early nineties, Cambodia has managed to evolve from a country devastated by war to becoming part of the group of lower middle-income countries.[45] Cambodia's development efforts are reflected in some remarkable health outcomes such as a significant decline in child mortality rates and the early achievement of related MDGs. This success is acknowledged through inclusion of Cambodia on the list of the 'ten fast-track' countries in the Partnership for Maternal, Newborn and Child Health.

Policy – The MoH's Third Health Strategic Plan 2016–2020 (HSP3), launched at the National Health Congress in March 2016 is a manifestation of RGC 's commitment for incremental progress towards the goal of UHC. HSP3 has been informed by the National Strategic Development Plan 2014–2018 which provided the foundation for investing in health as a means to develop human capital and build a more productive workforce for the social and economic development of the country.

HSP3 also reflects the vision, goals and targets of the SDGs. The overarching policy goal of HSP3 is 'improved health outcomes of the population, with increased financial risk protection in access to quality health care services'. The key areas of focus of HSP3 are to improve equity in access and financing, as well as quality of care.

The unfinished business from the MDGs are mainly addressed under Health Development Goals 1 and 2 – Reproductive, Maternal, Newborn And Child Health (RMNCH), nutrition, as well as communicable diseases including HIV/AIDS, TB, malaria and other neglected tropical diseases, while Health Development Goals 3 and 4 aim to address the new areas under the SDGs including NCDs, emerging and re-emerging diseases, environment and health and UHC. The monitoring and evaluation framework of HSP3 involves monitoring of 75 defined core indicators.[46]

To build on strong progress for children in key social sectors, RGC is prioritizing an integrated approach to ensuring infant and child survival, growth, care, development and learning through its multi-sectoral Early Childhood Care and Development National Policy and National Action Plan. Implementation is overseen by the National Committee for Early Childhood Care and Development and this involves 13 line ministries.

Within the past four-to-five years, RGC has taken action to address the nutritional status of children under-five through the instalment of a nutrition coordination body and development

[45] The Economic Burden of Malnutrition in Pregnant Women and Children under Five Years of Age in Cambodia: http://www.mdpi.com/2072-6643/8/5/292/htm
[46] The Third Health Strategic Plan (HSP3) 2016–2020. Phnom Penh: Ministry of Health; 2016.

of the National Strategy for Food Security and Nutrition 2014-2018 and the Fast Track Road Map for Improving Nutrition 2014-2020. In 2015, Cambodia joined the Scaling Up Nutrition (SUN) movement, thererby strengthening this commitment.

Within this collective drive to improve nutrition nationwide, the Council for Agricultural and Rural Development (CARD) reports directly to the prime minister and is a key RGC stakeholder in the coordination and implementation of nutrition-specific and nutrition-sensitive interventions. Additionally, the National Strategy For Food Security And Nutrition (NSFSN) is making a contribution through a multi-dimensional and integrated approach over a wide range of development themes.

To improve food security and nutrition, strategies, policies and investments in the fields of agriculture, forestry and fisheries, water resources management, health, water and sanitation – education and social protection are all decisive to the collective nutrition goal. NSFSN was developed to complement the existing sector strategies and plans; to fill existing gaps; and to serve as a platform for joint inter-sectorial action to enhance food security and nutrition[47].

It is recognized that for Cambodia to achieve the new SDGs in the area of nutrition and WASH by 2030, fast-tracked new and expanded efforts are vital. With this in mind, the Cambodian 2014-2018 National Strategy for Food Security and Nutrition sets ambitious targets to curtail malnutrition and it promotes a joint approach to tackling related development challenges so they can be undertaken more effectively.

To make a real difference in improving children's nutritional status, as well as their overall health, it is recognized that interventions in the areas of WASH and nutrition are inextricably linked and they must be approached jointly in order to achieve substantial success in improving the health status of children in Cambodia.

This nutrition-focused programme will also consider strengthening other bottlenecks towards health and WASH to reduce the prevalence of malnutrition and related morbidity. RGC has enacted the rights of persons with disabilities. In July of 2009 it introduced an inaugural national disability law; the Law on the Protection and the Promotion of the Rights of Persons with Disabilities (Kingdom of Cambodia, 2009).

This legislation aims, among other things, to develop programmes for physical and mental rehabilitation to enable persons with disabilities to fulfil their potential and fully exercise their capacities and talents in society.

As part of this drive, RGC has also demonstrated its commitment to the Disability Rights Initiative Cambodia (DRIC) 2014-2018[48]. The ratification of the Convention on the Rights of Persons with Disabilities (CRPD) and adoption of the National Disability Strategic Plan 2014-2018 (NDSP) are indications of RGC's future dedication to supporting people with disabilities.

[47] Cambodia–WHO, Country Cooperation Strategy 2016–2020 (2016).
[48] https://www.unicef.org/cambodia/1-DRIC_ProDoc_Final_Eng.pdf

Furthermore, one key objective of the 2014-2018 NDSP is to provide those with disabilities equal access to quality health services as well as physical and mental rehabilitation. Persons with severe disabilities that are poor are identified as entitled to preferential policies on health care services, treatment, physical rehabilitation and monetary support to assist with their disability-related expenses.

Health and Nutrition sector financing[49] – In January 2016, MOH developed the national budget for its Third Strategic Health Sector Plan (HSP3, 2016–2020). Following WHO and UNICEF's advocacy and support, for the first time, nutrition was included in the budget. Over the next five years, approximately US$24.6 million will be needed to implement MOH strategy, of which 54.5 per cent is supply; US$6 million for the treatment of Severe Acute Malnutrition (SAM) over five years; US$3.7 million for daily iron-folic acid; US$0.5 million for vitamin A supplements; and US$3 million for micronutrient powder supplementation.

Nevertheless, there is still a need for increased funding to address the constant burden of malnutrition as MoH's expenditure for nutrition remains limited. A recent MoH publication led by WHO and the Clinton Health Access Initiative showed that health expenditure in Cambodia decreased from 0.4 per cent (US$3.9 million) – 17 to 0.1 per cent of MoH's budget from 2012-to-2014. In 2014, most of the US$0.75 million was used to purchase iron-folic and vitamin A supplements.

According to the need (costing HSP3) and the budget allocated in 2014, US$3.5 million should be additionally invested from public funding and other development partners' budget. MoH's 2015 National Nutrition Report supports this exercise, as for the first time it is possible to track funding from development partners and analyse effectiveness and efficiency.

In addition, UNICEF continues to closely collaborate with MEF and line ministries to ensure the additional budget is being dedicated to nutrition. The table below shows the percentage distribution of MoH's budget allocations by programme.

Table 3: Health and Nutrition National Budget Allocation by Programme (2015-2017)

	2015	***2016***	***2017***
MoH Total Budget (in Million Riels)	**1,023,141.0**	**1,110,791.3**	**1,201,854.6**
Programme Budget as % of total	100.0%	100.0%	100.0%
Programme 1: Reproductive health, youth, maternal, infant and child health and nutrition	**6.01%**	**6.69%**	**6.08%**
1.1 Sub-programme 1: Nutrition	0.01%	0.06%	0.07%
1.2 Sub-programme 2: Reproductive health	0.08%	0.83%	0.77%
1.3 Sub-programme 3: Maternal and infant health	0.43%	1.57%	1.30%
1.4 Sub-programme 4: Child health	3.60%	4.22%	3.94%
Programme 2: Combating communicable diseases	**1.53%**	**1.63%**	**1.52%**
Programme 3: Combating non-communicable diseases and other public health issues	**0.44%**	**0.30%**	**0.25%**
Programme 4: Strengthen health system	**92.02%**	**91.37%**	**92.15%**
4.1 Sub-programme 1: health service provision	54.13%	59.67%	56.45%

[49] National Nutrition Report 2016-Pg 39.

4.3 Sub-programme 3: Human resource development	10.25%	26.08%	33.83%

Source: MEF Programme Budget Book 2015-2017

By looking at the share of programme budget allocation, it would appear as if programme one received the biggest budget allocation for interventions. Nonetheless, more than half of this programme budget, or more than two thirds of budget allocation under sub-programme four on child health, is a government grant to Kuntha Bopha children hospitals[50] and budget allocation under sub-programme three on maternal and infant health is mostly office supplies allocated for the whole ministry.

Based on realistic costing of the fast track roadmap for improving nutrition, nutrition together with maternal and infant, and child health sub-programmes and other sub-programmes are still significantly under funded.

Based on the programme budget data of MoH 2015-2017, the cost of drug supplies and personnel costs are grouped under sub-programme one and sub-programme three of programme four, respectively. It is difficult to see a complete picture of total budget allocation toward each programme and sub-programmes because most ministries have allocated personnel costs under one separate sub-programme of supporting programme.

Sub-programme one on nutrition in 2017 does not capture the complete picture of budget allocation for nutrition because, for example, budget allocation for purchase of Ready-to-Use Therapeutic Food (RUTF)/BP-100 is allocated under sub-programme one of programme four, which is managed by MoH's Finance Department.

The share of personnel costs and drug supply represented around 57 per cent of MoH's total expenditure. The increasing share of personnel costs in the last three years is due to salary reform (increase) of the whole government which aimed to reach a minimum monthly salary of above one million riels, or US$250, for all civil servants and armed forces personnel. This has resulted in budget decreases for sanitation and hygiene supplies, gasoline, oil and office supplies – despite an overall budget increase. Part of the increasing share of RGC's contribution to the health equity fund, health insurance coverage for the poor, including deliveries at public health facilities, covers the operation costs of health centres and hospitals which includes drug supplies procured at those levels.

Public health system – Cambodia has an established public health system network, including those at the central, provincial and community levels, as well as those in operational districts. Service availability and the utilization of certain services have improved; the percentage of health centres with at least one secondary midwife increased to 80 per cent in 2014 and the percentage of deliveries at health facilities increased to 83 per cent in 2014[51]. These figures mask the quality of the health services, particularly in rural and remote areas[52]. Additionally, utilization of public providers still remains relatively low for outpatient

[50] Kuntha Bopha Children Hospitals (five branches in total) have been mostly funded by Swedish Development Agency (SIDA) and through other fund-raising activities by the hospital. Due to SIDA's decreasing fund support to the hospital, RGC will increasingly subsidize and fully fund the five hospitals to keep them functioning, saving Cambodian children's lives by giving free health care services to all children.

[51] CDHS (2014).

[52] A nationwide assessment of the quality of care at health facilities was completed in 2015.

services. Sixteen per cent of ill, or injured patients currently seek care first in the public sector, while 43 per cent sought care for their last health care at private providers[53].

Families visit private practitioners and clinics more for curative care, whereas preventive activities such as immunization, tuberculosis (TB) testing and HIV/AIDS prevention and control are the domain of the public sector. Wealthier families tend to use private providers, while the poor depend on providers from the informal sector. The private sector and informal providers account for 61per cent and 26 per cent, respectively, of all service provision[54].

RGC has started strengthening reinforcement of the compliance for facility-based licensure, while enacting a new law on regulation of health practitioners. Stewardship for the entire health sector, including private health services and those meeting the needs of the poor, is central to health strategy and planning in the coming years.

In addition to the need for stronger oversight and regulation, the remaining challenges include the need to improve the safety and quality of health services in the public and private sectors, as well as overcoming remaining health inequities – both geographically and among various economic and social groups.

A nationwide assessment of the quality of care at health facilities was completed in 2015. This is helping to inform policy discussions and focusing attention on the increased importance of safety and quality in health care, with a concentration on various entry points, especially through a longer-term investment in human resources to improve the competency of health personnel.

Supply-side measures, such as mass screening to identify acutely malnourished children, including the management of SAM and performance-based financing mechanisms, such as a Special Operating Agency, offer an opportunity to further strengthen service delivery.

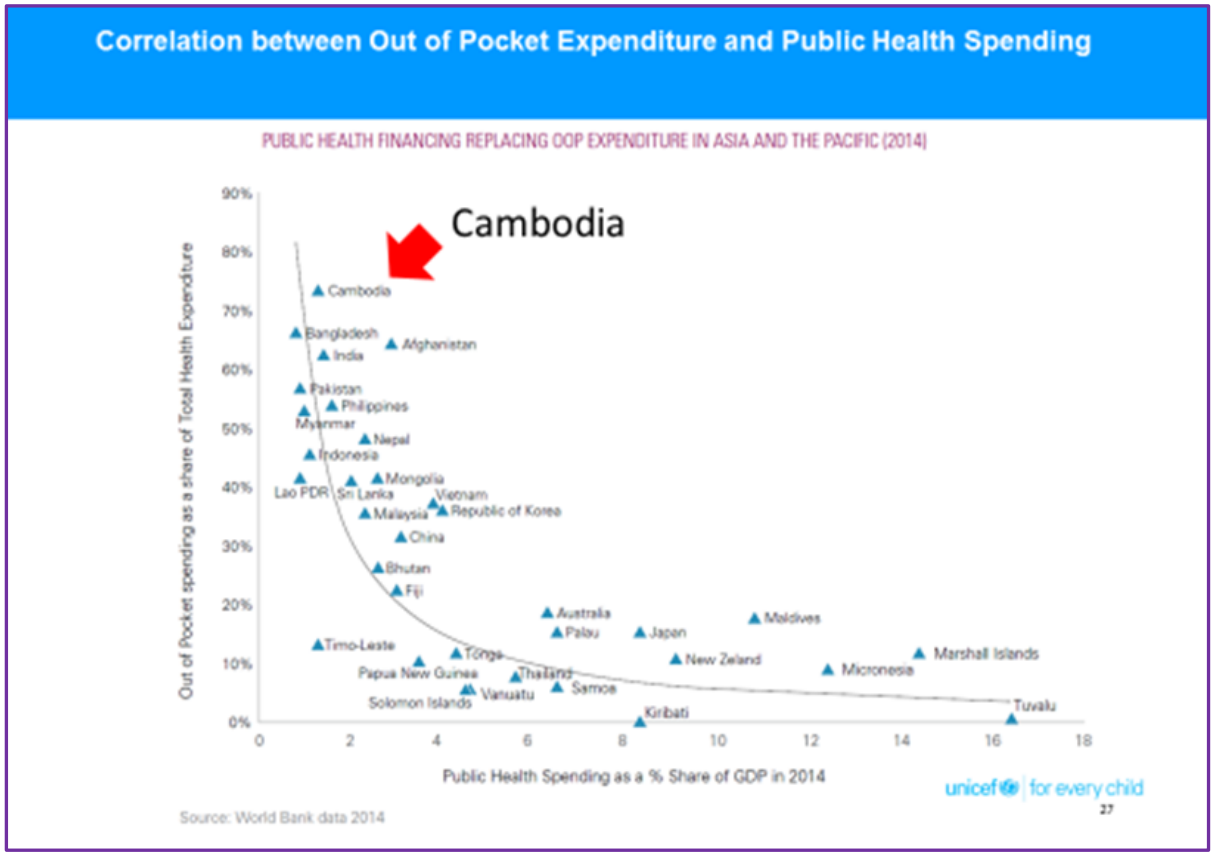
There have been gains in providing financial risk protection to the poor. However, despite this achievement other vulnerable populations, mobile and migrant populations, people with disabilities, ethnic minorities, elderly and the near-poor are bearing financial hardship when assessing health care. There has been an increase in the proportion of unhealthy individuals seeking care from health providers, with a greater increase among the lowest two income quintiles. In particular, the use of reproductive, maternal and child health services has increased.
It is worthwhile to note that utilization of public health services by HEF beneficiaries is much higher than that by the general population level.

However, there is a gap in distribution of health services and health outcomes across the population, including the urban-rural and rich-poor.

In addition, the social health protection coverage of other vulnerable populations is a major concern .

[53] Cambodia Socio-Economic Survey 2014. Phnom Penh: National Institute of Statistics, Ministry of Planning; 2015.
[54] Ibid.

Figure 18: Correlation between Out-of-Pocket Expenditure and Public Health Spending in Asia

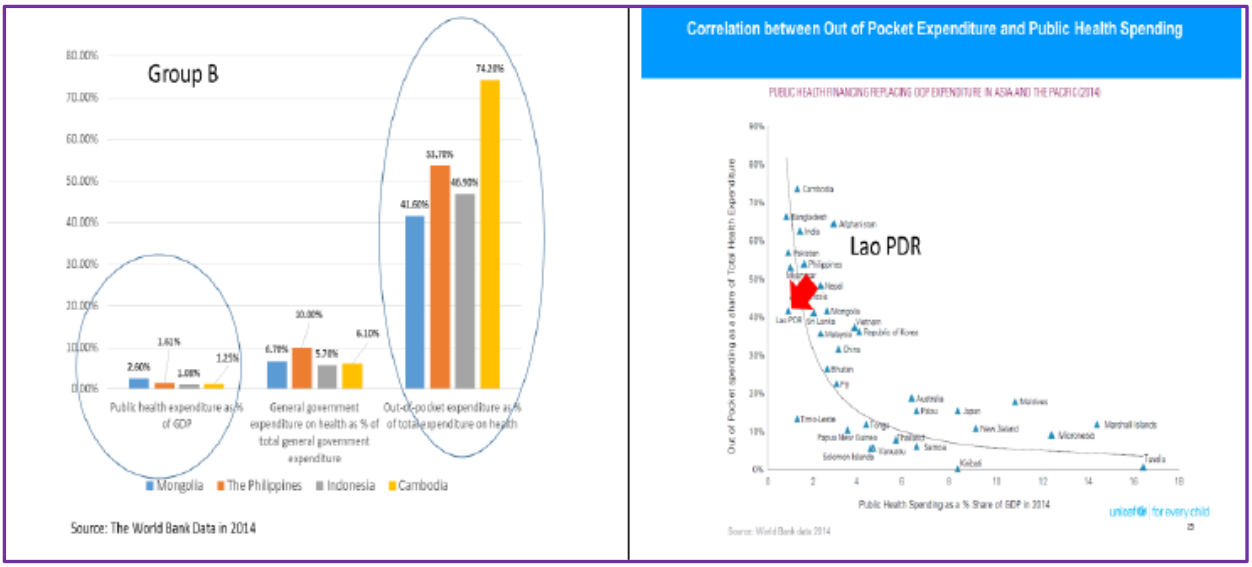


The high burden of out-of-pocket costs in health spending on individual households requires greater attention to investing in a sustainable social health protection system for all.

According to the National Health Accounts Report (2015), the total health expenditure was distributed as follows: out-of-pocket expenditure US$622 million (60.3%); donors US$209 million (20.2%); government v US$199 million (19.3%); and health insurance US$2 million (0.2%)[55]. These shares have remained relatively consistent over time. RGC expenditure on health as a share of total government expenditure was 6.5%.

Figure 19: Correlation between Out-of-Pocket Expenditure and Public Health Spending in Asia

[55] USAID: Health Financing Profile, Cambodia 2016.

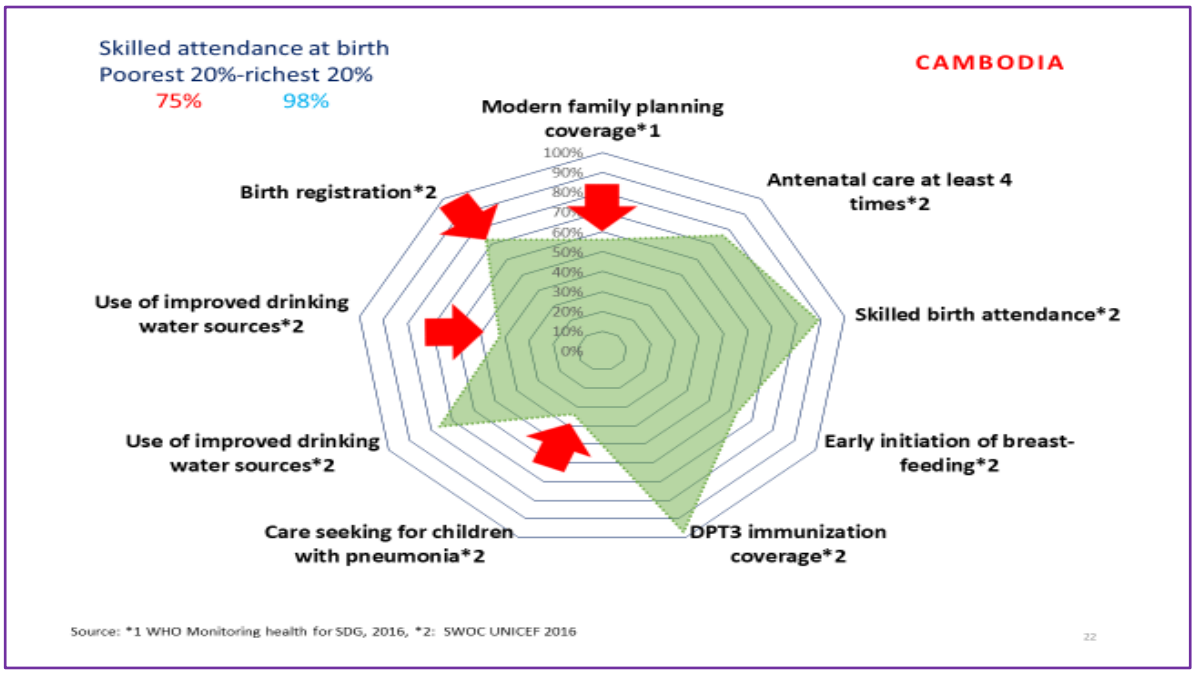


3.2 Maternal and newborn care

Poor maternal health and newborn care continue to undermine the well-being and rights of women and adolescent girls, while also weakening children's chances of surviving and thriving. Between 2000 and 2014, there has been a considerable decline in neonatal mortality, which echoes global trends.

Cambodia, selected as one of the five fast-track countries in the Partnership for Maternal, Newborn and Child Health, has benefitted from substantial development support to extend and expand the quality of maternal and child health interventions. It can be assumed that this support is positively reflected in the decrease of neonatal mortality and the early achievement of relevant MDGs.

Figure 20: Key Maternal and Child Health Indicators in Cambodia



Analysis reveals that despite these advances in health sector development, an additional series of socio-economic and demographic characteristics considerably influence NMR and its inequities. Seemingly, there continue to be pockets of vulnerable groups that are lagging behind. This analysis highlights the importance of the urban-rural and poor-wealth divides in NMR inequities, together with inequities in access to, and utilization of quality basic health care interventions.

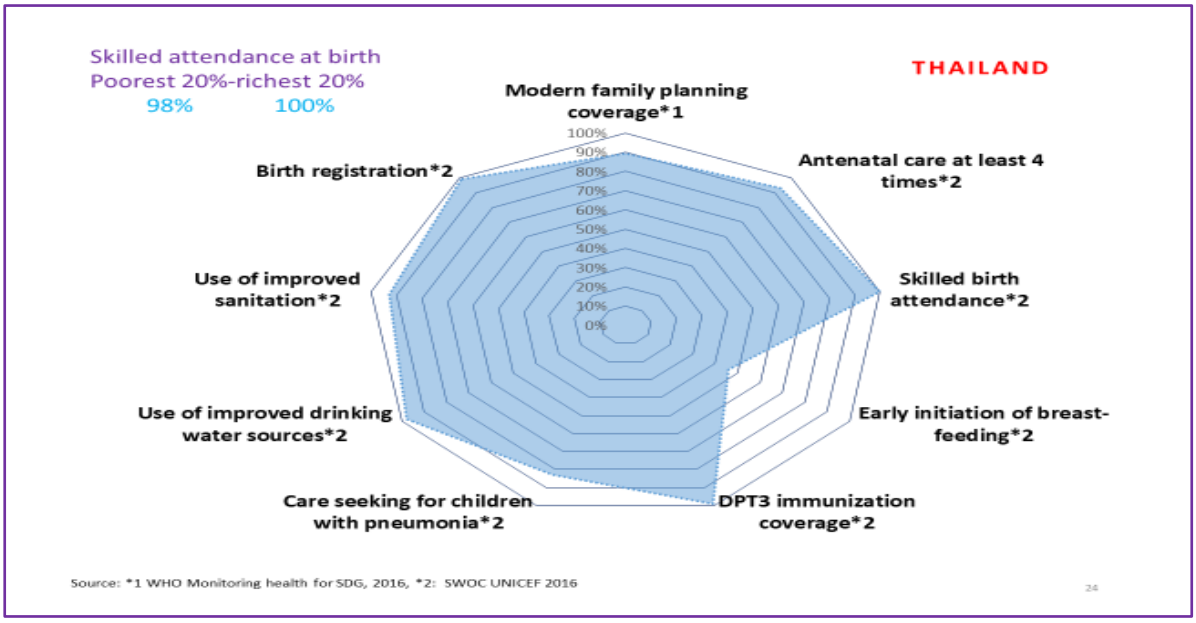
This calls for future policy and programming efforts to be more deliberate in their equity approach. Quality improvements in health services and targeted interventions for specific socio-economic groups are required to further accelerate progress in reducing neonatal mortality and addressing Cambodia's pressing unfinished agenda in health.

Antenatal care – Antenatal care (ANC) visits, especially when exceeding four visits, is frequently used as an indicator to reflect the quality of health services and client satisfaction. In Cambodia, ANC rates have markedly increased over the last decade whilst exacerbating regional inequity.

The danger of disregarding prenatal services is paramount in the context of Cambodia. In 2014, NMR for mothers who did not receive any antenatal services was 6.26 times higher than for those who received four ANC visits or more. The association between inadequate prenatal care and neonatal mortality may be mediated by increased risk of pre-term delivery and low birth weight babies in these pregnancies[56].

[56] The unfinished health agenda: Neonatal mortality in Cambodia.

Figure 21: Key Maternal and Child Health Indicators in Thailand



Urban-rural differences existed for various components of antenatal care. Urban women and rural women were equally likely to have been informed about signs of pregnancy complications; to have been weighed; and to have their blood pressure measured. However, urban women were more likely than rural women to have blood and urine taken for testing. Women in rural areas were more likely than those in urban areas to take intestinal parasite drugs, but rural and urban residents were equally likely to take iron tablets or syrup during pregnancy. Antenatal care content was also greatly related to education and wealth.

Women with a secondary education or higher, and women in the highest wealth quintile were more likely to have received more services than other women.

Ninety per cent of mothers received postnatal care within the crucial first two days of delivery, with 76 per cent receiving care within four hours of delivery. Only nine per cent of mothers received no postnatal care.

Urban women were more likely to receive post-natal care (98 per cent) than rural women (89 per cent) during the first two days after delivery.

Women with a secondary education or higher (94 per cent) were more likely to receive post-natal care within two days of delivery than women with either no schooling (80 per cent) or only a primary school education (90 per cent). Only 57 per cent of women who did not deliver in a health facility received a postnatal check-up[57].

Both, improved access and utilization of quality basic health care services and adequate attention to relevant socio-economic factors will be required to promote further accelerated progresses in the reduction of NMR in Cambodia.

[57] Ibid.

3.3 Preventive and curative nutrition services

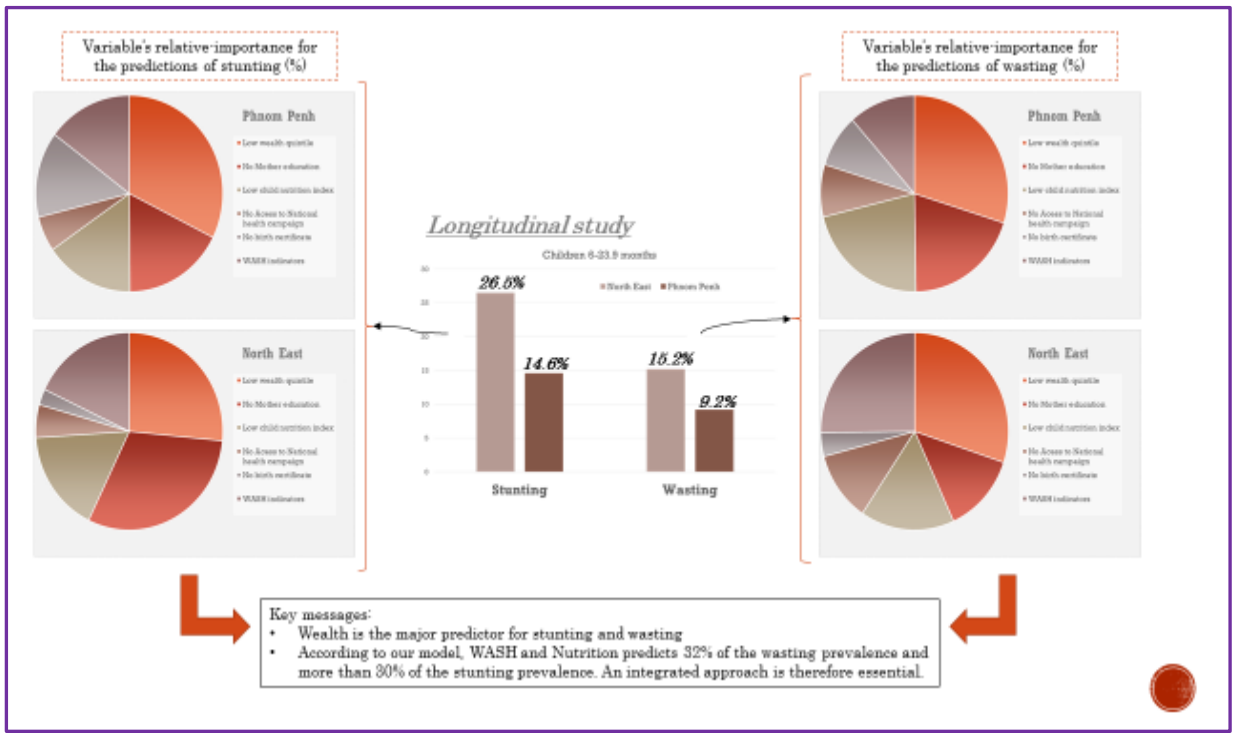
Improvements in nutrition in Cambodia have lagged behind economic and human development, as indicated by the bulk of indicators lagging behind global nutrition targets[58].

The progress that has been made towards addressing child malnutrition in the country is attributed to increases in purchasing power, access to food, exclusive breast feeding practices, access to vitamins and mineral supplements, iodization of salt and immunization coverage.

However, child mortality in Cambodia remains among the highest in Asia, predominately due to high neonatal mortality, inadequate complementary feeding practices, poor nutritional status of women of a reproductive age and poor WASH coverage.

Malnutrition is considered the underlying cause of 45 per cent of child deaths and 20 per cent of maternal deaths and creates an economic loss of one to two per cent of GDP annually[59].

Figure 22: Predictors of Stunting and Wasting in selected provinces of Cambodia (Longitudinal Study findings, 2017)



Maternal nutrition - Pregnant women are vulnerable to inadequate nutritional status because of the high nutrient demands of pregnancy. Women living in developing countries, such as Cambodia, are particularly at risk for malnutrition during pregnancy.

[58] https://www.globalnutritionreport.org/files/2017/12/gnr17-Cambodia.pdf
[59] The unfinished health agenda: Neonatal mortality in Cambodia.

Intervention focusing on prevention, such as ensuring that pregnant and lactating mothers are adequately nourished; that children receive exclusive breastfeeding during the first six months of life; and the provision of adequate complementary feeding in addition to breastfeeding for children aged six-23 months, could help decrease the high stunting and wasting prevalence observed in sub-regions of Cambodia, especially in the northeastern region for example and within sub-groups.

During the last National Nutrition workshop held in November 2016, development partners highlighted the low diet diversity of women and no increase in diet once women were pregnant. Unfortunately, most pregnant women do not receive nutrition messages during ante-natal care counselling.

According to a UNICEF longitudinal study in Kratie, Ratanakiri and Phnom Penh, over 50 per cent of women did not receive nutrition messages during their last visit to a health care facility. In Phnom Penh, this prevalence reached 68.9 per cent[60].

Stunting – Overall, 32 per cent of Cambodian children under five are stunted and nine per cent are severely stunted. Analysis by age group indicates that stunting is apparent even among children less than age six months (16 per cent). In general, stunting increases with the age of the child, rising from 13 per cent among children age six-eight months, to 40 per cent among children age 36-47 months before declining to 36 per cent among children age 48-59 months.

There is very little difference in the level of stunting by gender. Stunting is highest when the birth interval is less than 24 months (37 per cent). Size at birth is an important indicator of children's nutritional status. Nearly two-in-three children (63 per cent) reported to have been very small at birth are stunted.

Children whose mothers are underweight are more likely to be stunted (44 per cent) than children of normal weight mothers (32 per cent).

The disparity in stunting prevalence between rural and urban children is substantial; 34 per cent of rural children are stunted, compared with 24 per cent of urban children.

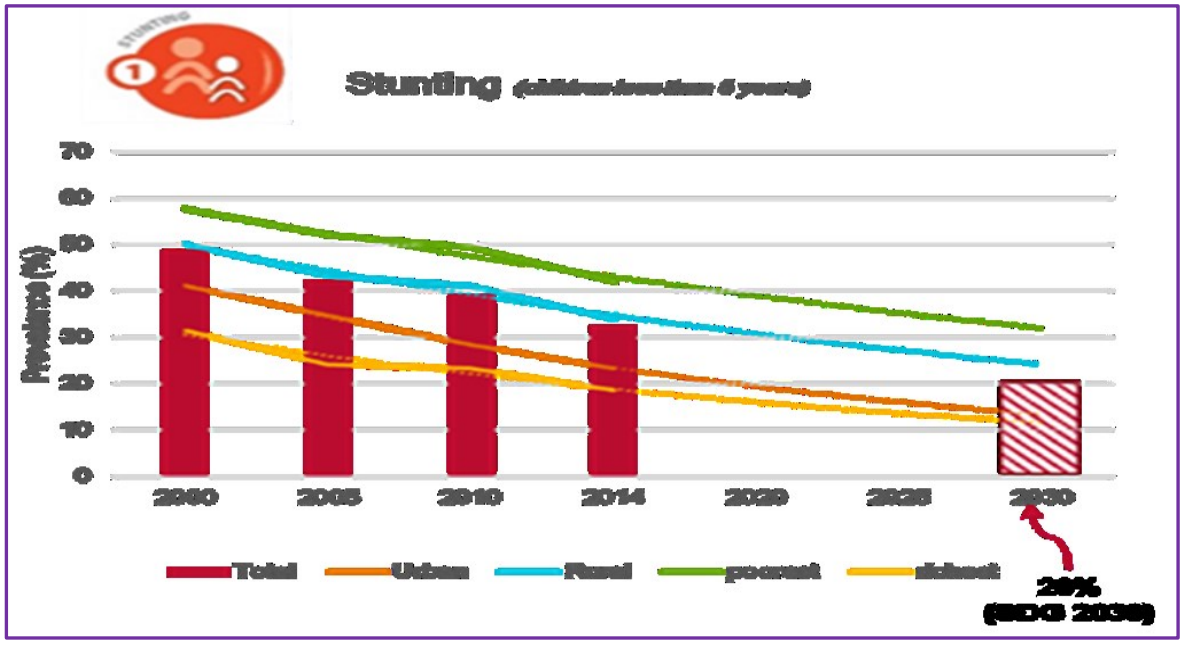
Variation in the nutritional status of children by province is quite evident, with stunting being highest in Preah Vihear/Stung Treng provinces (44 per cent) and Kampong Chhnang (43 per cent) and the lowest in Phnom Penh (18 per cent).

A mother's education and wealth quintile have an inverse relationship with stunting levels. For example, the prevalence of stunting is higher among children living in the poorest households (42 per cent) than among children in the richest households (19 per cent)[61].

[60] Current MUAC Cut-Offs to Screen for Acute Malnutrition Need to Be Adapted to Gender and Age: The Example of Cambodia – February 2016. The Economic Burden of Malnutrition in Pregnant Women and Children under Five Years of Age in Cambodia – May 2016.

[61] The unfinished health agenda: Neonatal mortality in Cambodia.

Figure 23: Stunting among children under five years by wealth quintile and location



The higher prevalence of stunting in the poorest wealth categories is in line with recent analysis of the inequalities in child undernutrition in 80 countries. This underlines the inequality of access to economic development for Cambodian households which probably results in inequality of access to an adequately nutritious diet for children during the critical window of the first two years of age.

Indeed, access to a diversity of nutrient-rich foods is a key link in the relationship between higher income and the lower prevalence of stunting. In addition, it is worth noting that in the four surveys, the prevalence of stunting among the poor was approximately and consistently twice as high as among the richest.

These findings indicate that the significant global decrease in stunting prevalence since 2000 was not accompanied by a narrowing of the wealth gap. However, in the 2014 survey stunting still affected about one fifth of the richest[62].

No decrease in inequality for living area toward stunting has been observed since 2000 because stunting decreased in a similar trend in both rural and urban areas. In the most recent Cambodian survey in 2014, the prevalence of stunting was 11 per cent higher in rural areas but a multivariate model indicated that the living area was not significantly associated with stunting, suggesting that the differences in stunting prevalence between rural and urban areas were related to the difference in household wealth status in these two areas instead.

The oldest children were more at risk of being stunted, probably because growth retardation is a cumulative process that develops mainly during the first two years of age. Stunting prevalence was consistently lower in children with mothers having the highest level of education.

[62] Persistent Inequalities in Child Undernutrition in Cambodia from 2000 until today.

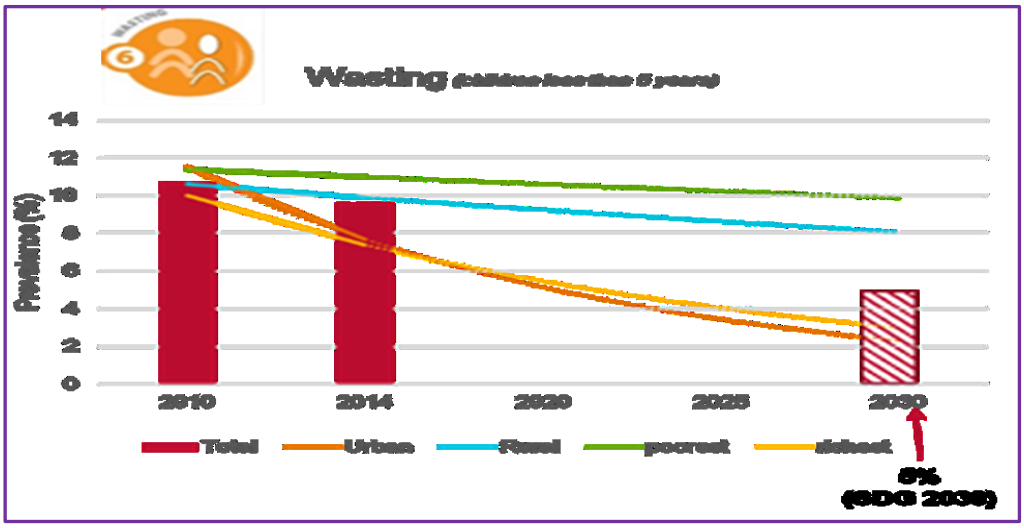
In Cambodia, the inequalities toward stunting related to the mother's education decreased significantly between 2005 and 2014, mainly due to a significant higher decrease of stunting prevalence in the category with no education, whereas no significant changes were observed in the category of higher education after 2005. These different trends of stunting, according to the mother's education, might explain why in 2014, the multivariate model indicated that mothers' education was not associated with stunting[63].

Wasting – Ten percent of children under five are wasted, and two per cent are severely wasted. There is a substantial correlation between wasting and size at birth. Babies who are very small and small at birth are more likely to be wasted (24 per cent and 17 per cent, respectively) than those of average or larger size at birth (nine per cent).

Secondary analysis confirms the prevalence of wasting decreased by half between 2000 and 2005, but remained a medium-high health problem thereafter, affecting approximately 10 per cent of children in 2014. In Cambodia, wasting was strongly related to the socioeconomic status of the household in 2005 and in 2014, with the poorest households exhibiting the highest prevalence.
From 2000 to 2014, wasting prevalence was neither significantly different between boys and girls, nor between mothers with different education levels. Inequality between residence areas appeared only in 2014 and became significantly higher in rural areas.

Multivariate analysis showed that in 2014, the wealth index is the only socioeconomic factor significantly linked to wasting prevalence. The other contributing factors were linked to the nutritional status of mothers instead, low body mass index (BMI) of mothers and low birth weight. This high prevalence of wasting in Cambodia is of concern because wasting has a direct and immediate impact on the mortality risk in children and was recently shown to be a stronger predictor of mortality than stunting or being underweight.[64].

Figure 24: Stunting among children under five years by wealth quintile and location



[63] Ibid.
[64] Persistent Inequalities in Child Undernutrition in Cambodia from 2000 until today.

Low birth weight – Birth weight is one of the major determinants of infant and child health and mortality. Children whose birth weight is less than 2.5 kg, or children reported to be 'very small' or 'smaller than average', are considered to have a higher than average risk of early childhood death.

In the five years preceding the 2014 CDHS, it was reported that 91 per cent of babies were weighed at birth. This represents a significant increase as the 2010 CDHS stated that 72 per cent of babies were weighed at birth. Among those births, for which the mother was able to report the baby's weight, eight percent were classified as low birth weight (less than 2.5 kg at birth) which is the same as the figure reported in 2010.

Low birth weight was more common among children of birth order six or higher (13 per cent) and first-born children (10 per cent) than among children of birth orders two through to five (6-7 per cent). Children born to mothers who smoke were more likely to be of low birth weight (11 per cent) than children born to mothers who do not smoke (eight percent). The proportion of low birth weight babies varied somewhat across provinces (from four per cent to 12 per cent). However, the proportion with a reported birth weight varied substantially, from a low of 56 per cent in Mondul Kiri/Ratanak Kiri provinces to a high of just under 100 per cent in Kampong Chhnang province.

Overweight and obesity – CDHS 2014 collected data on the evidence of overweight and obese women and children in Cambodia and the results are summarized in the sections below.

Children – Overweight and obesity affects a very small proportion of children in Cambodia. Overall, two per cent of children below the age of five were overweight (weight-for-height more than +2 SD). Overweight children tend to decrease in mass as they get older[65].

Women – The prevalence of under-nutrition and over-nutrition evolved in opposite trends from 2000 to 2014, with a significant decrease in underweight and a significant increase in overweight women[66].

The prevalence of being overweight increased consistently and signifi cantly from 2000 to 2014, especially between 2010-2014 when the overweight prevalence increased from 10.9 to 18.3 per cent[67].

Even if being overweight mostly affected the richest population, the inequality between wealth groups has tended to narrow since 2010, when a more rapid rise was observed in the prevalence of being overweight in the poorest households.

Indeed, since 2000, the prevalence of being overweight in the poorest group has increased fi ve-fold, whereas the prevalence of being overweight in the wealthiest group has only doubled.

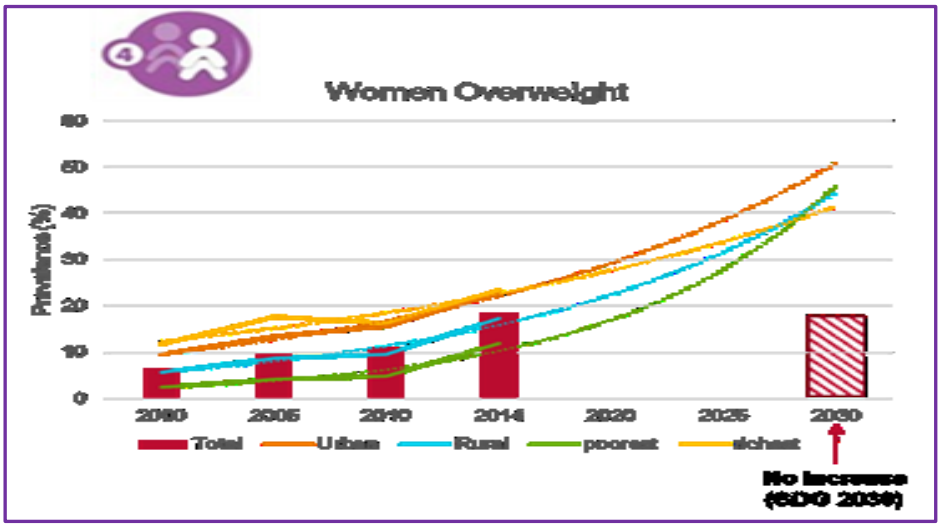
This may be due to several factors, among them increased access to energy-rich foods and

[65] CDHS (2014).
[66] Inequalities in Nutrition between Cambodian Women over the Last 15 Years (2000–2014).
[67] CDHS (2014).

changes in physical activities as being overweight is primarily driven by imbalanced diets and more sedentary lifestyles.

While overweight prevalence was not related to the level of education in the 2000 and 2005 surveys, the risk of being overweight was higher in women with no education in the 2010 and 2014 surveys, with a shift of the most-at-risk group from the highest-to-lowest educational groups.

Figure 25: Prevalence of Overweight among Women by wealth quintile and location



Anaemia – In Cambodia, anaemia is a serious public health concern affecting over 50 per cent of children under the age of five years[68]. Anemia is of multifactorial origin – but both nutritional and non-nutritional factors contribute to it. From the four Cambodian surveys undertaken, it appears that the prevalence of anaemia cannot be reduced to below 40 per cent, even in women of the highest wealth group, or with the highest education.

Micronutrient interventions to improve anaemia prevalence are likely to have limited impact in the Cambodian setting. Iron deficiency prevalence was low in children above two years of age and also in women. The focus of current interventions to reduce the high prevalence of anaemia in children and women should be broadened to include zinc and folic acid for women of a reproductive age, as well as effective anti-hookworm measures.[69]

Breastfeeding and complementary feeding[70] – Poor breastfeeding and complementary feeding practices put infants and young children at high risk of malnutrition very early on in life. The National Nutrition Programme (NNP) and its partners have worked closely to achieve Infant And Young Child Feeding (IYCF) goals for many years. Since 2000, the national IYCF programme has improved notably. Training and educational materials in different types/forms and channels related to IYCF have been developed and used nationwide by different agencies, both governmental and non-governmental. Unfortunately challenges remain as shown during all the different target groups of the 1,000-day window.

Pregnant women feeding – Pregnant women are vulnerable to inadequate nutritional

[68] CDHS (2014)
[69] Frank Wieringa, et al. 2016. The high prevalence of anemia in Cambodian children and women cannot be satisfactorily explained by nutritional deficiencies or hemoglobin disorders.
[70] National Nutrition Annual Report 2016.

status because of the high nutrient demands of pregnancy. Inappropriate feeding practices and the significant number of pregnant women with a low Mid-Upper-Arm Circumference (MUAC, which is close to 20 per cent in the northeastern regions, according to UNICEF/IRD/Fia/NNP, are factors which will increase the risk of low birth weight, early stunting and at a longer stage none optimal cognitive development.

Exclusive breastfeeding – The 2014 CDHS demonstrates a decline in the prevalence of exclusive breastfeeding, from 75-to-65 per cent between 2010-2014. As shown in the secondary analysis, the deterioration is happening both among urban populations and the wealthiest populations. Statistically, a child born in an urban area, or into a wealthy family is 3.6 to 5 times more likely not to be exclusively breastfed compared to one born in a rural area, or into an impoverished household.

In addition, from 2010 to 2014, the prevalence of newborns receiving pre-lacteal feeding increased by 8.6 per cent. This almost doubled in urban areas, reaching more than 50 per cent in 2014 compared to more than 25 per cent in 2010. Giving an infant water or milk-based pre-lacteal food delays the child's first consumption of breast milk, thereby depriving the infant of the many benefits of breastfeeding. The proportion of breastfed children aged 12-23 months declined, from 73.7 per cent in 2005 to 58 per cent in 2014. This is a 22 per cent reduction[71].

During National Nutrition day on 6 November 2016, it emerged that only 7.9 per cent of children aged 5.9 months in Phnom Penh; 22.1 per cent in Kratie; and 23.9 per cent in Ratanakiri were still being exclusively breastfed, while at the age of three months, almost two-thirds of children (60.3 per cent in Kratie and 63.6 per cent in Ratanakiri) were exclusively breastfed. However, there was a high prevalence of predominant breastfeeding within the first six months (over 90 per cent in the North East and towards 70 per cent in Phnom Penh, according to UNICEF sources).[72]

Continued breastfeeding – The prevalence of children aged six-23 months who continue to be breastfed is high – above 65 per cent in most of the provinces where data was collected by different partners (Phnom Penh, Kratie, Ratanakiri, Stung Treng, Kampot, Kampong Thom, Kampong Cham, Tboung Khmum). However, from the age of 20 months, a significant reduction of children still being breastfed can be observed.

In the UNICEF targeted provinces, approximately 50 per cent are not breastfed anymore; in Kratie around 60 per cent;and 35 per cent in Ratanakiri. It is important that continued breastfeeding is sustained so babies can gain the health benefits of this practice, such as protection against common childhood illnesses, the provision of key nutrients to the growing infant, as well as greater linear growth.

Complementary feeding – Overall in 2016, UNICEF/IRD/Fia/NNP intervention activities revealed that less than 25 per cent of Cambodian children age 6-23 months in the selected provinces of Phnom Penh, Kratie, Ratanakiri, Stung Treng had the minimum acceptable diet.

[71] Ibid.
[72] Ibid

An exception seemed to exist in several districts where NGOs HKI and GIZ were working, as this prevalence reached almost 42 per cent in these districts.

Micronutrients intake[73] **–** This section examines the micronutrient intake among women of a reproductive age and children under five years of age.

Women of reproductive age – In Cambodia, over 70 per cent of pregnant women receive standard iron and folic acid supplements during pregnancy and after delivery through the national health system[74]. In the last 10 years, Cambodia has also piloted weekly iron and folic acid supplementation for women of a reproductive age. However, despite evidence of the impact of iron supplements during pregnancy, factors such as cost and the need for behavioural change have hampered implementing this policy on a wider scale.

In contrast, food fortification efforts, such as iron-fortified fish sauce, are underway. Early analysis suggests these intervention activities have the potential to improve the 'iron status' of women of a reproductive age in an effective and cost-effective manner.

A national survey of over 2,000 women of reproductive age concluded that neither iron deficiency nor vitamin A deficiency were prevalent in Cambodian women, with less than 10 per cent of women having an iron deficiency, regardless of the indicator used and less than one per cent having vitamin A deficiency[75].

However, marginal or low iron status affected more than one-third of women overall and this was more common in rural areas and affected almost half of women of a reproductive age in the west and northern regions of the country. This is a health concern given high iron needs during pregnancy.

Interventions such as iron-fortified foods are needed to improve the overall iron status of women of a reproductive age in the country. Vitamin A status has considerably improved over the last decade and marginal vitamin A status appears not to be a major health concern in Cambodian women at present.

The survey concludes that the contribution of iron and vitamin A deficiency to the high prevalence of anaemia in Cambodian among women of a reproductive age seems to be limited and the cause of anaemia in Cambodia needs to be further investigated in order to guide current policies on anemia.

Children – The incapacity to provide adequate nutrition to young children (6-23 months) has a direct impact on their micronutrient status. For example, The zinc and iodine and vitamin

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[73] Detailed secondary analyses – Arnaud Laillou, et al. 2016: Beyond Effectiveness – The Adversities of Implementing a Fortification Program. A Case Study on the Quality of Iron Fortification of Fish and Soy Sauce in Cambodia; Frank Wieringa, et al. 2016: Low Prevalence of Iron and Vitamin A Deficiency among Cambodian Women of Reproductive Age; Greffeuille V, et al. 2016: Inequalities in Nutrition between Cambodian Women over the Last 15 Years (2000–2014); Arnaud Laillou, et al. 2016 Low Urinary Iodine Concentration among Mothers and Children in Cambodia; Geoffrey Smith, et al. 2016: High Prevalence of Vitamin D Deficiency in Cambodian Women: A Common Deficiency in a Sunny Country; Kuong K, et al. 2016: Stability of Vitamin A, Iron and Zinc in Fortified Rice during Storage and Its Impact on Future National Standards and Programs -- Case Study in Cambodia.

[74] Cambodian Demographic and Health Survey (2014).

[75] In November and December 2012, a nationwide cross-sectional, household serological survey was conducted among women aged 15-39 years in Cambodia.

B1 status of children 6-23 months is considered a serious public health issue.

Perhaps due to on-going programmes, vitamin A status was not a public health issue in children. Iron deficiency, measured by indicators of iron stores, was especially prevalent in children aged 6-23 months (prevalence between 10-15 per cent) and associated with approximately 12 per cent of anaemia cases.

In older children (24-59 months) and women, the prevalence of iron deficiency was low, suggesting other causes than iron for anaemia such as *hemoglobinopathies*, other vitamins (A, B9 and B12) and unknown causes.

The conventional activities promoted in the MoH's Fast-Track 2014-2020 (supplementation and maternal and newborn programme are likely to have contributed significantly to the decrease in anaemia and vitamin A deficiency observed since 2000. However, the stagnation since 2010 highlights the limitation of current guidelines.

With the current findings and typical activities (supplementation, fortification, food diversity), we can only aim to reduce anaemia prevalence from 56 per cent to 40 per cent among children less than five years of age[76].

Salt iodization – The 2014 CDHS evaluation on urinary iodine concentrations showed that over 60 per cent of mothers and their children had a urinary iodine level of less than 100 µg/L as their respective median urinary iodine is 62.8 µg/L and 72 µg/L. These levels are considered to be a moderate public health problem. However, in both groups, the prevalence of the population with a urinary iodine level of less than 20 µg/L was above 12 per cent (12.8 per cent for children and 14.8 per cent for mothers) which represents a population with a high risk of developing severe health complications[77].

3.4 Immunization

Cambodia has a functional national vaccine delivery system that has demonstrated its capability to respond to new vaccine-preventable disease threats. An expanded programme on immunization was established in the country in 1986 and this achieved national coverage for basic vaccines by 1989.

The National Immunization Programme (NIP) began in 2000 and Cambodia was declared polio-free the same year. The country achieved measles-free staus and maternal and neonatal tetanus-free status in 2015.

NIP currently provides 11 vaccines that are administered through over 1,141 health centres, 81 health posts and maternity wards in 99 referral hospitals. Access to vaccinations is additionally supplemented by mobile outreach activities.

[76] National Nutrition Report 2015.
[77] Low urinary iodine concentration among mothers and children in Cambodia, Laillou et al. (2015-UNICEF/MOH/IRD secondary analysis).

Six new and under utilized vaccines have been introduced into the routine immunization programme since 2005, of which three were introduced in the past two years[78].
MoH has successfully transitioned from the Vaccine Independence Initiative (VII) to a regular procurement services mechanism managed by UNICEF for its provision of traditional vaccines. UNICEF managed the procurement and delivery of vaccines for the NIP for a total cost of US$8.2 million in 2016. Vaccines are largely funded by the public-private vaccine alliance GAVI, but this also includes the national budget for vaccine procurement to further improve sustainability of the immunization programme.

Coverage – The vaccine programme is heavily dependent on external funding. The most recent 2014 CDHS found that 73 per cent of children, aged 12–23 months, were fully vaccinated. In 2015, WHO and UNICEF collectively estimated the coverage for three doses of the diphtheria-tetanus-pertussis vaccine to be 89 per cent effective. Data indicates that the first-dose Measles-Containing Vaccine (MCV) coverage for one-year-old children is 95 per cent effective[79].

Communities with low immunization coverage tend to be in unregistered villages or remote locations; have high numbers of ethnic minority households; or have a greater proportion of mobile workers with families often located in urban settings, leading to pockets that are not covered and this potentially contributes to future outbreaks of diseases, such as the recent outbreak of measles. The current multi-year national immunization strategy has plans to expand immunization services in these high-risk communities.

Vaccination coverage in Cambodia is good, but more work is needed to ensure that geographic and wealth disparities in coverage are minimized. Recent 2014 CDHS data provides information for the assessment of the immunization programme in reaching out to all population subgroups.

Children in urban areas are more likely to be fully vaccinated than those in rural areas (86 compared to 71 per cent). The percentage of children fully vaccinated is lowest in Mondul Kiri/Ratanak Kiri (44 per cent), Preah Vihear/Stung Treng (56 per cent) and Kampong Cham provinces (57 per cent). The provinces with the highest proportion of children fully vaccinated are Banteay Meanchey (91 per cent), Phnom Penh (89 per cent), Battambang/Pailin (89 per cent) and Takeo (88 per cent).

Evidence suggests that the percentage of children fully vaccinated increases substantially if their mother has a higher level of education. For example, children of mothers with a secondary education or higher are much more likely to be fully vaccinated (84 per cent) compared to children whose mothers have no schooling (58 per cent).

The percentage of children fully vaccinated also increases according to the wealth of the household; children living in the wealthiest households are more likely to be fully vaccinated (91 per cent) than children from the poorest households (61 per cent).

[78] WHO 2016.
[79] WHO Country Cooperation Strategy 2016–2020.

Cold chain management – Vaccines need to be kept in a narrow temperature range from the point of manufacture to their use in an immunization session. This is called the 'cold chain' which is crucial to vaccine supply chains. UNICEF invests in cold and supply chain infrastructure and management worldwide to improve the conditions in which vaccines and other lifesaving health commodities are delivered.

Regarding the situation in Cambodia, strong cold-chain management systems are in place. NIP maintains a detailed database of cold chain equipment nationwide, including the facility, equipment make and model, purchase date and type of electricity supply. It has been determined that about two-thirds of the equipment in use is now over 10 years-old but there are plans and donor funds available to replace this equipment in the next five years.

Cambodia's capacity to successfully conduct mass vaccination campaigns in response to health threats is noteworthy. In March 2016, RGC, with financial support from Gavi, launched a Japanese encephalitis vaccination programme targeting 4.1 million children in the nine months-to-14 years-old age group. A total 4,171,429 doses of the Japanese encephalitis vaccine were administered over the month-long programme and rapid coverage assessments in all provinces found overall coverage in the target population at 92 per cent[80].

Prevention – As Cambodia's immunization programme matures, it will become increasingly important to strengthen the quality of surveillance and respond to suspected clusters of vaccine-preventable diseases. At present the quality of vaccine-preventable disease surveillance and outbreak investigation at the sub-national level is variable.

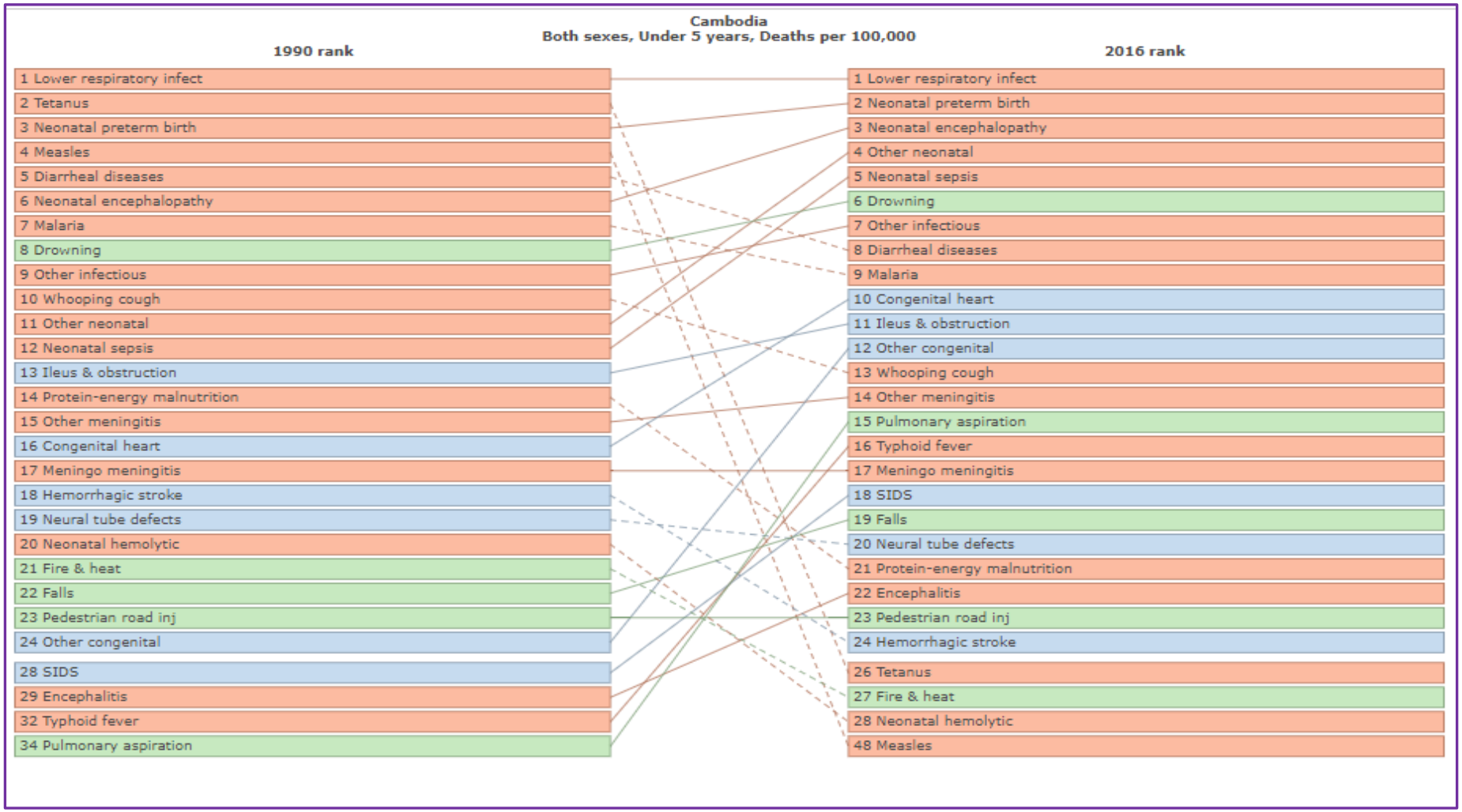
3.5 Childhood Illnesses: what causes the most deaths in children under five?

Among children under five, WHO statistics indicate that premature birth, pneumonia and birth asphyxia were the leading causes of death in 2014.

There has been a significant decline in diarrhoeal diseases and – due to high vaccination coverage and the implementation of a measles elimination campaigns by MoH – measles is no longer a major cause of death[81]

[80] WHO 2016.
[81] WHO 2016.

Figure 26: Causes of Deaths among Under Five Children in Cambodia (1990 compared to 2016)



Acute respiratory infections (ARI) – In the two weeks preceeding the 2014 CDHS, the prevalence of ARI was estimated by asking mothers whether their children under the age of five had been ill with a cough and symptoms of short, rapid breathing. These symptoms are compatible with ARI.

It was determined that six per cent of children under five showed ARI symptoms at some point in the two weeks preceding the survey. Only about three per cent of children under the age of six months experienced ARI symptoms. The prevalence of ARI increased to six per cent among children six-11 months and seven per cent among those 12-23 months.

After the age of 23 months, ARI prevalence decreased with increasing age. The prevalence of ARI was significantly higher among children whose mothers smoke (10 per cent) than among children whose mothers do not smoke (five per cent). There was only minor variation in the prevalence of ARI symptoms between urban and rural children.

Diarrhoea - Dehydration caused by severe diarrhoea is a major cause of morbidity and mortality among young children, although the condition can be easily be treated with oral rehydration therapy (ORT). Exposure to diarrhoea-causing agents is frequently related to the use of contaminated water and to unhygienic practices in food preparation and disposal of excreta. Overall, 13 per cent of all children under the age of five had diarrhoea and two per cent had diarrhoea with traces of blood.

The occurrence of diarrhoea varies by the age of the child. Similar to fever, young children age six-11 and 12-23 months are more prone to diarrhoea (20 per cent and 19 per cent, respectively) than children in other age groups. The prevalence of diarrhoea is about the same among rural and urban children and there is no variation by the sex of the child.

However, there are significant variations in the prevalence of diarrhoea by province. Children living in Battambang/Pailin provinces (21 per cent), Preah Vihear/Stung Treng provinces (19 per cent), and Takeo province (19 per cent) are more susceptible to diarrhoea than children living in other provinces. Children living in Kampot/Kep and Prey Veng provinces have the lowest prevalence of diarrhoea (five per cent each). The prevalence of diarrhoea is higher among children who live in the poorest households; in households without an improved source of drinking water (in both the dry and rainy seasons); and in households with a non-improved or shared toilet facility[82].

Under-nutrition – As noted, long-term under-nutrition poses a serious health problem for children, affecting the poorest groups the most of all[83]. A lack of proper nutrition also poses a threat to economic development. The burden of disease associated with under-nutrition extends beyond standard analysis. In addition to the effects of poor pre-pregnancy BMI, inadequate weight gain during pregnancy can lead to growth retardation within the uterus. Foetal growth retardation may be associated with impaired immune competence, as well as an increased risk of chronic disease in later life. Chronic undernutrition, especially in conjunction with a poor environment, is associated with impaired cognitive development and severe undernutrition during infancy may contribute to lasting intellectual deficits. The risk

[82] Cambodia Demographic and Health Survey, 2014.
[83] Persistent Inequalities in Child Undernutrition in Cambodia from 2000 until today.

factor attribution would also contribute to a better understanding of morbidity/mortality.

3.6 Gender-responsive adolescent health and nutrition[84]

Cambodia has the youngest population in South-East Asia, with 22 per cent aged between 15 and 24 years. These young people face many sexual and reproductive health issues such as sexually transmitted infections, unwanted pregnancies, risky abortions and HIV/AIDS. These health concerns are exacerbated by a lack of sexual and reproductive health information, knowledge, youth-friendly services, poor education attainment (i.e. low school enrolment, high dropout rates, and high repetition rates) and the effect of rural-to-urban migration for employment which often places young people at a social and economic disadvantage, especially those resident in rural areas. Limited information is available about the sexual and reproductive health of adolescents and youth in Cambodia and information that is available generally relates to sub-populations[85].

Teenage marriage – Rates of teenage marriage among young men have remained relatively constant across the survey years. Females report that sexual intercourse prior to marriage is rare. On the other hand, data shows a steady increase in pre-marital sex among young males. For young women, the mean age difference between themselves and their most recent sexual partner decreases with age. On average, there is a six-year age difference between sexually active 15-17 year-old females and their most recent sexual partner and this difference is only four years for 20-24 year-old females who have had sex. Females almost exclusively report that their most recent sexual partner was their spouse, or cohabiting partner compared with only three-quarters of young men.

More than one-in-twenty young married women aged 15 to 24 has had an abortion and the introduction and broader availability of medical abortions has corresponded with a decline in the number of surgical abortions being performed. However, the increase in medical abortions has also been accompanied by an increase in the percentage of young women who have an incomplete medical abortion which leads to the need for a follow-up surgical abortion. In 2014 almost one-in-ten abortions required both medical and surgical interventions.

3.7 Health care utilization by persons with disabilities in Cambodia[86]

There exists a growing body of evidence to suggest that persons with disabilities experience both a high need for health and a low capacity to pay, relative to persons without a disability. This combination presents a serious challenge to health equity and universal health coverage goals of providing access to all the services that people need without creating financial hardship. In 2016, WHO commissioned a secondary analysis of health care utilization by persons with disabilities in Cambodia using 2014 CDHS results, which adopted for the first time an internationally standardized measure of disability known as the 'Washington Group Short-Set Questionnaire'.

The analysis revealed the following key findings: (i) persons with disabilities were more than

[84] National Institute of Statistics, Cambodia, 2016: Sexual and Reproductive Health of Adolescents and Youth in Cambodia Analysis of 2000-2014 Cambodia Demographic and Health Survey Data.
[85] Ibid.
[86] WHO 2017: Health care utilization of persons with disabilities in Cambodia, based on the Cambodia CDHS 2014.

twice as likely to be ill or injured, report a severe health condition if ill or injured and seek treatment or advice relative to persons without disabilities in the last month; (ii) persons with disabilities on average spent three to four times the amount on total health care-related treatment and travel costs relative to persons without disabilities, depending upon the degree of disability over the last month; (iii) at health care providers, persons with disabilities spent approximately 30 per cent more on treatment and double on associated travel relative to persons without disabilities over the last month; (iv) by two measures of poverty, including a calculated measure of household wealth and participation in the poor household ID programme, persons with disabilities experience a rate of poverty approximately four to six per cent higher than persons without disabilities; (v) persons with disabilities were less likely to draw upon income and savings and were more likely to draw upon support from relatives in order to finance health care related expenses, relative to persons without disabilities.

Three-quarters of the estimated population with disabilities in Cambodia remain uninsured. On grounds of health equity there exists a case to expand coverage of current social protection support for persons with disabilities. The study also revealed some evidence of lower capacity to pay for health care demonstrated by higher rates of poverty, lower educational achievement and the higher likelihood of drawing upon external support to finance health care. No significant statistical effect of disability on health care utilization according to whether the person lives in a rural or urban area, or in a poor or non-poor household was found when looking for other influencing factors.

3.8 HIV/AIDS

The risk of mother-to-child transmission of HIV remains a problem. While HIV prevalence has been decreasing in Cambodia, low-risk females represent an increasingly high proportion of new infections . In 2014, 48 per cent of new infections were the result of spousal transmission, the majority being husband to wife. This has been linked to the propensity of married men to visit sex-workers; an unwillingness to use condoms; and women's lack of power in relationships and an inability to negotiate safe sex. The burden of care for family members with HIV also falls more heavily on women and girls and impacts on their ability to contribute in other ways to the family's economic and social welfare and education of girls. The HIV situation in Cambodia is largely a continuing story of success. However, of particular concern is the prevention of new infections among women, children and young people. This is examined in more detail after a brief presentation of overall trends.

Overall trends – According to 2015 estimates of the Joint United Nations Programme on HIV/AIDS (UNAIDS), 4,061 children aged 0-to-14 years in Cambodia are living with HIV. No estimates are currently available for the number of children affected by HIV. The National Multisectoral Orphans and Vulnerable Children Task Force defines children affected by HIV as those under 18 years of age who are living with HIV, in addition to children whose families have experienced HIV/AIDS, including death. The prevalence of HIV in the general population (15-49 years) has steadily declined over the past decade – from two per cent in 1998 to 0.7 per cent in 2013 and 0.6 per cent in 2014. The National AIDS Authority

estimates that some 75,000 people were living with HIV in Cambodia in 2014. The country aims to end the spread of HIV by 2020.[87]

Coverage of HIV testing in pregnant women and antiretroviral therapy in HIV-positive pregnant women has resulted in a decrease in the mother-to-child transmission rate, from 25 per cent in 2005 to around eight per cent in 2014. The HIV programme managed by the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) is heavily dependent on external funding from mainly the Global Fund, but also includes a national budget for the procurement of Anti-Retrovirals (ARV). UNICEF managed the procurement and delivery of ARVs, tests kits and Opportunistic Infections (OI) drugs for the programme at a total cost of US$8 million in 2016.

RGC recently introduced the Cambodia 3.0 initiative which strives for the elimination of new HIV infections by the 2020 target date and seeks to integrate prevention of mother-to-child transmission of HIV with maternal, newborn and reproductive health, particularly at the service-delivery level. Pockets of new infections remain high among sub-populations engaged in higher-risk behaviour. Many are young and at multiple risk of HIV infection and exploitation, violence and abuse. These populations are difficult to reach and the outreach network faces challenges in coordination and coverage.

Contraception – According to UNFPA, a 14.4 per cent unmet need for contraception exists among Cambodian women aged 15-19[88] and HIV prevention information is also low for sexually active young females. Cambodian female sex workers have a high prevalence rate of HIV with over 13 per cent,[89] which could be due in part to limited preventative measures being undertaken. In a survey conducted among most-at-risk young people in Cambodia aged between 10-24 years, almost 32 per cent of sexually active females surveyed had never received a condom and 37 per cent had not received HIV/AIDS information in the preceding three months.[90] Sexual education is not a key strategy taught in the Cambodian curriculum despite the fact engaging young people in education is a key measure to preventing the spread of HIV. Opportunities to obtain knowledge about sexual health are extremely limited for young people out-of-school.

Stigma and discrimination, often associated with HIV infection, is leading to exclusion and isolation of adolescents in Cambodia. Fear of stigma and discrimination is the main reason why people are reluctant to get tested, disclose their HIV status, access healthcare and take ARV drugs.

HIV and at-risk populations – Although Cambodia has made substantial progress towards combatting HIV, the large young population in Cambodia make the needs of those living with HIV and at-risk populations unique to this country. This demographic has a large gap in access to healthcare and often lacks understanding of sexual and reproductive health. Many young people are reliant on their families and communities for often inaccurate information on HIV. HIV prevalence is 0.1 per cent for both genders aged 15-24.[91] Key groups of drug

[87] The National AIDS Authority Cambodia Country Progress Report - Monitoring Progress Towards the 2011 UN Political Declaration on HIV and AIDS, 2015.
[88] UNFPA Cambodia Youth Data Factsheet, 2015.
[89] Ibid.
[90] Ibid.
[91] http://www.unaids.org/sites/default/files/country/documents/KHM_narrative_report_2015.pdf

users, men who have sex with men (MSM) and transgender people are being targeted to help reduce prevalence. In Asia, over 95 per cent of diagnoses of new HIV infections among adolescents are found in one of these vulnerability categories. Despite recent progress, HIV has tightened its grip on the nation's most vulnerable and marginalized populations. For Cambodian adolescents, risks are high in urban settings, especially for those in socially marginalized groups such as drug users, sex workers and MSM. Adolescents, at a key transition period are at risk of HIV transmission through risky drug and sexual health behaviour and face barriers in access to healthcare and health information.

3.9 Early childhood care and development

Evidence shows that early stimulation, caregiving, attachment, bonding and creating safe contexts for children have a positive influence on their brains and can help children grow, learn and thrive. Since the foundation of the brain's architecture is put into place during the first five years of life, experience during this period leaves one of the strongest influences on development.

Through a combination of Early Childhood Development (ECD) and child protection interventions, including direct support to families and strengthening systems to be more responsive and accountable, young children can also be protected from violence and given the opportunity to develop and grow in a healthy way.

Evidence also shows that with investment in the early years of a child's life, children perform better in schools, are more socially aware, grow into more balanced individuals and as adults, participate productively in the economy and live more fulfilling lives. Many countries divide responsibility for Early Childhood Care and Development (ECCD) between health providers for children aged 0-3 years and education for children above three years.

The 2014 CDHS data stated that 15 per cent of children aged 36-59 months were attending an organized early childhood education programme and this figure continues to increase. Children living in urban areas (36 per cent) are much more likely to attend an early childhood education programme than children living in rural areas (11 per cent).

Participation in early childhood education varies substantially by province, from a high of 40 per cent among children in Phnom Penh to a low of only five per cent among children in Pursat province. Considerable differences are observed by a mother's education and household wealth quintile. Only seven per cent of children whose mothers have no education attend an early childhood education programme, compared to 26 per cent of children whose mothers have a secondary education or higher. Thirty-eight per cent of children living in the richest households attend an early childhood education programme, compared with only seven per cent of children in the poorest households.

Analysis of the four domains of child development shows that at least seven-in-10 children in the 36-59 months age group (27 per cent) are developmentally on track in literacy and numeracy. There is practically no difference in literacy and numeracy between boys and girls. A much higher proportion of urban children than rural children are on track in the literacy-numeracy domain (43 per cent compared to 25 per cent). Forty-one per cent of

children whose mothers have a secondary education or higher, are on track in the literacy-numeracy domain, as compared with only 13 per cent of children whose mothers have no education. Nearly half of children (46 per cent) in the richest households are on track in the literacy-numeracy domain, compared with 18 per cent of children in the poorest households .

Parenting education and support requires significant strengthening to raise self-confidence and the competence of caregivers; the improvement of the home environment through education, supplies and services; and to ensure access to clean water and sanitation; health care services; early child care centres with comprehensive services; and adequate care and feeding practices. In turn, these can help to ensure good nutrition, particularly iron, iodine intake, breastfeeding and adequate growth before birth and in the first two years of life.

4. Every child learns

Goal Area 2 within UNICEF's new Strategic Plan 2018-2021 aims to ensure that every child learns. Education is a right enshrined in articles 28 and 29 of CRC. It is also a driver of equity, poverty reduction, empowerment, peaceful and inclusive societies and economic growth. Educating girls is particularly transformative; evidence shows schooling for girls, especially at the secondary level, opens lifelong opportunities for them. Goal Area 2 therefore supports the achievement of multiple SDGs, in particular Goals 4 and 5 in both humanitarian and development contexts.

4.1 Education Policy Context

Cambodia is known to have comparatively strong legal and policy frameworks and this is also true for the education sector. There are strong provisions for ensuring that all children have the right to an education, however fulfilment remains a key issue. Within the Education Strategic Plan (ESP) 2014-2018 there is also provision for equity-oriented programmes to address the needs of coverage, or out-of-school children. There is also room for improving the coordination of the various programmes. One important gap is that primary education is not compulsory.

The main policy frameworks in Cambodia's education system are the Education Law of 2007 which enshrines the right to free public education of at least nine years duration ('basic education'). The Education Law has jurisdiction over all other education policies and the Education Strategic Plan (ESP).

The strategic plan is consistent with the Rectangular Strategy of the RGC, a comprehensive policy framework to support growth, employment, equity and efficiency which has been in effect since 2004 and is now in Phase III.

In turn, ESP is consistent with NSDP 2014-2018, which carries forward the overall development agenda. One of the components of the Rectangular Strategy and the NSDP is the precise strengthening of the quality of education.

The three policy objectives of ESP 2014-2018 are:

- Policy 1: Ensuring equitable access for all to education services.
- Policy 2: Enhancing the quality and relevance of learning.

- Policy 3: Ensuring effective leadership/management of education staff at all levels.

The public education system of Cambodia consists of:

- Pre-school or pre-primary education (three years).
- Primary education (six years).
- Lower secondary education (three years).
- Upper secondary education (three years).
- Non-formal education (mainly adult literacy and school equivalency).
- Technical, vocational and skills training programmes.
- Higher education.
- Teacher education (pre-school training centre, regional training centre, provincial training centres, National Institute of Education).

Other significant policy documents include:

- ESP-MTR conducted in October/November 2016.
- Rapid Education Sector Analysis (RESA) conducted in Sept 2016.
- CDMP MTR of MoEYS (2014-2018) conducted in Sept 2017.
- Child-Friendly Schools (CFS) policy (2007).
- Teacher Policy (TP) was approved in 2013, identifying the broad policy goals, objectives and strategies for teachers.
- Teacher Policy Action Plan (TPAP)[92], was developed to support the implementation of the TP and was approved in 2015. TPAP further details the strategies, sub-strategies, programmes and activities that need to be pursued to achieve a quality teaching workforce and it includes budget and timescale projections for activity completion.

Aligning with the SDG4 Education 2030 agenda, the 2016 MTR of ESP 2014-2018 adopted the following policy objectives: 1) Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; and 2) Ensure effective leadership and management of education staff at all levels.

[92] TPAP is a policy document outlining proposed reforms of the education system, together with strategies, activities, timescales and budgets to achieve these reforms.

MoEYS benefits from reasonably strong management capacity, particularly at the national level with a number of strategic plans which strengthen its capacity to identify education trends and take premedial policy and programming actions such as ESP and the Education Management Information System (EMIS) Master Plan 2014-2018. Nevertheless, a lack of published quality data on children with disabilities in EMIS, as well as solid data on children with disabilities, or out-of-school, means they have not been included in enrolment and cost projections leaving them largely invisible in RGC's mainstream plans and budgets.

This is also true of children from ethnic minorities. Efforts are already underway to address this and MoEYS is committed to publishing data on these two groups in EMIS in the next couple of years. However, it is not only about unpublished data, but is also a data quality issue in terms of identification of children with disabilities in the current school census form.

There is no clear screening and diagnosis process available to produce reliable data. On a more positive note, recent changes have been made to the organizational structure – with the creation of a Special Education Department – which may help to strengthen institutional systems to address the needs of vulnerable children and out-of-school children, including through improved identification and tracking of students with disabilities

Education sector financing – In line with the key role education has taken in the development agenda of Cambodia, RGC has increased the national budget allocated to MoEYS[93] in recent years. MoEYS' total recurrent budget as a share of total national recurrent budget increased from 15.9 per cent in 2012 to 17.8 per cent in 2018[94]. This percentage is expected to increase to 25.4 per cent by 2020 (ESP-MTR), with a projection for three per cent of GDP in 2020. The ESP projects annual increases of 22 per cent in the education budget. The projections for 2017-2020 are more modest, with annual growth rates around 10-12 per cent. Overall, MoEYS' total recurrent expenditure in percentage of nominal GDP increased from 1.8 per cent in 2012 to 2.8 per cent in 2018, while MoEYS' total budget (recurrent and capital) expenditure in percentage of nominal GDP increased from 1.8 per cent in 2012 to 3.2 per cent in 2018[95].

One of the major drivers behind the funding increase to MoEYS has been the growth in the wage bill, particularly teachers' salaries, which increasingly accounted for approximately 77.75 per cent, 80.1 per cent, and 81 per cent of RGC's recurrent budget allocated to MoEYS in 2015, 2016 and 2017, respectively.

As most of the budget increase is absorbed by salary, less of a proportion is left for programmatic interventions. Capital budget provision has increased from 2.1 per cent of RGC's capital budget in 2015, the first year to have a capital budget allocated explicitly to MoEYS, to 14.4 per cent in 2017. This represents a further indication of a greater commitment to finance long-term investments.

[93] Due to a lack of functional classification, this section is able to provide information about the budget of MoEYS only. Education services also existed under other ministries, for example the University of Agriculture under the Ministry of Agriculture, Forestry and Fisheries (MAFF) and the University of Health Science under MoH etc.
[94] Budget Law 2012-2018.
[95] Ibid.

Recent improvements in budget allocation to ensure better working conditions for teachers are important steps toward ensuring a more adequate level of funding. An effective implementation of PFMR should also contribute to ensure more timely disbursement of funds, a higher degree of budget execution and a strengthened link between funding and education policy priorities. The funding requirements for the plan were revised based on the ESP-MTR and with consideration of the funding gap and the mid-term expenditure framework set by MEF.

While the indicator of access to early childhood education remains very low, it is still significantly under-funded; only 0.3 per cent, compared to other sub-sectors as shown in the MoEYS programme budget allocation table below. Excluding personnel costs and other cross-cutting interventions, the ECE budget is the smallest share of MoEYS' total recurrent budget for programmatic interventions compared to other sub-sectors.

Given the increase in capital budget allocation, prioritization should be also given to building more state pre-schools or classrooms, especially in rural areas. While ECE is an important intervention for early childhood development for the child to reach their full potential, it is also a strategy to address over-age enrollment in Grade 1 of primary school, one of the main factors contributing to dropout at upper primary and lower secondary school.

Table 4: MoEYS Budget Allocation by Sub-Sector 2015-2017

Recurrent Budget Allocation by Sub-Sector (in % of total recurrent budget)	***2015***	***2016***	***2017***
Total Recurrent Budget	100	100	100
Early Childhood Education	1.3	0.3	0.3
Primary Education	3.7	4.0	3.6
Secondary Education	4.6	4.0	4.0
Informal Education	1.4	0.9	0.7
Other support to general education (curriculum, teaching and learning materials, teacher training, school health, library…)[96]	3.1	2.9	2.4
Higher Education	3.4	1.8	1.7
Sports	3.4	2.8	2.2
Youth	0.6	0.6	0.5
Support programme (central & Provincial) Inclusive of all personnel cost	78.6	82.7	84.6

Source: MEF Programme Budget Book 2015-2017

The Public Expenditure Tracking Survey (PETS) report in 2017 shows that all schools managed to receive and spend all school operation budgets allocated to them following MEF and MoEYS streamlining of the budget flow to schools, with no perceived leakage of funds. However, there were some public finance bottlenecks identified in the report and this issue delayed disbursement of the first quarter tranche. The delay was due to the budget request and approval process involving the Provincial Department of Education, Youth and Sports and Provincial Department of Economy and Finance.

[96] Curriculum, teaching and learning materials, teacher training, school health, library.

Another issue is over-reporting and underreporting of fund receipts which is related to poor record keeping for school operation funds. The report also shows that the total amount of operational funds received by the school related positively to all quality indices (school quality, financial quality, classroom quality, and environmental quality outcomes) except classroom quality. More funds meant better quality if dedicated to quality improvement purposes.

The PER Report (2017) shows that 'Currently, about 10 per cent of MOEYS teacher salaries go to redundant teachers in schools with excess staff, while teacher shortages in other schools are equivalent to 40 per cent of the current payroll. The number of misallocated teachers is increasing. This would call for [the] reallocation of teachers to nearby schools, especially for primary education. When not possible, it is recommended to provide monetary incentives for teachers in nearby schools/locations to travel and do a shift in the school in need'.

The same PER report also showed that small schools in less populated and remote provinces face higher per student costs and they are also in a worse condition. Reforming the school operation budget to align budget allocation according to school needs, based on enrolment figures, is essential to improving equity budget allocation.

4.2 Out-of-school girls and boys[97]

Early Childhood Education – Cambodia has made considerable progress in providing education opportunities for children and young people in the past eight years due to the new expansion of ECE services policies.

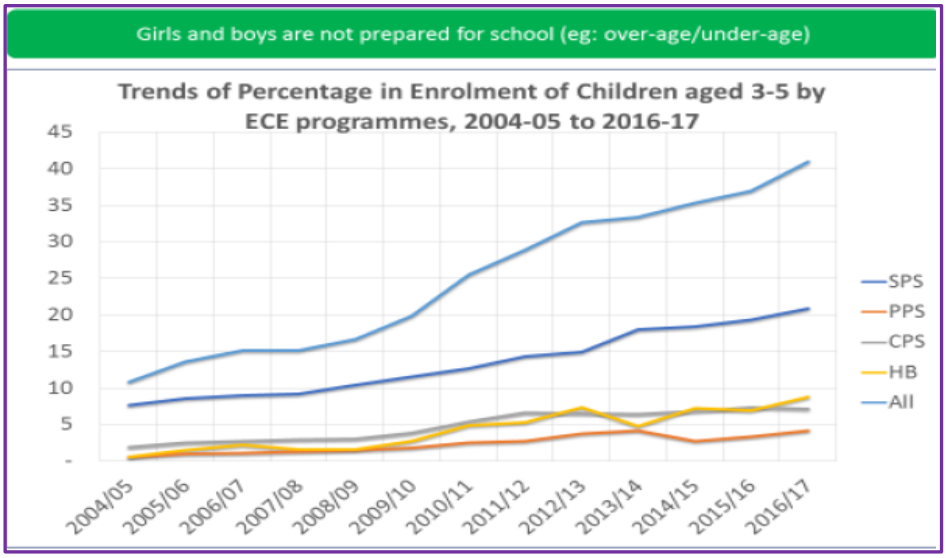
The MoEYS programme of expansion of pre-school classrooms and the growth of Community Pre-Schools, (CPS) which is a major initiative of the Second Education Sector Support Programme (GPE1), allowed enrolment in public pre-primary to grow by 139 per cent between 2007/08 until the 2016/17 school years (EMIS, 2016/17). However, the public pre-primary classes can currently absorb only 20.87 per cent of children aged three-to-five.

The expansion of CPS and home-based learning programmes contributed to the growth of overall enrolment of children aged three-to-five from 15.1 per cent to currently 40.9 per cent during the same period (EMIS figures). However, there may be quality and standard issues with the two interventions especially regarding the home-based programme.

In 2017, the Ministry of Interior (MoI), in collaboration with MoEYS, jointly drafted a sub-decree to ensure transition and quality support from MoEYS to CPS, including a plan to gradually take CPS under MoEYS management. CPS is currently fully funded by a large number of communes using commune *sangkat* funds, as well as development partner funds.

[97] MoEYS, All Children Learning by 2030 Global Initiative on Out-of-School Children Cambodia Country Study (final draft) 2017. The study draws on MoEYS Education Management and Information Statistics (EMIS) (201520152011/20122015/2016).

Figure 27: Enrolment of Children aged three-to-five years by type of ECE Programme



Attendance figures and pupil-teacher ratios (PTRs) show that the registration figures underestimate the actual situation and that teacher recruitment has failed to keep pace with increases in enrolment and pre-school openings. Addressing the recruitment problem with contract teachers[98] is unsatisfactory owing to the small number of training hours undertaken.

Although progress is being made, the JSR Aid Memoire noted that more resources are needed, as well as more accurate mapping of provision. The integration of CPS into a coordinated public, community and private provision is the option selected by MoEYS, but in order to be sure that all areas are receiving an equitable and quality service, more accurate mapping and an ECE results framework are needed.

Primary Education – Nationally, Cambodia is close to achieving universal access to primary education, with Net Enrolment Rates (NER)[99] consistently above 90 per cent over the past decade. Recent NER figures are shown in Table 5 below.

Table 5: Primary Net Enrolment Rate 2010-2016

Academic year	Net Enrolment Rate (Primary)		
	Total (per cent)	Urban (per cent)	Rural (per cent)
2010-11	95.2	93.8	95.5
2011-12	96.4	87.8	98.4
2012-13	97.0	83.2	100.2[1]
2013-14	95.6	83.6	98.4
2014-15	94.5	82.9	97.2
2015-16	93.9	83.3	96.5

Source: EMIS Education Statistics and Indicators Annual report by year.

Although the urban population grew from 19.5 per cent of the total population in 2008 to 21.4 per cent in 2013 (ADB, 2014), lower enrolment rates were recorded in urban areas. While patterns of enrolment have not been analyzed, a drop in urban enrolment correlates well with the increased prevalence of private education institutes in urban areas, indicating that demand for private education may partly explain the reduced

[98] A contract teacher is a non-qualified, or qualified but retired teacher who can temporarily be employed to cover staff shortages in a school. These teachers are selected nominally by the school support committee, but in reality primarily by the school director.

[99] NER is defined as total enrolment in primary education aged six-11) / (population aged six-11) x 100.

enrolment in public schools. High access to primary education may be lost if progression and retention until the last grade is not improved.

Repetition is still high in the first grade of schooling, at 11.3 per cent. Dropout is pervasive in some regions, particularly towards the end of the primary school cycle as students become more likely to leave school rather than repeat a year. For example, in rural areas, the dropout rate in Grade 3 is 4.1 per cent; by Grade 4 it reaches 5.8 per cent; and it further climbs to 6.7 per cent in Grade 5 (RESA, 2016). Ninety-six per cent and 57 per cent of the non-enrolled children in pre-primary and primary, respectively, mention they are 'too young' or they 'do not want to go to school'.

In addition to increased awareness about the value of education, moving towards per-student spending allocation formulas would increase incentives for principals to encourage enrollment. In addition, especially for upper-secondary, Stung Treng, Oddar Meanchey and Ratanak Kiri are provinces in which a lack of schools is a significant determinant of children being out-of-school Local cost-benefit analysis should determine whether expanding access through the construction of more schools, or reducing access costs through transport, housing options, or grant options is the most preferred in these provinces[100].

After a period of an increasing Primary Completion Rate (PCR)[101], EMIS reports show a period of stability from 2010/11 to 2013/14 before a recent decline between 2014/15 to 2016/17.

The table and figure below[102] give rise to a concern over the recent boys' PCR, with district level analysis showing that this problem is more severe in larger rural districts in central and northern provinces.

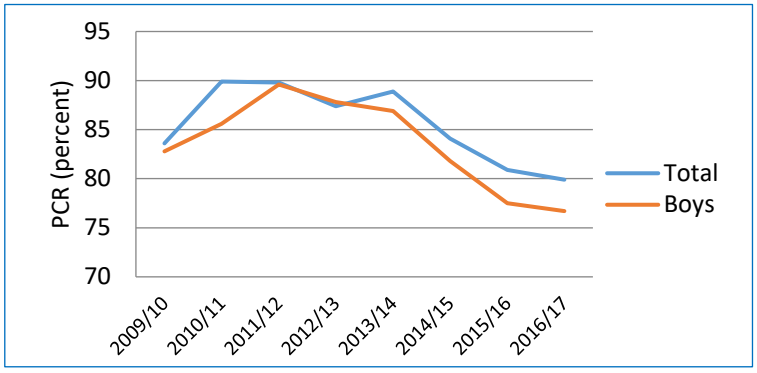
Table 6: Primary Completion Rate 2009-2017

Year	Primary Completion Rate	
	Total	Boys
2009/10	83.6	82.8
2010/11	89.9	85.6
2011/12	89.8	89.6
2012/13	87.4	87.8
2013/14	88.9	86.9
2014/15	84.1	81.8
2015/16	80.9	77.5
2016/17	79.9	76.7

In Cambodia, girls' enrolment lags behind that of boys in primary school but their better rates of progression lead to the higher female PCR. Early dropout and lack of completion in public primary schools is due to overage enrolment and students who are required to repeat grades; both conditions are strong indicators of early dropout. UNICEF has been supporting the Primary Education Department to equip schools with the capacity to provide accelerated learning programmes to allow overage students to catch up with their peers.

[100] World Bank (2017). Cambodia Public Expenditure Review Discussion Paper: Increasing education expenditure while also expanding government stewardship.
[101] The completion rate is defined as: number of new pupils in Grade 6 in year T)/(total number of population aged 11 in year T) x 100.
[102] All rates from EMIS Education Indicators and Statistics from appropriate years.

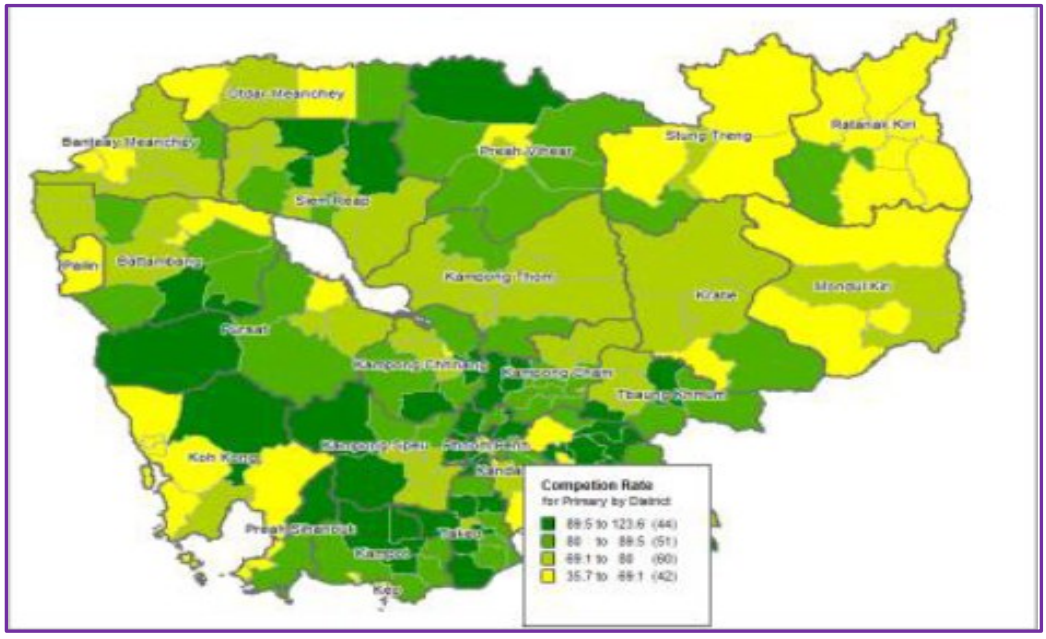
Figure 28: Primary Completion Rate trend



An additional issue that affects access to school and completion is the lack of separate latrines, safe water and hand-washing facilities.

According to EMIS 2015/16 figures: 41.9 per cent of primary schools had no water source (45.2 per cent urban; 41.5 per cent rural) and 14.1 per cent of primary schools had no latrines (7.7 per cent urban; 14.8 per cent rural).

Figure 29: Primary School Completion Rate by Districts



In 2015, UNICEF commissioned a simulation study on dropout at primary and lower secondary schools using data from Cambodia Socio-Economic Surveys from 2003-2012. The findings showed that the main factors of school dropouts in Cambodia are closely related to student and more importantly, family characteristics.

Overaged students, working students, students from a large family size and students whose parents have a low education are more likely to drop out-of-school. If age increases by one year from the average age, the probability of dropout increases by around five per cent for both primary and lower secondary levels.

If a student works for an additional one hour above the average working hours, the probability of dropout increases by about five per cent at primary level and 12 per cent at the lower secondary level. A higher share of a household's expenditure on education reduces the probability of school dropout.

Financial intervention such as a scholarship that directly goes into overall income may have little impact on the probability of dropout. If a scholarship is given directly to cover education expenditure, it will likely help decrease the dropout headcount.

The study also assessed the effectiveness of the scholarship amount being given at primary and lower secondary schools which showed that the current amount of primary scholarship is effective, while the amount at secondary schools need to be increased to keep potential working age children at school.

However, there is a need to conduct an evaluation on the national scholarship programme to see how efficient and effective the programme is in addressing dropout and keeping children in schools.

Lower Secondary Education – The Gross Enrolment Rate (GER)[103] for lower secondary has remained stable at a (low) level of around 55 per cent over the past three years. In upper secondary grades, the figure was just 24.3 per cent in 2015/16.

Throughout the period 2007/08-2015/16, dropout at lower secondary school (Grades 7-9) remained very high at around 20 per cent and this has not showed any significant improvement. Given this situation, progress with regard to completion of lower secondary has been very slow.

The 'push' and 'pull' factors on adolescents to drop out of school increases with age. Factors include: increasing demand by some sectors of the economy, for example, the garment industry for females and the construction industry for males; outward migration to work in other provinces or overseas, sometimes illegally; and/or a lack of enough education services within an accessible distance, especially in remote, rural districts.

Migration, legal or other, is not comprehensively monitored. However, from the most recent Inter-Censal Population Survey, in 2013 there were approximately 4.2 million migrants, of which only 2.5 per cent were cross-border. The same survey estimated that of all migrants in Cambodia, 8.3 per cent were between 10 and 19 years-old.[104]

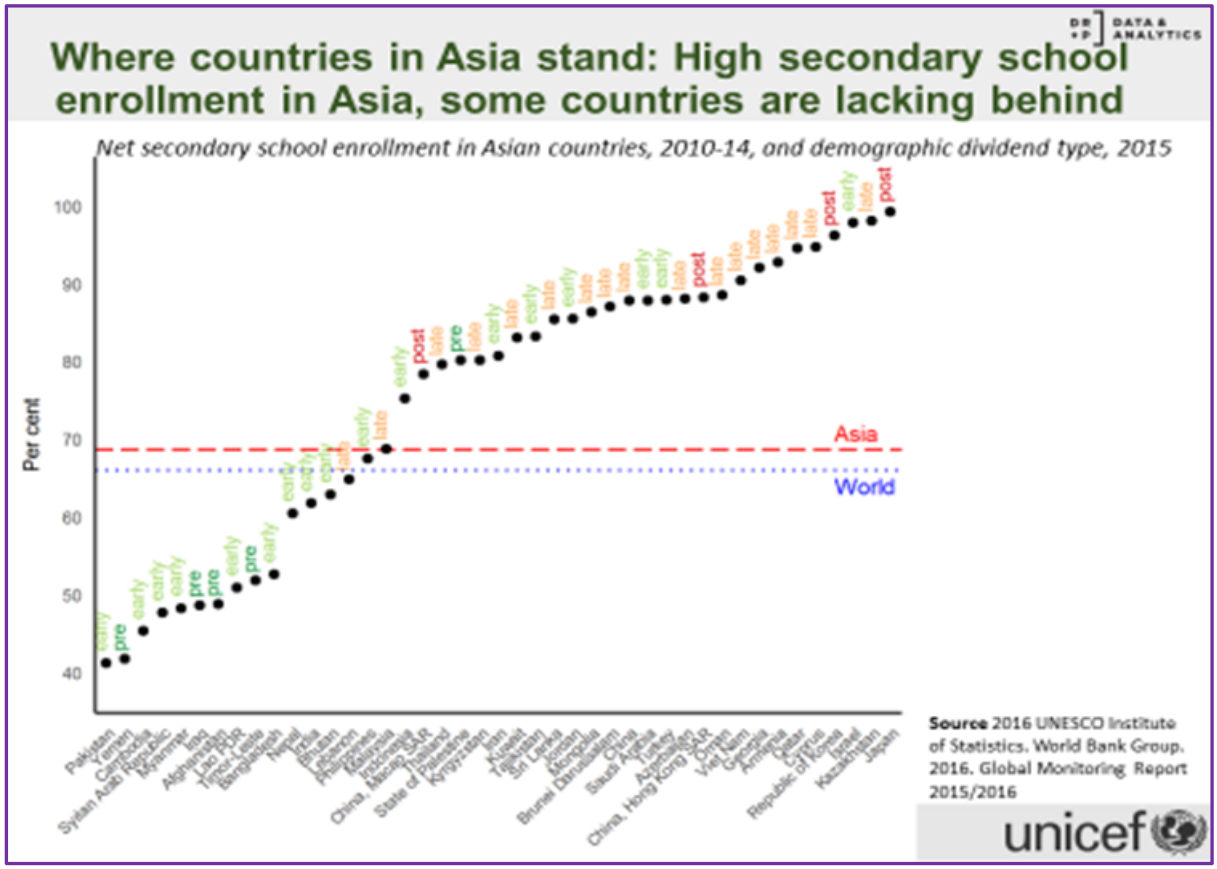
The numbers of out-of-school children in rural areas are almost double the proportion found in urban areas at the lower secondary level.

Economic factors were reasons given by 43.5 per cent of females and 36.8 per cent of males for not attending school at the time of the 2014 CSES.

School performance indicators are correlated with poverty and lack of infrastructure and resources including sanitation. Rural and remote areas, especially in the northern, north-east and far west provinces, show particularly poor indicators.

[103] Gross Enrolment Rate is defined as: total enrolment in lower secondary education / (total population aged 12-14) x 100 – this is a more reliable indicator at secondary school because of the low proportion of children who actually complete primary education at the appropriate age. Figures include public and private schooling.
[104] Creamer, O., Jordanwood, M., and Sao. S (2016) The Impact of Migration on Children in Cambodia, UNICEF, April 2016.

Figure 30: Net Secondary School Enrolment in Asian Countries 2010-2014



Upper Secondary Education – Dropout rates in upper secondary schools reached 23.8 per cent in the last academic year. Almost one-in-two male students in rural areas dropped out without completing the last grade of education. Upper secondary education indicators mirror the effects at lower secondary, with magnified pressures to drop out-of-school reflecting students' increased age.

Multilingual education – Among those most likely to miss out on formal education are the country's ethnic minority populations. Cambodia's ethnic minorities are mainly based in the five north-eastern provinces,[105] the largest being the *Kuy, Tampuen, Jarai, Bunong, Kavet* and *Kreung*, with over 200,000 native language speakers. The percentage of children from these groups who have never attended school is high, especially in Ratanakiri province, where 64 per cent of Cambodia's ethnic minorities reside[106].

Key factors for this lack of school attendance include: (i) high numbers of incomplete schools in rural areas; (ii) the historical absence of province-wide multilingual education (MLE) for the majority of children who do not speak the national language of Khmer, the main language of instruction; (iii) a lack of qualified MLE teachers, and; (iv) adaptive learning materials and textbooks.

To address the significant gap in school attendance, MoEYS first introduced MLE in 2002,

[105] Ratanakiri, Mondulkiri, Stung Treng, Preah Vihear and Kratie provinces.
[106] UNICEF, Cambodia Out-of-School Children Report, 2017.

with the support of partners including CARE International and UNICEF. The MLE programme enables pre-primary and primary-age children from ethnic minorities to learn in their mother tongue, while being progressively introduced to Khmer language as they advance through their education.

MoEYS also took care to establish the institutional framework for the MLE programme, with the development of the first Multilingual Education National Action Plan (MENAP), enabling full institutionalization of MLE and its incremental expansion.

Through this plan, MoEYS has established clear development targets, including increasing the number of multilingual education pre-schools by 88 per cent and the number of MLE primary schools by 100 per cent by 2018. As a result, enrolments in MLE have increased significantly, with nearly 5,000 primary students enrolled in 2016 – an increase of 22 per cent in one year.

While MLE is expanding access to some of the hardest-to-reach children, ensuring these children complete secondary education remains a challenge. Indeed, gross enrolment for lower secondary education in Ratanakiri province was 41 per cent in 2015-16, well below the national average of 55.7 per cent for the same period. In rural areas of this province, only 68 per cent of students transitioned to lower secondary school and only 11 per cent of students completed upper secondary education in 2015-16. These high student dropout rates are largely associated with the high opportunity costs of education. Opportunity costs of education are felt particularly strongly among families in the poorest quintiles, many of whom reside in the northeast region of Cambodia.

The lack of children from ethnic minority communities completing a full course of education reduces the potential of children from this group going onto become teachers and educating their counterparts in MLE in generations to come. In fact, a lack of qualified MLE teachers is already an obstacle to education for many children from ethnic minorities. Thus, without targeted interventions to address the causes of student dropout, the potential shortfall of qualified teachers will not be proactively addressed.

Children with disabilities – Due to societal norms, parental expectations for children with disability are typically low, which has knock-on effects, such as their education is not prioritized[107]. Some children with disabilities are never formally identified in a system sense, and so therefore the data on children with disability attending, or not attending school can only ever be an estimate and this is often unreliable.

Available data suggests that among children with disabilities of a schooling age (defined as 6-14 years), 70 per cent of these children were attending school in the academic year, prior to a survey compared to 90 per cent of children without disabilities[108]. For the all-age sample, 35 per cent of persons with disabilities had received no formal education compared to 14 per cent of the non-disabled population.
A similar proportion of the disabled population had completed primary school compared to

[107] UNICEF Cambodia, 2014: Aituation Analysis for Disability-Inclusive Governance And Community Development in Cambodia.
[108] Cambodia Inter-Censal Population Survey, 2013.

the non-disabled population (47 per cent compared to 52 per cent), yet persons with disabilities were approximately half as likely to complete secondary school than those without disabilities (16 per cent compared to 30 per cent)[109].

On average, persons with disabilities experienced 1.6 years or one-third less education than persons without disabilities. Inequalities in educational achievements are notably higher for persons with severe disabilities.

Approximately half of children with severe disabilities (48 per cent) attended school in the year prior to the survey and approximately half of the all-aged sample of persons with severe disabilities had completed no formal education (49 per cent)[110]. Across all education levels, persons with severe disabilities reported significantly lower completion rates and had completed approximately half the number of years of education compared with persons without disabilities.

4.3 Learning outcomes

Teachers - The availability of well-trained and supported teachers in all schools remains a critical issue for quality improvement and learning outcomes. The ESP-MTR notes the drop in Pupil/Teacher Ratios (PTR) nationally from 46.2 in 2013 to 44.8 in 2015. However, it also notes the figure masks disparities between rural and urban areas and among provinces. Six provinces have PTRs higher than 50 and some districts have PTRs in excess of 100.

This highlights the need for localized teacher recruitment and deployment strategies. Despite regular wage increases and incentives to work in rural and remote schools, teacher wages remain low (at 60 per cent of the wages of other professional workers in Cambodia)[111] and many teachers supplement their income with other jobs, including private tutoring to students within their own schools.[112]

Teacher Training Centres – The TPAP places great emphasis on enhancing the quality standards of Teacher Training Colleges (TTCs) and, in particular, reinforcing the qualifications of teacher trainers. Cambodia has 26 TTCs across the country, comprising a pre-school TTC; 18 Provincial TTCs-PTTCs, to train primary education teachers; six Regional TTCs-RTTCs, to train lower secondary education teachers; and the National Institute for Education (NIE) to train upper secondary teachers.

One of the targets of TPAP is that by 2020, 30 per cent of teacher trainers at PTTCs will hold a master's degree. For trainers at RTTCs, the target is that 90 per cent will hold a master's degree. The Teacher Task Force (TTF) appointed by MoEYS has identified several constraints to embark on a process of fast upgrading of teachers and trainers.
Among these is the limited current capacity of TTCs to offer a teacher education programme that would meet the standards required for a bachelor of education degree. Also, in terms of

[109] Ibid.
[110] Ibid.
[111] Cambodian teachers earn 60 per cent [of] the average monthly income of other professionals. Even though still underpaid compared to other professionals, teachers in Vietnam are in a slightly better position. Their income is 88 per cent of the average monthly income of other professionals.' (RESA, p.92). NB: The comparison jobs listed between countries was not consistent, casting doubt on the validity of the figures.
[112] RESA 2016.

their own qualification, teacher trainers in these centres will need to upgrade themselves. However, no higher education institution in Cambodia offers a post-graduate programme or equivalent courses for the development of teacher trainers.

Teacher qualifications – In the last 15 years, the education level of Cambodian teachers has improved considerably, but the combination of the Teacher Policy and TPAP aims to further raise qualifications standards. The current situation is that about 40 per cent of upper secondary education teachers hold at least a bachelor's degree. Most teachers in lower secondary education hold at least an upper secondary certificate.

The main challenge of upgrading the current teacher workforce to the qualifications set in the new teacher policy lies in upgrading primary education teachers. In 2015, 32.6 per cent of primary education staff had an education level below upper secondary, with the need being greatest in remote/rural areas. In Mondul Kiri province only 19 per cent of primary school staff hold the minimum education standard, compared with primary school staff in Kep province (90 per cent) and a high proportion of those in Svay Rieng (86 per cent) and Kampot (76 per cent) have attained at least an upper secondary certificate.[113]

Over one-half of trainers of primary school teachers at PTTCs holds a bachelor's degree and almost one-quarter holds an upper secondary certificate. The proportion of trainers with the required master's-level qualification is PTTC trainers 15 per cent and RTTC trainers 31 per cent.[114] Infrastructure improvements combined with the initiatives in education policy – especially the approval of the TPAP in 2015 – has led to a more strategic approach to improving education quality. This is key to the development of a capable and qualified teaching force that is able to deliver a curriculum that will provide quality learning outcomes.

Curriculum, textbooks and learning materials – Development of teaching materials, curriculum and training has progressed also, leading to a greater emphasis on education quality and learning outcomes as an overarching issue. Concerns over results from Cambodia's first Early Grades Reading Assessment (EGRA) in 2010 lead to an overhaul of curriculum and teaching methods, with the new textbooks returning to a more phonics-based approach. Textbooks for Grades 1, 2 and 3 were approved by MoEYS in 2011, 2012 and 2013, respectively.

The new textbooks are a departure from previous models as the early parts include teaching instructions, thereby removing the need for a teacher guide. Use of the new teaching methods has shown initial improvements in learning outcomes following pilot testing and in the 2012 EGRA (Primary Education Department reports).[115] MoEYS has also delivered a large-scale textbook orientation programme for each new textbook, but as the budget required to support such a comprehensive initiative reduced the available training duration to three days, not all teachers were fully confident of delivering the new curriculum[116.] MoEYS'

[113]EMIS: Education Statistics and Indicators 2015/16 (all figures in this paragraph).
[114] Data supplied by TTD correct from 01-Jan-2017 (latest surveyed figures do not include non-lecturing staff or staff currently undertaking training. Note that these figures are higher than the ESP-MTR CBI baseline (2015/16) for teacher trainer qualifications (page 19).
[115] Kann Puthy (2012) Towards Reading For All, MoEYS Primary Education Department.
[116] Unpublished data from 138 schools survey (2016) in TRAC+ EG development project by World Education, Inc.

commitment to a curriculum review resulted in a new curriculum framework[117] for all levels of education. This was approved in 2015. The new EG learning materials, including criteria-referenced tests, will also be piloted and phased in from the 2018/19 academic year starting with Grade 1[118]. In future, efforts should be made to ensure that all learning materials are accessible to children experiencing various forms of disability.

Learning assessments – There has been considerable progress in the implementation of learning assessments, including interventions by GPE1and GPE2. The creation of the Education Quality Assurance Department (EQAD) in 2009,[119] as a progression from the former Inspectorate of Education was an initiative to improve quality standards of monitoring and evaluation at all education systems levels, as well as beginning the process of the establishment of national testing.

The results of assessments are beginning to be disseminated but they are not impacting on system performance. EGRA was introduced in 2010 and more recently, Early Grade Mathematics Assessments (EGMA) have been undertaken. Assessments over a national sample of students have been organized for Grades 3, 6 and 8 covering Khmer language, mathematics and physics, the last for Grade 8 only. A variety of objective assessments have shown significant disparity between teacher assessments of student performance which determine student pass and promotion rates and actual student achievement. Some examples of this are shown below.

Table 6: Disparity between teacher-assessed pass rates and various administered EGRA/EGMA tools

Year	Tool	Grade	Result	National promotion rate (EMIS) (not by subject)
2010	EGRA (Primary Education Dept. (PED))	1	Letter recognition task: 50 per cent zero scores (Children unable to identify a single character correctly)[120]	2010 G1 = 77.5 per cent
2010	EGRA (PED)	2	Letter recognition task: 25 per cent zero scores	2010 G2 = 84.4 per cent
2012	EGRA (PED)	1	Letter recognition task: 35 per cent zero scores	2012 G1 = 80.4 per cent
2012	EGRA (PED)	2	Letter recognition task: 17 per cent zero scores	2012 G2 = 85.6 per cent
2015	EGMA (SESSP/PED)	1	8 per cent of students sample met standard required for G1 maths[121]	2015 G1 = 83.5 per cent
2015	EGMA (SESSP/PED)	2	8 per cent of students sample met standard required for G2 maths	2015 G2 = 87.1 per cent
2015	EGMA (SESSP/PED)	3	2 per cent of students sample met standard required for G3 maths	2015 G3 = 87.0 per cent

[117] Available to download from MoEYS website.
[118] All aspects of this are currently in the approval process. Detail is contained in the draft document: USAID (2017) Cambodia Technical Assistance for Coordination and Collaboration in Early Grade Reading Annual work plan (draft 3.1).
[119] Educational sub-decree 84, *prakas* 2792. EQAD functions are summarized on the MoEYS website.
[120] Research Triangle Institute (RTI)/USAID (2015) Assessment of Early Grade Reading in the Education Sector in Cambodia, RTI, North Carolina, 2015.
[121] MoEYS / SESSP (2016) Analysis of Early Grade Mathematics Assessment for Grades 1, 2, 3, and 6 in Cambodia, MoEYS, Cambodia, 2016.

2015	National Learning Assessment (NLA) by Education Quality Assurance Dept. (EQAD) (Khmer language)	3	24.4 per cent of G3 tested could not write a single word on dictation test.[122]	2015 G3 = 87.0 per cent
2015	EQAD National Test (Maths)	3	Quote: "The overall average correct of 41 per cent suggests that the average grade three student mathematics achievement is not at the expected (or desired) level."[123]	2015 G3 = 87.0 per cent

Analysis of the figures show that key disparities are evident by geographical area of residence and the socio-economic background of children. The gender analysis shows that girls achieve slightly higher results than boys. Irregular attendance in classes also has a negative link with learning outcomes and migration issues are highly significant. The PETS Report (2017) showed the level of student achievement in mathematics and physics tests is low.

"Regressions for 3rd and 8th Grade test scores show that, apart from the socioeconomic background of the student, absenteeism negatively affects scores, while those doing their homework obtain better marks. Increase parent engagement in school-related meetings and enhance parents' awareness. According to international experience, this leads to both improved student performance and school efficiency. Teacher behavior in class (e.g. using blackboard) and understanding of the curriculum affects student results strongly. Moreover, students in small schools and in schools with double shift tend to perform worse. Introduce the requirement of passing quality enhancing teaching certificates based on knowledge of the curriculum and classroom behavior 'best practices'. Use mobile technologies to better control for teacher absenteeism." – World Bank (2017): Cambodia Public Expenditure Review Discussion Paper.

School scholarships – One proven intervention for keeping children in school is the provision of scholarships. MoEYS has implemented a lower secondary education student scholarship programme since 2002 as part of its ESP pro-poor priority interventions to cover the cost of schooling for poor students.

As part of the initiative, poor families receive a conditional cash transfer provided their children enrol in school, pass school tests and have an 80 per cent attendance record. Priority for scholarships is given to girls if there is gender disparity and the academic performance of poor students is also taken into consideration. With new enabling legislation introduced in 2015, the scholarship scheme was expanded to reach a large number of lower secondary students. The legislation targets poor students, ID poor cardholders, or populations with similar living standards.

The expansion of the lower secondary scholarship programme has seemingly had a positive effect in improving student attendance. Indeed, one study (Cambodian Economic

[122] MoEYS (2016) Results of Grade Three Student Achievements from the National Assessment in 2015, EQAD, MoEYS, Cambodia, April, 2016.
[123] Ibid.

Association, 2015) simulating the effects of scholarships on the probability of school dropout found increased expenditure on education positively affected students' decision to stay in school. The simulation showed that with a scholarship of US$90 for lower secondary-aged students, the probability of dropout reduced by over 10 percentage points; and with a scholarship of US$135 the probability reduced by over 13 percentage points.

Further expansion of the scholarship programme, for both primary and secondary education, is envisaged in the National Social Protection Policy Framework, prepared under the leadership of MEF and adopted by the Council of Ministers in July 2017. The policy framework, however, foresees a phased approach to expansion, with activities up to 2020 aimed at reinforcing the implementation mechanisms of the scholarship programmes and the preparation of research for the eventual expansion of coverage and level of benefits.

In 2017, UNICEF, with funding from SIDA and Starwood through the UNICEF Australian National Committee, supported MoEYS to provide additional scholarships for upper secondary students from ethnic minority groups in the five northeastern provinces considered at risk of dropping out because of financial reasons.

Following a careful selection process, students from Grades 11 and 12 received a scholarship of US$150 twice per year, partially funded through MoEYS' programme budget and topped-up with funds from UNICEF.[124] In coordination with MoEYS' General Secondary Education Department (GSED) and provincial and district authorities, scholarship recipients are monitored to ensure compliance with the agreed conditions.

In 2017, approximately 520 students from ethnic minority communities are expected to benefit from joint MoEYS-UNICEF scholarship support. In the school year 2017-2018, a second cohort of students will be selected to receive MoEYS-UNICEF's scholarship support.

It is anticipated that this subsidy programme will help to ensure that some of the hardest-to-reach children are able to stay in school and complete a full course of education. Furthermore, by ensuring that students from ethnic minority backgrounds complete their formal education, it is envisioned that a larger pool of graduates will pursue teaching as a career in their communities given their niche linguistic skills. If this assumption proves correct, the sustainability of the MLE programme will be more secure for future generations.

Violence in schools – Schools have an important role in protecting children from violence. For many children, though, educational settings expose them to violence and may teach them violence. Children can be exposed to corporal punishment, cruel and humiliating forms of psychological punishment, sexual and gender-based violence and bullying. Often bullying is associated with discrimination against students from poor families or marginalized groups, or those with personal characteristics such as in appearance, or because of a disability. Despite corporal punishment being explicitly prohibited in Cambodian schools[125], quite often this ban is not adequately enforced. Cambodian teachers remain commonly reported

[124] While MoEYS provides US$90, UNICEF contributes US$60 to make a total of $150. There are, therefore, two streams of scholarships for students: a MoEYS scholarship of US$90 and a separate MoEYS-UNICEF scholarship of $150. These two streams are being provided to different students simultaneously. Both are provided twice per year. CARE International Cambodia is also providing scholarships to a separate stream of students from ethnic minorities in the northeast region.
[125] See Article 35 of the Education Law 2007 and Article 12 of the Sub-Decree on the Teachers Professional Code.

perpetrators of physical violence which negatively impacts on attendance, drop-out rates and learning outcomes. A 2014 UNICEF VAC survey found that teachers were the most common perpetrators of childhood physical violence outside of home settings among females and males aged 13-to-17 and 18-to-24 who experienced physical violence – with male teachers cited more often than female teachers across all groups.

In line with MoEYS' child protection policy, the ministry, with support from UNICEF, has developed an in-service teacher training package on positive discipline. This is aimed to foster secure, child-friendly and non-violent relationships between teachers and their students and it draws on national and international experiences and best practices.

The package and tools, which has so far been used to train teachers from over 400 primary schools in three provinces, focuses on effective ways to manage classrooms, resolve conflicts non-violently and create positive student-teacher relationships so students feel more comfortable talking with their teachers about violence-related issues.

4.4 Skills development of adolescent girls and boys

Adolescence is a critical time in which poverty and inequity can pass onto to the next generation. This is especially true with Cambodia's large percentage of young people where there is a clear link between family financial security and adolescent employment rates. Children from poor families in Cambodia are highly vulnerable, often facing daily threats to their health, education, safety and overall development.

With increasing economic pressure placed upon adolescents to help share the family economic burden, the socio-economic context of an adolescent in Cambodia is a key variable in determining educational attainment and resulting employment.

The national MDG target on enrolment in lower secondary school was missed, remaining as noted at around 55 per cent over the last three years, far below the target of 75 per cent. This is mainly due to poor flow rates and large overage enrolment in primary school, poor transition rates and high dropout rates.

The economic options offered with the growth of garment factories and the construction sector has meant that the opportunity cost for school is high at the lower secondary level. Research shows that school-going children who work more than 23 hours per week are likely to drop out. While the gender gap in lower secondary schools is being addressed, regional discrepancies and income disparities are high[126]. The vast majority of youth (72.4 per cent) leave school because of economic reasons and the average age of leaving school is 16 years, according to the International Labour Organization (ILO) in 2013. Youth unemployment is low, 2.4 per cent in 2014, compared to other countries in the region. Total unemployment in the population stands at 0.4 per cent in 2014, according to the World Bank. The main challenge facing Cambodian youth revolves around employment quality. Many are in the informal economy, earning low wages, do not have a written contract, nor access to benefits. Approximately half of youth are employed in the agricultural sector and 46.8 per cent are working as contributing family workers. Those not in employment,

[126] Cambodia Labour Force and Child Labour Survey 2013 National Institute of Statistics (NIS). Cambodia: ILO, 2013.

education or training (NEET) was 8.7 per cent in 2012, with young women more likely to have this status than young men, at 11.9 per cent and 4.8 per cent, respectively (ILO, 2015).

RGC, partners and the UN recently launched the 2017-2018 United Nations Joint Programme on Youth Employment in Cambodia. This programme seeks to promote decent employment among youths, women and vulnerable citizens. The programme will provide collective opportunities for RGC and partners, including UN, civil society organizations and the private sector to join hands in addressing employment issues and to thelp enhance better quality jobs for youths, especially the marginalized.

5. Every child is protected from violence and exploitation

Goal Area 3 within UNICEF's new Strategic Plan 2018-2021 seeks to ensure that every girl and boy is protected from violence and exploitation, in both humanitarian and development contexts. This includes all forms of violence, including gender-based violence (GBV), sexual exploitation and abuse. The duty to protect children from violence and exploitation is enshrined in numerous articles of the CRC, including articles 19, and 34 to 38. Goal Area 3 supports the achievement of multiple SDGs, in particular Goals 5, 8 and 16.

5.1 Child Protection Policy Context[127][128]

Every child has the right to grow up in a safe and nurturing environment, free from violence and exploitation. Cambodia has seen increased momentum regarding the introduction of laws to protect children and women. The Inter-Country Adoption Law; the Law on Suppression of Human Trafficking and Sexual Exploitation and its Explanatory Note;the Law on the Protection and Promotion of the Rights of Persons with Disabilities; the Law on Domestic Violence; the Sub-Decree on the Management of Residential Care Institutions (2015); and the Juvenile Justice Law (JJL) are among the major achievements[129].

Child protection sector financing – RGC's budget for child protection, including violence prevention and response, alternative care and child justice, is limited and the system relies heavily on donor funding. To build an effective child protection system, the country needs to adopt a systems-based approach based on a national vision for protecting children from harm. This includes having a legal framework and a comprehensive child protection law, in addition to defining a unified commune-level service delivery mechanism; improving government agency coordination and collaboration with NGOs; enhancing the human resource base, particularly qualified social workers; and strengthening monitoring and accountability systems.

RGC's budget does not categorize the child protection budget separately. Moreover, because child protection activities are conducted through different ministries, it is difficult to get a sense of the overall amount spent.

An exercise to identify the child protection budget was conducted in several ministry

[127] The section draws heavily on the draft 'A Statistical Profile of Child Protection In Cambodia' .
[128] See comprehensive list of secondary analysis – Child Protection List of New Knowledge 2016 and 2017, UNICEF May 2017.
[129] See the list of child protection 'new knowledge' which includes a detailed list of all new, laws, policies etc.

programme budgets, however, due to lack of explicit activities dedicated to child protection, it was not possible to produce a complete package of a child protection budget.

This report therefore uses the budget of the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY), the primary government agency responsible for children's protection, to indicate the proportion of the budget spent on this sector.

The share of MoSVY's total recurrent budget in the total national level recurrent budget increased from 4.3 per cent in 2010 to 5.7 per cent in 2017 and 5.8 per cent in 2018. The allocated budget increased from US$53.3 million in 2010 to US$219.1 million in 2018[130].

A substantial portion of MoSVY's annual budget (76.4 per cent in 2010 and 87.1 per cent in 2017) goes to servicing retirees and veterans, civil servant's work-related injuries and death, and social assistance transfer to the Cambodian Red Cross, leaving only a small percentage (23.6 per cent in 2010 and 13 per cent in 2017) to be spent on other services, including children. The table below presents the budget allocation by economic classification and programme budget allocation of MoSVY for 2016-2017.

Table 7: Budget for social affairs work and non-social affairs work under MoSVY's Budget

MOSVY Budget	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*
Total Recurrent Budget (TRB) in Mn USD	53.3	63.8	87.2	101.5	139.6	159.3	176.3	185.1
MoSVY RB in % of National Level TRB	4.3%	4.7%	5.6%	5.7%	6.8%	7.0%	6.4%	5.7%
MoSVY social affairs work in % of MoSVY TRB	23.6%	25.5%	15.3%	15.0%	12.3%	12.1%	12.3%	12.9%
Sum of Non-MoSVY Work on Social Affairs	76.4%	74.5%	84.7%	85.0%	87.7%	87.9%	87.7%	87.1%
MoSVY social affairs work in % of National Level TRB	1.0%	1.2%	0.9%	0.9%	0.8%	0.8%	0.8%	0.7%

Source: MEF Budget Book 2010-2017.

The child welfare budget is part of the sub-programme two budget under programme one; however, the budget for the Department of Child Welfare is very small compared to the demand of work and interventions needed.

So far, many interventions are still funded by development partners and NGOs. Other MoSVY departments also have contributed to the welfare of children including children with disabilities, children in conflict with the law, child adoption, monitoring of the child rights indicator and others.

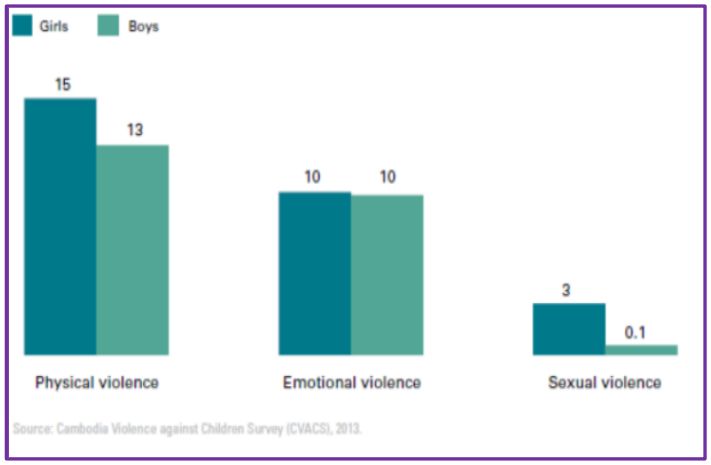
5.2 Violence

The experience of violence in childhood is commonplace in Cambodia. In 2015, the estimated murder rate among children aged 0-19 years was one per 100,000. Beyond the

[130] Budget Law 2010-2018. Exchange rate used: US$1=4050 riels.

toll on individuals, the social and economic impact includes extra strains on the health-care system due to excessive use of services. In extreme cases, such violence against children can result in disability or death, as well as increased levels of violence and criminality.[131]

Figure 31: Percentage of adolescents aged 13-17 years who have experienced violence in the past 12 months, by sex, by type of violence (CVACS, 2013)



The *Economic Burden of Violence Study*, based on research from the 2013 VAC) revealed that selected health consequences of violence against children accounted for one per cent of Cambodia's GDP, or a total of US$168 million. The loss of productivity due to childhood violence accounted for 0.55 per cent of GDP, or US$83 million. According to the VAC survey, 53 per cent of females and 54 per cent of males aged 18-24 reported at least one incident of physical violence prior to the age of 18. Among 13-17 year-olds experiencing physical violence over the past 12 months, 15 per cent were girls and 13 per cent boys.

Emotional violence in childhood is also widespread. Among those aged 18-24, 19 per cent of females and 25 per cent of males reported experiencing emotional violence before the age of 18. The percentage was smaller among 13-17 year-olds; 10 per cent of both boys and girls in this age group said they had experienced emotional violence over the past 12 months. Four per cent of females and six per cent of males aged 18-24 reported any type of sexual violence prior to the age of 18. Among those aged 15-17, three per cent of girls and less than one per cent of boys reported incidents of sexual violence over the previous 12 months. While the lifetime experience of violence is high, fewer children have experienced violence in the last 12 months[132].

Both the VAC survey and the 2014 CDHS suggest that the majority of perpetrators of violence against children are known to the victims and come from their own families or communities. Of the 13-17 year-olds who reported sexual violence prior to the age of 18, the most common perpetrators of the first incident were friends (for girl victims), or family members (for boy victims). The average age at which 18-to-24-year-olds first experienced sexual violence prior to the age of 18 was 15 for females and 10 for males. Similarly, respondents aged 13-17 were likely to have experienced physical violence from a parent, a caregiver, an adult relative, or a community member.

Vulnerabilities of women with disabilities to violence – A study was undertaken in 2013 on gender-based violence and human rights violations experienced by women with disabilities in Cambodia. The research found that women with disabilities and women without disabilities faced similar levels of sexual, physical and emotional violence from partners.

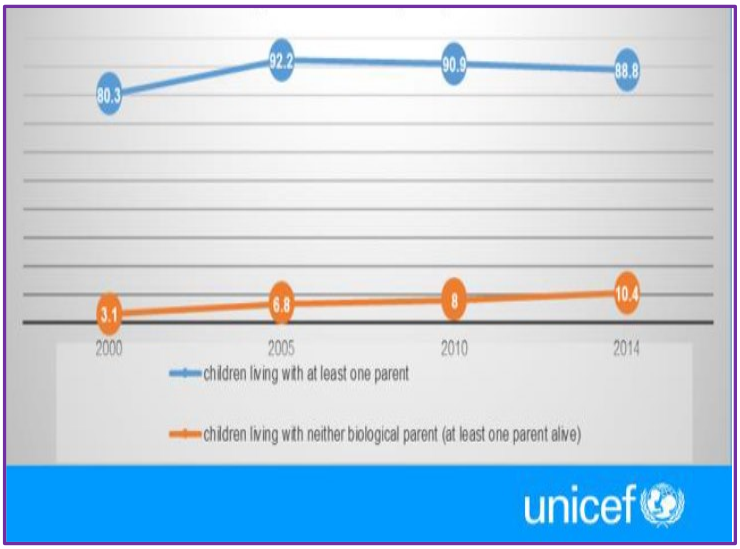
[131] Cambodia Violence Against Children Report, 2013.
[132] Ibid.

However, the picture that emerged in terms of family violence, excluding partners, was starkly different. Women with disabilities experienced much higher levels of all forms of this violence. They were much more likely to be insulted, made to feel bad about themselves, belittled, intimidated and subjected to physical and sexual violence compared to their non-disabled peers. These results, building on scarce developing country evidence, point to an urgent need for mainstream services to ensure that women with disabilities can access help. There is also a need to provide services for people with disabilities that address gender concerns. Similarly, it is critical that discriminatory attitudes which condone and perpetuate violence against women with disabilities are challenged and transformed[133].

Alternative care for children – Decades of research shows that living in residential care can harm a child's social, physical, intellectual and emotional development. In particular, children who are placed in residential care institutions in their early childhood are at risk of being deprived of critical social and emotional development which can affect their future learning abilities.

Many children in residential care institutions come from families who cannot afford to feed, clothe or educate them. Poor families are sometimes coerced or manipulated into giving up their children by operators who hope to profit from the residential care home, or by trafficking children. Despite their best intentions, some donors and foreign volunteers have unwittingly increased the number of profit-seeking residential care homes by funding their operations and paying high fees to conduct altruistic activities, a practice known as 'orphanage tourism' or 'voluntourism'.

Figure 32: Children's Living Arrangements



RGC's Policy on Alternative Care for Children (2006); the Minimum Standards on Alternative Care for Children (2008); the *Prakas* on procedures to implement the policy on alternative care for children (2011); and the recent Sub-Decree on the Management of Residential Care Institutions (2015) clearly state that family- and community-based care are the best options for the alternative care of children and that institutional care should be a last resort and a temporary solution and that the primary role in protecting and caring for children lies with their family. However, new mechanisms to prevent the admission of new vulnerable children to residential institutions and to respond to abuse and violence of children in residential care facilities still need to be strengthened and fully operational at the national and sub-national

[133] Triple Jeopardy: Gender-based violence and human rights violations experienced by women with disabilities in Cambodia, DFAT, Australia 2013.

level.

MoSVY undertook a mapping survey of residential care facilities in Cambodia, with support from UNICEF[134]. This provides new data on the situation of the institutionalization of children and confirms that far more residential care institutions are operational in Cambodia than previously recorded by MoSVY. According to the findings, 16,579 children were found to be living in 406 residential care institutions spread across Cambodia, far more than what was known to MoSVY.

Previously available data through MoSVY's inspection process had recorded 254 institutions, with 11,171 children living in them. Many residential care institutions are out of the ministry's regulatory framework; 38 per cent of them have never been inspected by MoSVY; 12 per cent are not registered with any branch of government and 21 per cent do not have a memorandum of understanding with RGC. This lack of accountability raises significant concerns over the well-being of the children living in them.

An Action Plan was signed in October 2016 by MoSVY to support implementation of the Sub-Decree on the Management of Residential Care Institutions, a significant policy breakthrough that aims to regulate residential care in Cambodia and the accompanying Statement of Commitment, both of which require MoSVY to undertake a number of critical actions to promote family and community-based care.

The action plan aims to improve child care by promoting family preservation, de-institutionalization, the reintegration of children and alternatives to institutional care. Specifically, the plan aims to reintegrate 30 per cent of children in residential care institutions (about 3,500 children) in the five priority provinces of Battambang, Kandal, Phnom Penh, Preah Sihanouk and Siem Reap. The plan covers guiding principles, key strategic actions, expected results by province, roles and responsibilities and critical success factors[135].

5.3 Harmful practices against girls and boys

Child marriage – In Cambodia, marriage is illegal without parental consent before the age of 18. From 16-to-18, girls and boys can legally marry if they have parental approval. In this report, 'child marriage' is defined as marriage or union before the age of 18, in line with the rights perspective, even though marriage is legal in Cambodia with parental consent from the age of 16. Child marriage in Cambodia has been in decline over time. In 1989, 28 per cent of women aged 20-24 were married before the age of 18 compared to 19 per cent in 2014. Progress has been even faster when it comes to the marriage of girls under the age of 15, declining from seven per cent in 1989 to two per cent in 2014. However, progress in reducing child marriage overall appears to have stalled in the last five years and too many girls are still marrying in their adolescent years. The median age at first marriage among women in Cambodia has remained more or less stable for the past two decades at around

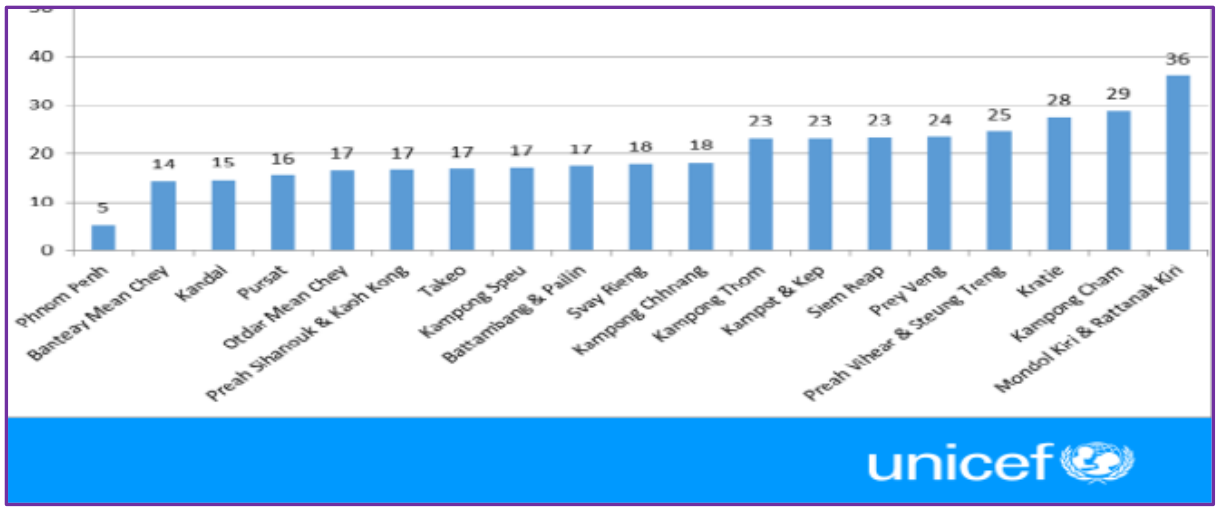
[134] MoSVY released two key publications: 'The Mapping of Residential Care Facilities' and the 'Action Plan for Improving Child Care in Cambodia'.
[135] See additional information in the provincial operational plan regarding the five provinces. There is no information about new knowledge from other studies that were undertaken recently, namely the study on funding and financial models of RCI, Alternative Care Community Practices and the Capacity Development plans for Family Support, Foster Care and Adoption and enhance alternative care for CWD.

20-21 years-old.

Child marriage is known to be widespread among certain ethnic groups and in certain parts of the country. Unfortunately, information on ethnicity was not collected in the 2014 CDHS and therefore could not be analyzed in relation to child marriage. However, the proportion of young women aged 20-24 who were married before the age of 18 shows wide variations by geographic location – ranging from a high of 36 per cent in Mondul Kiri and Ratanak Kiri provinces to a low of five per cent in the capital Phnom Penh.

If the rate of progress in reducing child marriage seen over the last 25 years continues, the proportion of women aged 20-to-24 who were married as children may continue to drop; from 28 per cent in 1989, to 19 per cent in 2014, to 14 per cent in 2030. However, if the rate of decline doubles, the prevalence of child marriage could fall to as low as 11 per cent by 2030.

Figure 33: Percentage of women aged 20-24 married/in union before age 18, by province



Child labour – In Cambodia, the Labour Law (1997) allows children as young as 12 years-old to work in light and non-hazardous employment that does not interfere with their education. The minimum legal age for general employment in the country is 15 years and 18 years for hazardous work (as defined in the law). Child labour takes many different forms. However, a priority is to eliminate without delay the worst forms of child labour as defined by Article 3 of ILO Convention No. 18: labour that jeopardizes the physical, mental or moral well-being of a child, either because of its nature or because of the conditions in which it is carried out (also known as 'hazardous work').

Of Cambodia's nearly four million children aged five-to-17 years, 19 per cent were economically active in 2014. No significant difference was found between the number of economically active girls (19 per cent) and boys (20 per cent). The percentage of working children declined from 2012- 2013, with no significant changes since that time. A 2012 report from ILO and NIS provides more specific information on types and conditions of child labour in Cambodia. That year, the majority of children aged five-17 (81 per cent) were not working or looking to work, while 19 per cent were working or economically active.

This data is similar to that reported in the Cambodia Socio-Economic Survey. According to the ILO/NIS report, 11 per cent of all children aged five-to-17 in Cambodia were engaged in child labour (six per cent in hazardous conditions; five per cent in some other form of child labour), while a further eight per cent were working but not considered to be child labourers.

Of the total number of working children, 57 per cent were engaged in child labour while 43 per cent were working but not considered to be child labourers. Among the child labourers, 55 per cent were exposed to hazardous conditions and 45 per cent worked in other forms of child labour.

The ILO/NIS report also provides disaggregated data. It shows that participation in economic activity and child labour was lower among children in urban compared to rural areas, but there were no differences by sex. Kampong Cham and Battambang provinces had the largest numbers of working children and child labourers and Kep had the smallest.

Less than one per cent of all economically active children performed domestic work, 88 per cent of whom were girls. Around half (49 per cent) of all child labourers aged five-to-17 were unpaid family workers and the largest share of child labourers worked more than 48 hours per week. The ILO/INS report also found that, of the total child population aged 5-17 years, an estimated three per cent (129,106 children) were migrants. Just over one in three (38 per cent) of all working children were migrants.

Child trafficking – The lack of comprehensive data on trafficking makes it impossible to know the precise number of people, including children, affected. While trafficking can be for any purpose, including domestic servitude or labour, the limited related data available for Cambodia is focused on commercial sexual exploitation.

Other forms of trafficking known to exist include trafficking for the purposes of marriage, forced labour, or forced begging. Several small studies reveal the extent to which children are being trafficked for sexual exploitation. For example, 41 per cent of the 165 cases of trafficking for sexual purposes reported by NGOs in 2007-2008 were found to be children, the youngest aged just eight years-old. Girls and women aged 13-25 were most often trafficked. According to the International Justice Mission, sexual trafficking in Cambodia has declined significantly over the last decade.

The methodology used in two prevalence studies conducted by the organization was limited to specific types of commercial sexual establishments in selected urban centres. However, it indicated that commercial sexual exploitation of children declined from eight per cent in 2012 to two per cent in 2015.

This finding should be viewed in light of the 1999 estimate from ILO's International Programme for the Elimination of Child Labour, which showed that more than 15 per cent of commercial sex workers in Cambodia were aged between nine and 15 years-old.
In 2014, the Anti-Trafficking Police in Cambodia rescued 101 underage victims of trafficking and referred them to MoSVY, while the ministry identified and assisted 336 victims, including 218 minors, who were among those repatriated from Thailand. While sexual trafficking has declined, labour trafficking remains a significant and growing concern in Cambodia,

according to the International Justice Mission.

The 2015 Walk Free Survey sought to identify instances of both forced marriage and forced labour within the general population. It estimated that as many as 256,800 Cambodians (or 1.65 per cent of the total population) live in conditions of modern slavery and that over 75 per cent of them were victims of labour trafficking. Many were identified in the fishing and seafood industries, manufacturing sector, or in forced marriages. Child specific data was not available.

According to the US government's 2015 Trafficking in Persons (TIP) report, Cambodia is a source, transit and destination country for forced child labour and child sex trafficking. All of Cambodia's provinces are a source for trafficking, while destinations primarily include cities within Cambodia, the rest of the region and increasingly, Africa.

The report also reveals how children from impoverished families are highly vulnerable to forced labour and that parents are often complicit in this practice.

The demand for the sale of virgin women and girls continues to be a problem. Cambodian men are the largest source of demand for child prostitution, however, men from the region and overseas countries also engage in child sex tourism.

The TIP report placed Cambodia in the 'Tier 2 Watch List' in 2015, indicating that the country has not made serious and satisfactory efforts to counteract trafficking. Cambodia has hovered around Tier 2 and Tier 3 for the last seven years (Tier 1 is considered the best and Tier 3 the worst).

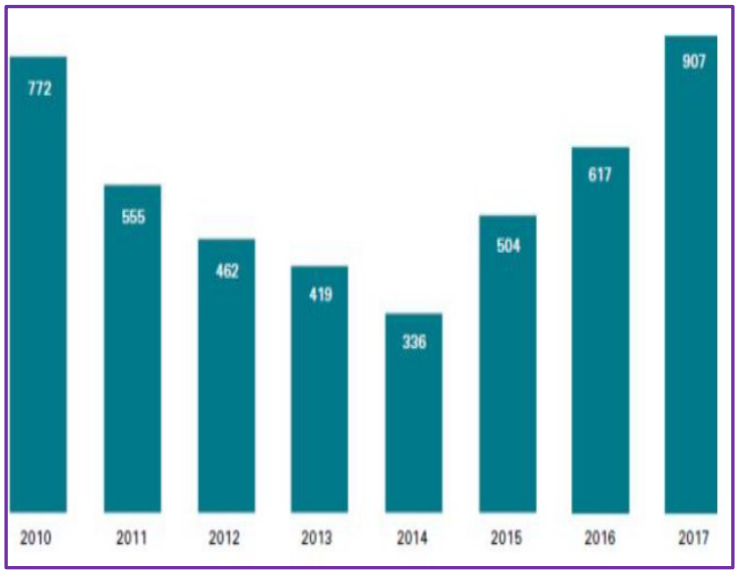
5.4 Juvenile justice

Although the 2009 Penal Code specifies 18 years as the legal age of criminal responsibility in Cambodia, the court may pronounce a criminal conviction against a minor as young as 14, depending on the circumstances. In Cambodia, up to half of all children charged with a felony are treated as adults in the criminal justice system.

Children from poor families face particularly high risks of unlawful deprivation of liberty since they cannot afford legal representation. Reports indicate that children are at risk of violence at every stage of the process when in contact with the law – from the time of arrest to being held in detention and appearing in court.

According to MoI data, 907 juveniles are currently in prison and most are male (see figure 34). Between 2010 and 2014, there was a 56 per cent decrease in the number of juveniles in prison, followed by an increase in the last few years.

Figure 34: Number of Juveniles aged 14-17 years in prison
(**Source**: Ministry of Interior, 2017)



The long-awaited draft juvenile justice law was signed by Royal Proclamation in July 2016 and came into force in January 2017. The law is the first measure of its kind to protect children in conflict with the law in Cambodia.

It focuses on diversion (the conditional channelling of children in conflict with the law away from judicial proceedings through the implementation of programmes that enable children to be dealt with by non-judicial bodies, thereby avoiding the negative effects of formal judicial and a criminal record) as the proper response to alleged youth criminality rather than punishment, which is the current approach in a country that lacks a system tailored to the needs of children.

The new law must be properly implemented so that it actually benefits children. UNICEF has proposed to RGC to hold a consultative process involving concerned ministries and NGOs to work on the development of a three-year implementation plan that will detail the necessary next steps for the implementation of the law.

This plan may include various reforms. In the short-term it will be important to address the urgent situation of children in prisons and provide training to concerned community members and legal actors. In the mid-term considerations can be given to training police, judges and prosecutors, while developing effective diversion programmes and strengthening training schools and rehabilitation centres.

In the long-term, the establishment of specialized courts for juvenile justice can be considered. There are various actions that need to be taken within the framework of the new law and an implementation plan involving key actors is critical to take this work forward[136].

5.5 Birth registration

Registering children at birth is critical – both for access to essential services as well as protection in the event of separation, abandonment or abuse. Birth registration can also safeguard underage children from marriage, child labour and conscription into the armed forces. Birth registration is both a right and also a way of ensuring that other rights violations do not go unnoticed. To safeguard their children's future, Cambodian parents are obliged to register their child's birth under sub-decree 103 on civil status (civil registration). The quantity of birth registration in Cambodia has improved slightly since 2010, however, the births of 27 per cent of children under age five (approximately 1.6 million) were not registered in 2014. The level of birth registration shows some disparities, except by sex. Birth registration increases with age; the wealth status of households; the educational level

[136] Juvenile Justice Law, 2016

of mothers; and residence in urban areas, compared to rural.

Significant regional variations are conspicuous; the four provinces of Phnom Penh, Svay Rieng, Kandal and Otdar Meanchey had a registration rate of over 80 per cent, while the provinces of Kratie, Mondul Kiri and Ratanak Kiri had less than 50 per cent. Levels of birth registration are consistently higher among children from urban rather than rural areas. Similarly, birth registration is consistently higher among those living in the richest 20 per cent of households – which is measured by an index of possession of household assets rather than income – than children from the poorest 20 per cent of households.

In the course of about a decade, the gap in birth registration rates between children in the highest and lowest wealth quintiles increased slightly. If trends observed between 2010 and 2014 continue, Cambodia will be able to achieve universal birth registration by 2025, which is target 16.9 of the SDGs. Available data indicates that such progress is possible; the rate of increase since 2010 is already faster than the average rate achieved over the nine-year period from 2005-to-2014.

5.6 Rights of child migrants[137]

The urban population in Cambodia is expected to double by 2030. As highlighted earlier in this analysis, older adolescents, aged 15-19, are increasingly migrating towards urban spheres thereby putting them at increased risk of crime, hazardous working conditions and violence.

Rapid population growth has put considerable pressure on Phnom Penh; specifically within its urban poor communities. Children and adolescents constitute one of the most vulnerable segments of the population residing within these communities.

The UNICEF Urban Poor study of 2017 revealed that 50 per cent of families in urban poor communities survive on less than one US dollar a day. This extreme poverty is interlinked with most of the key protection risks faced by children and adolescents in marginalized communities such as domestic violence, sexual abuse, child trafficking, early marriage, child labour and substance abuse.

Socio-economic and structural barriers have left children and adolescents exposed to a number of health and sanitation-related risks. Adolescents residing in urban poor communities are also noted to be at a higher risk of coming into conflict with the law. Statistics gathered through this study confirm that some child protection risks are more acutely felt within urban poor communities.

Many children have limited access to pre-schools and the quality of education being imparted to adolescents is sometimes questionable. In the school environment, adolescents are exposed to risks such as corporal punishment, bullying and general neglect from teachers. The interplay of economic barriers, socio-cultural norms and risks at school put children and adolescents from urban poor communities in need of immediate care and

[137] Additional information on cross-border migration as well as in-countrymigration available in the UNICEF study has good data and includes figures on forced repatriations.

support from authorities, as this deprived group are more vulnerable to sexual exploitation, trafficking, etc.

6 Every child survives in a safe and clean environment

Goal Area 4 within UNICEF's new Strategic Plan 2018 – 2021 focuses on the impact of the environment on children's survival and development and prioritizes a safe and clean environment for children – a right enshrined in article 24 of CRC. This Goal Area contributes to Sustainable Development Goals 6, 11, 13 and 16.

No child should die or suffer as a result of drinking contaminated drinking water; being exposed to other people's excreta; or being deprived of WASH facilities. No child should have to stay away, or even abandon their basic right to an education, over the lack of a clean and private toilet. No mother or newborn should contract an infection from an unsanitary delivery room when they are at their most vulnerable. No person should suffer the indignity of having to defecate in the open.

Access to safe water, improved sanitation and proper hygiene is vital to the well-being of children. It contributes to good health and nutrition (Goal Area 1), quality learning (Goal Area 2) and dignity – especially for women and girls.

This is why the 2030 Agenda for Sustainable Development recognizes safe drinking water, effective sanitation and WASH, both as an objective and as a driver of progress on many of the SDGS, including health, nutrition, education and gender equality.
To meet these targets, there is a need for a better understanding of progress made so far and a strategic approach to meet the challenges that lie ahead in the collective effort to reach every community, every family, and every child. SDG targets 6.1 and 6.2 relate to drinking water, sanitation and hygiene and are far more ambitious than the previous MDG target 7c, which aimed to halve the proportion of the population without access to water and sanitation by 2015.

First, the SDG targets call for universal and equitable access for all, which implies eliminating inequalities in service levels. Second, they include hygiene, which was not addressed in the MDGs. Third, they specify that drinking water should be safe and affordable and that sanitation should be adequate. Lastly, they include references to ending open defecation and to the needs of women and girls and those in vulnerable situations.

6.1 WASH Policy Context

One of the key distinguishing features of WASH in Cambodia is that responsibility for the different components of this area are distributed across a number of RGC bodies and there is a critical need for strengthened overall strategic or programmatic coherence. In rural communes, water services are organized under the Ministry of Rural Development with a community-based management system.

Urban communes are regulated under the Ministry of Industry and Handicraft (MIH) through a business licence management model. The (urban or rural) classification is not affected by the installation of piped water systems and for this reason, MIH, in agreement with MRD,

also implements public-private partnership (PPP) contracts for piped systems in many rural communes.

Further adding to this complex and fragmented situation is the vast number of government ministries that play a role in water and sanitation, plus the multiplicity of donors, NGOs and private operators that are active in the water sector with limited coordination. The decentralization process to improve service delivery is still on-going.

Other key challenges in this sector include uneven institutional capacities, especially at the decentralized level; arsenic contamination of groundwater in some areas, especially along the Mekong River; the availability and use of unimproved water sources in rural areas; and the prevalence of corruption.

In 2003, the Council of Ministers approved a National Policy On Water Supply And Sanitation (NPWSS) for both rural and urban areas and in 2004, the Ministry of Industry, Mines and Energy (MIME) prepared a national strategy on urban water. In 2010, MIME also developed an action plan for the urban water supply.

A master plan for sanitation in Phnom Penh has been developed under the Ministry of Public Works and Transport (MPWT) and supported by the Japan International Cooperation Agency (JICA). Coherence was brought to the rural WASH sector with the formulation of the Rural Water Supply, Sanitation and Hygiene (RWSSH) Vision of full coverage by 2025, along with the National Strategy on Rural Water Supply, Sanitation and Hygiene (NSRWSSH) 2011-2025 and the rural WASH NAP 2014-2018.

RGC's vision for the sector is that every rural citizen has sustained access to a safe water supply, improved sanitation services and the ability to live in a hygienic environment by 2025. This vision is clearly stated in the 2003 NPWSS. The NSRWSSH 2011-2025 is to support RGC to achieve this vision.

The strategy has five key objectives:

- Water supply: By 2015 50 per cent and by 2025, 100 per cent of the rural population will have sustainable access to an improved water supply.
- Sanitation: By 2015 30 per cent and by 2025, 100 per cent of the rural population will have sustainable access to improved sanitation services and live in a hygienic environment.
- Hygiene promotion: By 2015 30 per cent and by 2025, 100 per cent of the rural population will practice basic, safe hygienic behaviour.
- Enabling environment: By 2015, institutional arrangements, legal instruments and human resources will be operational and able to rapidly increase and sustain services.
- Financing: Funding for capital and recurrent expenditure will be available.

The strategy identifies 2010-2015 as a transition period to strengthen institutional arrangements and undertake capacity building, with 2015-2025 to be focused on expansion of services.

Enhanced understanding of the links between WASH and under-nutrition in recent years has informed improvements in multi-sectoral policies and programmes. However, substantial knowledge gaps remain. Research and programmes to date have largely focused on rural settings, but the extent to which the conditions of poverty, overcrowding and poor quality water and sanitation services interact to magnify these risks in densely populated peri-urban areas has received less attention.

Water and Sanitation sector financing – In order to reach the 2025 goals for rural and urban subsectors, about US$92 million is required annually for spending on water supply infrastructure and about US$119 million annual on capital spending for sanitation, which includes the development of new facilities, as well as replacement of existing infrastructure.

For water supply, this is about 2.7 percent of the 2014 national budget of US$3.4 billion and for sanitation about 3.5 per cent.[138] The total for water supply and sanitation of US$211 million per year in order to reach 100 per cent coverage by 2025 is about 1.4 per cent of total 2013 GDP of US$15.25 billion.

About US$24 million per year on average would be needed to finance operation and maintenance of current and future infrastructure. Moreover, additional software financing is needed, especially in the rural subsectors, for community mobilization, capacity building, promotion and operational expenditures[139].

The urban sanitation sector has been characterized by project-based investments in critical flood protection measures, as well as sewer systems in Phnom Penh and two other towns. As indicated in the Cambodia Water and Sanitation Sector Review, a strategic vision and coherent institutional framework – at national and service provider level – is required to address the entire sanitation value chain: collection, management; treatment and disposal of faecal waste, including networked sewers, waste water and septage treatment; and faecal sludge management solutions for on-site solutions. The fact that the urban sanitation sector is still in the early stages of development is reflected in a scorecard that illustrates key bottlenecks in terms of enabling policy environments, as well as challenges to expand and increase service levels in a sustainable way.

Government financing for WASH – Rural water supply, sanitation and hygiene fall significantly under the mandate of MRD. The ministry allocated a budget toward two sub-programmes: promoting rural water supply service provision; and promoting rural sanitation service provision under programme two for rural WASH, with responsibility by the Rural Water Supply Department and the Rural Health Department.

Since the ministry started formulating and implementing the programme budget in 2015, the budget allocation for WASH is clearly presented, creating space for budget advocacy for WASH given its small budget allocation against WASH indicator gaps and disparities, as well as national targets.

Budget allocation to sub-programme one: ‘Promote rural water supply service provision’ is

138 World Bank ‘Service Delivery Assessment’ 2015.
139 Ibid.

only 1.9 per cent of MRD's total budget (recurrent and capital) in 2015 and increased to 2.5 per cent in 2017. Sub-programme two: 'Promote rural sanitation service provision' is only 0.9 per cent of MRD's total budget in 2015 and increased to 1.6 per cent in 2017. Budget allocation by province is also not aligned with provincial targets which need to be reallocated to realign with provincial indicators[140].

There is also spending in other areas contributed from part of the school operation budget and commune/*sangkat* fund. However, it is difficult to generate a WASH budget from the two due to line item budget challenges. The record is available at individual school and commune/*sangkat* accounts. In 2016 and 2017, MoEYS, with support from MEF, allocated a specific budget for the construction of WASH facilities at around 200 schools lacking WASH facilities.

6.2 Updated status of key WASH indicators

During 2016, the Joint Monitoring Programme (JMP) global database was restructured and expanded to incorporate new information required for SDG monitoring. While very few countries have disaggregated information on the populations using safely managed water and sanitation services, the database on basic services has been further expanded to include new estimates by wealth quintile and by subnational region for over 80 countries. The data from the JMP 2017 Report is presented overleaf for Cambodia.

Table 8: Per cent Distribution of Population by type of Drinking Water, Sanitation and Hygiene, by location

Cambodia	***Drinking water***			***Sanitation***			***Hygiene***		
	National	Rural	Urban	National*	Rural*	Urban*	National	Rural	Urban
	2015	2015	2015	2015	2015	2015	2015	2015	2015
Safely managed	24	16	55	-	-	-	-	-	-
Basic service	51	54	40	49	39	88	66	60	88
Limited service	0	0	0	8	7	9	13	15	5
Unimproved	12	15	2	3	4	1	-	-	-
No service	13	15	2	41	51	3	22	26	7

Source: *WHO/UNICEF JMP (2017)*

Basic drinking water services – The availability of water resources in Cambodia is generally high. The country has abundant rivers, dominated by the Mekong and water bodies, including the great lake of Tonle Sap, which are fed by relatively high rainfall.

Table 9: Per cent Distribution of Population by type of Improved Sources Drinking Water, by location

[140] For more detailed analysis, please refer to the forthcoming UNICEF budget analysis for WASH (2017).

	National	Rural	Urban
Year:	2015	2015	2015
Proportion of population with improved:	75	70	96
Proportion of population with improved sources which are:			
Accessible on premises	58	54	75
Available when needed	-	-	-
Free from contamination	24	16	55
Safely managed	**24**	16	55

Notes: The indicator for SDG 6.1, safely managed drinking water services are defined as use of an improved drinking water source which is accessible on premises, available when needed and free from contamination. To make an estimate of safely managed services, information on the use of improved drinking water sources is combined with information on the accessibility, availability and quality of drinking water. Estimates are based on the minimum value of these criteria or, where estimates are available for both rural and urban, a population weighted average of the two. The JMP reports estimates for safely managed drinking water provided information is available for at least 50 per cent of the population on quality of drinking water and either accessibility or availability.

According to JMP, 70 per cent of the rural Cambodian population had access to an improved water source in 2017 – a considerable increase from 22 per cent in 1990 (annual growth rate of +1.5 per cent)[141]. Piped connection on premises increased from 0 per cent to 7 per cent, and this increase has accelerated in recent years.

However, this still means that around one-in-three Cambodians in rural areas still lacks access to an improved water source as per JMP definition. These estimates also do not reflect the multiplicity of water sources concurrently used by households – especially the poorest who, during the country case study, were observed using different water points in accordance with their needs and changing supplies influenced by the dry/wet seasons.

In Cambodia, there are an estimated one million small wells fitted with donated AFRIDEV pumps or locally-made hand pumps. The number of these interventions has helped increase access. However, according to the 2017 JMP report, rural water coverage in Cambodia still lags behind neighbouring countries.

Data shows that, out of nine countries, Cambodia has the second lowest safe water coverage and the proportion of households with access to safe drinking water increased only marginally during the evaluation period – 54 per cent in 2013, up from 49 per cent in 2005.

This small increase suggests that the large Rural Water Supply (RWS) programmes implemented since 1980, including those supported by UNICEF, and public investment poured into the sector have not been sufficient to effectively provide access to ‘clean water’ in relatively dense regions. This is particularly true in the Mekong delta provinces.

Access to an improved water source is also subject to geographical variations, with access of 82 per cent in urban areas compared to 50 percent in rural areas and 27.1 per cent in Kep province, compared to 98.5 per cent in Svay Rieng province[142].

[141] WHO/UNICEF Joint Monitoring Programme 2017 report.

[142] Water Supply and Sanitation in Cambodia World Bank ‘Service Delivery Assessment’ 2015.

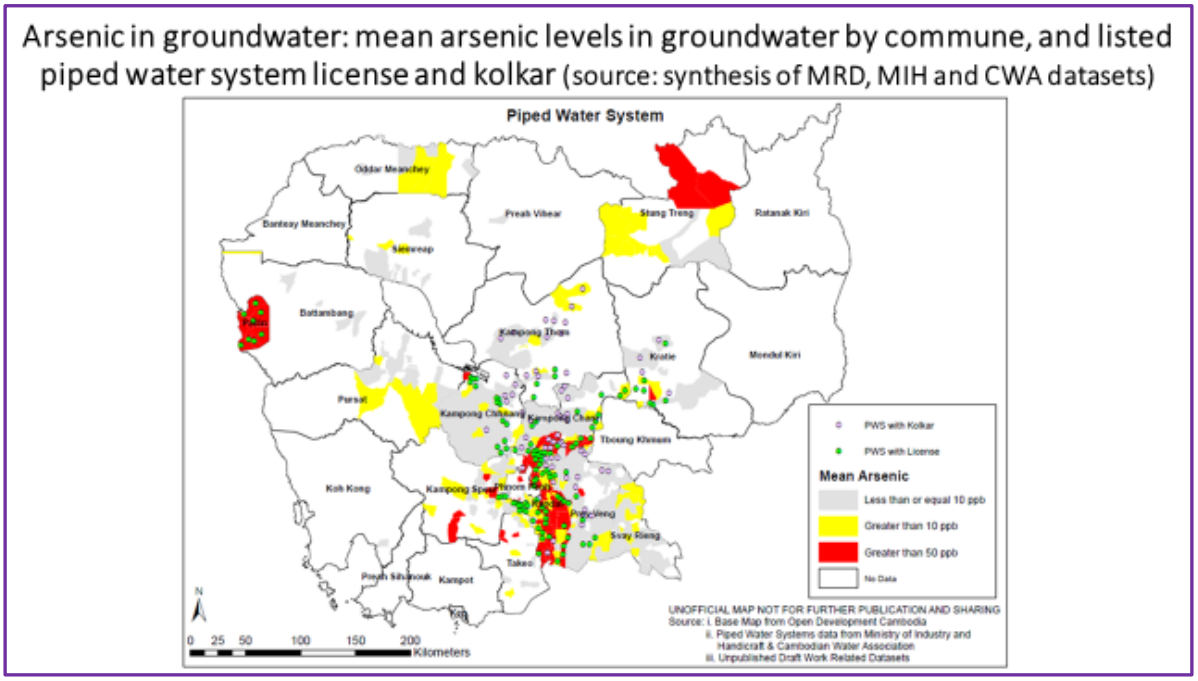
Gaps in access also exist between different wealth quintiles: there is a gap in access to sanitation in urban areas between the richest (100 per cent access) and poorest (36 per cent access) wealth quintiles, although this gap narrowed between 1995 and 2012.

A significant proportion of wells are not operating, or are unproductive in the dry season, especially in areas with high levels of irrigation.

This requires supplementary water supply interventions and the establishment of sustainable operation and maintenance systems.

Water quality is also a challenge, with an estimated 1,600 villages in six provinces and parts of Phnom Penh at risk of arsenic contamination[143].

Figure 35: Mean Arsenic Levels in Groundwater by Commune



Schools – According to EMIS 2015/16 figures: 41.9 per cent of primary schools were without a water source (45.2 per cent urban, 41.5 per cent rural) and 14.1 per cent of primary schools without latrines (7.7 per cent urban, 14.8 per cent rural) – only slightly increasing from 40 per cent in 2005/2006. Approximately, 17 per cent of primary schools did not have a toilet in the 2013/2014 school year. Even where toilets are available, their type, condition and number often do not meet the standards set by the National School Health Policy. While EMIS includes basic published information on water and sanitation, there is also room for enhancement to include data on the functionality, gender separation and hygiene aspects of school WASH facilities[144].

Health facilities – Access to WASH in health care facilities is fundamental to infection prevention and control and tackling antimicrobial resistance and quality of care – a

[143] Arsenic JICA Review , UNICEF 2017.
[144] EMIS 2015/2016.

prerequisite for UHC and health outcomes. However, reliable data on WASH in Cambodian health care centres, like in many other developing countries, is lacking, and available data suggests the need for further improvement.

The National Institute of Public Health (NIPH), the Demographic and Health Survey (DHS) and MoH, with support from WA, WHO and UNICEF, conducted an assessment of WASH in health care centres in five provinces in Cambodia.

A facility-based cross-sectional survey was conducted in the five selected provinces of Kampong Chhnang, Kampong Thom, Tbong Khmom, Kratie and Ratanakiri. One hundred and one (101) out of 202 health centres were selected using a simple random sampling method. The survey also covered all the 16 referral hospitals.

The survey findings concluded there was a water supply in health care facilities, but 50 per cent lacked safe drinking water, mainly for clients; there is a shortage during the dry season; and six per cent still rely on unimproved/open source. The survey noted that there is reasonably good sanitation; all health care facilities had improved toilets, but these were far from reaching JMP global basic standard including a lack of toilets meeting the needs of people with reduced mobility; a lack of toilets designated for women and girls with menstrual hygiene management facilities; relatively poor hand hygiene facilities at the point of care and within toilets; and poor health care waste management which was more problematic with segregation than treatment and disposal.

Sanitation and Hygiene – The JMP 2017 estimate suggests a steady increase in improved sanitation coverage in rural areas since 2000 from 10 per cent to 56 per cent in 2015. Open defecation has reduced from 82 per cent to 40.6 per cent .

Figure 36: Rural Basic Sanitation Coverage by Wealth Quintile 2000-2015

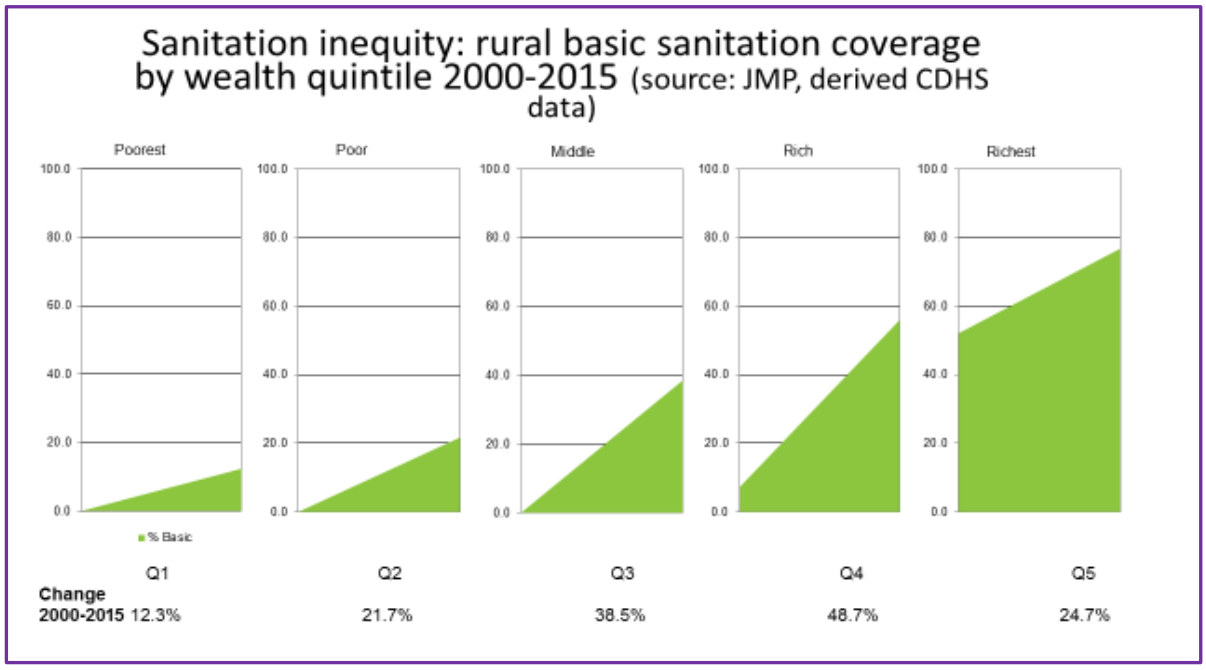


Table 10: Safely Managed Sanitation Calculation

Safely managed sanitation calculation	National	Rural	Urban
Year:	2015	2015	2015
Proportion of population with improved:	56	46	97
Proportion of population with improved facilities which are:			
Sewer connected	11	3	44
Septic tanks	38	36	44
Latrines and other	0	0	0
Disposed in situ	-	-	-
Emptied and treated	-	-	-
Wastewater treated	-	-	-
Safely managed	**-**	-	-

Notes: The indicator for SDG 6.2, safely managed sanitation services are defined as use of an improved sanitation facility which is not shared with other households and where excreta are disposed in situ or transported and treated offsite. To make an estimate of safely managed services, information on use of different improved sanitation facilities types (sewer connections, septic tanks and latrines and other) is combined with information on containment, emptying, transport and treatment. The JMP reports estimates for safely managed sanitation when information on excreta management is available for at least 50 per cent of the population using the dominant type of improved sanitation facility (sewer connections or on-site sanitation systems).

There is also a wide geographical variation in access to improved sanitation, in which access varies from 87.5 per cent in urban areas to 38.5 per cent in rural areas and most notably 11.5 per cent in Ratanakiri province to 91.3 per cent in Phnom Penh .

National development plans set the goal of 30 per cent rural sanitation coverage by 2015, and 100 per cent by 2025. JMP estimates for 2015 suggest Cambodia met its own 2015 goal, however the NSDP goal of 60 per cent by 2018 will still require rapid acceleration.

KAP Study for Rural WASH in Cambodia[145] – In 2016, MRD, in partnership with WASH development partners, conducted the second Knowledge, Attitudes and Practices (KAP) Study for rural WASH in Cambodia. This study provided an update on the status of WASH behaviour since the 2010, when the first KAP study was conducted. It is therefore useful in reporting progress made in achieving the objectives of the Rural Water Supply Sanitation and Hygiene Strategy, 2010-2025, as well as progress toward achievement of the CMDGs.

The study also established baseline data for the National M&E system and for the National Action Plan for Rural Water Supply Sanitation and Hygiene 2014-2018. This included information on the level of knowledge, attitudes and practices from 1,629 respondents living in rural households in 13 provinces in the Coastal, Plain, Plateau-Mountain and Tonle Sap regions.

A comparison between the 2010 and 2016 KAP studies was done in order for MRD to demonstrate the areas in which progress has been made and the areas that require further improvement.

[145] The Department of Rural Health Care, Ministry of Rural Development National Water, Sanitation and Hygiene Knowledge, Attitudes, and Practices (KAP) Survey in 2016 (draft). 2010 WASH KAP.

This comparison shows that while there have been significant improvements in terms of both access to improved water and sanitation, as well as WASH knowledge, attitudes and practices since 2010, many gaps remain and a few areas show declining trends.

In terms of access, the percentage of households with latrines has increased significantly since 2010 (30 per cent to 62 per cent) and there was a modest increase in access to improved water (61 per cent to 64 per cent). In addition, the percentage of households using improved latrines increased from 81 per cent to 99 per cent. However, 38 per cent of respondents still lacked access to a latrine and approximately 36 per cent lacked access to an improved water source.

Although there have been many positive changes in WASH knowledge and attitudes, among the most notable is increased knowledge of handwashing at critical times. It appears that knowledge in other areas, such as how to prevent diarrhoea, are still in need of improvement. Since 2010, the percentage of households with knowledge of the importance of handwashing before eating increased from 73 per cent to 88 per cent; handwashing after defecation from 37 per cent to 45 per cent; and handwashing after work from two per cent to 34 per cent. However, knowledge of handwashing before preparing meals declined significantly, from 48 per cent in 2010 to 22 per cent in 2016.

In addition, in regard to preventing diarrhoea, fewer respondents mentioned drinking untreated water as a cause of this illness (77 per cent) than in 2010 (84 per cent) and fewer respondents cited drinking treated water as a way to prevent it (76 per cent) than in 2010 (83 per cent).

Furthermore, although somewhat improved since 2010, knowledge about the other causes of diarrhoea remains low, with just 59 per cent of respondents mentioning causes such as not handwashing before eating (up from 53 per cent) and 33 per cent citing not handwashing after defecation (up from 22 per cent).

However, higher levels of knowledge of these activities were found when respondents were asked about how to prevent diarrhoea, with 76 per cent reporting that it could be prevented by handwashing with soap (up from 72 per cent) and 62 per cent reporting it could be prevented by using latrines to defecate (up from 39 per cent).

In terms of practices, among the most notable changes are the decrease in open defecation among both adults and children; an increase in the frequency of cleaning latrines; and an increase in the use of water filters. Among adults, the practice of open defecation, or burying faeces decreased from 69 per cent to 27 per cent and for children it decreased from 74 per cent to 26 per cent.

Instead, more respondents reported using their own latrines, with 55 per cent of children reporting the use of toilets in 2016, up from 24 per cent in 2010. In regard to cleansing practices after defecation, the share of adults using water for cleaning increased (57 per cent to 75 per cent), while the use of water for cleaning children decreased, from 97 per cent to 92 per cent.

In addition, the frequency of cleaning latrines every day increased from 46 per cent to 65 per cent. Regarding the treatment of drinking water, while practices remained the same at 74 per

cent in 2010 and 2016, the methods used appear to have changed, with a decrease in households boiling water (84 per cent to 72 per cent) and an increase in households using filters (14 per cent to 37 per cent).

Finally, although handwashing practices remained nearly the same for critical times: before eating (78 per cent to 79 per cent); when hands are dirty, (63 per cent to 60 per cent) and increased after defecation (30 per cent to 55 per cent), there was also a significant decrease in the share of respondents reporting handwashing after returning home from work/being outside (53 per cent to 30 per cent).

It was determined that handwashing practices remained low after eating (18 per cent); before preparing food (16 per cent); after cleaning an infant who has defecated (seven per cent); after touching animals (six per cent); and after the disposal of animal faeces (two per cent).

Accessible WASH in Cambodia

Universal access to clean water and sanitation can only be achieved when the needs of people living with disabilities are included in policies and the design of infrastructure and development programmes. Research conducted in Cambodia in 2014[146] revealed a lack of awareness by WASH providers of the needs of people with disabilities; little communication between the disability and the WASH sectors; and because of a lack of expressed demand, the assumption that standard provisions were adequate for everyone. This prompted efforts to introduce a disability perspective in legislation, policy and development work to achieve inclusive access to water and sanitation.

Since the launch of a resource book in 2006[147] to provide information and ideas for service providers to make facilities and services more accessible to people with disabilities and other vulnerable groups, some improvements have been noted in the legislative and policy area. These include the Law on the Protection and Promotion of the Rights of Persons with Disabilities in 2009.

This mandates that all public buildings should be accessible to people with disabilities and the formulation of strategic plans that begin to take into account issues of accessibility. The next challenge is to translate these into action through clear guidelines which specify accessibility standards, including WASH, disability mainstreaming at all levels of government and the inclusion of a disability perspective in the planning of projects and programmes.

Increasingly, development organisations in the WASH sector are aware of the need for inclusive WASH services and facilities. Several WASH projects by both the WASH and disability sectors have successfully included the needs of people with disabilities regarding clean water and sanitation, but rarely in terms of hygiene promotion. Several manuals, guides and designs for inclusive WASH facilities have been produced, but most are in English, therefore inaccessible to many native Khmer speakers.

[146] Water Aid, 2014: Accessible WASH in Cambodia.
[147] Ibid

Members of the disability sector noted a lack of technical knowledge on WASH and members of the WASH sector expressed a lack of understanding of disability. The cost of installing accessible WASH facilities was reported to be a barrier. Despite evidence that demonstrates it costs less than three per cent of the overall cost to make a school latrine accessible, the general perception is different. Consequently, there is a need to conduct local cost-benefit studies and use evidence for policy advocacy and awareness creation.

6.3 Child-responsive urban settings

According to a World Bank study (2015) on urbanization in East Asia, Cambodia has one of the smallest proportions of total land mass, after Mongolia and Lao PDR, that can be categorized as 'urban'. It is estimated that over 80 per cent of Cambodia's 15.58 million inhabitants reside in rural areas[148]. The rate of urban spatial expansion, however, is the second fastest, after Lao PDR, with 4.3 per cent on average and one of the fastest growing urban populations at 4.4 per cent per year. The main centre of urban growth remains the capital Phnom Penh which faces a number of issues associated with a lack of urban planning and basic urban infrastructure and services, including but not limited to water supply, waste management/sanitation and drainage, particularly in peri-urban areas.

The most recent UNICEF and WHO joint monitoring programme estimates for Cambodia (July 2017) indicate that 72 per cent of the urban population are likely to have some form of piped water connection. While cumulatively, 75 per cent of the urban population are likely to have access to some form of improved water supply. Eleven per cent are still dependent on unimproved water sources, with six per cent reporting the use of a surface source as their main supply of water, which potentially equates to between 250,000-325,000 people using unimproved water sources across all urban areas.

Urban sanitation data sources show that cumulatively, by 2013 (based on CIPS and CSES 2013 data) 89 per cent of the urban population may have access to improved sanitation of some form. Eight per cent are still openly defecating, with the remaining three per cent using some form of unimproved sanitation – which in total would equate to between 250-325,000 people being forced to use unimproved sanitation, or continuing to openly defecate.

Rapid population growth has put considerable pressure on Phnom Penh, specifically within its urban poor communities. Children and adolescents constitute one of the most vulnerable segments of the population residing within these communities. The results of the Phnom Penh Survey[149] conducted by UNICEF in 2016 suggest that they face risks including domestic violence, sexual abuse, child trafficking, early marriage, child labour and substance abuse. Socio-economic and structural barriers have left children and adolescents exposed to a number of health and sanitation-related risks.

Adolescents residing in urban poor communities are also noted to be at risk of coming into conflict with the law. Statistics gathered through this study highlight that some of the child protection risks are more acutely felt within urban poor communities.

Over 50 per cent of families in urban poor communities survive on less than one US dollar a

[148] World Bank.
[149] The Phnom Penh Survey 2016: A Study on Urban Poor Settlements in Phnom Penh, UNICEF 2016.

day and this extreme poverty is interlinked with most of the key protection risks faced by children and adolescents.

A family's subsistence needs often forces parents to devote the majority of their time towards identifying and engaging in employment opportunities, leaving them with very little time to care for and supervise their children.

This leaves adolescents susceptible to joining gangs, substance abuse, alcohol consumption and conflict with the law. Poor sanitation practices and facilities leave a number of children vulnerable to waterborne diseases. Many households are also not consuming safe drinking water, which can adversly impact on the growth and development of children.

7. Conclusion

Overall, Cambodia has achieved remarkable development progress in a comparatively short period of time and it is well-poised in the post-2015 era of the SDGs.

Despite this significant achievement, Cambodia is expected to remain on the UN's Least Developed Country classification until at least 2025, based on the criteria of poverty reduction, human resource weaknesses – including indicators of health, nutrition, education and literacy – and economic vulnerability.

From this assessment it is evident that many of the development challenges that continue to face Cambodia arise from similar causes and remain an impediment to the realization of the full spectrum of rights among all of the country's children, adolescents and women.

These include:

1) Insufficient budget allocation for the implementation of high impact interventions/services.

2) The lack of a legislative framework and effective re-enforcement supporting implementation.

3) Inadequate monitoring of the quality of programme implementation and subsequent responsive corrective actions.

4) Limited capacity to deliver effective services and interventions equitably.

5) The promotion of behaviour, demand for services and social norms, including around gender and disability that contribute to realization of child rights and utilization of quality services/interventions.

6) Prohibitive direct and indirect user fees for social services.

7) Continuing heightened vulnerability to natural disasters and climate change and limited national and community capacity to respond to these incidents.

Priority will need to be given to these themes highlighted across all sectors.

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