Migration impacts on Cambodian children and families left behind

REPORT 2019

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FOREWORD

Migration is an increasingly important economic lifeline and a factor driving social mobility for families in Cambodia. Over the last fifteen years, internal and international/cross-border migration has been one of the most significant transformational changes in Cambodian society and the trend is set to continue. Rural-rural migration accounts for 13 percent, rural-urban 57 percent and cross border for 31 percent of total migration. Migration poses both opportunities and challenges for migrants and their families, especially children. Globally the separation of families due to labor migration is a well-established practice. There is an observable socio-economic gradient in the patterns of family separation and the practices of maintaining relationships over space and time. Migrants from and within less developed countries (LDCs) are considered to be at greater risk of poor wellbeing outcomes (health and psychological) than those with greater economic and social advantage. Migration may have health impacts for the migrants as well as for their families left behind. The current study focuses on the families left behind, primarily children and their caregivers.

Despite the large flow of internal and international/cross-border labor migration and its importance to economic development and poverty alleviation, little is known of the health and social consequences to migrants and their families in Cambodia. The link between migration and institutionalization of children of migrant workers is also poorly understood. This study addresses the significant health and social consequences to left behind children and family members of migrant workers in Cambodia and how migration lead to institutionalization or fostering of children of migrant workers.

This study adopted a mixed-methods approach, including a quantitative household survey (n=1,459) and 115 qualitative interviews with family members of the migrant households. Key informant interviews with local authorities, management, case-workers and children living in residential care institutions (RCIs) were also conducted to complete eight extended case studies of RCIs. The household survey covers 56 districts across 13 provinces aiming to understand impacts of migration on Cambodian children and families left behind. The survey sample design includes two cohorts: the Younger Child Cohort (aged 0 to 3 years) and the Older Child Cohort (aged 12 to 17 years). Households with no history of parental migration were also included for comparison.

This study engaged government, non-governmental actors, international organizations including IOM, Louvain Cooperation, Plan International Cambodia, Family Care First, The University of Hong Kong, civil society actors, and research organizations (both national and international) across all phases of the research – from conception to formulation of policy recommendations. Therefore, the relevant policy context and reports on consultation with local experts about the research were mapped out to inform an intervention framework reflecting culturally and contextually relevant interventions for the Cambodian setting.

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LIST OF ACRONYMS

APQ-9 :
Alabama Parenting Questionnaire-Short Form

BMI :
Body Mass Index

CCWC :
Commune council for women and children

CD-RISC :
Connor-Davidson Resilience Scale

CREDI :
Caregiver-Reported Early Development Instruments

CRUMP :
Cambodian Rural Urban Migration Project

CSI :
Coping Strategy Index

DDS :
Dietary Diversity Scale

HSCL-25 :
Hopkins Symptoms Checklist-25

IOM :
International Organization of Migration

LMP :
Labor Migration Policy

LCSI :
Livelihood Coping Strategy Index

MHICCAF :
Migration and Health Impacts on Cambodian Children and Families

MRCs :
Migrant Resource Centers

NIS :
National Institute of Statistics

SDQ :
Strengths & Difficulties Questionnaires

TPO :
Transcultural Psychological Organization

UHK :
University of Hong Kong

UN :
United Nations

UNDESA :
UN Development Economic and Social Affairs

WFP :
World Food Program

DEFINITIONS OF KEY TERMS

MIGRANT HOUSEHOLDS

Households where either one or both spouses have departed for employment as an internal or international labor migrant for a period of at least six months at the time of the survey.

NON-MIGRANT HOUSEHOLDS (THE COMPARISON GROUP)

Households where both parents are present, where neither spouse has a history of labor migration (both internal and international) six months prior to the survey.

CHILD LEFT BEHIND/LEFT BEHIND CHILD (INDEX CHILD)

A child under 18 years at the time of the survey who is living in a migrant household and where one or both parents are labor migrant workers currently for a period of at least six six months at the time of the survey.

The child sample consists of two cohorts: the Younger Child Cohort (0-3 years old) and the Older Child Cohort (12-17 years old).

CAREGIVER

A person living in the migrant household who is responsible for taking on the responsibility of caring for the left behind child on a daily basis, for a period of at least six months at the time of the survey. Care consists of activities such as; arranging daily schedules, preparing or ensuring access to meals, assisting the child's educational and social needs (including play), washing clothes, looking after the child when he/she is sick, guardianship and representation to health and/or education authorities.

According to the caregiver's relationship to the left behind child, caregivers are classified into three types: the parent (maternal/paternal), -/grandparent-/kinship-caregiver.

RESIDENTIAL CARE INSTITUTIONS (RCIs)

A centre that provides services to all types of children who have been abandoned or cannot stay with their biological families or relatives in communities.

សេចក្តីសង្ខេបប្រតិបត្តិ

ទោះបីជាការចំណាកស្រុកទៅរកការងារធ្វើទាំងនៅក្នុងប្រទេស និងទៅក្រៅប្រទេស ឬឆ្លងដែនយ៉ាងច្រើនសន្ធឹកសន្ធាប់ជាកត្តាដ៏មានសារៈសំខាន់ចំពោះការអភិវឌ្ឍសេដ្ឋកិច្ច និងការកាត់បន្ថយភាពក្រីក្រយ៉ាងណាក៏ដោយ ប៉ុន្តែការយល់ដឹងនៅមានកម្រិតតិចតួចនៅឡើយអំពីផលប៉ះពាល់ផ្នែកសុខភាព និងសង្គមមកលើពលករចំណាកស្រុក និងក្រុមគ្រួសាររបស់ពួកគេនៅក្នុងប្រទេសកម្ពុជា។ ចំណែកឯ ទំនាក់ទំនងរវាងការធ្វើចំណាកស្រុក និងការទុកដាក់កូនៗរបស់ពលករចំណាកស្រុកនៅមណ្ឌលមើលថែក៏មិនទាន់មានការយល់ដឹងច្បាស់លាស់ផងដែរ។ ការសិក្សាស្រាវជ្រាវនេះគឺឆ្លើយតបទៅនឹងសំណួរស្រាវជ្រាវគន្លឹះចំនួនពីរដូចខាងក្រោម៖

១. តើមានផលប៉ះពាល់ផ្នែកសុខភាព និងសង្គមសំខាន់ៗចំពោះកូនៗដែលត្រូវបានទុកចោល និងសមាជិកគ្រួសាររបស់ពលករចំណាកស្រុកនៅក្នុងប្រទេសកម្ពុជាដែរឬទេ?

២. តើការធ្វើចំណាកស្រុកបណ្តាលឱ្យកូនៗរបស់ពលករចំណាកស្រុក ត្រូវបានទុកដាក់នៅមណ្ឌលមើលថែ ឬក្រោមការមើលថែជំនួស ដែរឬទេ?

ការសិក្សានេះបានប្រើប្រាស់វិធីសាស្ត្រស្រាវជ្រាវចម្រុះ រួមមានការស្ទង់មតិគ្រួសារតាមបែបបរិមាណក្នុងទ្រង់ទ្រាយធំ (n=1,459) និងការសម្ភាសន៍បែបគុណភាពជាមួយនឹង ១១៥ សមាជិកគ្រួសាររបស់ពលករចំណាកស្រុក។ ការសម្ភាសន៍ជាមួយអ្នកផ្តល់ព័ត៌មានសំខាន់ៗរួមមានអាជ្ញាធរក្នុងមូលដ្ឋានថ្នាក់គ្រប់គ្រងបុគ្គលិកសង្គមកិច្ច និងកុមារដែលរស់នៅមណ្ឌលថែទាំកុមារ (RCIs) ក៏ត្រូវបានធ្វើឡើងដើម្បីធ្វើឲ្យសម្រេចបាននូវករណីសិក្សាស៊ីបែបដំរៅ (extended case studies) ចំនួនប្រាំបីនៃមណ្ឌលថែទាំកុមារផងដែរ។ ការស្ទង់មតិតាមគ្រួសារគ្របដណ្តប់ទៅលើស្រុកចំនួន 56 នៅក្នុងបណ្តាខេត្តចំនួន 13 ក្នុងគោលបំណងស្វែងយល់អំពីផលប៉ះពាល់នៃការធ្វើចំណាកស្រុកមកលើកុមារ និងគ្រួសារកម្ពុជាដែលត្រូវបានទុកចោល។ ការរៀបចំសំណាកសម្រាប់ស្ទង់មតិគឺបែងចែកជាពីរក្រុម៖ ក្រុមកុមារអាយុតិច (អាយុចាប់ពី 0 ដល់ 3 ឆ្នាំ) និងក្រុមកុមារអាយុច្រើន (អាយុចាប់ពី 12 ដល់ 17 ឆ្នាំ)។ គ្រួសារដែលពុំធ្លាប់មានប្រវត្តិឪពុកម្តាយធ្វើចំណាកស្រុក ក៏ត្រូវបានដាក់បញ្ចូលក្នុងការសិក្សាស្រាវជ្រាវនេះដើម្បីធ្វើការប្រៀបធៀប។

លទ្ធផលនៅក្នុងការសិក្សានេះគ្រប់ដណ្តប់ទៅលើប្រធានបទដូចខាងក្រោម៖ ការចំណាកស្រុកនិងស្ថានភាពសេដ្ឋកិច្ចសង្គមលក្ខណៈ និងប្រវត្តិនៃការចំណាកស្រុករួមទាំង គោលដៅ រយៈពេលប្រាក់បញ្ញើ និងការប្រាស្រ័យទាក់ទងរវាងគ្រួសារនៅផ្ទះ និងពលករចំណាកស្រុក ព្រមទាំងសុខភាពផ្លូវកាយ និងផ្លូវចិត្តរបស់កុមារ និងអ្នកថែទាំ។ ការសិក្សាស្រាវជ្រាវនេះបានធ្វើការប្រៀបធៀបនូវគោលដៅនៃការចំណាកស្រុក (នៅក្នុងប្រទេស និងឆ្លងដែនទៅក្រៅប្រទេស) ប្រភេទនៃការចំណាកស្រុក (ឪពុកជាពលករចំណាកស្រុក ម្តាយជាពលករចំណាកស្រុក ទាំងម្តាយឪពុកជាពលករចំណាកស្រុកទាំងពីរ) និងការរៀបចំការថែទាំកុមារ។ ដោយមានការពាក់ព័ន្ធ ការសិក្សានេះក៏បានប្រៀបធៀបជាមួយនឹងទិន្នន័យស្ទង់មតិសុខភាពប្រជាសាស្ត្រកម្ពុជា (ឆ្នាំ2014) និងទិន្នន័យស្ទង់មតិស្តីពីការចំណាកស្រុក និងគ្រួសារដែលត្រូវបានទុកចោលនៅតំបន់ជនបទនៅក្នុងប្រទេសកម្ពុជា (CRUMP) (ឆ្នាំ2015) ហើយការសិក្សានេះក៏បានធ្វើការពិចារណាទៅលើភាពខុសគ្នារវាងសមាសភាគនៃសំណាកប្រៀបធៀបដែលអាចកើតឡើងផងដែរ។ លទ្ធផលនៃការសិក្សាស្តីពីផលប៉ះពាល់នៃការចំណាកស្រុកមកលើសុខភាពរបស់កុមារ និងគ្រួសារកម្ពុជា (MHICCAF) ត្រូវបានសង្ខេបដោយប្រើប្រាស់ទម្ងន់សំណាកដើម្បីឆ្លុះបញ្ចាំងនូវការរៀបចំសំណាកនៅក្នុងតារាងទាំងអស់នៅក្នុងរបាយការណ៍នេះ។ ប្រធានបទដែលបានជ្រើសរើស (និងប្រធានបទរង) ដែលទទួលបានការវិភាគទិន្នន័យបែបគុណភាពក៏ត្រូវបានបង្ហាញដោយអមជាមួយនឹងការរកឃើញតាមបែបបរិមាណនៅពេលដែលពាក់ព័ន្ធគ្នា។ ផ្នែកចុងក្រោយនៃការរកឃើញរបស់ការសិក្សាស្រាវជ្រាវនេះ ស្វែងរកដំណើរឆ្ពោះទៅរស់នៅក្នុងមណ្ឌលថែទាំកុមារ និងចាកចេញពីមណ្ឌលថែទាំរបស់កុមារដោយផ្អែកលើទៅករណីសិក្សាបន្ថែមនោះ ។

ការសិក្សានេះមានការចូលរួមពីសំណាក់បុគ្គលពាក់ព័ន្ធរួមមានបុគ្គលមកពីស្ថាប័នរដ្ឋាភិបាល បុគ្គលមកពីស្ថាប័នមិនមែនរដ្ឋាភិបាល បុគ្គលមកពីអង្គការអន្តរជាតិ បុគ្គលខាងសង្គមស៊ីវិល បុគ្គលមកពីស្ថាប័នសិក្សាស្រាវជ្រាវផ្សេងៗទាំងថ្នាក់ជាតិ និងអន្តរជាតិ នៅគ្រប់ដំណាក់កាលទាំងអស់នៃការសិក្សាស្រាវជ្រាវនេះ ពោលគឺចាប់តាំងពីការផ្តួចផ្តើមគំនិតដំបូងរហូតដល់ការបង្កើត អនុសាសន៍គោលនយោបាយផ្សេងៗ។ អាស្រ័យហេតុនេះ បរិបទគោលនយោបាយពាក់ព័ន្ធ និងរបាយការណ៍ស្តីពីការពិគ្រោះយោបល់ជាមួយនឹងអ្នកជំនាញក្នុងស្រុកចំពោះការសិក្សាស្រាវជ្រាវ ត្រូវបានបង្កើតឡើងដើម្បីជាព័ត៌មានក្នុងការបង្កើតគម្រោងអន្តរាគមន៍ ដែលឆ្លុះបញ្ចាំងអំពីអន្តរាគមន៍ដែលឆ្លើយតបនឹងវប្បធម៌ និងបរិបទនៅក្នុងប្រទេសកម្ពុជា។

លទ្ធផលនៃការសិក្សាស្រាវជ្រាវ

ប្រវត្តិគ្រួសារ

- ជិតពីរភាគបី (៧៥%) នៃកុមារដែលត្រូវបានទុកចោលមានជីដូនជីតាជាអ្នកថែទាំបឋម ហើយមានតែកុមារ ១៤% ប៉ុណ្ណោះដែលមានឪពុក ឬម្តាយជាអ្នកថែទាំបឋម។ កៅសិបប្រាំភាគរយ (៩៥%) នៃអ្នកថែទាំក្នុងចំណោមនោះគឺជាស្ត្រី។
- អ្នកថែទាំជិត ៤០% នៅក្នុងគ្រួសារពលករចំណាកស្រុកគឺជាមនុស្សចាស់មានអាយុលើសពី ៦០ ឆ្នាំ។ អ្នកថែទាំភាគច្រើន (៩៥%) គឺជាស្ត្រី។
- ឪពុក និងម្តាយប្រមាណ៣ក់កណ្តាលធ្វើការជាកម្មករនៅក្នុងវិស័យកសិកម្ម។ ឪពុកជាពលករចំណាកស្រុកមានចំនួនមួយភាគបី និងម្តាយជាពលករចំណាកស្រុកមានចំនួន ២០% ហើយពួកគាត់ធ្វើការងារជាកម្មករសំណង់។
- រចនាសម្ព័ន្ធគ្រួសារភាគច្រើនបំផុតនៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុក គឺមានឪពុកម្តាយពីរនាក់ និងកូនម្នាក់ ចំណែកគ្រួសារធំ ដែលមានជីដូន ឬជីតាជាអ្នកថែទាំបឋមគឺជា រចនាសម្ព័ន្ធគ្រួសារភាគច្រើនរបស់ពលករចំណាកស្រុក។ ឪពុម្តាយចំនួន ៩% នៅក្នុងគ្រួសារដែលធ្វើចំណាកស្រុកបានលែងលះគ្នា ដែលចំនួននេះគឺខ្ពស់ខ្លាំងជាងអត្រាលែងលះក្នុងចំណោមគ្រួសារដែលមិនធ្វើចំណាកស្រុក។

លក្ខណៈនៃចំណាកស្រុក

- គ្រួសារជាង ៦០% មានទាំងឪពុកម្តាយ ជាពលករចំណាកស្រុកចេញឆ្ងាយពីផ្ទះ។ ចំណាកស្រុកដែលទូទៅបំផុតចំពោះគ្រួសារពលករចំណាកស្រុកទាំងនោះគឺការធ្វើចំណាកស្រុកទៅក្រៅប្រទេសរបស់ឪពុកម្តាយទាំងពីរ (៤៦%) និងធ្វើចំណាកស្រុកនៅក្នុងប្រទេសរបស់ឪពុកម្តាយទាំងពីរ (២៦%)។ ប្រទេសគោលដៅចម្បងសម្រាប់ការធ្វើចំណាកស្រុកទៅក្រៅប្រទេសគឺប្រទេសថៃ ខណៈដែលទីក្រុងភ្នំពេញគឺជាគោលដៅចម្បងសម្រាប់ពលករចំណាកស្រុកនៅក្នុងប្រទេស។ មូលហេតុចម្បងដែលធ្វើឲ្យមានការធ្វើចំណាកស្រុកគឺដោយសារតែគ្រួសារជាប់បំណុល និងតម្រូវការស្វែងរកការងារធ្វើ។
- ១៩%នៃកុមារនៅក្នុងក្រុមកុមារអាយុតិចគឺរស់នៅក្នុងគ្រួសារមានឪពុកជាពលករចំណាកស្រុកខណៈដែល១៣%នៃកុមារក្នុងក្រុមកុមារអាយុច្រើន រស់នៅក្នុងគ្រួសារមានម្តាយជាពលករចំណាកស្រុក ។
- ក្នុងករណីដែលឪពុកជាពលករចំណាកស្រុក ម្តាយគឺជាអ្នកថែទាំបឋម ចំណែកករណីដែលម្តាយធ្វើចំណាកស្រុកតែម្នាក់ឯង ឬធ្វើចំណាកស្រុកជាមួយនឹងប្តីរបស់ខ្លួន ដូចនេះជីដូនខាងម្តាយភាគច្រើនគឺជាអ្នកទទួលខុសត្រូវមើលថែទាំកូនរបស់ពួកគេ។

ចំណូលគ្រួសារ បំណុល និងប្រាក់បញ្ញើ

- គ្រួសារដែលគ្មានពលករចំណាកស្រុកមានចំណូលគ្រួសារជាមធ្យមខ្ពស់បំផុត បន្ទាប់មកគឺគ្រួសារដែលមានឪពុកធ្វើ

ចំណាកស្រុក។ នៅពេលធ្វើការប្រៀបធៀបជាមួយនឹងគ្រួសារគ្មានពលករចំណាកស្រុក គ្រួសារពលករចំណាកស្រុកមានចំណាយជាមធ្យមខ្ពស់ជាងទៅលើថ្នាំពេទ្យ ប៉ុន្តែមានចំណាយទាបជាងទៅលើសម្ភារៈទំនាក់ទំនង និងការអប់រំកូនៗរបស់ពួកគេ។

- នៅក្នុងចំណោមគ្រួសារទាំងអស់ ពួកគេសុទ្ធតែមានអត្រាជំពាក់បំណុលខ្ពស់ ដែលក្នុងនោះគ្រួសារគ្មានពលករចំណាកស្រុកមានចំនួន ៦១% និងគ្រួសារពលករចំណាកស្រុកមានចំនួន ៥៤% កំពុងធ្វើការដើម្បីដោះបំណុល។ ការជំពាក់បំណុល និងប្រាក់កម្ចីមិនទាន់ទូទាត់របស់គ្រួសារពលករចំណាកស្រុកមានចំនួនប្រហាក់ប្រហែលទៅនឹងគ្រួសារគ្មានពលករចំណាកស្រុកដែរប៉ុន្តែបំណុលដែលពួកគេជំពាក់នោះគឺមានអត្រាការប្រាក់ខ្ពស់ជាង។
- ពលករចំណាកស្រុកជាឪពុកមានភាគរយប្រាក់បញ្ញើខ្ពស់ជាង ហើយផ្ញើប្រាក់មកផ្ទះច្រើនជាងពលករចំណាកស្រុកជាម្តាយ។
- ពលករចំណាកស្រុកនៅក្រៅប្រទេសផ្ញើប្រាក់បញ្ញើច្រើនបំផុត។ ទោះបីជាការចំណាកស្រុករបស់ពលករ ត្រូវបានមើលឃើញយ៉ាងច្បាស់ថា គឺជាមធ្យោបាយធ្វើឱ្យសេដ្ឋកិច្ចរបស់គ្រួសារពលករចំណាកស្រុកជាច្រើនគ្រួសារមានការរីកចម្រើនក៏ដោយ ប៉ុន្តែវាមានភាពខុសគ្នាយ៉ាងច្បាស់ចំពោះប្រភេទនៃការចំណាកស្រុក (ពលករចំណាកស្រុកឆ្លងដែនធៀបនឹងពលករចំណាកស្រុកក្នុងប្រទេស)។

ប្រវត្តិជំងឺ និងឥរិយាបថស្វែងរកការព្យាបាលសុខភាព

- ចំនួនសមាជិកគ្រួសារដោមធ្យម ដែលធ្លាប់មានជំងឺណាមួយនៅក្នុងរយៈពេល ៣០ ថ្ងៃនៅមុនពេលធ្វើការស្ទង់មតិនេះគឺមានចំនួនខ្ពស់នៅក្នុងចំណោមគ្រួសារពលករចំណាកស្រុកបើធៀបជាមួយនឹងគ្រួសារគ្មានពលករចំណាកស្រុក។ នៅក្នុងរយៈពេល ៣០ ថ្ងៃមុនពេលស្ទង់មតិ កុមារជាច្រើនត្រូវបានរាយការណ៍ថាឈឺនៅក្នុងចំណោមគ្រួសារពលករចំណាកស្រុក បើធៀបជាមួយនឹងកុមាររស់នៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុក។
- នៅក្នុងរយៈពេល ១២ ខែចុងក្រោយ ៩% នៃសមាជិកគ្រួសារពលករចំណាកស្រុកមានរបួស ដែលចំនួននេះទាបខ្លាំងជាងចំនួននៅក្នុងចំណោមគ្រួសារគ្មានពលករចំណាកស្រុក។
- ភាពទូទៅនៃការប្រើប្រាស់សេវាថែទាំសុខភាព គឺមានលក្ខណៈប្រហាក់ប្រហែលគ្នារវាង គ្រួសារគ្មានពលករចំណាកស្រុក និងគ្រួសារពលករចំណាកស្រុក៖ សេវាកម្មថែទាំសុខភាពឯកជន គឺត្រូវបានប្រើប្រាស់ទូទៅច្រើនជាងសេវាសុខភាពរបស់រដ្ឋ។
- ថ្លៃចំណាយទៅលើការព្យាបាលកុមារដែលមានជម្ងឺគឺខ្ពស់ខ្លាំងនៅក្នុងគ្រួសារពលករចំណាកស្រុក បើធៀបជាមួយនឹងគ្រួសារគ្មានពលករចំណាកស្រុក។ ប៉ុន្តែពុំមានភាពខុសគ្នាសម្រាប់ថ្លៃចំណាយទៅលើមនុស្សធំដែលមានជំងឺឡើយ។

សន្តិសុខស្បៀងនៅក្នុងគ្រួសារ

- គ្រួសារដែលបានផ្តល់សម្ភាសន៍ជិត ៦% បានរាយការណ៍ថាធ្លាប់ជួបបញ្ហាអត់ឃ្លានចាប់ពីកម្រិតមធ្យមដល់កម្រិតធ្ងន់ធ្ងរ។
- គ្រួសារពលករចំណាកស្រុកមានពិន្ទុខ្ពស់ខ្លាំងចំពោះយុទ្ធសាស្ត្រសម្របខ្លួនផ្អែករលើការបរិភោគ (CSI) ដែលបង្ហាញថាពួកគេបានប្រើប្រាស់យុទ្ធសាស្ត្រសម្របខ្លួនញឹកញាប់ និងម៉ឺងម៉ាត់ដើម្បីជម្នះបញ្ហាកង្វះស្បៀងអាហារ ដោយត្រូវបានកំណត់ថាជារយៈពេលដែលគ្រួសារបានប្រឈមនឹងកង្វះស្បៀងអាហារឬមានប្រាក់កាសមិនគ្រប់គ្រាន់ដើម្បីទិញស្បៀងអាហារនៅក្នុងរយៈពេលប្រាំពីរថ្ងៃចុងក្រោយ។
- កុមារនៅក្នុងគ្រួសារពលករចំណាកស្រុកភាគច្រើនងាយនឹងខ្វះស្បៀងអាហារពីគេ និងកាត់បន្ថយចំនួនដងនៃការបរិភោគអាហារ ឬកាត់បន្ថយបរិមាណម្ហូបអាហារនៅពេលដែលគ្រួសារបស់ពួកគេប្រឈមនឹងបញ្ហាកង្វះស្បៀងអាហារ។

- យុទ្ធសាស្ត្រទូទៅដែលត្រូវបានប្រើប្រាស់សម្រាប់សម្របខ្លួននៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុក និងគ្រួសារពលករចំណាកស្រុក គឺមានលក្ខណៈប្រហាក់ប្រហែលគ្នា ប៉ុន្តែគ្រួសារពលករចំណាកស្រុកភាគច្រើនងាយនឹងឱ្យកូនរបស់ពួកគេឈប់ទៅរៀនជាបណ្តោះអាសន្ន ឬលក់របស់របរនៅក្នុងគ្រួសារដោយសារតែការខ្វះខាតស្បៀងអាហារ។

ស្ថានភាពអាហារូបត្ថម្ភ និងសុខភាពផ្លូវការរបស់អ្នកថែទាំពេញវ័យ

- អ្នកថែទាំនៅក្នុងគ្រួសារពលករចំណាកស្រុកមានរបបអាហារមិនចម្រុះមុខច្រើនឡើយ បើធៀបជាមួយនឹងអ្នកថែទាំក្នុងគ្រួសារគ្មានពលករចំណាកស្រុក។ អ្នកថែទាំជាស្ត្រីប្រមាណ ១១% មានរូបរាងស្គមហើយ ៣០% គឺលើសទម្ងន់ឬមានជំងឺធាត់ជ្រុល។ អ្នកថែទាំជាបុរសប្រមាណ ១៤% មានរូបរាងស្គម ហើយ ២០% គឺលើសទម្ងន់ ឬមានជំងឺធាត់ជ្រុល។
- អ្នកថែទាំនៅក្នុងគ្រួសារដែលមានទាំងឪពុកម្តាយធ្វើជាពលករចំណាកស្រុកងាយនឹងលើសទម្ងន់ ជាពិសេស អ្នកថែទាំដែលជាជីដូនជីតា។
- អ្នកថែទាំនៅក្នុងគ្រួសារពលករចំណាកស្រុកបានរាយការណ៍ដោយខ្លួនឯងថាមានស្ថានភាពសុខភាពផ្លូវកាយខ្សោយជាងអ្នកមើលថែនៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុកដែលមូលហេតុចម្បងគឺដោយសារតែមានវ័យចំណាស់។

ការលូតលាស់ និងការអភិវឌ្ឍរបស់កុមារ

- ប្រហែលជា ៧០%នៃកុមារដែលមានអាយុចាប់ពី ៦ ដល់ ២៣ ខែ គឺទទួលបានអាហារូបត្ថម្ភគ្រប់គ្រាន់ខ្ពស់ជាងកម្រិតអប្បបរមានៃភាពចម្រុះនៃរបបអាហារ។

- ក្នុងចំណោមកុមារអាយុចាប់ពី ០ ដល់ ៣ ឆ្នាំ កុមារចំនួន ១៩%គឺក្រិន ៩% គឺស្គមស្គាំង និង ១៤% ទៀតគឺមិនគ្រប់ទម្ងន់។ ក្នុងចំណោមកុមារអាយុចាប់ពី ១២ ដល់ ១៧ ឆ្នាំ កុមារចំនួន ២៥% គឺក្រិន ហើយ ១១% ទៀតគឺស្គមស្គាំង។
- កុមារាបង្ហាញពីស្ថានភាពខ្វះអាហារូបត្ថម្ភ បើធៀបជាមួយនឹងកុមារី ដែលមានអត្រាខ្ពស់គួរឱ្យកត់សម្គាល់នៃភាពក្រិនក្នុងចំណោមក្រុមកុមារអាយុតិច និងក្រុមកុមារអាយុច្រើន និងអត្រាស្គមស្គាំងខ្ពស់នៅក្នុងចំណោមក្រុមកុមារអាយុច្រើន។
- សម្រាប់ក្រុមកុមារអាយុតិច កុមារនៅក្នុងគ្រួសារពលករចំណាកស្រុក គឺមានពិន្ទុរបបអាហារចម្រុះខ្ពស់ និងការអភិវឌ្ឍឆាប់រហ័សព្រមទាំងមានស្ថានភាពអាហារូបត្ថម្ភល្អប្រសើរជាង បើធៀបទៅនឹងកុមារក្នុងក្រុមអាយុតែមួយនៅក្នុងចំណោមគ្រួសារគ្មានពលករចំណាកស្រុក។
- សម្រាប់ក្រុមកុមារអាយុច្រើន កុមារនៅក្នុងគ្រួសារពលករចំណាកស្រុក មានពិន្ទុរបបអាហារចម្រុះទាប។ ទោះជាយ៉ាងនេះក្តី ពួកគេពុំមានស្ថានភាពមិនល្អផ្នែកអាហារូបត្ថម្ភផ្សេងទៀតឡើយ បើធៀបទៅនឹងកុមារនៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុក។

សុខភាពផ្លូវចិត្ត និងការគាំទ្រសង្គមសម្រាប់អ្នកថែទាំ

- បើធៀបជាមួយនឹងអ្នកថែទាំនៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុក អ្នកថែទាំនៅក្នុងគ្រួសារពលករចំណាកស្រុកគឺមានស្ថានភាពលំបាកខ្លាំងទាំងផ្នែកសុខភាពផ្លូវចិត្តទូទៅ និងភាពធន់នឹងជំងឺ។ អត្រានៃការបាក់ទឹកចិត្ត និងការថប់បារម្ភនៅក្នុងចំណោមអ្នកថែទាំគឺមានកម្រិតខ្ពស់ គឺការធ្លាក់ទឹកចិត្តចំនួន ៤៣ ភាគរយ និងការថប់បារម្ភ

ចំនួន ៥០ ភាគរយ ពោលគឺអត្រាដែលរកឃើញនៅក្នុងចំណោមអ្នកថែទាំនៅក្នុងគ្រួសារដែលមានពលករចំណាកស្រុកខ្ពស់គួរឱ្យកត់សម្គាល់ជាងអ្នកថែទាំនៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុក។

- អ្នកថែទាំនៅក្នុងគ្រួសារដែលមានម្តាយជាពលករចំណាកស្រុក និងគ្រួសារដែលមានទាំងឪពុក និងម្តាយជាពលករចំណាកស្រុក ភាគច្រើនមានសុខភាពផ្លូវចិត្តខ្សោយ ខណៈដែលអ្នកថែទាំនៅក្នុងគ្រួសារដែលមានឪពុកជាពលករចំណាកស្រុក មិនសូវបានរាយការណ៍ពី ទំនាក់ទំនងជិតស្និទ្ធជាមួយនឹងគ្រួសារ និងសហគមន៍ប៉ុន្មានឡើយ។
- អ្នកថែទាំនៅតែបង្ហាញអាការៈនៃការតានតឹងចិត្តដែលកើតចេញពីបទពិសោធប៉ះទង្គិចផ្លូវចិត្តកាលពីអតីតកាលកាលពីសម័យសង្គ្រាមស៊ីវិល មានន័យថា អ្នកថែទាំដែលមានវ័យចាស់មានកម្រិតតានតឹងផ្លូវចិត្តខ្ពស់ជាងអ្នកថែទាំវ័យក្មេង។ ភាពជាស្ត្រី និងភាពជាមនុស្សចាស់ (អាយុចាប់ពី ៦០ ឆ្នាំឡើង) គឺជាកត្តាហានិភ័យចម្បងដែលពាក់ព័ន្ធនឹងសុខភាពផ្លូវចិត្តខ្សោយ។
- ចំពោះការគាំទ្រសង្គមរបស់អ្នកថែទាំនៅក្នុងគ្រួសារពលករចំណាកស្រុកគឺមិនខុសគ្នាពីអ្នកថែទាំនៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុកនោះទេ ប៉ុន្តែពួកគេមានទំនាក់ទំនងជាមួយនឹងគ្រួសារមិនសូវជិតស្និទ្ធដូចជាអ្នកថែទាំនៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុកនោះទេ។

សុខភាពផ្លូវចិត្តរបស់កុមារ (ក្រុមកុមារអាយុច្រើន)

- កុមារ និងអ្នកថែទាំមានទស្សនៈខុសគ្នាចំពោះសុខភាពផ្លូវចិត្តរបស់កុមារភាព។ យោងតាមការរាយការណ៍របស់កុមារ កុមារដែលត្រូវបានទុកចោលគឺមិនមានការលំបាកទេបើការរាយការណ៍ដោយខ្លួនឯងអំពីសុខមាលភាពផ្លូវចិត្ត ដោយបានវាស់វែងដោយកម្រងសំណួរអំពីភាពខ្លាំង និងបញ្ហាលំបាក (កុមារអាយុចាប់ពី ១២ ទៅ ១៧ ឆ្នាំ)។ យោងតាមការរាយការណ៍របស់អ្នកថែទាំ កុមារដែលមានម្តាយជាពលករចំណាកស្រុកនៅក្នុងប្រទេស គឺមានសុខុមាលភាពផ្លូវចិត្តខ្សោយ។
- ការធ្វើចំណាកស្រុករបស់ឪពុកម្តាយ ជាពិសេស ការធ្វើចំណាកស្រុកទៅក្រៅប្រទេស/ឆ្លងដែន គឺពាក់ព័ន្ធជាមួយនឹងពិន្ទុទាបនៃភាពធន់នឹងជំងឺរបស់កុមារ។ ជាក់ស្តែង កុមារនៅក្នុងគ្រួសារដែលមានឪពុកជាពលករចំណាកស្រុកបង្ហាញពីអាកប្បកិរិយាផ្តល់ផលប្រយោជន៍ដល់សង្គម។ កុមារីបង្ហាញពីការមានប្រៀបនៅក្នុងអាកប្បកិរិយាផ្តល់ផលប្រយោជន៍ដល់សង្គម និងភាពធន់នឹងជំងឺបើធៀបទៅនឹងកុមារាទាំងអស់។

មុខងារនៃគ្រួសារចំពោះកុមារ (ក្រុមកុមារអាយុច្រើន)

- អ្នកថែទាំនៅក្នុងគ្រួសារពលករចំណាកស្រុក ភាគច្រើនលើកថាពួកគាត់អនុវត្តរបៀបចិញ្ចឹមបីបាច់ថែរក្សា/ការថែទាំបែបវិជ្ជមាន ជាងអ្នកថែទាំនៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុក ប៉ុន្តែយោងតាមទស្សនៈរបស់កុមារការអនុវត្តការចិញ្ចឹមបីបាច់ថែរក្សា/ការថែទាំនោះគឺគ្មានអ្វីខុសប្លែកឡើយចំពោះពួកគេ។
- កុមារីនៅក្នុងគ្រួសារពលករចំណាកស្រុក គឺមិនសូវមានទំនាក់ទំនងវិជ្ជមានជាមួយនឹងអ្នកថែទាំរបស់ពួកគេនោះទេ បើធៀបជាមួយនឹងកុមារីឯទៀតនៅក្នុងគ្រួសារគ្មានពលករចំណាកស្រុក ហើយកុមារដែលមានម្តាយជាពលករចំណាកស្រុកនៅក្រៅប្រទេសមានទំនាក់ទំនងជាមួយអ្នកថែទាំរបស់ពួកគេមិនសូវល្អប៉ុន្មានឡើយ។ សរុបមក កុមារាគឺមិនសូវនិយាយប្រាប់ពីទំនាក់ទំនងជិតស្និទ្ធជាមួយនឹងអ្នកថែទាំរបស់ពួកគេដូចជាកុមារីនោះទេ។

ទំនាក់ទំនង និងការប្រាស្រ័យទាក់ទង

- ពលករចំណាកស្រុកជាឪពុក និងពលករចំណាកស្រុកជាម្តាយជាងមួយភាគបី រក្សាទំនាក់ទំនងជាមួយក្រុមគ្រួសាររបស់ពួកគាត់ជារៀងរាល់ថ្ងៃ។ វិធីសាស្ត្រទំនាក់ទំនងដែលគ្រួសារពលករចំណាកស្រុកប្រើប្រាស់ជាទូទៅបំផុតគឺតាមរយៈទូរសព្ទដៃ បន្ទាប់មក គឺតាមបណ្តាញសង្គម។
- ប្រហែលជាមួយភាគបីនៃពលករចំណាកស្រុកជាឪពុក និងពលករចំណាកស្រុកជាម្តាយមក លេងក្រុមគ្រួសាររបស់ខ្លួនមួយឆ្នាំម្តង។ ពលករចំណាកស្រុកក្នុងប្រទេសមានការប្រាស្រ័យទាក់ទង និងមកលេងក្រុមគ្រួសាររបស់ខ្លួនញឹកញាប់ជាងឪពុកម្តាយជាពលករចំណាកស្រុកជានៅក្រៅប្រទេស ប៉ុន្តែកម្រិតនៃប្រាក់បញ្ជើគឺមិនមានភាពខុសគ្នានោះទេ។

ដំណើរឆ្ពោះទៅរកការរស់នៅក្នុងមណ្ឌលថែទាំកុមារ (RCIs)

- ចំណាកស្រុក គឺជាកត្តាមួយក្នុងចំណោមកត្តាជាច្រើនផ្សេងទៀតធ្វើឱ្យកុមារទៅរស់នៅក្នុងមណ្ឌលថែទាំកុមារ។ ការសិក្សានេះបានកំណត់ដំណើរឆ្ពោះទៅទូទៅចំនួនពីរនៃការចូលទៅរស់នៅក្នុងមណ្ឌលថែទាំកុមារ៖ 1) ចំណាកស្រុក ជាកត្តាជំរុញ/បង្ក (Factor) និង 2) ចំណាកស្រុកជាកត្តាកំណត់ (Determinant)។ ដំណើរឆ្ពោះទៅទាំងពីរនេះគឺបានបង្ហាញស្ទើរតែស្មើគ្នានៅក្នុងការសិក្សានេះ ដោយមាន ចំណាកស្រុកជាកត្តា និង ចំណាកស្រុក ជាកត្តាកំណត់។
- កូនរបស់ឪពុកម្តាយជាពលករចំណាកស្រុក ដែលរស់នៅក្នុងមណ្ឌលថែទាំកុមារ ជានិច្ចកាលតែងតែជួបប្រទះនូវស្ថានភាពប្រឈមជាច្រើននៅក្នុងជីវិតគ្រួសាររបស់ពួកគេ រួមមានភាពក្រីក្រគោកយ៉ាក អំពើហិង្សាក្នុងគ្រួសារ ឪពុកម្តាយជាអ្នកញៀនស្រា និងអស្ថេរភាពនៃការថែទាំ។ ភាពក្រីក្រ និងអស្ថេរភាពក្នុងគ្រួសារ គឺជាកត្តាជំរុញមួយដ៏ចម្បង ខណៈដែលឱកាសសិក្សារៀនសូត្រដែលផ្តល់ជូនតាមរយៈមណ្ឌលថែទាំកុមារ គឺជាកត្តាអូសទាញដ៏ខ្លាំងក្លាសម្រាប់ដំណើរឆ្ពោះទៅរកការរស់នៅក្នុងមណ្ឌលថែទាំកុមារ។
- ជាទូទៅ កុមារទទួលស្គាល់ចំពោះស្ថេរភាពនៃការថែទាំនៅមណ្ឌលថែទាំកុមារ ប៉ុន្តែពួកគេមិនទទួលបានភាពកក់ក្តៅពីការរស់នៅជួបជុំគ្រួសារ។
- ការធ្វើសមាហរណកម្មគឺអាស្រ័យទៅលើកត្តាជាច្រើន ដោយផ្តោតការពិចារណាជាពិសេសទៅលើការរៀបចំចាត់ចែងការថែទាំ និងការអប់រំ។

អនុសាសន៍គោលនយោបាយ

បម្រែបម្រួលគន្លងសុខភាព

១ - បម្រែបម្រួលគន្លងសុខភាពកុមារ

- ផែនការសកម្មភាពជាតិស្តីពីគំនិតផ្តួចផ្តើមសម្រាប់ការកាត់បន្ថយភាពអត់ឃ្លានឱ្យដល់កម្រិតសូន្យនៅកម្ពុជា (ឆ្នាំ២០១៦-២០២៥) និងគោលនយោបាយជាតិស្តីពីការគាំពារ និងអភិវឌ្ឍន៍កុមារតូច (ឆ្នាំ២០១០) គួរតែពង្រីកវិសាលភាពគោលដៅរបស់ខ្លួនឱ្យបានដល់កុមារដែលមានអាយុលើសពីប្រាំឆ្នាំឡើងទៅ។ ទោះបីជាមានកិច្ចអន្តរាគមន៍គោលនយោបាយដែលកំណត់គោលដៅក្នុងការកាត់បន្ថយបញ្ហាកង្វះអាហារូបត្ថម្ភក្នុងចំណោមកុមារអាយុក្រោមប្រាំឆ្នាំក៏ដោយ ប៉ុន្តែកិច្ចអន្តរាគមន៍តាមអាយុជាក់លាក់ ក៏ត្រូវការដាច់បាច់សម្រាប់ កុមារដែលស្ថិតក្នុងក្រុមអាយុច្រើនជាងនេះផងដែរ។ កិច្ចអន្តរាគមន៍ដើម្បីធានាឱ្យមានអាហារមានជីវជាតិគ្រប់គ្រាន់សម្រាប់កុមារ គួរតែជាក់បញ្ចូលនូវការផ្តល់កម្មវិធីអាហារនៅតាមសាលារៀនសម្រាប់សហគមន៍ក្រីក្រ ការលើកកម្ពស់ការទទួលបានសេវាថែទាំសុខភាពកុមារ និងការអប់រំដល់អ្នកថែទាំកុមារអំពីរបបអាហារចម្រុះច្រើនមុខសម្រាប់កុមារគ្រប់កម្រិតអាយុរហូតដល់អាយុ ១៨ ឆ្នាំ។ បុគ្គលិកសុខាភិបាលតាមសហគមន៍ និងបុគ្គលិកផ្នែកការពារកុមារ/សុខុមាលភាពកុមារ អាចជ្រើសរើសនៅតាមភូមិដើម្បីឱ្យពួកគាត់ជួយដល់គ្រួសារពលករចំណាកស្រុក ដែលប្រធានភូមិ/រដ្ឋបាលភូមិបានកំណត់ក្នុងការបង្កើតផែនការអាហារូបត្ថម្ភសម្រាប់អ្នកថែទាំក្នុងពេលដែលអវត្តមានឪពុក/ម្តាយ។

- កម្មវិធីសុខភាពកុមារតូច ក្មេងជំទង់ និងយុវជននៅថ្នាក់ជាតិ ទីភ្នាក់ងារពាក់ព័ន្ធដែលធ្វើការងារនៅក្នុងវិស័យនេះ រាប់បញ្ចូលទាំងទីភ្នាក់ងារម្ចាស់ជំនួយ ត្រូវចាត់ទុកចំណាកស្រុកថាជាកត្តាកំណត់គន្លឹះនៃលទ្ធផលសុខភាពរបស់កុមារ។ នៅថ្នាក់ក្រោមជាតិគណៈកម្មាធិការទទួលបន្ទុកកិច្ចការនារី និងកុមារតាមភូមិឃុំ (គ ក ន ក) អាចបង្កើតយន្តការដើម្បីកំណត់គ្រួសារដែលមានកុមារងោយរងគ្រោះ និងធ្វើការសម្របសម្រួលជាមួយនឹងអ្នកផ្តល់សេវាសុខភាពពាក់ព័ន្ធ និងមន្ត្រីសុខុមាលភាពដើម្បីតាំទ្រផែនការគ្រប់គ្រងករណីសម្រាប់កុមារដែលត្រូវទុកចោល។
- កិច្ចអន្តរាគមន៍គោលនយោបាយ គួរតែផ្តោតការយកចិត្តទុកដាក់លើការពង្រឹងកម្មវិធីគាំពារសុខភាពសង្គម (ឧទាហរណ៍ មូលនិធិសមធម៌សុខាភិបាល) ដើម្បីបង្កើនការដាក់បញ្ចូលប្រជាជនវ័យក្មេង ជាពិសេស នៅក្នុងតំបន់ជនបទ និងកាត់បន្ថយការជាប់បំណុលដោយសារការចំណាយប្រាក់ផ្ទាល់ខ្លួនច្រើនទៅលើការព្យាបាលជំងឺ។ ឧបសគ្គ និងថ្លៃចំណាយទៅលើ មូលនិធិនេះចាំបាច់ត្រូវតែដោះស្រាយដើម្បីធានានូវការទទួលបានកាន់តែល្អប្រសើរ រួមទាំង ការអប់រំដល់ប្រជាជនដែលអាចជាពលករចំណាកស្រុកនាពេលអនាគត អំពីសារៈសំខាន់នៃកម្មវិធីធានារ៉ាប់រងសង្គម និងសុខភាពផងដែរ។ មធ្យោបាយដ៏មានប្រសិទ្ធភាពផ្នែកសុខាភិបាលនៅក្នុងទម្រង់ជាកិច្ចព្រមព្រៀងទ្វេភាគីជាមួយនឹងប្រទេសទទួលកម្លាំងពលកម្មដើម្បីលើកទឹកចិត្តឱ្យក្រុមនិយោជកនៅក្នុងប្រទេសគោលដៅទាំងនោះផ្តល់នូវកិច្ចគាំពារសង្គមដល់ពលករ និងក្រុមគ្រួសាររបស់ពួកគាត់ ហើយការងារទាំងនេះអាចសម្របសម្រួលដោយក្រសួងការបរទេស ក្រសួងពាណិជ្ជកម្ម ក្រសួងការងារ និងបណ្តុះបណ្តាលវិជ្ជាជីវៈ និងក្រសួងសុខាភិបាល។
- ផែនការយុទ្ធសាស្ត្រអប់រំ ឆ្នាំ២០១៤-២០១៨ នៅក្នុងប្រទេសកម្ពុជាអាចត្រូវបានលើកកម្ពស់ ដោយផ្តោតទៅលើការពង្រីកវិសាលភាពការអប់រំកុមារតូចដើម្បីធានាថាកុមារចាប់ពីពេលកើតរហូតដល់ពេលចូលរៀន អាចទទួលបានការអភិវឌ្ឍន៍រាងកាយ និងចិត្តសង្គមបែបវិជ្ជមានទាំងនៅក្នុងផ្ទះ ក៏ដូចជានៅក្នុងសហគមន៍ផងដែរ។ ការបង្កើនការយល់ដឹងជាសាធារណៈអំពីសារៈសំខាន់នៃការអប់រំកុមារតូច និងការវិនិយោគក្នុងគោលនយោបាយគាំទ្រគ្រួសារគឺពិតជាមានសារៈសំខាន់ខ្លាំងណាស់។
- ពុំមានគោលនយោបាយជាក់លាក់ណាមួយដែលដោះស្រាយបញ្ហាមនុស្សវ័យជំទង់ឡើយ ប៉ុន្តែមានផែនការយុទ្ធសាស្ត្រពាក់ព័ន្ធមួយចំនួន ដូចជា ផែនការយុទ្ធសាស្ត្រជាតិ ឆ្នាំ ២០១៤-២០១៨ ដែលបានលើកឡើងអំពីមនុស្សវ័យជំទង់ និងសុខភាពបន្តពូជ គឺជាផ្នែកដ៏សំខាន់មួយនៃយុទ្ធសាស្ត្រជាតិសម្រាប់សុខភាពបន្តពូជ និងសុខភាពផ្លូវភេទ។ ចំណុចនេះគឺជាផ្នែកដ៏សំខាន់ដែលត្រូវធ្វើការពិចារណានៅពេលបង្កើតគោលនយោបាយនាពេលអនាគត។ គោលនយោបាយសម្រាប់ពលករចំណាកស្រុកគួរតែដាក់បញ្ចូលផងដែរនូវក្រុមគ្រួសាររបស់ពួកគាត់ដែលត្រូវបានទុកចោល។ កិច្ចអន្តរាគមន៍ និងវិធានការបង្ការជាមុនគឺត្រូវការជាចាំបាច់ដើម្បីបញ្ចៀសកុំឱ្យមានបញ្ហាប្រឈមផ្នែកសុខភាពផ្លូវចិត្តនៅពេលក្រោយ ព្រមទាំងលើកកម្ពស់ភាពធន់របស់កុមារ ជាពិសេសដើម្បីជួយឱ្យកុមារអាចសម្របខ្លួនដោះស្រាយជាមួយនឹងស្ថានភាពតានតឹង ពាក់ព័ន្ធនឹងចំណាកស្រុក។
- ការផ្តោតការយកចិត្តទុកដាក់លើការពង្រឹងភាពធន់ អាចការពារផលប្រយោជន៍នៃការអភិវឌ្ឍន៍បែបវិជ្ជមាន និងធានាថាបុគ្គលគ្រប់រូបមានធនធាន និងសមត្ថភាពគ្រប់គ្រាន់ដើម្បីសម្របខ្លួនកាន់តែល្អប្រសើរទៅនឹងស្ថានភាពតានតឹង និងទុក្ខលំបាកផ្លូវចិត្តផ្សេងៗ។ អ្នកបង្កើតគោលនយោបាយ និងបុគ្គលិកផ្តល់សេវាថែទាំសុខភាពគួរតែមានការយល់ដឹងច្បាស់លាស់អំពីហានិភ័យចំពោះសុខភាពផ្លូវចិត្តដែលអាចកើតមាន នៅពេលដែលកុមារត្រូវបានទុកចោលដោយគ្មានការថែទាំពីឪពុក ឬម្តាយ។ វិធីសាស្ត្រផ្អែកលើភាពរឹងមាំ ឧទាហរណ៍ គម្រោងអភិវឌ្ឍយុវជនបែបវិជ្ជមានអាចត្រូវបានលើកឡើង និងដាក់បញ្ចូលទៅក្នុងការតម្រូវឱ្យប្អូនធម៌ជាក់លាក់នៅក្នុងប្រទេសកម្ពុជាដើម្បីបណ្តុះភាពធន់ឬភាពងាយនឹងជាសៈស្បើយឡើងវិញរបស់កុមារ និងធនធានខាងក្រៅរបស់ពួកគេ។

- ការថែទាំសម្រាប់កូនជំនាន់ទីបីក៏អាចនៅតែជួបបញ្ហាប្រឈមផងដែរ។ សេវាកម្មដែលផ្តោតលើជំនាញចិញ្ចឹមកូន និងការគាំទ្រអាចលើកទឹកចិត្តដល់អ្នកថែទាំទទួលបន្ទុកក្នុងការកែប្រែទស្សនៈរបស់ពួកគេអំពីការចិញ្ចឹមកូន សិក្សាជំនាញចិញ្ចឹមកូន និងផ្តល់ពេលសម្រាកពីតម្រូវការនៃការថែទាំ។ ការអប់រំពីការចិញ្ចឹមបីបាច់កូន ដូចជា កម្មវិធីចិញ្ចឹមបីបាច់កូនតាមបែបវិជ្ជមាន (Positive Parenting Program) អាចយកមកពិចារណាដើម្បីលើកកម្ពស់សុខុមាលភាពកុមារ និងទំនាក់ទំនងនៅក្នុងគ្រួសាររបស់ពួកគេបាន។
- គោលនយោបាយនានា ដូចជា ផែនការសកម្មភាពជាតិស្តីពីគំនិតផ្តួចផ្តើមសម្រាប់កាត់បន្ថយភាពអត់ឃ្លានឱ្យដល់កម្រិតសូន្យនៅកម្ពុជា (ឆ្នាំ២០១៦-២០២៥) និងគោលនយោបាយជាតិស្តីពីការគាំពារ និងអភិវឌ្ឍន៍កុមារតូច (ឆ្នាំ២០១០) អនុវត្តចំពោះហានិភ័យលើអាហារូបត្ថម្ភតាមយេនឌ័រសម្រាប់កុមារ។ លើសពីនេះទៅទៀត លទ្ធផលដែលទទួលបាន ក៏បានទាញចំណាប់អារម្មណ៍បន្ថែមទៅលើភាពងាយរងគ្រោះរបស់ក្មេងប្រុសវ័យជំទង់ចំពោះសុខុមាលភាពផ្លូវចិត្តទន់ខ្សោយនៅក្នុងប្រទេសកម្ពុជាផងដែរ។ អ្នកបង្កើតគោលនយោបាយគួរតែបង្កើតយន្តការបន្ថែមដើម្បីវាយតម្លៃកិច្ចអន្តរាគមន៍ចំពោះយេនឌ័រដាក់លាក់ ជាពិសេសដើម្បីដោះស្រាយហានិភ័យចំពោះក្មេងប្រុសនៅក្នុងចំណោមប្រជាជនទូទៅ (ទាំងកុមារចំណាកស្រុក និងគ្មានចំណាកស្រុក)។

២ - បម្រែបម្រួលគន្លងសុខភាពរបស់អ្នកថែទាំ

- លទ្ធផលទាំងនេះគួរបញ្ជាក់ឱ្យឃើញពីសារៈសំខាន់នៃ "ការយកចិត្តទុកដាក់ថែទាំចំពោះអ្នកថែទាំ"។ កិច្ចអន្តរាគមន៍ដើម្បីគាំទ្រការផ្តល់សេវាថែទាំដល់មនុស្សចាស់អាច រួមមានការផ្តល់ពេលសម្រាកសម្រាប់អ្នកថែទាំមានវ័យចំណាស់ (ឧទាហរណ៍ តាមរយៈការបង្កើតបណ្តាញគាំទ្រសង្គមតាមភូមិ) ការទទួលស្គាល់យ៉ាងខ្លាំងចំពោះមនុស្សចាស់នៅតាមសហគមន៍ (ឧទាហរណ៍ នៅក្នុងទម្រង់ជាទិវា "ការថែទាំអ្នកថែទាំ") ការអប់រំជាសាធារណៈសម្រាប់លើកកម្ពស់ការយល់ដឹងអំពីអាហារូបត្ថម្ភសម្រាប់មនុស្សចាស់ និងអាកប្បកិរិយាហូបចុក និងកិច្ចខិតខំប្រឹងប្រែងកែលម្អសេវាថែទាំសុខភាពកាន់តែមានសមធម៌សម្រាប់ មនុស្សចាស់ជាពិសេសមនុស្សចាស់នៅតាមតំបន់ជនបទ។ តម្រូវការនៃការថែទាំ និងពេលវេលាសម្រាប់ថែទាំកុមារដែលឪពុកម្តាយទុកចោល អាចធ្វើឱ្យមានការលំបាកចំពោះអ្នកថែទាំដែលមានវ័យចំណាស់ក្នុងការធ្វើសកម្មភាពរាងកាយជាប្រចាំ ក៏ដូចជា សកម្មភាពផ្សេងៗទៀតផងដែរ។ ដូច្នេះ ការផ្តល់ការគាំទ្រដល់អ្នកថែទាំដែលមានវ័យចំណាស់ដើម្បីឱ្យពួកគាត់បានចូលរួមក្នុងការអភិវឌ្ឍន៍ស្មារតីគឺជាការចូលរួមផ្នែកវប្បធម៌ និងសាសនាដ៏សំខាន់មួយ ព្រមទាំងបង្កើតបានជាផ្នែកដ៏សំខាន់មួយនៃការឈានចូលវ័យចំណាស់ "ប្រកបដោយសុខភាពល្អ" នៅក្នុងជីវិតរបស់ពួកគេនៅក្នុងប្រទេសកម្ពុជា។
- ការសិក្សានេះ ក៏បានគូសបង្ហាញឱ្យឃើញអំពីតម្រូវការសុខភាពផ្លូវចិត្តផ្អែកលើវប្បធម៌សម្រាប់ប្រជាជនកម្ពុជាដែលមានវ័យចំណាស់ដែលធ្លាប់បានឆ្លងកាត់របបខ្មែរក្រហម។ អ្នកថែទាំបានបង្ហាញពីអាការៈនៃការតានតឹងផ្លូវចិត្ត ដែលកើតចេញពីបទពិសោធន៍ប៉ះទង្គិចផ្លូវចិត្តរបស់ពួកគាត់កាលពីអតីតកាលនៅក្នុងអំឡុងពេលសង្គ្រាមស៊ីវិល ដោយសារតែអ្នកថែទាំដែលមានវ័យចំណាស់មានកម្រិតតានតឹងចិត្តខ្ពស់ជាងអ្នកថែទាំដែលមានវ័យក្មេង។
- ការធ្វើចំណាកស្រុកទៅរកការងារធ្វើក្នុងចំណោមយុវជនក្មេង។ជំនាន់ក្រោយ ធ្វើឱ្យចំនួនមនុស្សចាស់ដែលត្រូវទទួលបន្ទុកមើលថែចៅ។មានចំនួនកាន់តែច្រើនឡើង។ អ្នកបង្កើតនយោបាយ និងអ្នកជំនាញថែទាំសុខភាពគួរតែយល់ដឹងទូលំទូលាយអំពីប្រជាជនដែលងាយរងគ្រោះទាំងនេះ។ នៅកម្រិតគោលនយោបាយចាំបាច់ត្រូវតែធ្វើការពិចារណាលើបញ្ហាសុខភាពផ្លូវចិត្តក្នុងចំណោមអ្នកថែទាំដែលត្រូវបានគេទុកចោល ជាពិសេស អ្នកថែទាំ ជាស្ត្រីដែលជាញឹកញាប់ទទួលខុសត្រូវក្នុងកិច្ចការថែទាំកុមារ។
- ដើម្បីគាំទ្រប្រជាជនវ័យចំណាស់ដែលមានចំនួនយ៉ាងច្រើន ជាពិសេស នៅក្នុងសហគមន៍នៅតាមជនបទ ការធ្វើកិច្ចអន្តរាគមន៍គាំទ្រការផ្តល់សេវាថែទាំសុខភាពផ្លូវចិត្តសម្រាប់

មនុស្សចាស់គួរតែកំណត់គោលដៅជាក់លាក់។ ក្នុងវិស័យសេវាកម្ម រួមមាន បុគ្គលិកសុខាភិបាល បុគ្គលិកសង្គមកិច្ច និងអ្នកវិជ្ជាជីវៈផ្សេងទៀតដែលបម្រើការងារពាក់ព័ន្ធនឹងការថែទាំមនុស្សចាស់ គួរតែទទួលបានការបណ្តុះបណ្តាលស្តីពីកំណត់រក និងការដោះស្រាយបញ្ហាតានតឹងផ្លូវចិត្តដែលកើតមានជាទូទៅក្នុងចំណោមមនុស្សចាស់។ ដើម្បីផ្តល់សេវានេះដល់ក្រុមមនុស្សចាស់ដែលត្រូវការជាចាំបាច់បំផុត និងដែលងាយរងគ្រោះបំផុត ការស្វែងយល់អំពីសុខភាពផ្លូវចិត្តនៅតាមសហគមន៍ និងការចុះសួរសុខទុក្ខតាមផ្ទះ គួរតែពង្រឹងបន្ថែមទៀត។

- នៅពេលធ្វើការវាយតម្លៃពិន្ទុសុខភាពផ្លូវកាយ ស្ថានភាពអាហារូបត្ថម្ភ និងភាពចម្រុះនៃរបបអាហារជារួម វាច្បាស់ណាស់ដែលថាអ្នកថែទាំជាស្ត្រីយ៉ចំណាស់ (ជីដូន) របស់កុមារដែលត្រូវឪពុកម្តាយទុកចោលគឺជាអ្នកដែលងាយរងគ្រោះខ្លាំងបំផុត។ នៅកម្រិតគោលនយោបាយ វាពិតជាសំខាន់ដែលគួរតែធ្វើការពិចារណាទៅលើបញ្ហាសុខភាពផ្លូវចិត្តនៅក្នុងចំណោមអ្នកថែទាំដែលគេទុកចោល ជាពិសេស ស្ត្រីយ៉ចំណាស់ដែលជាញឹកញាប់តែងតែទទួលខុសត្រូវក្នុងការថែទាំកុមារ។ គួរតែមានការផ្តោតការយកចិត្តទុកដាក់បន្ថែមទៀតទៅលើការលើកកម្ពស់កិច្ចគាំទ្រសង្គមតាមយេនឌ័រ ដូចជាសេវាកម្មអាចផ្តល់ជូនដើម្បីពង្រឹងការគាំទ្រគ្រួសារសម្រាប់អ្នកថែទាំជាបុរសហើយអ្នកថែទាំជាស្ត្រីគួរតែត្រូវបានលើកទឹកចិត្តឱ្យចូលរួមក្នុងសកម្មភាពសហគមន៍នានាដើម្បីបង្កើនធនធានរបស់ពួកគាត់នៅក្នុងសហគមន៍។ ចាប់ពីវិស័យសេវាកម្មមន្ត្រីសុខាភិបាលបុគ្គលិកសង្គមកិច្ចនិងអ្នកវិជ្ជាជីវៈផ្សេងទៀតដែលបម្រើការងារនៅក្នុងវិស័យថែទាំមនុស្សចាស់ត្រូវតែមានការយល់ដឹងអំពីសុខភាពផ្លូវចិត្ត និងតម្រូវការអាហារូបត្ថម្ភរបស់ពួកគាត់និងថាតើតម្រូវការនិងសុខភាពផ្លូវចិត្តទាំងនោះមានការប្រែប្រួលយ៉ាងដូចម្តេចខ្លះទៅតាមយេនឌ័រ ហើយត្រូវតែទទួលការបណ្តុះបណ្តាលដើម្បីជួយគាំទ្រ និងព្យាបាលពួកគាត់យ៉ាងដូចម្តេច។

តួនាទីនៃប្រាក់បញ្ញើ

- បំណុលក្នុងគ្រួសារគឺបញ្ហាទូទៅក្នុងចំណោមគ្រួសារពលករចំណាកស្រុក និងគ្រួសារគ្មានពលករចំណាកស្រុក ដោយក្នុងនោះ គ្រួសារគ្មានពលករចំណាកស្រុកចំនួន ៦១ ភាគរយ និងគ្រួសារពលករចំណាកស្រុកចំនួន ៥៤ ភាគរយជំពាក់បំណុលគេ។ គ្រួសារពលករចំណាកស្រុកប្រមាណ ៧៣% យកប្រាក់បញ្ញើមកដោះបំណុល ខណៈដែលគ្រួសារផ្សេងទៀតដោះបំណុលដោយប្រើប្រាក់ដែលរកបានពីសកម្មភាពរកចំណូលផ្សេង ឬពីអាជីវកម្មដែលខ្លួន។ ផ្ទុយមកវិញ គ្រួសារគ្មានពលករចំណាកស្រុកប្រើប្រាស់តែសកម្មភាពបង្កើតប្រាក់ចំណូល និងអាជីវកម្មរបស់ពួកគេជាប្រភពនៃការសងបំណុលប៉ុណ្ណោះ។ ការសិក្សានេះគូសបញ្ជាក់ឱ្យឃើញអំពីសារៈសំខាន់នៃប្រាក់បញ្ញើដើម្បីសម្រួលដល់លទ្ធភាពទទួលបានសេវាវេជ្ជសាស្ត្រ ការអប់រំរបស់កូនៗ និងការសងបំណុល។

- គោលនយោបាយស្តីពីទេសន្តរប្រវេសន៍ការងារ (LMP) ផ្តល់នូវគម្រោងសម្រាប់ដោះស្រាយតម្រូវការជាច្រើនផ្សេងៗគ្នារបស់ពលករចំណាកស្រុក។ គោលនយោបាយនេះ រួមបញ្ចូលនូវបទប្បញ្ញត្តិស្តីពីសេវាហិរញ្ញវត្ថុដើម្បីជួយសម្រួលដល់ការផ្ទេរប្រាក់មកផ្ទះ និងការគាំទ្រការវិនិយោគផលិតកម្មនៅក្នុងសហគមន៍កំណើត។

- គោលនយោបាយនេះ គួរតែបង្កើតនូវគម្រោងអភិបាលកិច្ចអំពីចំណាកស្រុករបស់ពលករដែលទូលំទូលាយ និងមានប្រសិទ្ធភាព ដែលអាចការពារ និងលើកកម្ពស់ស្ត្រី និងបុរសនៅពេញមួយវដ្តនៃការធ្វើចំណាកស្រុក ហើយជានាថាការធ្វើចំណាកស្រុកគឺជាជម្រើសដែលទទួលព័ត៌មានពេញលេញ និងផ្តល់នូវបទពិសោធន៍វិជ្ជមាន និងទទួលបានប្រាក់ចំណូលសម្រាប់ពលករម្នាក់ៗ ក្រុមគ្រួសារ និងសហគមន៍របស់ពួកគាត់ ដែលទាំងនេះចូលរួមចំណែកដល់ការអភិវឌ្ឍន៍ប្រទេសកម្ពុជាផងដែរ។

- រដ្ឋាភិបាលអាចគាំទ្រគ្រួសារនីមួយៗក្នុងការសម្រេចចិត្តធ្វើចំណាកស្រុកតាមរយៈការធ្វើយុទ្ធនាការដើម្បីផ្តល់ព័ត៌មាននៅតាមតំបន់ដែលមានអត្រាចំណាកស្រុកច្រើន។ ឧទាហរណ៍ការបង្កើតឲ្យមានមជ្ឈមណ្ឌលធនធានពលករទេសន្តរប្រវេសន៍ (MRCs)។ មជ្ឈមណ្ឌលទាំងនេះអាចផ្តល់ការទទួលបានព័ត៌មាន និងការសម្របសម្រួលជម្រើសដែលទទួលបានព័ត៌មានពេញលេញចំពោះការធ្វើចំណាកស្រុក ដោយមានការសម្របសម្រួលពីដៃគូជាមួយបណ្តាញផ្តល់ការងារ និងតំបន់ដំណើរការក្នុងស្រុក។ មជ្ឈមណ្ឌលធនធានពលករទេសន្តរប្រវេសន៍ ក៏អាចធ្វើសិក្ខាសាលា (ដែលរៀបចំដោយក្រសួងការងារដោយសហការណ៍ជាមួយដៃគូពាក់ព័ន្ធនានា) ស្តីពីការប្រើប្រាស់ប្រាក់បញ្ញើឲ្យមានភាពប្រសើរឡើង។

- យោងតាមការស្នងមតិរបស់អង្គការពលកម្មអន្តរជាតិ និងអង្គការអន្តរជាតិទេសន្តរប្រវេសន៍ (ILO-IOM) ថ្លៃសេវាគឺ ២.៤ ភាគរយសម្រាប់ប្រាក់ដែលផ្ញើ។ រដ្ឋាភិបាលអាចសម្របសម្រួលធ្វើយ៉ាងណាឱ្យការផ្ទេរប្រាក់កាន់តែមានតម្លៃសមរម្យ និងផ្តល់កម្មវិធីឥណទានដើម្បីជួយទ្រទ្រង់ដល់គ្រួសារពលករចំណាកស្រុកផ្សេងៗ។ ការធ្វើឱ្យទៅជាផ្លូវការការធ្វើឱ្យទៅជាបច្ចេកវិទ្យាឌីជីថល និងការតម្រូវទៅតាមតម្រូវការចំពោះផលិតផលគឺពិតជាមានអត្ថប្រយោជន៍ណាស់ដើម្បីបំពេញតាមតម្រូវការកាន់តែប្រសើរសម្រាប់ពលករចំណាកស្រុក និងក្រុមគ្រួសាររបស់ពួកគាត់នៅក្នុងប្រទេសកម្ពុជាដែលពឹងផ្អែកទៅលើបុរាក់ផ្ញើជាទៀងទាត់តាមរយៈការបង្កើតតំណភ្ជាប់ជំរឹងមាំរវាងការផ្ទេរប្រាក់អន្តរជាតិ និងសេវាហិរញ្ញវត្ថុក្នុងស្រុកនៅក្នុងប្រទេសកម្ពុជា។ កិច្ចខិតខំប្រឹងប្រែងជាច្រើនពីសំណាក់ក្រុមហ៊ុនផ្តល់សេវាចល័តដើម្បីកាត់បន្ថយថ្លៃចំណាយលើសេវាកម្មផ្ទេរប្រាក់ និងសុវត្ថិភាពហិរញ្ញវត្ថុកាន់តែប្រសើរសម្រាប់ពលករចំណាកស្រុក កំពុងត្រូវបានអនុវត្ត។

- មានក្រុមហ៊ុន និងសហគ្រាសមួយចំនួនបានបង្កើតសេវាកម្មហិរញ្ញវត្ថុតាមទូរស័ព្ទ ដូចជាការទូទាត់ប្រាក់តាមទូរសព្ទដៃ និងកម្មវិធីផ្ទេរប្រាក់ដែលជួយឱ្យបុគ្គលម្នាក់ៗអាចធ្វើការផ្ទេរប្រាក់ឆ្លងប្រទេសបានដោយប្រើប្រាស់សារ USSD តាមទូរស័ព្ទដៃយ៉ាងលឿន។ ក្រុមហ៊ុនមួយចំនួនបានចាប់ដៃគូជាមួយនឹងក្រុមហ៊ុនបរទេសមួយចំនួនដើម្បីពង្រីកសេវាផ្ញើប្រាក់សម្រាប់ពលករចំណាកស្រុកកម្ពុជាដែលធ្វើការនៅក្រៅប្រទេស។ បុគ្គលសំខាន់ៗដែលមកពីស្ថាប័នរដ្ឋអាចស្វែងរកគោលការណ៍ណែនាំនិយ័តកម្មដើម្បីបង្កើតឱ្យមានគំរូភាពជាដៃគូ និងស្ថាប័នមិនមែនធនាគារអាចពន្លឿនការកែច្នៃផលិតផលថ្មី។ បុគ្គលសំខាន់ៗខាងវិស័យឯកជនអាចកំណត់និងគាំទ្រដំណោះស្រាយប្រកបដោយភាពច្នៃប្រឌិត រួមមានការពង្រឹងបណ្តាញដឹកជញ្ជូនបែបឌីជីថល ការដាក់ឱ្យដំណើរការកម្មវិធីគាបូបលុយតាមទូរសព្ទដៃ និងការបង្កើតការសន្សំភ្ជាប់នឹងការផ្ញើប្រាក់។ ព័ត៌មានតម្រង់ទិសមុនចេញដំណើរតាមរយៈវេទិកាប្រព័ន្ធផ្សព្វផ្សាយសង្គមដើម្បីជូនដំណឹងដល់ពលករ ដែលធ្វើដំណើរទៅក្រៅប្រទេស និងក្រុមគ្រួសាររបស់ពួកគេអំពីផលិតផលទាក់ទងនឹងការផ្ទេរប្រាក់ផ្លូវការដែលមានដើម្បីជានាការផ្លាស់ប្តូរជាបន្តបន្ទាប់ពីផលិតផលទាក់ទងនឹងការផ្ទេរប្រាក់មិនផ្លូវការទៅជាផ្លូវការ និងការបញ្ចូលទីផ្សារហិរញ្ញវត្ថុ។

ទំនាក់ទំនងរវាងចំណាកស្រុក និងការដាក់កុមារនៅមណ្ឌលមើលថែ

- លទ្ធផលនេះ ផ្តល់កស្តុតាងបន្ថែមកាន់តែជាក់លាក់នៃមូលហេតុធ្វើឱ្យមានភាពក្រីក្រក្នុងគ្រួសារ ដែលជាកត្តាជំរុញ (push factor) និងឱកាសអប់រំដែលជាកត្តាទំនាញ (pull factor) នៅតាមដំណើរឆ្ពោះទៅរកការរស់នៅក្នុងមណ្ឌលមើលថែកុមារ។ ការចូលរួមចំណែកមួយចំណោមការចូលរួមចំណែកដ៏ពិសេសនៃការសិក្សាបច្ចុប្បន្ននេះ គឺដើម្បីធ្វើការពិភាក្សាដេញដោលថាតើចំណាកស្រុកចូលរួមចំណែកយ៉ាងពិសេសយ៉ាងម៉េចដល់បម្រែបម្រួលគន្លងទាំងនេះ។ ការសិក្សាស្រាវជ្រាវទ្រង់ទ្រាយធំបន្ថែមគឺមានភាពចាំបាច់ដើម្បីពិនិត្យលម្អិតទៅលើចំនួនកុមារកាន់តែច្រើននៅក្នុងមណ្ឌលថែទាំកុមារ ជាពិសេសដើម្បីធ្វើការពិចារណាទៅលើកម្រិតនៃកត្តាចំណាកស្រុកទៅលើការចូលរបស់កុមារ

ទៅក្នុងមណ្ឌលថែទាំកុមារ។ ការសិក្សាបែបគុណភាពទ្រង់ទ្រាយតូចនេះគឺមិនអាចផ្តល់នូវការប៉ាន់ប្រមាណអំពីកម្រិតក្នុងប្រភេទណាមួយបានឡើយ។

- កត្តានានាដែលមិនបានឆ្លុះបញ្ចាំងនៅក្នុងការសិក្សានេះផ្តល់ជាមធ្យោបាយអាចទៅរួចសម្រាប់ការធ្វើអន្តរាគមន៍។ ភាពក្រីក្រក្នុងគ្រួសារ និងអស្ថេរភាពក្នុងគ្រួសារក្លាយជាកត្តាកំណត់មួយដ៏សំខាន់ចំពោះដំណើរការទៅរកការដាក់កុមារនៅមណ្ឌលមើលថែ។ កិច្ចអន្តរាគមន៍របស់សហគមន៍ក្នុងការគាំទ្រដល់ការពង្រឹងដំណើរប្រព្រឹត្តទៅនៃគ្រួសារ និងដើម្បីដោះស្រាយអាកប្បកិរិយាប្រជុំយប្រថានរួមមាន អំពើហិង្សាក្នុងគ្រួសារ ការសេពគ្រឿងស្រវឹង និងប្រើប្រាស់គ្រឿងញៀន អាចជួយគាំទ្រដល់គ្រួសារ និងកុមារក្នុងការបន្តរស់នៅក្នុងសហគមន៍ នៅក្នុងគ្រួសាររបស់ពួកគេ ឬជាមួយសាច់ញាតិ ឬក្នុងការថែទាំជំនួសផ្សេងៗទៀត។
- ការពិចារណាទៅលើកិច្ចអន្តរាគមន៍ ដែលមានចេនាសម្ព័ន្ធផ្សេងៗគ្នាពាក់ព័ន្ធនឹងលទ្ធភាពចូលរៀននៅថ្នាក់អនុវិទ្យាល័យសម្រាប់កុមាររស់នៅតាមទីជនបទដាច់ស្រយាលគួរតែលើកយកមកធ្វើការពិចារណា ដោយសារតែលទ្ធភាពចូលរៀននៅថ្នាក់អនុវិទ្យាល័យ /ការបណ្តុះបណ្តាលវិជ្ជាជីវៈអាចជាកត្តាហានិភ័យបន្ថែមមួយទៀតសម្រាប់គ្រួសារមួយចំនួន។ កង្វះខាតឱកាសការងារដែលអាចចិញ្ចឹមជីវិតបាននៅក្នុងសហគមន៍ ក៏អាចចូលរួមចំណែកបង្កឱ្យមានភាពក្រីក្រក្នុងគ្រួសារ ដូចនេះការពិចារណាបន្ថែមអំពីវិធីសាស្ត្រដោះស្រាយឧបសគ្គនេះគឺត្រូវតែទទួលបានការយកចិត្តទុកដាក់។ ប្រសិនបើឪពុកម្តាយត្រូវតែធ្វើចំណាកស្រុកដើម្បីទទួលបានឱកាសចិញ្ចឹមជីវិតប្រកបដោយភាពយូរអង្វែង សហគមន៍អាចព្យាយាមផ្តល់នូវការគាំទ្រការធ្វើផែនការដើម្បីសម្របសម្រួលដល់ការរៀបចំការផ្តល់ការថែទាំប្រកបដោយភាពវិជ្ជមានសម្រាប់កុមារដើម្បីឱ្យពួកគេអាចបន្តរស់នៅក្នុងសហគមន៍ និង/ឬកសាងភាពជាដៃគូជាមួយនឹងដៃគូជាតិដើម្បីសម្របសម្រួលការធ្វើចំណាកស្រុកគ្រួសារប្រកបដោយសុវត្ថិភាពទៅកាន់តំបន់ដែលមានឱកាសការងារ ធ្វើដូច្នេះទើបកុមារអាចទៅជាមួយឪពុកម្តាយរបស់ពួកគេបាន។
- ការកំណត់ការអនុវត្តល្អនៅក្នុងការពង្រឹងការថែទាំត្រូវតែធ្វើឡើងនៅមូលដ្ឋានសហគមន៍នៅក្នុងតំបន់ជនបទ រួមមានការវាយតម្លៃម៉ត់ចត់នៃកិច្ចអន្តរាគមន៍ដើម្បីជួយសម្រួលដល់ការពង្រីកវិសាលភាពនៅទូទាំងប្រទេស។ ការពិចារណាប្រកបដោយយកចិត្តទុកដាក់ខ្ពស់ទៅលើធនធានដែលត្រូវការចាំបាច់ និងការធ្វើចំណាយផ្សេងៗគឺពិតជាមានសារៈសំខាន់ខ្លាំងណាស់សម្រាប់ភាពជោគជ័យនៃការអន្តរាគមន៍នាពេលអនាគតដើម្បីគាំទ្រដល់កិច្ចអន្តរាគមន៍បឋមសម្រាប់កុមារដែលទៅរស់នៅក្នុងមណ្ឌលថែទាំកុមារ ក៏ដូចជាកម្មវិធីសមាហរណកម្មដោយជោគជ័យ។ លទ្ធផលពីការសិក្សាស្រាវជ្រាវនេះផ្តល់នូវចំណុចជាច្រើននៃកិច្ចអន្តរាគមន៍សក្តានុពលផ្សេងៗចំពោះបុគ្គល គ្រួសារ សហគមន៍ ស្ថាប័ននានា និងរដ្ឋាភិបាលផងដែរ។

EXECUTIVE SUMMARY

Despite the large flow of internal and international/cross-border labor migration and its importance to economic development and poverty alleviation, little is known of the health and social consequences to migrants and their families in Cambodia. The link between migration and institutionalization of children of migrant workers is also poorly understood. This study addresses two key research questions:

1 - Are there any significant health and social consequences to left behind children and family members of migrant workers in Cambodia?
2- Does migration result in institutionalization or fostering of children of migrant workers?

This study adopted a mixed-methods approach, including a large-scale quantitative household survey (n=1,459) and 115 qualitative interviews with family members of the migrant households. Key informant interviews with local authorities, management, case-workers and children living in residential care institutions (RCIs) were also conducted to complete eight extended case studies of RCIs. The household survey covers 56 districts across 13 provinces aiming to understand impacts of migration on Cambodian children and families left behind. The survey sample design includes two cohorts: the Younger Child Cohort (aged 0 to 3 years) and the Older Child Cohort (aged 12 to 17 years). Households with no history of parental migration were also included for comparison.

The findings of this study cover the following topics: migration and socio-economic status, migration dynamics and history including destinations, durations, remittances and communication between origin households and migrants; and child and caregiver physical and mental health. Detailed comparisons are made about migration destinations (internal and international-cross-border), migration types (father-migrants, mother-migrants, both-parents-migrant), and child caregiving arrangements. Comparison is made, where relevant, to the Cambodia Demographic Health Survey (2014) and Migration and Left-behind Households in Rural Areas in Cambodia (CRUMP) survey (2015), considering, where possible, differences in the composition of the comparison samples. The results of Migration and Health Impacts on Cambodian Children and Families study (MHICCAF) are summarized using sample weights to reflect the sampling design in all tables throughout this report. Selected themes (and subthemes) generated through qualitative data analysis are also presented alongside the quantitative findings, where relevant. The final section of the findings explores the pathways into and out of RCIs based on the extended case studies.

This study engaged government, non-governmental actors, international organizations, civil society actors, research organizations (both national and international) across all phases of the research – from conception to formulation of policy recommendations. Therefore the relevant policy context and reports on consultation with local experts about the research

were mapped out to inform an intervention framework reflecting culturally and contextually relevant interventions for the Cambodian setting.

Key Findings

Household Profile

- Almost two-thirds (75%) of left behind children have grandparents as their primary caregiver, only 14 percent have a parent as primary caregiver. Ninety-five percent of caregivers are women.
- Nearly 40 percent of the caregivers in migrant households are elderly above the age of 60. The majority (95%) of caregivers are female.
- Around half of fathers and mothers are agricultural laborers. One third of father-migrants and 20 percent of mother-migrants work as construction workers.
- Two parents with one child is the most common living arrangement among non-migrant households; the extended family with a grandparent as the primary caregiver is the predominant family structure among migrant households. Nine percent of parents in migrant households are divorced, significantly higher than the divorce rate among non-migrant households.

Migration Dynamics

- Over sixty percent of households have both parents away working as migrant workers. The most common pattern among migrant households is international migration of both parents (46%), followed by internal migration of both parents (26%). Thailand is the main destination for international migration and Phnom Penh is the main destination among internal migrants. The main reasons for migration are household debt and the need to search for work.
- Nineteen percent of children in Younger Child Cohort live in a father-migrant household compared to 13 percent of children in the Older Child Cohort who live in a mother-migrant household.
- Mothers are primary caregivers when fathers are away as migrant worker, while the maternal grandmother is most likely to take up caregiving responsibility when mothers migrate alone or with their spouses.

Household Income, Debt and Remittance

- Non-migrant households have the highest average household income, followed by father-migrant households. When compared to non-migrant households, migrant households have the higher average expenditure on medical products but lower expenditure on communication equipment and child education.
- There is a high prevalence of indebtedness among all households with 61 percent of non-migrant households and 54 percent of migrant households paying off debt. Migrant households have a similar amount of debt and outstanding loans as non-migrant households, but they have higher debt interest.
- Father-migrants have a higher percentage of remitting money and send more remittances home than mother-migrant.
- International migrants send home the highest amount of remittances. While labor migration is clearly a pathway for economic prosperity for many migrant households, there are clearly differences by migrant typology (cross-border vs internal migrant workers).

Illness Profiles and Health Seeking Behavior

- The average number of family members who experienced any form of illness in the 30 days prior to the survey is higher among migrant families compared to non-migrant families. During 30 days prior to the survey, more children reported being sick within the migrant households compared to children living in non-migrant households.
- The percentage of family members injured in the past 12 months among migrant household is 9 percent, which is significantly lower than non-migrant households.
- The general pattern of utilization of health care facilities is similar among non-migrant and migrant households: the private sector is more commonly used than public health service.
- The costs associated with medical treatment for sick children were significantly higher in migrant households, compared to non-migrant households, but with no difference in cost for sick adults.

Household Food Security

- Nearly 6 percent of interviewed households report experiencing moderate to severe hunger.
- Migrant households have higher consumption-based coping strategies scores (CSI), indicating more frequent and severe coping strategies used to tackle food insufficiency, defined as a period when the household faced a food shortfall or insufficient money to purchase food in the past seven days.
- Children in migrant households are more likely to borrow food and reduce the number of meals or reduce portion size of meals when their households have food insufficiency.
- The general pattern of using livelihood coping strategy in non-migrant and migrant households is similar, but migrant households are more likely to withdraw their children from school temporarily or sell their household goods due to food insufficiency.

Nutritional Status and Physical Health of Adult Caregivers

- Caregivers in migrant households have poorer diversity of dietary intake compared to those in non-migrant households. Around 11 percent of female caregivers are thin, and 30 percent are overweight or obese. Around 14 percent of male caregivers are thin, and 20 percent are overweight or obese.
- Caregivers in both-parents-migrant households are more likely to be overweight, particularly for grandparent caregivers.
- Caregivers have a poorer status of self-reported physical health in migrant households than in non-migrant households, with older age as the main reason.

Child Growth and Development

- Around 70 percent of children aged 6 to 23 months are receiving nutritional adequacy above the minimum for dietary diversity.
- Among the children aged 0 to 3, 19 percent are stunted, 9 percent are wasted, and 14 percent are underweight. Among the children aged 12 to 17, 25 percent are stunted, and 11 percent are wasted.
- Boys show disadvantages in nutritional status compared to girls, with a significantly higher rate of stunting in the Younger and Older Child Cohort and higher prevalence of wasting in the Older Child Cohort.
- For the Younger Child Cohort, children in migrant households are more likely to have higher scores of dietary diversity and early development, and better nutritional status compared to their peers in non-migrant households.
- For the Older Child Cohort, children in migrant households have lower scores of dietary diversity: however, they are not worse off on other nutritional status measures compared to children in non-migrant households.

Mental Health and Social Support of Caregivers

- As compared to caregivers in non-migrant households, caregivers in migrant households are worse off on both general mental health and resilience. The prevalence of depression and anxiety among the caregivers is as high as 43 percent and 50 percent, respectively: significantly higher prevalence is found among caregivers in migrant households than among non-migrant households.
- Caregivers in mother- and both-parents-migrant households are more likely to experience poor mental health, while caregivers in father-migrant households are less likely to report close relationships with family and community.
- Caregivers still show the symptoms of distress stemming from their past trauma experience during the civil war period, meaning elderly caregivers have a higher level of distress than younger caregivers. Being female and elderly (60 years old and above) are the key risk factors related to poor mental health.
- Caregivers in migrant households do not differ from those in non-migrant households in terms of social support, however they perceive a weaker relationship with family.

Mental health of Children (Older Child Cohort)

- Child and caregiver views on child mental health differs. Based on child reports, children left behind are not worse off in terms of self-reported psychological well-being measured by the Strengths & Difficulties Questionnaire (12 to 17 years old). Based on caregiver reports, children of mother-internal-migrants have poorer psychological wellbeing.
- Parental migration, particularly international/cross-border migration, is associated with lower scores of child resilience. In fact, children in father-migrant households exhibit more prosocial behaviors. Girls show advantages in prosocial behaviors and resilience compared to boys overall.

Family Functioning of Children (Older Child Cohort)

- Caregivers in migrant households are more likely to say they adopt positive parenting/caregiving than those in non-migrant households, but there is no significant difference on parenting/caregiving practice from the child's perspective.
- Girls in migrant households are less likely to be positively attached to their caregivers compared to their counterparts in non-migrant household and children of mother-international-migrants have weaker attachment to their caregivers. Overall, male children are less likely to report a close attachment to their caregivers compared to females.

Contact and Communication

- More than one third of father-migrants and mother-migrants maintain contact with their family every day. The contact method used most commonly in households of migrants is the phone call, followed by social media.
- Around one third of father-migrants and mother-migrants visit once a year. Internal-migrants have a higher a frequency of contact and visitation than international-migrant parents but they do not differ on the intensity of remittance.

Pathways into Residential Care Institutions (RCIs)

- Migration is one of several factors which contributes to a child's entry to institutional care. The study identified two common pathways into RCIs: 1) Migration as a Factor and 2) Migration as a Determinant. The two pathways are represented almost equally in the study: Migration as a Factor and Migration as a Determinant.
- Children of migrant parents who live in RCIs often have experienced a number of challenging situations in their family lives, including extreme poverty, domestic violence, parental alcoholism and caregiving instability. Family poverty and instability are important push factors while the educational opportunities available through RCIs are a strong pull factor along the pathway to the RCI.
- Children, in general, appreciate the stability of the RCI while missing the warmth of a family life.
- Re-integration depends on a number of factors, with special consideration given to the caregiving and educational arrangements.

Policy Recommendations

Health Trajectories

1 - Health trajectory of children

- The National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) and the National Policy on Early Childhood Care and Development (2010) should extend their target beyond five year old children. While existing policy interventions target reducing malnutrition among children under five years of age, age-specific interventions are also required for those in older age groups. Interventions to ensure nutritionally adequate food for children should include providing school feeding programs for poor communities, improving access to child health services, and education for caregivers on the diversification of diet for children of all ages up to age 18. Community-level health workers and child protection/welfare workers can be mobilized at the village level to support migrant households identified by the village chief/administrator to develop a nutritional plan for caregivers during absence of parent/s.
- Early-childhood, adolescent and youth health programs at the national level, relevant agencies working within this space including donor agencies, need to graft migration as a key determinant of child-health outcomes. At the sub-national level, the village commune council for women and children (CCWC) could establish mechanisms to identify families with vulnerable children and coordinate with relevant health providers and welfare officers to support case-management plans for left behind children.
- Policy interventions should concentrate on enhancing social health protection schemes (e.g. Health Equity Fund) to increase the inclusion of young people – especially in rural areas and reduce indebtedness for high out-of-pocket health expenditure. The barriers and costs to the fund need to be addressed to ensure greater uptake, including educating prospective migrant workers on the importance of social and health insurance schemes. Health diplomacy in the form of bi-lateral agreements with labor receiving countries to encourage employer groups in destination countries to provide social protection for workers and families may be facilitated by the Ministry of Foreign Affairs, Ministry of Commerce, Ministry of Labor and Vocational Training, and Ministry of Health.
- The Education Strategic Plan 2014-2018 of Cambodia can be leveraged to focus on expansion of Early Childhood Education to ensure children from birth to school entry achieve positive physical and psychosocial development in the home and community. It is critical to increase public awareness about the importance of early education and invest in family-friendly policies.
- There is no specific policy addressing adolescents but there are a few relevant strategic plans such as the National Strategic Plan 2014-2018, which mentioned adolescent and reproductive health, as part of the national strategy for reproductive and sexual health. This is an important area of future policy development. The policy for migrant workers should also include their families left behind. Early intervention and prevention are needed to avoid later mental health challenges, and promote child resilience, particularly to enable children to cope with migration-related stress.
- A focus on strengthening resilience can protect positive development gains and ensure individuals have the resources and capacities to better adapt to stress and adversities. Policy makers and health-care workers should have a greater awareness of potential mental health risks when children are left behind without parental caregivers. A strength-based approach, for example, Positive Youth Development framework could be explored and integrated with cultural-specific needs in Cambodia to foster child resilience and external resources.
- Caregiving for the third generation still can be challenging. Services focusing on parenting skills and support can encourage responsible caregivers to reframe their perceptions of parenting, learn parenting skills and provide respite from the demands of caregiving. Parenting education, such as the Triple P-Positive Parenting Program, can be considered to improve the wellbeing of children and their family relationships.

- Policies such as the National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) and the National Policy on Early Childhood Care and Development (2010) apply to these gendered nutritional risks for children. The results further draw attention to adolescent boys' vulnerability to poorer psychological well-being in Cambodia. Policy makers should further develop mechanisms to assess gender specific interventions, in particular to address the risk for boys among the general population (both migrant and non-migrant).

2 - Health trajectory of caregivers

- These findings highlight the importance of 'Caring for the Caregiver'. Interventions to support elderly care provision can include: providing respite for elderly caregivers (e.g. by establishing social support networks at village level); greater acknowledgement of the elderly by community (e.g. in the form of 'caring for caregiver' day); public education for the improvement of the elderly's nutrition knowledge and dietary behaviors; and, efforts to make health care more equitable for older people, especially those in rural areas. The demands of caregiving and time consumed in care of left behind children may limit the access of elderly caregivers to routine physical activities, as well as other activities. So, providing support for elderly caregivers to participate in spiritual development is an important cultural and religious engagement and forms a key part of 'healthy' aging in Cambodian life.
- The study also highlights the culture-specific mental health needs of Cambodia elderly population who experienced the Khmer Rouge period. The caregivers showed the symptoms of distress stemming from their past traumatic experience during the civil war period, as elderly caregivers had a higher level of distress than younger caregivers.
- Employment-driven out-migration among the younger generation leaves an increasing number of older people to take responsibility as caregiver for their grandchildren. Policy makers and health-care professionals should have an increased awareness to this vulnerable population. It is important at the policy level to consider mental health issues among caregivers left behind, especially the female elderly who often take the responsibility for childcare tasks.
- To support a large population of elderly citizens especially in rural communities, the interventions to support elderly mental care provision could be specifically targeted. The service sectors including health workers, social workers, and other professionals working in elderly care should be trained to identify and treat common psychological distresses among the elderly. To reach out to the most needed and vulnerable group of elderly, community-based awareness raising on mental health and home visits should be strengthened

- When assessing the physical health scores, nutritional status and dietary diversity as a whole, it is clear that the female elderly caregivers (grandmothers) of left behind children are the most vulnerable. It is important at the policy level to consider mental health issues among caregivers left behind, especially the female elderly who often take the responsibility for childcare. There should be different focuses on enhancing social support by gender: services can be provided to strengthen family support for male caregivers; female caregivers should be encouraged to be engaged in community activities to enhance their resources at the community level. From the service sector, health workers, social workers, and other professionals working in the elderly care sector must be aware of the potential mental health and nutritional needs of and how they may vary by gender and be trained to support and treat them.

The Role of Remittances

- Household debt is common among both migrant and non-migrant households, with 61 percent of non-migrant households and 54 percent of migrant households having debt. Seventy-three percent of migrant households use remittances to pay back loans with the remaining households using income generating or business activities to make repayments. In contrast, non-migrant households exclusively use income generating activities and their business as the source of debt repayment. The study highlights the importance of remittances in facilitating access to medical care, children's education, and paying off debt.
- The Labor Migration Policy (LMP) provides a framework for addressing diverse migrant needs. The policy includes provisions on the development of financial services to ease remittances transfer and support productive investments in the communities of origin.
- The policy should develop a comprehensive and effective labor migration governance framework that protects and empowers women and men throughout the migration cycle, ensures that migration is an informed choice, and enables a positive and profitable experience for individual workers, their families and communities, that also contributes to the development of Cambodia.
- Governments can support families in making a decision to migrate, through information campaigns in areas with high levels of migration. For instance, by creating Migrant Resource Centers (MRCs). Such centers can provide access to information and facilitate informed choice in migration by facilitating partnerships with local job-network providers or domestic processing zones. MRCs can also conduct budgeting workshops (organized by Ministry of Labor in partnership with other relevant partners) on better utilization of remittances.
- According to the ILO-IOM survey, the service fee is 2.4 per cent for remitting money. The

Government can facilitate making remittance transfers more affordable and offering credit schemes to support migrant families. It would be helpful to formalize, digitize and customize products to better fit the needs of migrant workers and families in Cambodia who are dependent on regular remittances through forming stronger linkages between international remittances and local financial services in Cambodia. Efforts are being made by mobile providers to reduce costs of remittance transfers and better financial securities for migrant workers.

- There are several companies and ventures establishing mobile financial services, such as mobile money payment and transfer applications that enable individuals to transfer money across the country using USSD messages. Some companies have partnered with several foreign companies to expand these services to Cambodian migrant workers abroad offering wallet-to-wallet remittance services for migrant workers abroad. Public sector actors can explore regulatory guidelines to enable partnership models and non-bank institutions to accelerate product innovation. Private sectors can identify and support innovative solutions, including strengthening digital delivery channels, launching mobile wallet apps and developing remittance-linked savings. Pre-departure orientation information through social media platforms to inform aspirant and out–ward bound migrant workers and families, on formal remittance products available to ensure gradually transitioning from informal to formal remittance products and a more inclusive financial market.

Linkage between Migration and Children's Institutionalization

- The findings specifically offer further evidence of the salience of family poverty—a push factor—and educational opportunities—a pull factor—along the pathway to the RCI. One of the unique contributions of the current study is to debate about how migration specifically contributes to these trajectories. Further large-scale research is needed in order to examine in detail the larger populations of children in RCIs, especially to consider how prevalent of a factor migration is to children's entry to RCIs. This small-scale qualitative study is unable to provide any type of estimation about prevalence
- The factors uncovered in the study do offer possible pathways for intervention. Family poverty and family instability appear as the important determinants along the path to institutionalization for children. Community interventions to support strengthening family functioning and to address risky behaviors including domestic violence, alcohol and drug abuse, could help to support families and children to remain in the community, within their families, or in kinship or other foster care.
- Consideration of different structural interventions regarding accessibility to secondary schools for children living in more remote rural areas could be considered, as accessibility to secondary school/vocational training may be an additional risk factor for some families. A lack of viable employment opportunities within communities also may contribute to family poverty, thus further consideration about how to address such structural barriers deserves attention. If parents need to migrate in order to pursue sustainable livelihood opportunities, communities could seek to offer planning support to facilitate positive alternative caregiving arrangements for children to remain in local communities, and/or build partnerships with national allies to facilitate safe family migration to areas where employment opportunities are available so that children can come with their parents.
- There is a need for the identification of best practices in strengthening community-based care in rural areas, including rigorous evaluation of interventions in order to facilitate scaling up across the country. Thoughtful considerations of required resources and costings are crucial for any future success of interventions to support primary prevention of children from entering RCIs as well as successful reintegration programs. The findings from the current study offer a number of points of potential interventions on the individual, family, community, institutional and government level.

This ground breaking research would not have been made possible without the generous financing by IOM’s Development Fund and the New Venture Fund, and a multiplicity of government agencies (in particular the Ministry of Social Affairs, Veteran and Youth Rehabilitation, the National Committee Counter Trafficking, the Ministry of Health, and the Ministry of Planning) who strongly endorsed and supported the research at national and sub-national levels.

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This technical report was the result of a multi-disciplinary, participatory action research process that involved a range of stakeholders, based on field visits and established models and frameworks which explore the health and social impacts of migration on left behind children and family members.

Foremost, allow me to express my gratitude and sincerest appreciation to the principal investigators, Associate Professor Lucy Jordan from the Hong Kong University and Dr. Kolitha Wickramage, Global Migration Health Research and Epidemiology Coordinator, IOM’s Migration Health Division for their technical oversight in analyzing and producing this comprehensive technical report. My sincere gratitude and appreciation to Dr. Amaury Peeters, Country Director for Louvain Cooperation and his team for their tireless efforts in the field to interview and collect the stories and data from over 1,500 households across Cambodia.

The study team comprised of the following persons: Associate Professor Dr. Lucy Jordan, and Dr. Yao Fu from the University of Hong Kong; Troy Dooley, Dr Kolitha Wickramage, Brett Dickson, and Ms. Chanthida Dum from IOM; Dr. Amaury Peters, Ms. Thida Kim, Dr. Khem Thann, Sean Chanmony, Rong Chandary, So Dane and the 28 field-based research enumerators including team leaders and household recruiters for the quantitative part and 6 field researchers for the qualitative part undertaken by Louvain Cooperation in Cambodia.

I wish to recognize the invaluable contribution of the late Professor Chesmal Siriwardana from the London School of Hygiene and Tropical Medicine who played a catalytic role in developing the original research study proposal with IOM’s Migration Health Division. Professor Siriwardana tragically died in 2017, who was passionate about advancing the evidence-base at the nexus of migration and mental health in developing countries.

I would also like to extend my appreciation to all the experts who contributed to this research from Save the Children and PLAN International and members of the Family Care First Initiative who all provided valuable technical inputs into the research methodology and research tools.

I believe this research provides the first empirical data and comprehensive understanding of the migration impacts on the health of Cambodian families and children left behind due to parental migration. This research informs social and health policy and appropriate interventions to address the core issues identified. I want to reiterate IOM’s commitment to work closely with all related stakeholders in ensuring safe and orderly migration that benefits all.

01

Intro-duction

1. Background

1.1. CAMBODIA

Cambodia is a lower-middle-income country (LMIC) having graduated from a low-income country (LIC) in 2016[1] by maintaining economic growth above 7 percent for over two decades. Between 1990 and 2016, Cambodia has made significant reductions in child and maternal mortality; increased rates of life expectancy; noticeable declines in deaths due to HIV/AIDS, malaria and tuberculosis, and improvements in the levels of stunting among children, although the latter remains high (UNDAF, 2019).[2]

Cambodia has been experiencing rapid social and economic change since the rule of the Khmer Rouge in the 1970s and the subsequent upheavals towards transitioning to democracy in the 1990s.[3] In Cambodia there is recognition of the intergenerational impact of family processes due to past experiences of trauma.[4]

1. UNDP National Human Development Report 2018 (forthcoming).
2. United Nations Development Assistance Framework 2019–2023 Cambodia.
3. De Jong, J.T., Komproe, I.H., Van Ommeren, M., et al. (2001) Lifetime events and Laezer, K.L. & Hoegger Klaus, E. (2017). Individuelles und kollektives Trauma. Eine Spurensuche zu den psychischen Folgen des Khmer-Rouge-Regimes im heutigen Kambodscha. In: B. Bretthauer, S. Lenz, J. Werdes. (Hg.). Kambodscha. Ein politisches Lesebuch. Berlin: Regiospectcra Verlag, S. 37-47.
4. Nigel P. Field, Edia Tzadikario, Dalen Pel & Thearom Ret (2014) Attachment and Mother-Child Communication in Adjustment to the Death of a Father Among Cambodian Adolescents, Journal of Loss and Trauma, 19:4, 314-330, DOI: 10.1080/15325024.2013.780411.

1.2. MIGRATION TRENDS IN CAMBODIA

Migration is an increasingly important economic lifeline and a factor driving social mobility for families in Cambodia. Over the last fifteen years, internal and international/cross-border migration has been one of the most significant transformational changes in Cambodian society and the trend is set to continue. A recent World Food Program (WFP) survey[5] indicates that the rural-urban and cross-border migration has intensified especially since 2013. WFP estimates that around 35 percent of households in rural areas report having at least one migrant by 2016. Rural-rural migration accounts for 13 percent, rural-urban 57 percent and cross border for 31 percent of total migration. Migration poses both opportunities and challenges for migrants and their families, especially children.

1.2.a. Internal migration

In 2013, the National Institute of Statistics (NIS) estimated that nearly one-quarter of the Cambodian population had changed their location

5. World Food Program. Vulnerability and migration in Cambodia. 2019. Available from <https://docs.wfp.org/api/documents/WFP-0000105976/download/>.

BOX 1 — DEMOGRAPHICS AND MIGRATION DATA

POPULATION: 16 million (2017)

GDP/CAPITA: USD1,384 (2017)

PERSONAL REMITTANCES: USD 325 million (WB 2017)

LABOR MARKET ENTRIES: 250-300,000/year with a total working population of 9.4 million

24.5% of population changed residence (NIS 2013)

1.1 million Cambodian international migrants (UN DESA 2017)

680,000 Cambodians living in Thailand

Estimated poverty rates for Cambodia vary due to placement of poverty line, although most estimates put the poverty rate at 14% (ADB 2014).

*UNDESA, ADB, World Bank & Cambodian NIS figures

of residence.[6] Limited job opportunities and low farm incomes have led to internal migration of large segments of the rural population to Phnom Penh and other cities. As a consequence of rapid urbanization, the percentage of rural-urban migration of total internal migration increased from 25 percent in 2013 to 80 percent in 2016.[5,7]

Phnom Penh is the most preferred option for both permanent and long-term internal migrants. Migration is beginning to put enormous strains on the cities especially in terms of creating decent jobs, providing basic social services (including affordable housing, safe drinking water and sanitation, public schools, and health care facilities), ensuring adequate garbage disposal and sewerage systems, creating urban public transport infrastructure and services, and guaranteeing safety and security of women and children.

1.2.b. International migration

Many Cambodians seek to overcome domestic socioeconomic challenges by migrating outside of Cambodia as low-skilled migrant workers. More Cambodians are migrating internationally than ever before due to increase in demand for low skilled migrant labor to Thailand and to Malaysia, South Korea, Japan and to new regions like the Gulf States. Based on data from the UN Development Economic and Social Affairs (UNDESA), about 1.1 million Cambodians were migrants living and working in other countries – 62 percent or 680,000 were residing in Thailand.[8] Thailand has become an increasingly more popular destination not only for long term but also seasonal and even permanent migrants.

According to the Thai Department of Employment, Ministry of Labor, the regularization process of undocumented migrant workers from Myanmar, Cambodia and Lao PDR in Thailand in 2018, managed to register over 1,320,035 migrant workers. Of those migrant worker 90 percent were successfully issued with passports from their country of origin, including visas and work permits by Thai authorities. Cambodians made up 30 percent or 350,840 workers who completed this registration and national verification process. In this regard between 2010 and 2013 the Cambodia – Thailand corridor became the ninth most important migration stream globally.[9] Therefore, migration is an increasingly important economic lifeline and a factor driving social mobility for families in Cambodia.

6. National Institute of Statistics (2013). Cambodia Inter-Censal Population Survey 2013. Phnom Penh, Cambodia. [online] Available from <http://www.stat.go.jp/info/meetings/cambodia/pdf/ci_fn02.pdf>.

7. UNESCAP 2016 United Nations, Economic and Social Commission for Asia and the Pacifc (UNESCAP) (2016), Statistical Database. Available from <http://www.unescap.org/stat/data/statdb/DataExplorer.aspx>.

8. United Nations, Department of Economic and Social Affairs. Population Division (2017). Trends in International Migrant Stock: The 2017 revision (United Nations database, POP/DB/MIG/Stock/Rev.2017). Available from <https://migrationdataportal.org/?i=groups&t=2017&cm49=764>.org/?i=groups&t=2017&cm49=764>.

9. United Nations, Department of Economic and Social Affairs, Population Division (2013). International Migration Report 2013.

Due to the high costs, long duration and centralized process for applying for a travel document, many of Cambodia's international migrants are employed with an irregular or illegal status.[10] They face risks and vulnerabilities because they are not included in legal frameworks and social protection schemes. Regardless of the legal documents they hold, international migrants may still become victims of exploitation and abuse due to inadequate protection of labor rights during recruitment and employment.

In the context of both international and internal migration, the impact on children and their caregivers when one or both parents migrate remains largely unknown in the Cambodian context.

1.2.c. Migration and its impacts on health

Globally the separation of families due to labor migration is a well-established practice. There is an observable socio-economic gradient in the patterns of family separation and the practices of maintaining relationships over space and time. Migrants from and within less developed countries (LDCs) are considered to be at greater risk of poor wellbeing outcomes (health and psychological) than those with greater economic and social advantage. Migration may have health impacts for the migrants as well as for their families left behind. The current study focuses on the families left behind, primarily children and their caregivers.

1.2.d. Migrant Workers

Migrant workers face many health challenges, and yet data on their health status and needs are limited and fragmented. A recent systematic review highlights the global prevalence of occupational health outcomes including injuries, mortality, and physical or psychiatric morbidity among international labor migrants. The authors identified 36 studies, of which 18 were included in a meta-analysis based on 7,260 international migrant workers. Migrants experience a range of physical and psychiatric comorbidities, and workplace injuries and accidents were relatively common.[11] The health of migrant workers may influence the health and well-being of family members who stay behind in origin areas through indirect and direct pathways.

10. Risks and rewards: Outcome of labour migration in South-East Asia, ILO-IOM 2017. Available from <https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_613815.pdf>.

11. Hargreaves S Rustage K Nellums LB et al. Occupational health outcomes among international migrant workers: a systematic review and meta-analysis. Lancet Glob Health. 2019; published online May 20. Available from <http://dx.doi.org/10.1016/S2214-109X(19)30204-9>.

1.2.e. Children of migrants (the 'Left Behind')

A growing body of literature examines the impact of parental migration on children who remain in origin communities including within East and Southeast Asia. Yet many gaps in knowledge across settings and labor migration dynamics still remain.[12]

A recent systematic review on the health impacts of migration on left behind children and adolescents in low-income and middle-income countries of both international and internal migrants argues that on balance migration results in poor child outcomes.[13] Most of the studies included in this systematic review and meta-analysis were from China, focused on internal migration, and were cross-sectional, which means temporal causal inference was limited. The review's major limitation was the fact that 82 percent (91 of the 111 studies) included in the analysis were conducted in one location, China, thus focusing on internal migration. The findings may not be generalizable beyond China especially since the sub-set of studies from international migrant households were small. No significant differences in risk of mental disorders were found among children and adolescents of international migrants compared with children of non-migrant parents. Overall no difference was found in nutrition outcomes in studies outside of China, with the exception of wasting and weight-for-height Z-scores in some instances. Taken overall, the findings suggested that, as a group, left behind children and adolescents have worse outcomes than children of non-migrant parents, especially with regard to mental health and nutrition. Compared with children of non-migrants, left behind children and adolescents had a 52 percent increased risk of depression, 70 percent increased risk of suicidal ideation, and an 85 percent increased risk of anxiety. Smaller increases in risk for wasting (13%), stunting (12%) and substance use (24%) were identified. Left behind children and adolescents had no increased risk of conduct disorders, being overweight or obese, anemia, unintentional injury, diarrhea, or abuse.

Hitherto, the evidence suggests mixed effects of parental migration on a broad range of health outcomes across different migration contexts. In some settings children benefited from the remittances their parents sent home in terms of improved education and reduced child labor, which could result in improved health, while on the other hand family separation might have long-term psychological and societal costs.[14,15,16]

12. Wickramage, K. and Siriwardhana, C., 2016. Mental health of migrants in low-skilled work and the families they leave behind. The lancet. Psychiatry, 3(3), p.194.

13. Fellmeth G, Rose-Clarke K, Zhao C, et al. Health impacts of parental migration on left-behind children and adolescents: a systematic review and meta-analysis. Lancet 2018; published online Dec 5. Available from <http://dx.doi. org/10.1016/S0140-6736(18)32558-3>.

14. Wickramage, K., Siriwardhana, C. and Peiris, S., (2015) Promoting the health of left behind children of Asian labour migrants: Evidence for policy and action. Migration Policy Institute. MPI Publications. Washington, DC. Available from <https://www.migrationpolicy.org/research/promoting-health-left behind-children-asian-labour-migrants-evidence-policy-and-action>.

15. Reyes, M., 2008. Migration and Filipino Children Left Behind: A Literature Review. Miriam College-Women and Gender Institute for the United Nations Childrens Fund (UNICEF).

16. Qin, J. and Albin, B., 2010. The mental health of children left behind in rural China by migrating parents: A literature review. Journal of Public Mental Health, 9(3), pp.4-16.

1.2.f. Elderly caregivers

Caregivers of children of migrant parents are emerging as another important group affected by out-migration. When a father migrates leaving a wife behind, the wife most often will remain as primary caregiver for the children.[17] In contrast when the mother migrates or when both parents migrate, non-parental caregivers, including grandparents may take on the caregiving role. A recent review showed relatively consistent results that being left behind was negatively associated with mental health in 10 of the 16 studies, with only two finding of a positive association.[18] The study designs were mostly cross sectional. Qualitative studies found parents of adult children who have migrated experienced higher level of loneliness and depression. Those left behind elderly caregivers experienced higher levels of depression, loneliness, cognitive impairment, anxiety and had lower scores on psychological health compared to older parents with no migrant children.

The review identified nine risk factors of mental health disorders among the left behind elderly: Gender (e.g. females had poorer mental health than males in five studies); Age; Marital status; Education; Economic status (e.g. income was associated with higher levels of loneliness, lower life satisfaction, and poorer mental health symptoms and low levels of self-perceived income was identified as a significant predictor of depression); Place of residence; Pre-existing disease condition (e.g. presence of chronic disease(s) was associated with poor mental health); Social support; and, other reported factors such as level of exercise and physical activity and increased frequency of the adult migrant children's visits.

In developing countries without social security and other welfare supports for older adults, intergenerational extended family is crucial for elderly health and well-being.[19] In East and some Southeast Asian cultures, residing with adult children demonstrates 'filial piety'[20] – where there is 'expectation for their children to provide physical, financial, instrumental and emotional support'. Often when they are older, parents want to live with their children so that they can receive daily assistance and support. This may contribute to positive mental health and well-being. In contrast, in developed countries with higher standards of living and systems for social protection in older adults, independent living is often preferred.[21]

17. Graham, E., Jordan, L.P., and Yeoh, B.S.A. (2015). Transnational family practices and the mental health of those who stay behind to care for children in South-East Asia. Social Science and Medicine 132: 225-235; Graham, E., Jordan, L. Yeoh, B.S.A. Lam, T. Sukamdi. (2012). Transnational families and the family nexus: Perspectives of Indonesian and Filipino children left behind by migrant parents. Environment and Planning A 44: 793-815.

18. Thapa, D.K., Visentin, D., Kornhaber, R. and Cleary, M., 2018. Migration of adult children and mental health of older parents 'left behind': An integrative review. PloS one, 13(10), p.e0205665.

19. Chan A. Aging in Southeast and East Asia: Issues and Policy Directions. J Cross Cult Gerontol. 005;20(4):269–284. pmid:17072767.

20. Croll EJ. The Intergenerational Contract in the Changing Asian Family. Oxf Dev Stud. 2006;34(4):473–491.

21. Kramarow EA. The elderly who live alone in the United States: Historical perspectives on household change. Demography. 1995; 32(3):335–352. pmid:8829970.

1.3.
HEALTH AND MIGRATION IN CAMBODIA

Despite the fact that migration across borders remains common in Cambodia, little is known on the health and social implications to children and families left behind due to the migration process. In 2013, the Cambodian Rural Urban Migration Project (CRUMP) study consisting of 4,500 households, indicated that 2,875 households had experienced recent out-migration of a household member.[22] Among these households, 46 percent consisted of a child living without at least one parent, and almost 20 percent of households had an elderly grandparent as the caregiver. The probability of living in poor socio-economic conditions was significantly higher for households that contained a child under the age of 12 years. Socio-economic conditions tended to be worse in households that contain a single parent (usually female) than in other households. This study concluded an urgent need for a comprehensive evidence-base on the health impacts of migration on migrants and their left behind families in Cambodia.

Existing evidence from Cambodia is a mix of reports examining a wide range of topics including social issues. One recent study identified mental health issues faced by Cambodian migrant workers in Thailand using qualitative methods, without a clear focus on health.[23] The presence of anxiety and depression-like issues was explored using local language terminology, and highlighted how poverty, lack of services and debt were associated with psychosocial health of these migrants.

Migration may positively influence the health care and access to health facilities of children.[24] However, a prior study conducted in Cambodia with children of left behind households indicated that children from non-migrant households are less likely to get sick[25] and the lack of warmth from primary parents resulted in poor relationship with parents and psychological distress among left behind children such as sadness and anger.[26] In addition, poverty-related migration may worsen the living condition of left behind families and put the left behind children at risk of HIV.[27]

Following extensive discussion with local health/migration authorities, child protection agencies, labor migration actors and relevant networks (e.g. Families Care First) it was decided to explore the evidence, if any, of the link between migration and institutionalization in Cambodia. According to one report, a significant share of the population of children residing in residential care institutions (RCIs) are not orphaned, with an estimated 80 percent of 13 to 17-year-old children having one or more parent alive.[28] In Cambodia referrals to orphanages are a result of poverty[1] and other factors such as the education being provided in such institutions.[29] There is, however, no specific data available on the risk of institutionalization for left behind migrant children.

In conclusion, there are relatively few studies in labor-sending countries in the Global South, and less overall in Cambodia, despite the largest source of international migrants being migrant workers from the Global South.[30] Significantly, the condition of caregivers of left behind children was not specifically addressed in previous migration's studies in Cambodia. The current study contributes to the evidence-base for this important area.

22. Zimmer, Z & Van Natta, M. A CRUMP Series Report. Migration and Left-Behind Households in Rural Cambodia: Structure and Socio-economic Conditions. Phnom Penh, Cambodia: UNFPA and National Institute of Statistics., 2015.

23. Meyer, S. R., Robinson, W. C., Chhim, S., & Bass, J. K. (2014). Labor migration and mental health in Cambodia: a qualitative study. The Journal of nervous and mental disease, 202(3), 200-208.

24. Piper, N. (2005). Gender and migration: A paper prepared for the policy analysis and research programme of the Global Commission on International Migration. Asia Research Institute. National University of Singapore.

25. Hing, V., Lun, P., and Phann, D. (2014). The impacts of adult migration on children's wellbeing: The case of Cambodia. Cambodia Development Resource Institute (CDRI).

26. Creamer, O., Jordanwood, M., and Sao, S. (2016). The impact of migration on children in Cambodia. Final report. UNICEF Cambodia.

27. Seponski, D., Lewis, D. (2010). My grandmother and Me: International service-learning in Cambodia with children infected and affected by HIV/AIDS. Information For Action. Journal on service-learning research with children and youth. 3 (2). Available from <http://www.service-learning-partnership.org/site/DocServer/IFA-CambodianYouth.Vol3No2.pdf?docID=4204>. f

28. National Institute of Statistics & MoSVY, (2016). National Estimation of Children in Residential Care Institutions in Cambodia.

29. Ibid.

30. Sweileh, W.M., Wickramage, K., Pottie, K., Hui, C., Roberts, B., Sawalha, A.F. and Zyoud, S.H., 2018 Bibliometric analysis of global migration health research in peer-reviewed literature (2000–2016). BMC public health, 18(1), p.777.

SCOPE AND OBJECTIVES

The study was guided by two main research questions:

RQ1: Are there any significant health and social consequences to left behind children and family members of migrant workers in Cambodia?

What are the specific health vulnerabilities and factors that enable positive health outcomes and resilience for children, caregivers and spouses in migrant households?

How do remittances contribute to health, educational and social protection of the families left behind?

What are the specific vulnerabilities of households with single migrant parent (either male or female) or of households with two migrating parents (e.g. parenting styles, attachment and communication issues)?

RQ2: Does migration result in institutionalization or fostering of children of migrant workers?

What are the pathways that lead the left behind children of migrant workers towards institutionalization?

How do the experiences of the children in RCIs differ from those of children who remain in the village when their parents migrate?

What are the factors that enable re-integration of children of migration to the community?

Based on consultation with government agencies such as the Ministry of Social Service and Social Welfare, United Nations (UN) agencies, non-governmental, academic and civil society network the report concluded with exploring:

What are the best interventions to address key issues identified through primary research activities and how to develop and deliver appropriate, culturally and contextually relevant interventions in the Cambodian setting?

What are the implications (immediate and long term) to migrant families, communities and the government for not addressing these health and social consequences?

02

Metho-dology

1. Study design

1.1. A MIXED-METHODS APPROACH

This study adopted a mixed-methods approach using both quantitative and qualitative study methods. To address Research Question I (RQ1) on health impacts on children and adults of left behind households, a large-scale household survey was combined with qualitative interviews to better triangulate the findings. To address Research Question II (RQ2) on the pathways into residential care among children of migrant parents; qualitative methods were conducted due to a lack of understanding about the factors, the sensitivity of undertaking research with children in institutionalized care settings, and the absence of registry-related information on migration and institutionalization. Figure 1 shows the workflow of this study.

The research team collected survey data from households in Cambodia where one or both parents of children aged 0 to 3 years old or 12 to 17 years old

FIGURE 1 — STUDY WORKFLOW

Quantitative Phase

A cross-sectional survey

- 1459 households
- Caregivers answer: household information; migration roster; questions for caregivers; questions for younger age cohort (0-3 years old)
- Children aged 12-17 years old answer: self-report questionnaires

Qualitative Phase

In-depth interviews with sampled households

- Interviews with children (n=37), caregivers (n=37) and parents (n=42) from village survey sample

Extended cases studies with RCIs

- 8 RCIs
- Interviews with children (n=26), caregivers (n=9), and directors/ managers (n=8) of RCIs

▼ ▼

OVERALL INTERPRETATION

are internal- or international- migrant workers matching defined inclusion criteria. The qualitative phase consisted of two components: (1) interviews with 12-to-17-year-old children and their caregivers from the survey households; and (2) another sample of extended-case studies of children in residential care settings inclusive of residential care institutions (RCIs), group homes, boarding school, and faith-based care settings.

1.2. ANALYTICAL FRAMEWORK

The analytical framework (Figure 2) encompasses the larger spheres of: a) migration dynamics, household socio-economic gradients and cultural/ contextual factors; b) parenting/caregiving dynamics and c) health-related outcomes - in terms of mental health and physical well-being, functional ability, health access and illness burden. The conceptualization identified therefore

FIGURE 2 — THE ANALYTICAL FRAMEWORK FOR STUDY

MIGRANT HOUSEHOLD

Migration Dynamics
- international vs. internal migration
- International (cross-border vs. regional vs. trans-continental)
- Irregular vs regular migration
- Migration dynamic (mother, father both parents)
- Prior history of migration, frequency and duration of migration
- Decision to migrate was made collectively or individually

CAREGIVER CHARACTERISTICS
(Age, Gender, Ethnicity, Religion, Parenting dynamics and caregiving characteristics; Awareness of violence (inter-personal, self-directed) within household , alcohol consumption, frequency of communication with migrant parent/s)

CHILD CHARACTERISTICS (e.g. Age, gender, ethnicity, religion, frequency of communication with migrant parent/s)

HOUSEHOLD CHARACTERISTICS (e.g. Infrastructure dynamics (Wall/roof/floor of house; source of water; ownership of water; type of toilet/sanitation; ownership; cooking fuel), household food consumption)

Socio-Economic status/wellbeing
- Household debt
- Home ownership
- Remittance (volume, predictability, frequency)
- Social and health protection
- Employment status of persons in household

OUTCOMES:

FOR CHILDREN[1]
a- CHILDHOOD DEVELOPMENT
b- DIETARY DIVERSITY & NUTRITIONAL STATUS
c- PSYCHOSOCIAL & MENTAL HEALTH
d- CURRENT ILLNESS & INJURY PROFILE
e- DISABILITIES
f- HEALTH CARE ACCESS & UTILISATION

FOR CAREGIVERS[2]:
a- DIETARY DIVERSITY & NUTRITIONAL STATUS
b- PSYCHOSOCIAL & MENTAL HEALTH
c- CURRENT ILLNESS & INJURY PROFILE
d- DISABILITIES
e- HEALTH CARE ACCESSS & UTILIZATION

SOCIETAL FACTORS[2]: Societal/cultural values/norms/perceptions (e.g. gender roles in parenting; elderly caregiving; role of women as 'breadwinner', gender roles in management of household resources)..

EXISTING DOMESTIC LEGAL, POLICY FRAMEWORKS AND SERVICES[3]: Child support and child protection services; Social/Health insurance schemes for migrant workers and families; Social protection and Financial support services; Programs to support caregivers; Domestic legal and policy frameworks to ensure protection of children; Labour migration governance & policies relating to family migration (e.g., reunification).

Notes:
1. *Please note measured outcomes differ for (0 to 3 years and 12 to 17 years). For instance, Child Development is assessed for early childhood and psychometric assessments for older child cohort).*
2. *Explored through qualitative research methods and review of literature*
3. *Explored through undertaking literature review, policy mapping, stakeholder analysis and consultation*

adopted a social determinant of health model, which emphasizes roles of the social resources and environment in determining individual health.[31] On the individual level, individual characteristic and behaviors were considered, with a particular focus on migration trajectories; on the physical environment level, living conditions, food security, and family dynamics are included in the model; in terms of the social and economic environment, access to health services, social support networks for the caregivers, and the historical context of Cambodia are highlighted as potential social determinants. Superimposed within the analytical framework are the key instruments utilized in the household questionnaire to explore/capture these determinants.

31. WHO, (2015). Health in all policies: training manual. <https://www.who.int/social_determinants/healthinallpolicies-hiap/en/>.

2. Sampling

2.1. DATA AND SAMPLE FOR THE QUANTITATIVE STUDY

The study collected primary data using probability proportional to size (PPS) multi-stage cluster sampling stratified by province and district. All provinces with a threshold of at least 1 percent of migrants aged 18 or older in the population were selected into the sample. In each province, all districts that contributed at least a 1 percent share of the domestic or international migrant population were selected. This stratified approach resulted in sampling from 56 districts in 13 provinces. The sampling covered 56 percent and 52 percent of the areas where internal and international migrants, respectively, originate resulting in broad coverage of the migrant population over age 18 in Cambodia. Within each district, 26 households were selected using multi-stage PPS cluster sampling. Stage one randomly selected communes with probabilities proportionate to the size of the

KEY DEFINITIONS

Participant categories and inclusion/exclusion criteria for the household survey

MIGRANT FAMILY:

Inclusion criteria: a family where either one or both spouses have departed for employment as a labor migrant (internal or international) for period of at least six months AND a family with birth or adopted child under 18 years of age, AND the left behind family have been living at the same residence for a period of at least six months at the time of data collection.

CHILD "LEFT BEHIND" (OR "LEFT BEHIND CHILD"):

A child (<18 years old) living in a migrant family household with at least one migrant worker parent who has been working for at least six months at the time of the survey.

CAREGIVER:

A person living in the migrant family household who is not the biological mother/father, but is responsible for taking on the burden of care for the left behind child on a daily basis, for a period of at least six months. Care consists of activities such as; arranging daily schedules, preparing or ensuring access to meals, assisting with the child's educational and social needs (including play), washing clothes, looking after the child when he/she is sick, guardianship and representation to health and/or education authorities.

COMPARATIVE (NON-MIGRANT) HOUSEHOLD:

Inclusion criteria: A family where one or both parents are present, AND neither spouse has a history of labor migration (both internal and international), AND a family with birth or adopted child under 18 years of age in the family unit. *Exclusion criteria:* one or both parents being absent from the same house for more than 60 days (average more than two days per week) for the preceding six months.

total over-18 migrant population from the commune. Stage 2 randomly selected villages using the same criteria. In stage 3, a local government list of migrant families in the village was randomly ordered to determine the sequence in which households were approached (a simple random sample–SRS). Thus, while not nationally-representative, the sample reflects the major areas of migration across Cambodia. Full details about the sampling design and protocol are available in Appendix 1.

Cambodian households where one or both parents were internal or cross-border/international migrants for a period of at least six months at the time of study enrolment were eligible for enrolment within the sampled areas (n=1,235). The sample consisted of children from two age-cohorts (0 to age 3 or 12 to 17 years old). The children's primary caregivers were also interviewed. A small sample of comparative households (n=224) where parents had no migration history during the past six months were also recruited from the same areas.

2.2. SAMPLE FOR THE QUALITATIVE STUDY

Locations based on the prevalence of out-migration and with residential care settings were identified using data from a recent Mapping Study on Residential Care.[32] A purposive sampling method was used to approach different types of institutional care settings taking into account two aspects (1) within areas of high concentration of RCIs (2) overlap with the survey data locations from the first phase. The officer in charge of each care setting was approached via local officials and local NGOs to ensure adequate permissions were obtained before any children were approached. Children meeting the criteria (see below) were approached and invited to participate in the study. For the comparison group in villages, the study team drew on data collected in the first phase of the project collecting survey data work. All survey households were informed at the time of consent (January-April 2018) that they might be contacted in the future for follow-up.

BOX 2 — DEFINITIONS OF PARTICIPANT CATEGORIES AND THEIR INCLUSION AND EXCLUSION CRITERIA FOR THE QUALITATIVE STUDIES

VILLAGE QUALITATIVE STUDY

CHILDREN OF MIGRANTS: Inclusion criteria: 1) 12 to 17 years old at the time of data collection; 2) one of or both parents were migrant workers for a period of at least six months; and 3) included in the first phase of survey.

CAREGIVERS OF LEFT BEHIND CHILDREN: Inclusion criteria: 1) caregivers of children between the age 12 to 17; 2) enrolled in survey during January to April 2018.

RESIDENTIAL CARE INSTITUTION QUALITATIVE STUDY

CHILDREN IN RCIS: Inclusion criteria: 1) 12 to 17 years old at the time of data collection; 2) one of or both parents were migrant workers for a period of at least six months; 3) had lived in the residential care setting for a period of at least six months.

STAKEHOLDERS: Inclusion criteria: 1) caregivers who had at least six continuous work experiences in organizations interviewed (had at least six continuous direct work experiences with children for staff from RCIs); 2) directors or managers of RCIs who had extensive knowledge about existing social policy and welfare system relevant to residential care/migration.

32. Mapping of Residential Care Facilities in the Capital and 24 Provinces of the Kingdom of Cambodia. Available from: <https://www.unicef.org/cambodia/reports/mapping-residential-care-facilities-capital-and-24-provinces-kingdom-cambodia>.

3. Implementation

3.1. QUANTITATIVE SURVEY

SURVEY IMPLEMENTATION WAS UNDERTAKEN IN 3 STAGES:

STAGE 1:

Consultation with key partners in government, UN agencies, networks of local experts working at nexus of migration and health to formulate key concepts of domains to explore, developing survey instruments, modifying questionnaires and using new technologies such as Kobo Toolbox - a tool used for collecting and managing field data in complex environments. The formative phase also involved exploring realities on survey administration by discussions with local and national authorities, and contextual understandings by visits to village settings in rural border areas experiencing high-net migration.

STAGE 2:

Obtaining requisite permissions from national and local level authorities by the UN migration agency, Louvain Cooperation in order to undertake the field research – especially in a context where household surveying could be viewed with suspicion during an election year (2017). Ethical approval for the study was obtained from the University of Hong Kong (HKU) and the Cambodian National Ethics Committee for Health Research.

STAGE 3:

The research team and field enumerators undertook three training sessions: an anthropometry workshop (led by a clinical nutritionist and epidemiologist from Sri Lanka); CREDI tool and other psychometric tool workshop (with resource persons from *Save the Children* and local mental health professionals) and a longer intensive training on survey implementation. Extensive field testing was conducted in the provinces of Kampong Chhnang and Kampong Cham followed by a workshop after this field testing to identify points of contention/ ambiguity. Some questions and approaches were recalibrated before nationwide administration. As shown in Table 1, the survey covered 13 provinces of Cambodia. A total of 1,459 households were interviewed, which were further divided into two distinct age cohorts of children (Table 2).

STAGE 4:

The research team approached 98 communes, and one commune was replaced due to denial of authorization approval. In total, 388 villages were approached, and two villages were dropped due to limited geographic accessibility. Among the 1,465 households approached, only one household refused to participate in this study. After data cleaning, there were 1,459 valid questionnaires (six cases were deleted due to high percentage of missing answers), which were further divided into two distinct age cohorts of children. The respondent rate was over 99%. Upon completion, the survey covered 386 villages in 97 communes within 56 districts from 13 provinces of Cambodia.

TABLE 1— NUMBER OF SAMPLED DISTRICTS, COMMUNES, VILLAGES, AND HOUSEHOLDS BY PROVINCES

Sampled provinces	Number of districts	Number of communes	Number of villages	Number of households
Banteay Meanchey (BMC)	9	16	63	232
Battambang (BTB)	6	9	38	156
Kampong Cham (KPC)	8	14	60	211
Kampong Speu (KPS)	1	1	6	26
Kampong Thom (KTM)	3	5	23	75
Kampot (KPT)	4	8	26	104
Kandal (KDL)	1	3	8	31
Prey Veng (PVG)	10	18	61	260
Pursat (PST)	1	1	6	26
Siem Reap (SRP)	5	8	37	130
Svay Rieng (SVG)	2	4	13	52
Takeo (TKV)	3	4	21	78
Tboung Khmum (TBK)	3	6	24	78
Total	**56**	**97**	**386**	**1459**

Figure 3- Map of Survey Sites

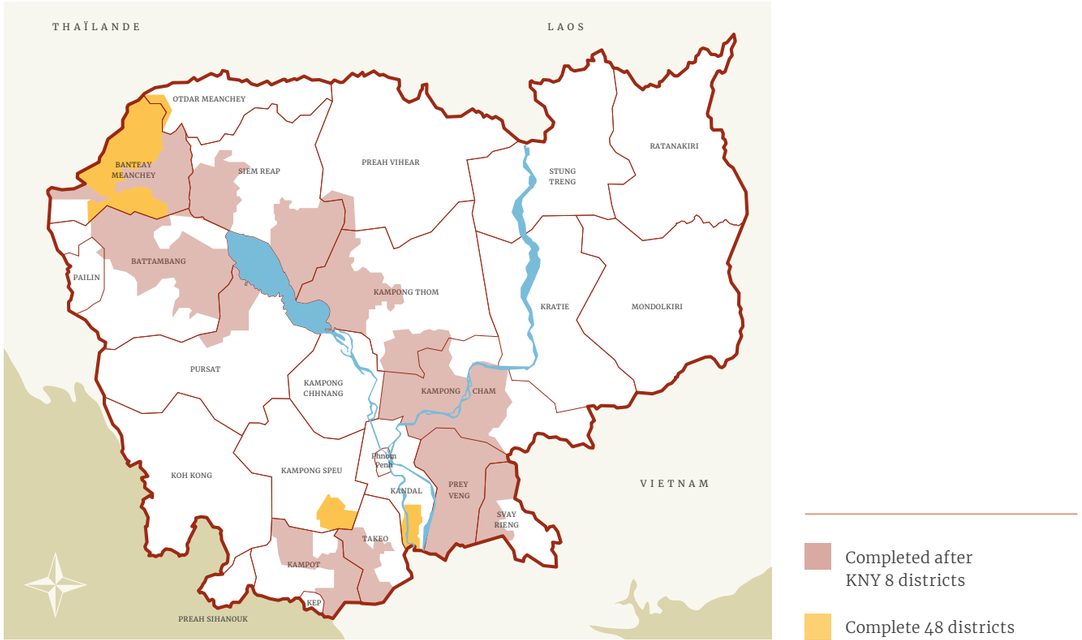


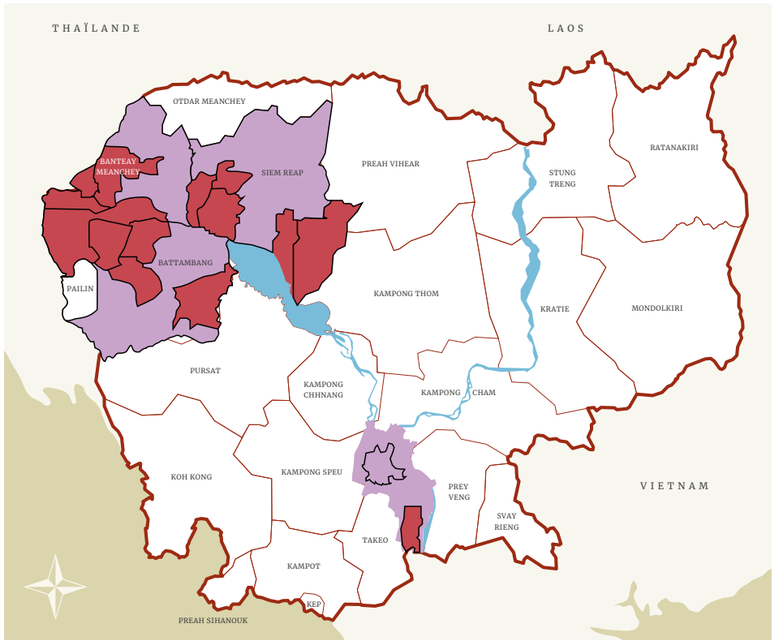
TABLE 2— OVERVIEW OF THE DEMOGRAPHICS OF RESPONDENTS BY AGE COHORT

Age cohort	0 to 3 years		12 to 17 years	
	Children	Caregivers	Children	Caregivers
Sample size	731	731	728	728
Age (mean)	1.62	45.92	13.83	55.34
Age (sd)	0.77	13.96	1.3	13.6
Female (%)	44.9	97.7	55.1	92.3
Male (%)	55.1	2.3	44.9	7.69

3.2.
QUALITATIVE INTERVIEWS

After undertaking a literature review and extensive consultation with agencies involved in child protection and migration management in Cambodia that included government agencies such as the Ministry of Social Service and Social Welfare, UN agencies, non-governmental, academic and civil society networks, the research team was able to construct a draft interview guide. A five-day training session on interview skills, research ethics and data analysis was conducted with a sub-set of enumerators that were involved in the quantitative data phase. The enumerators (Minimum education level: University graduates) were already sensitized to overall research goals. Upon completion of the training, three sessions of field testing were conducted in an RCI in Kampong Chhnang and later at in two RCIs in Phnom Penh. The interview guide was subsequently refined/modified in a 'lessons learnt' workshop after the field testing.

Figure 4- Map of Interview Sites



A total of 122 interviewees were recruited among which there were 37 households and 8 RCIs from areas highlighted in the Map of Interview Sites (Figure 1.3.4 & Table 3).

TABLE 3— COMPOSITION OF THE QUALITATIVE INTERVIEWEES

#	Household	RCI
Total	79	43
Caregivers	37	9
Children	37	26
Parents (returned)	5	-
Directors/managers	-	8

4. Key variables

This section presents the key variables used in the analysis. Variables are broadly classified according to those of the household, then those of individuals (the caregiver and that of the child/ren) within the household.

4.1. HOUSEHOLD LEVEL: MIGRATION DYNAMICS

Table 1.3.4 summaries the questions used to understand the current migrant status of households as well as migration history of family members.

4.1.a. Migration status and types

Caregivers of each household were asked, "Is the father/mother a current national or international migrant?". Based on their answers, household migrant status was classified as non-migrant or migrant depending on whether none, one or both parents were migrant for minimum of six months preceding the interview date. The initial information was collected during the screening process and verified during interview.[33] These questions further differentiated the households into three categories of migration types: father migration, mother migration and migration of both parents. Also, migration types were also categorized as internal, international or mixed (one of parent was an internal migrant while another one was an international migrant).

4.1.b. Migration history

Caregivers were asked to answer father's and mother's migration history, respectively. The questions included how long/where had the father (mother) migrated, and how long since the child was born had the father (mother) spent working away from home.

4.1.c. Caregiving arrangement

Caregivers were asked about their relationship to the index children. Based on previous regional studies, in consultation with local experts, and following the distribution of the survey responses, the original 18 types of caregiver-to-child relationships were further classified into three types: parent, (maternal/paternal) grandparents, or other kin in the families.

A series of criteria were used to identify the child's primary caregiver and defined as the person with the primary responsibility for the majority of the activities listed here:

Arranging daily schedules, preparing or ensuring access to meals, assisting the child's educational and social needs (including play), washing clothes, looking after the child when he/she is sick, guardianship and representation to health and/or education authorities

4.1.d. Remittance

Questions related to remittances asked whether and how much migrant parents had remitted to the household in the last 12 months, and if they

33. Some flexibility was allowed for the six-month criteria in relation to internal migration of parents, although the fieldwork team strived to ensure minimum inclusion of less than six months away of minimum of one parent.

remitted separately and/or together. Caregivers were asked a series of subjective questions to evaluate how the household had been impacted by remittances (e.g. Have remittances enabled you to keep your child enrolled in school for longer?) and objective questions including how the remittances were used and who decided the use of remittance.

4.1.e. Communication with migrant parent(s)

Caregivers reported how frequently and by which methods the migrant father/mother, maintained contact with households during the past six months, including calling back or visiting the village.

TABLE 4— MIGRATION-RELATED VARIABLES AND QUESTIONS

Component	Questions	Examples
Migration-related characteristics		
Migration status and types	Father or/and mother migrate; national/international migration	Is the father/mother a current national or international migrant?
Migration history	Duration of migration; Destination of migration	How long since {INDEX CHILD NAME} was born has the mother spent working away from home and separated from {INDEX CHILD NAME}? Where has the father/mother migrated?
Caregiving arrangement	What is caregiver's relationship to the index child?	
Communication with migrant parent(s)	The frequency of communication; Method of communication	During the past six months, how has father/mother maintained contact with household/family members?

4.2. HOUSEHOLD LEVEL: DEMOGRAPHIC VARIABLES

4.2.a. Demographic variables

The demographic section included information about all currently resident, non-resident (migrant) and day visitor members of the household (age, date of birth, gender, relationship to index child, completed education). Additional items such as the religious and ethnic background of household, as well as information about the caregivers' occupation were collected.

4.2.b. Household socioeconomic status

Household socioeconomic status assessed information related to household income, property, expenditure, and debts. Information about how many income activities that household involved, and which family member earned the income including the amount of income from specific income activity in the past 12 months before the survey. Questions related to household property included the ownership of household or land, as well as livestock and poultry raising activities in the household. Household expenditure referred to food and non-food expenditure in the month prior to the survey. Caregivers also answered about who decided on daily and large expenditure in the household.

4.2.c. Food insecurity

Food insecurity was measured by multiple aspects of food consumption in the household. Household Hunger Scale[34] assessed household food deprivation in the past 30 days. Information about the experience of anxiety about household food supply, or insufficient food supply was recorded. The total raw scores were categorized into three groups of hunger level: little to no hunger (0-1), moderate hunger (2-3) and severe hunger (4-6).

The Consumption-based Coping Strategy Index (CSI) measured coping strategies used by the household when they faced food shortfall or insufficient money to purchase food in the past seven days. Consumption-based coping

34. Ballard, T., Coates, J., Swindale, A., & Deitchler, M. (2011). Household hunger scale: indicator definition and measurement guide. Washington, DC: Food and Nutrition Technical Assistance II Project, AED.

strategies included strategies to reduce food consumed such as reduced the number of meals eaten per day. Coding and analysis of CSI followed the Comprehensive Food Security Monitoring Exercise Manual.[35] Each coping strategy had a standard weight related to its severity. A higher CSI score indicated more frequent and severe coping strategies used by the household.

The Livelihood Coping Strategy Index (LCSI) measured coping behaviors when households faced food shortages in the past 30 days prior to the survey. The livelihood coping strategies referred to medium to long-term strategies, such as asset depletion. Each strategy was categorized into a different severe level: stress, crisis, emergency and insurance. Then households were grouped according to their most severe strategy used. The total score represented four levels of food security: marginally food secure, moderately insecure, or severely insecure.

4.2.d. Illness and healthcare files

Illness and injury profiles captured how many household members were sick or injured in the last 30 days. This survey measured the following aspects of public healthcare: the type of health care provided accessed, the frequency of health care utilization; and the health care expenditure – all by type of people in household (child, adult caregiver). The healthcare types included service from the public sector, private medical sector, non-medical sector or overseas medical sector.

35. World Food Programme (WFP), 2014, Comprehensive Food Security Monitoring Exercise, available from <http://documents.wfp.org/stellent/groups/public/documents/communications/wfp291361.pdf?_ga=2.260529421.1092291274.1561350552-688587311.1561350552>.

TABLE 5— KEY MEASUREMENT COMPONENTS ON THE HOUSEHOLD LEVEL

Topic	Measurement	Sample Questions
Ethnicity	Ethnic background	What best describes the ethnicity of the household?
Religion	Religious background	What best describes the religious background of the household?
Household income	Amount of activities; Income activities	How much was earned from this activity?
Household property	Housing	Does this household own the land the house is on?
	Land ownership	Does your household own or operate any land that is used/ could be used for vegetable gardening, agricultural or farming activities (crop cultivation, livestock raising or private forestry)?
	Livestock and poultry raising activities	How many of the following animals does this household own?
	Fishery and other	Did your household raise fish (or any other aquatic product like frogs or crocodiles)
Household expenditures	Food/non-food expenditure	How much was from own production or received as payment in kind for work, or as gift, or free collection.
Debt	Total amount of debt; Primary purpose for which the household borrowed the money	Does your household have outstanding debts to other household or institute/company?
Food insecurity	Household Hunger Scale	In the past 30 days, how often has your household had no food to eat of any kind because of lack of resources to get food?
	Consumption-based Coping Strategy Index (CSI)	During the last seven days, how many times (in days) did your household have to employ one of the following strategies to cope with a lack of food or money to buy it? Relied on less preferred, less expensive food etc.
	The Livelihood Coping Strategy Index (LCSI)	Sold household goods (radio, furniture, refrigerator, television, jewelry, clothes, utensils etc.)
Illness/injury profile	Illness profiles; Injury profile; Disability profile of household; Addiction profile	How many children (0 to 18 years) in household were sick in the past 30 days?
Healthcare	Health care access, health care expenditure by household	Was any medical treatment sought for any injured family member/s?

4.3. INDIVIDUAL LEVEL: CAREGIVER

One target of this study is to explore the specific health conditions of caregivers in migrant households. Table 6 summarizes the instruments used to measure caregiver's health and well-being.

TABLE 6— KEY MEASUREMENT COMPONENTS FOR THE CAREGIVER

Individual level: Caregiver		
Topic	Measurement	Sample Questions
Nutrition intake	Dietary Diversity Scale	Number of eating following food in the last 24 hours: Cereals and grain: Rice, corn/maize, pasta, bread / cake and / or donuts, sorghum, millet, fonio etc.
Nutrition status	Anthropometric measurements	-
General physical health & mental health	SF-12 Health Survey	Does your health now limit you in these activities? If so, how much?
Cambodian cultural syndrome of distress	Baksbat	Dares not make decisions or cannot make decisions
Psychological well-being	Hopkins Symptoms Checklist-25	Suddenly scared for no reason
Resilience	Connor-Davidson Resilience Scale	I am able to deal with change.
Social support	These three items are selected from Social Provisions Scale	There are people I can depend on to help me if I really need it.

4.3.a. Nutrition intake

Dietary Diversity Scale (DDS) was used to measure a variety of caregiver's food consumption. Caregivers described food groups that they had consumed over the preceding 24 hours before the survey. According to Guidelines for Measuring Household and Individual Dietary Diversity[36] answers were aggregated into 12 food groups including cereals, vegetables and so on. Each food group variable was recoded as a dichotomous variable with values either 0 or 1 (number of times eaten =0 is coded as 0 while the number of time eaten > 0 is coded as 1). The sum of food groups was the indicator of dietary diversity on the individual level. The range of the final DDS score was 0 to 12.

4.3.b. Body mass index (BMI)

BMI (body mass index) is used to measure weather caregivers are within a healthy weight range. A BMI below 18.5 indicates thinness or acute undernutrition, a BMI of 25.0 and above indicates being overweight or obese, which reflects acute undernutrition.

4.3.c. Quality of life

Caregivers' general physical and mental health was measured by SF-12 Health Survey Version One (SF-12). The SF-12 is a short version of SF-36 and a widely used instrument to assess an adult's health status.[37] The SF-12 assesses physical health by items related to physical functioning, role-physical, bodily pain and general health and evaluates mental health by asking questions about vitality, social functioning, role-emotional and mental health. First, the score of items 1, 8, 9 and 10 were reverse scored. Second, answers to each question were recoded as a dichotomous indicator (0/1). Third indicator variables were weighted and the computation of aggregate scores for total physical and mental health scale were conducted. The final step was transforming the total score of each score to the norm-based scores by adding the respective constant.

4.3.d. Cambodian cultural syndrome of distress

The inventory Baksbat measured the Cambodian cultural syndrome of distress. The Baksbat is developed to measure trauma-related syndromes in the Cambodia context.[38] This measurement consists of three experiential clusters: broken courage, psychological distress and erosion of self. Caregivers were rated on the extent to which they experienced each syndrome on a 5-point Likert scale. This scale demonstrated excellent reliability (Cronbach's a = 0.94).

36. Food and Agriculture Organization of the United Nations (FAO), 2012, available from <http://www.fao.org/fileadmin/user_upload/wa_workshop/docs/FAO-guidelines-dietary-diversity2011.pdf>.

37. Ware, J. E., Keller, S. D., & Kosinski, M. (1995). SF-12: How to score the SF-12 physical and mental health summary scales. Health Institute, New England Medical Center.

38. Chhim, S. (2012). Baksbat (broken courage): The development and validation of the inventory to measure baksbat, a Cambodian trauma-based cultural syndrome of distress. Culture, Medicine, and Psychiatry, 36(4), 640-659.

4.3.e. Psychological well-being

Caregivers' psychological well-being was measured by the Hopkins Symptoms Checklist-25 (HSCL), which was validated for screen posttraumatic symptoms among the traumatized population.[39] The HSCL scale consists of two subscales: depression and anxiety. Items were rated on a 4-point scale ranging from "not at all" to "extremely". The two subscales both showed an excellent internal consistency in this study (Depression: Cronbach's a = 0.88; Anxiety: Cronbach's a = 0.89).

4.3.f. Resilience

The 10-item Connor-Davidson Resilience Scale (CD-RISC) measured caregivers' resilience. The CD-RISC[40] is a widely used instrument measuring an individual's ability to cope with adversity. The original scale uses a 5-point scale from 0 (never) to 4 (almost always) and this study used a scale from 0 "not all" to 3 "always" following prior local studies conducted by the Trans-cultural Psychological Organization (TPO). The CD-RISC showed good internal consistency in this study (Cronbach's a = 0.84).

4.3.g. Social support

Three items selected from the Social Provisions Scale[41] evaluated caregivers' social support. Caregivers indicated to what extent following statements describe their relationship with others: 1) There are people I can depend on to help me if I really need it; 2) There is a trustworthy person I could turn to for advice if I were having problems, and 3) I feel a strong emotional bond with at least one other person. Respondents rated from 1 "strongly disagree" to 4 "strongly agree".

4.3.h. Relationship scale

Respondents rated a Relationship Scale to describe how close were their relationship with family, community and significant other used in other similar studies in Cambodia conducted by TPO. Respondents specified the significant other in their life.

39. Mollica, R. F., Wyshak, G., de Marneffe, D., Khuon, F., & Lavelle, J. (1987). Indochinese versions of the Hopkins Symptom Checklist-25: a screening instrument for the psychiatric care of refugees. The American journal of psychiatry.

40. Connor, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: The Con-nor-Davidson resilience scale (CD-RISC). Depression and anxiety, 18(2), 76-82.

41. Cutrona, C. E., & Russell, D. W. (1987). The provisions of social relationships and adaptation to stress. Advances in personal relationships, 1(1), 37-67.

4.4. INDIVIDUAL LEVEL: CHILDREN

This section summarizes instruments used to measure developmental outcomes for children under age three years old and adolescents aged 12 to 17 years old, respectively (Table 7).

4.4.a. Nutrition intake

Dietary Diversity Scale was used for measuring the nutrition intake of children 6 to 24 months of age. Coding and analysis followed the steps suggested by Indicators for Assessing Infants and Young Child Feeding Practices.[42] As this scale was only available for children without breastfeeding, children who were breastfed were not included for the data analysis specifically on nutritional intake. Caregivers answered questions about consumption of food in the past 24 hours for the index child. Answers were aggregated into seven food groups. Each food group was recoded as a dichotomous variable with values either 0 or 1.

4.4.b. Nutrition status

Using the WHO Child Growth Standards, three indicators (stunting, wasting and underweight) were constructed to reflect the nutritional status of children. For children under age three, stunting, wasting and underweight are evaluated by children's height-for-age Z-score (-2 SD), weight-for-height Z-score (-2 SD), and weight for age Z-score (-2 SD). For the older child cohort, the nutritional indices are calculated using children's height-for-age Z-score (stunting) and weight-for-height Z-score (wasting).

4.4.c. Early development (aged 0 – 3 years old)

Children's early childhood development status was measured by Caregiver-Reported Early Development Instruments (CREDI) Short-form.[43] Following the scale developer guideline, selected items were reverse scored for specific age groups.

42. World Health Organization (WHO). Indicators for assessing infant and young child feeding practices: conclusions of a consensus meeting held 6-8 November 2007 in Washington DC, USA. World Health Organization (WHO), 2008.

43. McCoy, D. C., Sudfeld, C. R., Bellinger, D. C., Muhihi, A., Ashery, G., Weary, T. E., ... & Fink, G. (2017). Development and validation of an early childhood development scale for use in low-resourced settings. Population health metrics, 15(1), 3.

4.4.d. Education (aged 12 – 17 years old)

Children aged 12 to 17 years old answered questions about whether they were currently enrolled in the school or not. Additionally, they were asked to report their grades and enjoyment in school.

4.4.e. Child labor (aged 12 – 17 years old)

Information about child labor was reported by caregivers including whether children in the households had been involved in any paid or unpaid job in the week prior to the survey. Jobs included family farm, family business, fetching water, collecting firewood for household use, or household chores.

4.4.f. Psychological well-being (aged 12 – 17 years old)

Psychological well-being of children was measured by the Strengths & Difficulties Questionnaires (SDQ) according to both caregivers' and children's report.[44] The SDQ has five dimensions including internalizing and externalizing subscales as well as prosocial behaviors. Respondents rated 25 items from 0 (not true) to 2 (certainly true). The scores for hyperactivity, emotional symptoms, conduct problems and peer problems were summed to generate a total difficulties score. The prosocial score was not incorporated into the total difficulties score and summed up separately. The Cronbach's a of the total difficulties and prosocial subscales were 0.64 and 0.71 respectively for the caregiver's report; 0.72 and 0.63 for the children's report.

4.4.g. Resilience (12 – 17 years old)

Children's resilience was also measured by the 10-item Connor-Davidson Resilience Scale.[45] The CD-RISC showed an acceptable internal consistency in the adolescent sample of this study (Cronbach's a = 0.77).

44. Goodman, R. 2001. Psychometric Properties of the Strengths and Difficulties Questionnaire. Journal of the American Academy of Child & Adolescent Psychiatry, Volume 40, Issue 11, 1337 – 1345.

45. Connor, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: The Connor-Davidson resilience scale (CD-RISC). Depression and anxiety, 18(2), 76-82.

4.4.h. Parenting practice (12-17 years old)

Parenting practices were measured by the Alabama Parenting Questionnaire-Short Form (APQ-9).[46] Both caregivers and children reported the parenting practice from their perspectives. Items were scored from 1 (never) and 5 (always). The APQ-9 consists of three dimensions: positive parenting, inconsistent discipline, and poor supervision. As Cronbach's a of subscales inconsistent discipline and poor supervision were poor (less than 0.6), only positive parenting was retained for the data analysis. The internal consistency of positive parenting for the caregiver's and the children's report was acceptable (Cronbach's a = 0.76 and 0.73 respectively).

4.4.i. Attachment to parents (12-17 years old)

Children's quality of attachment to their parents were assessed by items adapted from People in My Life (PIML) instrument.[47] This scale consists of eight items with each item rated on a 5-point Likert scale (0 = not true, 4 = very true). This scale showed good internal consistency in the Khmer adolescent sample (Cronbach's a = 0.83).

46. Elgar, F. J., Waschbusch, D. A., Dadds, M. R., & Sigvaldason, N. (2007). Development and validation of a short form of the Alabama Parenting Questionnaire. Journal of Child and Family Studies, 16(2), 243-259.

47. Field,N.P, Tzadikario,E., Pel ,D. & Ret,T. (2014) Attachment and Mother-Child Communication in Adjustment to the Death of a Father Among Cambodian Adolescents, Journal of Loss and Trauma, 19:4, 314-330, DOI: 10.1080/15325024.2013.780411.

TABLE 7— KEY MEASUREMENT COMPONENTS FOR THE CHILDREN

Topic	Measurement	Sample Questions
Individual level: Children aged 0 to 3 years old		
Nutrition intake	Dietary Diversity Scale	Number of times eating following food in the last 24 hours: Cereals and grain: Rice, corn/maize, pasta, bread / cake and / or donuts, sorghum, millet, fonio etc.
Nutrition status	Anthropometric measurements	-
Early development	Caregiver Reported Early Child hood Development Instruments (CREDI)_Short Form	Does the child smile when others smile at him/her?
Individual level: Children aged 12 to 17 years old		
Nutrition intake	Dietary Diversity Scale	Number of times eating following food in the last 24 hours: Cereals and grain: Rice, corn/maize, pasta, bread / cake and / or donuts, sorghum, millet, fonio etc.
Nutrition status	Anthropometric measurements	-
Education	Enrolled in the school; Enjoyment of school; Self-report grade	Is the child currently enrolled in school?
Child labor	Hours of paid or unpaid work	During the past week, did (name) get any paid or unpaid work on a family farm or in a family business or selling goods in the street?
Psychological well-being	Strengths and Difficulties Questionnaire (SDQ)-reported by adolescents; Strengths and Difficulties Questionnaire (SDQ)-reported by caregiver	I try to be nice to other people. I care about their feelings.
Resilience	Connor-Davidson Resilience Scale	I can deal with whatever comes my way.
Parenting practice	Alabama Parenting Questionnaire reported by adolescents; Alabama Parenting Questionnaire reported by caregivers	Your parents tell you that you are doing a good job. You let your child know when he/she is doing a good job with something.
Attachment to parents	Adapted from People in My Life (PIML) instrument	I turn to my parents when I have a problem

5.1. ANALYTIC METHODS FOR THE QUANTITATIVE DATA

Bivariate analyses were conducted using t or chi-square test (as appropriate by the type of variables examined, i.e., means and proportions, respectively) between groups stratified by age, non-migrant and migrant households, destination of migration. Key outcomes on the household level were explored as to whether migrant and non-migrant households showed a significant difference in food insecurity and utilization of healthcare service.

Unadjusted prevalence rates and adjusted rates of health and wellbeing outcomes incorporating child and caregiver gender as well as migration typology, destination and caregiving arrangements are presented. Detailed tables for the adjusted models and by gender are included in the Appendices following the order of the report.

TABLE 8— CATEGORIES OF MIGRANT STATUS

Migration status (4 categories)	non-migrant households, father-migrant households, mother-migrant households and the households with both parents migrating.
Migration destination (7 categories)	non-migrant households, both-parents-internal-migrant, both-parents-international-migrant[48], father-internal-migrant, father-international migration, mother-internal-migrant, mother-international-migrant.
Migration and care arrangements (6 categories)	non-migrant households, father-migrant/mother-caregiver, father-migrant/kinship-caregiver, mother-migrant/kinship-caregiver [49], both-parent-migrant/grandparent-caregiver, both-parent-migrant/ kinship-caregiver.

Child and caregiver age and gender were accounted for in all adjusted models as applicable. Relevant information regarding gender and age disaggregation is included when relevant and is available in the appendices.

For the purposes of obtaining the population weights the stratification was incidental, because the study sampled every district in Cambodia that met the 1 percent province threshold and the 1 percent district threshold. Analytically, the sample can be seen as a multi-stage PPS cluster sample of village households in 56 districts. Probability weights were calculated for each village in the sample, with probabilities proportionate to the village population's contribution to the total migrant population. Weighted numbers were reported in all tables throughout this report.

48. Both-parents-international migrant households refer to those with both parents migrating and at least one of them was an international migrant worker.

49. Cases that have a father as a caregiver when mother migrates were omitted in the regression analysis due to small sample size (n = 5).

5.2. ANALYTIC METHODS FOR THE QUALITATIVE DATA

The audio-recording of each interview was transcribed in Khmer, then translated into English for further data analysis. First, descriptive codes (e.g. reasons of institutionalizations) were derived from a selective coding process. Second, analytical codes (e.g. poverty) which describe the shared experiences and patterns of participants were generated by open coding. Third, emergent thematic codes regarding the pathways to institutionalization and other alternative care arrangements of children were applied to gather deeper information. Additionally, selective coding was applied to triangulate the findings of quantitative study, when relevant. Researchers wrote analytic memos to document and reflect the coding process.

03

Results

1. Household Profile

Part 3 summarizes the key findings of this study. Sections 1 to 12 provide the details about the household survey, migration and socio-economic status, child and caregiver physical and mental health as well as in-depth material about the migration dynamics including destinations, durations, remittances and communication between origin households and migrants. Detailed comparisons are made about migration destinations (internal and international-cross-border), migration types (father-migrants, mother-migrants, both-parents-migrant), and child caregiving arrangements. Comparison is made, when relevant, to the Cambodia Demographic Health Survey (2014) and Migration and Left-behind Households in Rural Areas in Cambodia (CRUMP) survey (2015), taking into account, when possible, differences in the composition of the comparison samples. Migration and Health Impacts on Cambodian Children and Families (MHICCAF) study results summarized here use sample weights to reflect the sampling design in all tables throughout this report. Selected themes (and subthemes) generated through qualitative data analysis are also presented alongside quantitative findings, when relevant. The quotations selected for presentation under each theme or sub-theme were based on the following criteria: the quotations are illustrative of a particular theme; quotations encapsulate a range of views where heterogeneity of views is present; and they are focused and succinct.

KEY SUMMARY

95% of caregivers are women.

Almost two-thirds (75%) of left behind children had grandparents as their primary caregiver, only 14 percent had a parent as primary caregiver.

Near 50 percent of caregivers in non-migrant households were aged 30 to 39 years

Elderly above the age of 60 constituted 40% of primary caregivers for left behind children, with the majority (95%) being female.

Parents in non-migrant households were more likely to be older than migrant parents.

Around half of fathers and mothers were agricultural laborers. One third of father-migrants and 20 percent of mother-migrants worked as construction workers.

9% of parents in migrant households were divorced, significantly higher than the divorce rate among non-migrant households.

Two parents with one child is the most common living arrangement among non-migrant households; the extended family with a grandparent as the primary caregiver is the predominant family structure among migrant households.

There were a few noticeable differences in household characteristics by migrant destination.

1.1. CHARACTERISTICS OF PRIMARY CAREGIVER

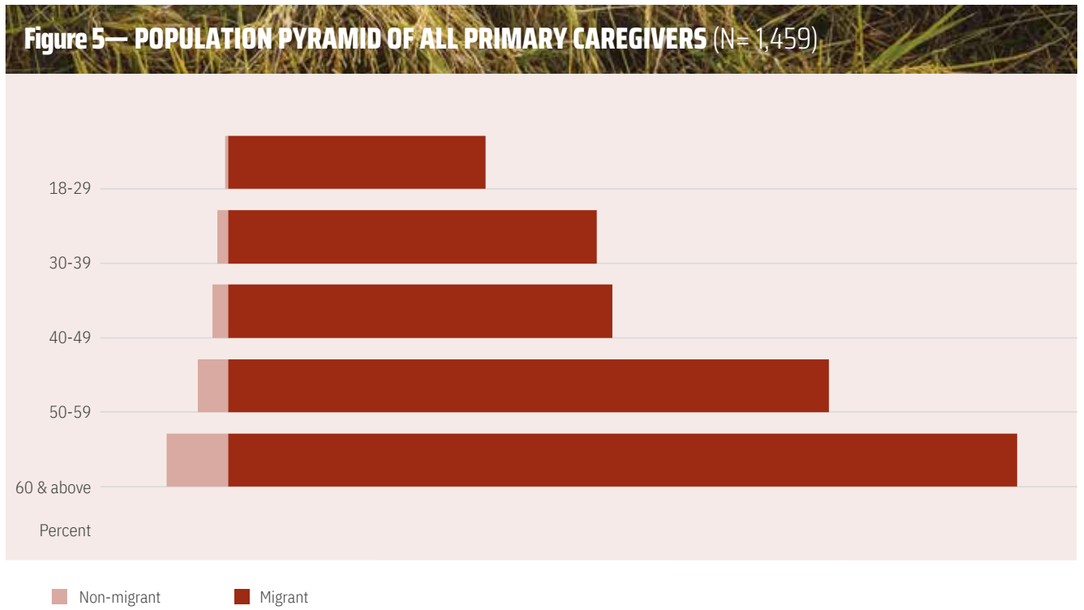
1.1.a. Caregivers' age and sex composition

Caregivers were mainly older and female: elderly aged 50 and above constitute more than 50 percent of caregivers while less than 5 percent of households had a male caregiver[50] (details in Table 1 in Appendices). The households of international migrants were slightly more likely to have a male caregiver.

The average age of primary caregivers in migrant households was significantly higher compared to caregivers in non-migrant households (53 years compared to 35 years). Over 40 percent of caregivers in non-migrant households were aged 30 to 39 years, with the majority being female (97%). Elderly above the age of 60 constituted 40 percent of primary caregivers for left behind children. The percent of male caregivers in migrant household was almost 50 percent higher compared with non-migrant households (5% vs 3%).

50. Cases that have a father as a caregiver when mother migrates were omitted in the regression analysis due to small sample size (n = 5).

Figure 5— POPULATION PYRAMID OF ALL PRIMARY CAREGIVERS (N= 1,459)



1.1.b. Caregiver's educational level

The percentage of caregivers having received no education among caregivers in migrant households was noticeably higher than caregivers in non-migrant households, 30 percent and 12 percent respectively. Overall, 28 percent of female caregivers and 2 percent of male caregivers had never attended school. This pattern is similar to results based on national adult samples (DHS, 2014), with men more likely to have attended school. The proportion of caregivers with no education was slightly higher in the international-migrant households (32% versus 27%).

1.1.c. Caregiver's occupation

The occupation of caregivers was similar among all households: slightly over half of caregivers worked in the agricultural sector, one third of them were homemakers.

1.2. CHARACTERISTICS OF PARENTS

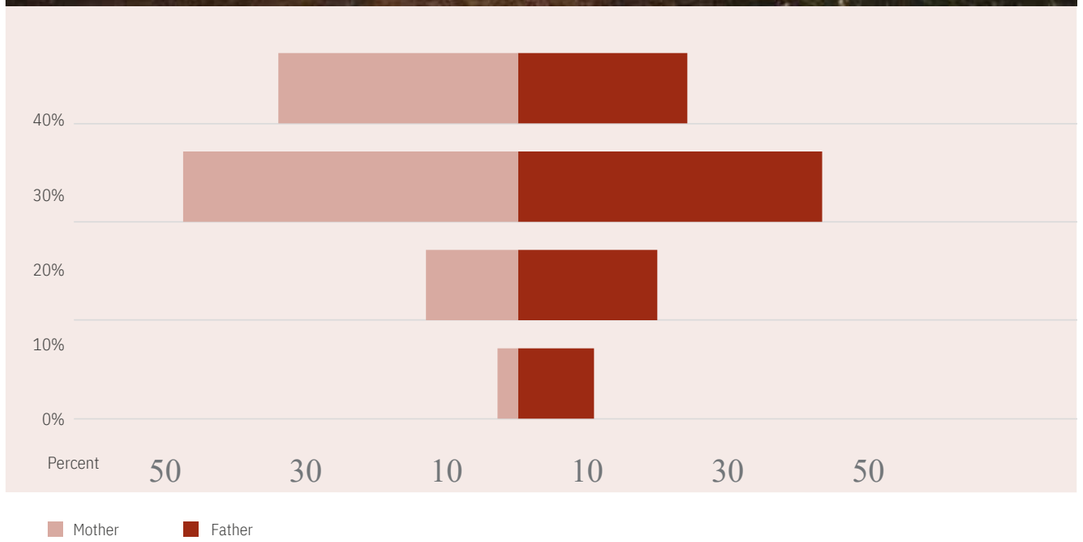
1.2.a. Age of index child's parents

Overall, 44 percent of fathers and almost half of mothers were aged between 30 to 39 years old. The average age of the father and mother was 35 and 33 years old, respectively (see Table 2 in Appendices). Fathers and mothers in migrant households were statistically more likely to be younger than parents in non-migrant households. The middle age group from 30 to 39 years constitutes the largest proportion of parents in both non-migrant and migrant households, but parents in migrant households were more likely to from the younger age group aged from 18 to 29 years.

1.2.b. Educational levels of parents

Around 40 percent of fathers and over half of mothers had completed primary school. The proportion of parents in non-migrant households with secondary school level or higher was greater than the percentage of migrant

Figure 6— AGE DISTRIBUTION OF PARENTS (FATHER N= 1,326; MOTHER N = 1,430)



parents. Overall, 12 percent of fathers had not completed any level of schooling as compared with 10 percent of males in national samples (DHS, 2014). This in in contrast to then11 percent of mothers who had not completed any level of education in this study, which was much lower when compared to all adult females in the national sample (19%).

1.2.c. Occupation of parents

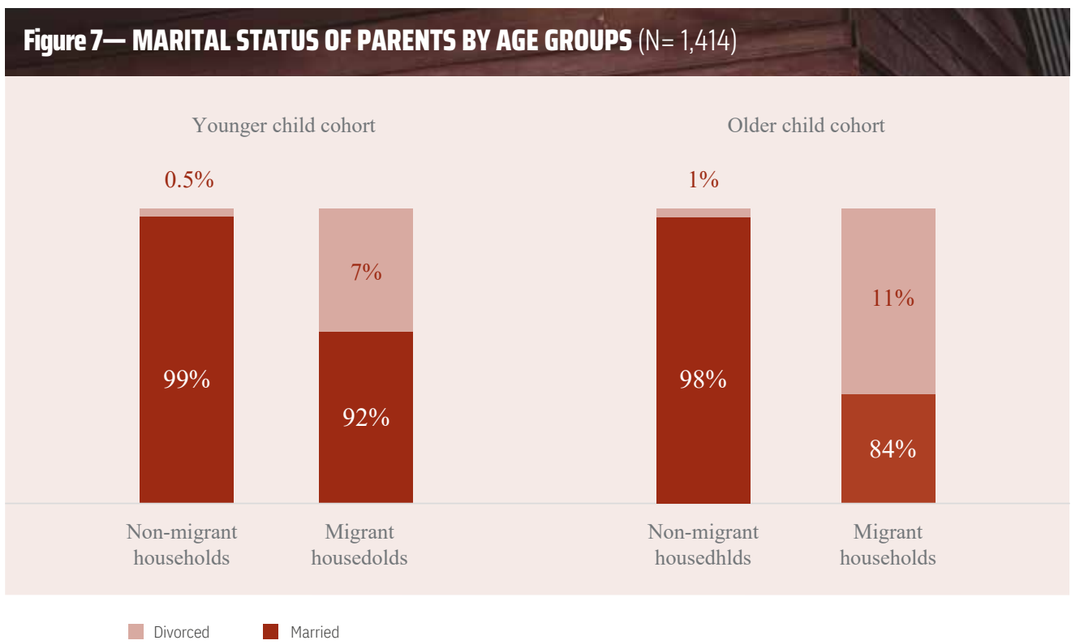
In non-migrant households, 54 percent of fathers were agricultural laborers similar to 51 percent in the national sample (DHS, 2014). In migrant households, the highest proportion of fathers (34%) were employed as construction workers, followed by factory workers (16%). Half of the mothers in non-migrant households (51%) worked in the agricultural sector compared to 44 percent according to national data (DHS, 2014). The top two types of occupation reported by mothers in migrant families was construction workers (22%) and garment workers (17%). According to an ILO-IOM survey in 2016,[51] 46 percent of Cambodian migrant workers in Thailand worked in the construction sector. This study also suggested that construction work is the predominant occupation among internal and international Cambodian migrants.

51. Risks and rewards: Outcome of labour migration in South-East Asia, ILO-IOM 2017, available from <https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_613815.pdf>.

1.2.d. Marital status of parents

The majority of parents were married (92%). The rate of divorce among the Older Child Cohort was 9 percent, significantly higher than the percent among the Younger Child Cohort (6%) (Figure 7). The divorce rate among parents of migrant households was 9 percent, which is much higher when compared with non-migrant households (0.5%). Children of migrant parents were more likely to live in divorced families in both age groups, with highest percent of parental divorce among the Older Child Cohort from migrant households (11%). The divorce rate of migrant families was much higher than the divorce rate of women and men aged 15 to 49 (3% and 1% respectively, DHS, 2014) in the national sample, suggesting an association between migration and marital status. The divorce rate among internal-migrant workers was 12 percent, which was significantly higher than among couples with at least one international-migrant worker (5%).

Figure 7— MARITAL STATUS OF PARENTS BY AGE GROUPS (N= 1,414)



Insights from Qualitative Interviews

Data from the qualitative phase of the study showed the complexities of the pathways that may lead to divorce. Migration may not be the direct reason for divorce, but it may influence marriage in connection with money issues, addiction and family/couple conflict.

Divorce before migration:
Divorce may push a mother to become a migrant worker as she does not have enough income to raise children after divorce.

Divorce after migration:
One example describes how both parents migrated to Thailand together where the husband would often get drunk and create trouble. Concerned about his safety, his wife took him back home, where he continued his drinking and they kept on arguing. The husband would refuse to work and only drink, which eventually resulted in the couple getting a divorce.

Children's voice:
"I don't want to live in Thailand. I am afraid to break up a family like my mother. Because my mother broke up the family after she went to Thailand. I am afraid I will be like her"

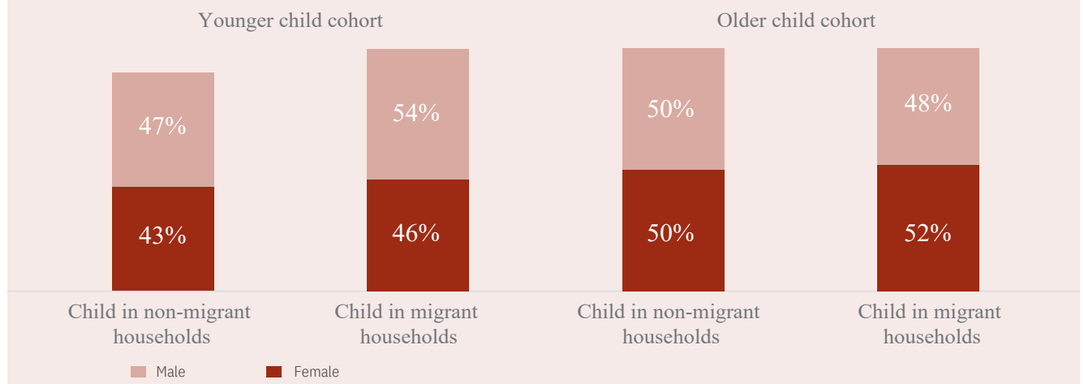
(Girl, 13 years old, both-parents-international-migrant)

1.3. CHILD'S AGE AND SEX COMPOSITION

The child sample consists of (1) Younger Child Cohort of 731 children aged 0 to 3 years old and (2) Older Child Cohort of 728 adolescents aged 12 to 17 years old. Overall, the average age of the younger cohort was 19 months and the average age of the older cohort was 14 years old. In both age cohorts, the proportion of girls in migrant households was slightly higher than the percent in non-migrant households.

52. Total refers to sum of sub-groups (e.g. by gender or by age groups within one age cohort).

Figure 8— PERCENT DISTRIBUTION OF CHILD GENDER BY HOUSEHOLD MIGRANT STATUS (N= 1,459)



In the Younger Child Cohort, children of migrant households (average age = 20 months) tended to be older than those in non-migrant households (average age = 14 months). In contrast to the Younger Child Cohort, the average age of Older Child Cohort in migrant households was significantly younger than those in non-migrant households (13.77 years vs 14.15 years).

TABLE 9— GENDER AND AGE DISTRIBUTION OF CHILDREN BY MIGRANT STATUS OF HOUSEHOLDS (N= 1,459)

Age groups	Non-migrant household			Migrant household			Full sample		
	Female	Male	Total	Female	Male	Total	Female	Male	Total[52]
Younger Child Cohort									
0-11 months	24.96	26.67	51.64	10.20	9.08	19.28	12.40	11.71	24.11
12-23 months	9.19	16.72	25.90	16.99	21.00	37.99	15.83	20.36	36.19
24-35 months	8.45	14.01	22.46	18.79	23.94	42.73	17.25	22.46	39.71
Total	42.60	57.40	100.00	45.98	54.02	100.00	45.48	54.52	100.00
Older Child Cohort									
12-14 years	37.69	33.66	71.35	41.22	38.17	79.39	40.70	37.50	78.19
15-17 years	12.03	16.61	28.65	10.53	10.08	20.61	10.75	11.06	21.81
Total	49.72	50.28	100.00	51.75	48.25	100.00	51.45	48.55	100.00

1.4. HOUSEHOLD DEMOGRAPHIC INFORMATION

1.4.a. Family size and family structure

Household size refers to the number of family members currently living in the household. According to the 2014 Demographic Health Survey, the average household size was 4.5 in Cambodia. The average household size of all sampled households was 5.1, suggesting a larger number of family members. The largest family in the sample is composed of 15 family members in the same household while the smallest households had only two people. Over one-half of households (56%) had more than four family members living in the household, in line with common patterns in family demographics in Cambodia. Compared to non-migrant households, migrant households tended to have a smaller family size including 2 to 3 family members (see details in Table 10). Such a finding is consistent with results of Cambodian Rural-Urban Migration Project (CRUMP, 2015) suggesting children in migrant households were more likely to live with fewer other family members compared to their peers in non-migrant families. International migrant households had a higher proportion of larger household size compared to internal migrant households (60% versus 50%).

TABLE 10— PERCENT DISTRIBUTION OF HOUSEHOLDS BY HOUSEHOLD SIZE, AND HOUSEHOLD STRUCTURE (N= 1,459)

Household composition	Full sample	Non-migrant	Migrant -total	Internal-migrant household	International-migrant households
Household size (%)					
2 persons	3.27	0	3.84	2.78	4.52
3 persons	16.93	14	17.45	21.03	15
4 persons	23.56	26.38	23.07	26.59	20.77
Above 4 persons	56.24	59.63	55.64	49.6	59.7
Family structure (%)					
Nuclear family	14.01	58.68	6.18	7.51	5.55
Extended family with parents as primary caregiver	12.47	39.42	7.74	8.13	7.74
Extended family with grandparents as primary caregiver	63.92	1.38	74.88	71.87	76.43
Extended family with other relative as primary caregiver	9.6	0.52	11.19	12.49	10.28

Regarding family structure, a nuclear family refers to a household consisting of two parents and their children. Extended family is a family that includes other kin in one household in addition to parents and their children. Overall, the majority of the sampled households (86%) were extended families while only 14% of sample households were nuclear families. Notably, about 59% of non-migrant household were nuclear families, compared to only 6% in the migrant samples. The extended family with a grandparent as the primary caregiver was the most predominant family structure among migrant households.

Insights from Qualitative Interviews

Qualitative findings were mainly consistent with quantitative results, which highlighted the predominant role of extended family structure. In the context of labor migration, Cambodian households may experience the fluctuating family dynamics: family members who live at one moment in the household, may migrate elsewhere in the future. Many in Cambodia adopted a diffuse parenting care model for the left behind children where the child's caregiving needs were usually provided by older female adults of the household or of neighboring household – especially in rural settings. Interviews suggest

that gender-based labor division in families was very clear: women, either mothers, grandmothers, aunts and sisters were normally the family members who took care of children and do other housework. The male figures may participate in raising children, but they limited themselves primarily to disciplining children or to supervise their study.

Older siblings may also become very involved with the care for their younger siblings. As one older sister explains:

"I sleep with my brother, he cannot sleep without me. I look like his mother, he cries when he doesn't see me."

Girl,
13 years old, Banteay Meanchey, Both-parents-international migrants

Parents may encourage this role as well when they leave for migration. One mother stressed to the oldest child when she had to leave them behind:

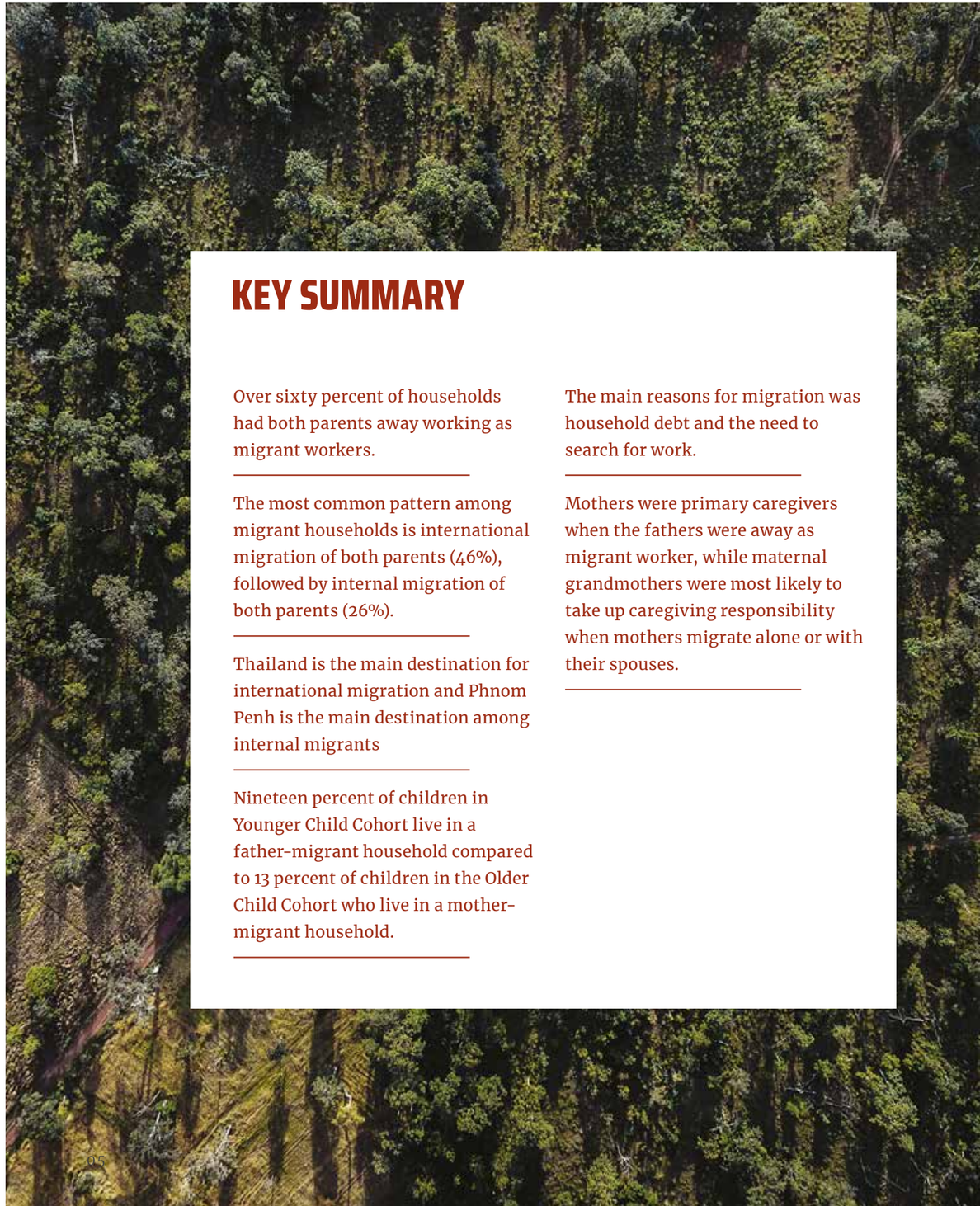
"Please take care of your siblings, love siblings and try to study, do not go for a walk a lot."

Boy,
16 years old, Battambang, Both-parents-international migrants

1.4.b. Household ethnic and religious background

The majority of households were Khmer (99%) and Buddhist (98%). There were no significant differences by ethnic or religious background.

2. Migration Dynamics



KEY SUMMARY

Over sixty percent of households had both parents away working as migrant workers.

The most common pattern among migrant households is international migration of both parents (46%), followed by internal migration of both parents (26%).

Thailand is the main destination for international migration and Phnom Penh is the main destination among internal migrants

Nineteen percent of children in Younger Child Cohort live in a father-migrant household compared to 13 percent of children in the Older Child Cohort who live in a mother-migrant household.

The main reasons for migration was household debt and the need to search for work.

Mothers were primary caregivers when the fathers were away as migrant worker, while maternal grandmothers were most likely to take up caregiving responsibility when mothers migrate alone or with their spouses.

2.1.
MIGRATION DENSITY OF RESEARCH SITES

Table 11 reports the migration density of 18 sampled provinces. All these provinces had a high prevalence of migrant households with children 0-3 and 12-17 who met the criteria for inclusion to the study—over 80 percent. Kampong Speu Province and Kandal which are located in the middle of Cambodia were more likely to have internal-migrants. Banteay Meanchey had the highest prevalence of households with at least one international-migrant worker (82%), followed by Battambang (69%).

TABLE 11— MIGRATION DENSITY OF SAMPLED PROVINCES

Provinces	Frequency	Percent in full sample	Percent of migrant households	Percent of internal-migrant households	Percent of international-migrant households
Banteay Meanchey (BMC)	232	15.9	84.76	18.4	81.6
Battambang (BTB)	156	10.69	84.87	31.18	68.82
Kampong Cham (KPC)	211	14.46	85.1	58.94	41.06
Kampong Speu (KPS)	26	1.78	82.02	100	0
Kampong Thom (KTM)	75	5.14	87.41	45.64	54.36
Kampot (KPT)	104	7.13	85.09	39.25	60.75
Kandal (KDL)	31	2.12	81.93	100	0
Prey Veng (PVG)	260	17.82	86.66	41.74	58.26
Pursat (PST)	26	1.78	85.41	45.93	54.07
Siemreap (SRP)	130	8.91	82.42	37.51	62.49
Svay Rieng (SVG)	52	3.56	85.32	36.85	63.15
Takeo (TKV)	78	5.35	84.77	43.03	56.97
Tboung Khmum (TBK)	78	5.35	83.78	50.81	49.19
Total	1,459	100	85.09	38.33	61.67

2.2.
CURRENT MIGRANT STATUS OF PARENTS

Among the sampled households, 85 percent had at least one migrant parent currently away with the remaining 15 percent in the non-migrant parent comparison group (see Table 12). The most common migration arrangement was both-parents-migrant: around two-thirds (63%). The next most common arrangement was father-migrant (14%) with 8 percent of households having only the mother-migrant.

There were some significant differences between the younger (children age 0 to 3 years old) and older (age 12 to 17 years old) child age cohorts, mainly with greater differences between the ratio of father-migrant households to mother-migrant households in the Younger Child Cohort compared to the Older Child Cohort (see Table 3 in Appendices). The percentage of father-migrant-households within the Younger Child Cohort was 19 percent, almost twice as high as the percentage (9%) in the Older Child Cohort sample. The percentage of mother-migrant households in the Older Child Cohort (11%) was higher than the proportion in the younger sample (5%).

Around half of fathers who migrated alone or together with mothers were aged from 30 to 39 years. Forty percent of mothers who migrated alone and 60 percent of mothers who migrated together with their husband were aged from 30 to 39 years.

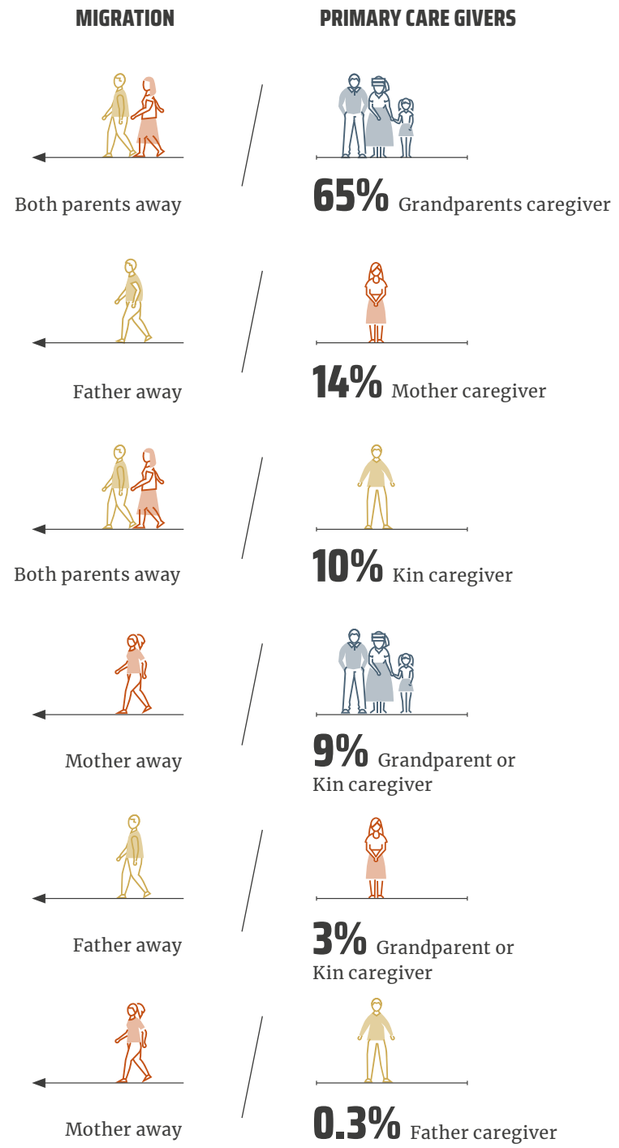
TABLE 12— DISTRIBUTION OF MIGRANT'S AGE BY PARENTAL MIGRATION HOUSEHOLD TYPE (N= 1,459)

Age groups (%)	Non-migrant households (15%)		Both-parent-migrant households (63%)		Father-migrant households (14%)	Mother-migrant households (8%)	Total	
	Father	Mother	Father	Mother			Father	Mother
Age 18-29	20.75	31.53	27.63	36.48	26.44	23.76	26.33	34.45
Age 30 – 39	41.46	41.31	47.13	50.04	52.37	59.97	47.01	49.44
Age 40 – 49	26.51	22.67	20.98	12.28	14.95	15.95	20.96	14.42
Age 50 and above	11.28	4.48	4.26	1.19	6.24	0.31	5.7	1.68

2.3. CAREGIVING ARRANGEMENTS IN MIGRANT HOUSEHOLDS

Children in the study were predominately cared for by the maternal grandparents when both parents migrated (72%) and when the mother migrated alone (74%) while non-migrant mothers overwhelmingly were the caregivers when the father migrated (83%). The most common care arrangement was to have maternal grandparents as primary caregivers when the mother or both parents migrated in both age cohorts. When both parents migrated, paternal grandparents and other kin were more likely to be caregivers of children in the older Child Cohort compared to the Younger Child Cohort. In summary, mothers were primary caregivers when fathers were away as migrant workers, while maternal grandmothers were most likely to take up caregiving responsibilities when mothers migrated alone or with their spouses.

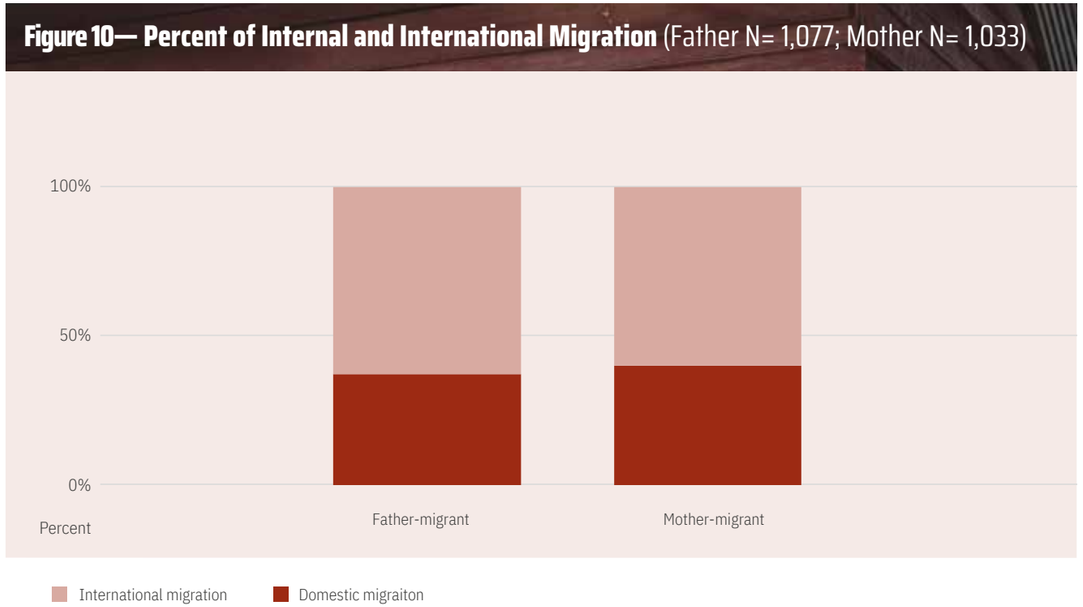
FIGURE 9— CAREGIVING ARRANGEMENTS FOR CHILDREN IN MIGRANT HOUSEHOLDS



2.4.
INTERNAL OR INTERNATIONAL MIGRATION

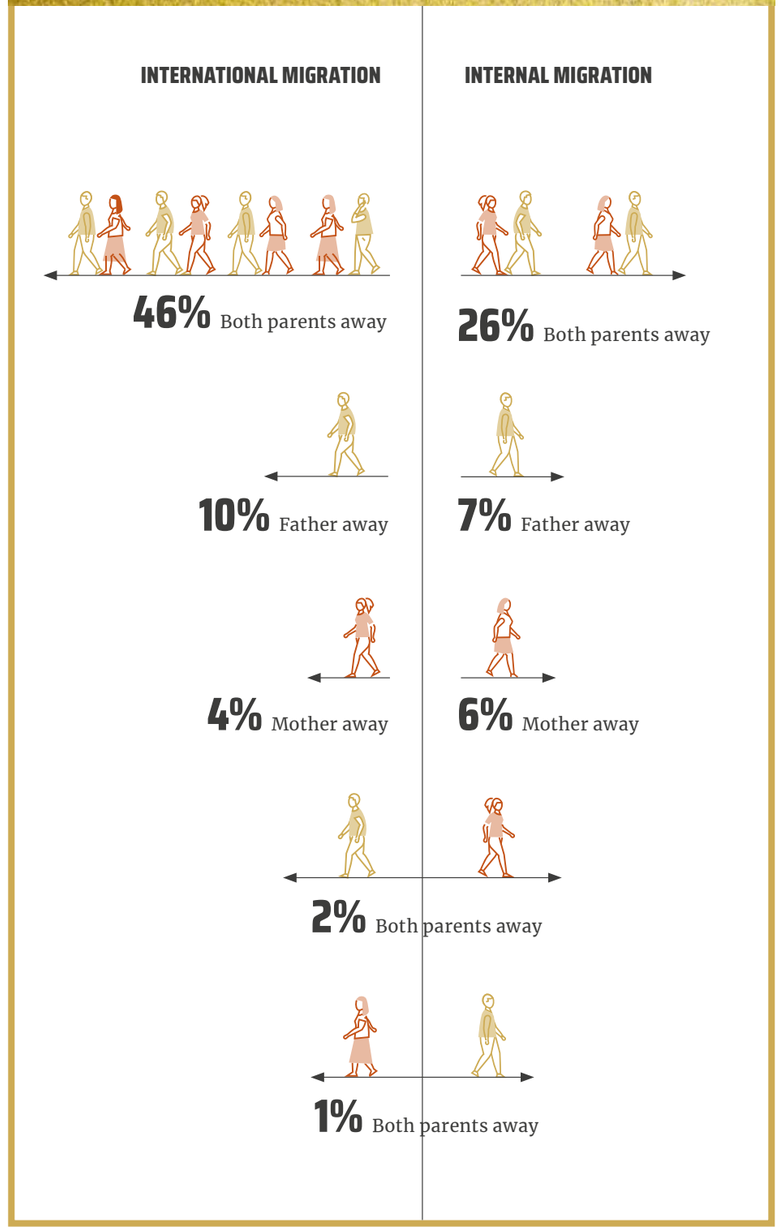
The major destinations were categorized as internal/domestic or international/cross-border migration (see Figure 10). The percentage of international migration among migrant fathers and mothers was 63 percent and 60 percent respectively. The percentage of father-international-migrant households was slightly higher in the Older Child Cohort (65%), than among the Younger Child Cohort (61%).

Figure 10— Percent of Internal and International Migration (Father N= 1,077; Mother N= 1,033)



The following combined categorization captures the parental migration status and caregiver status: father-international/internal-migrant, mother-international/internal-migrant, both-parents-international/internal-migrant.

FIGURE 11—
PARENT MIGRATION AND DESTINATION TYPES DISTRIBUTION



Parents were most likely to share the same type of migration, internal or international. The most commonly observed pattern was for both parents to migrate internationally at 46 percent. The second most common pattern was both-parents-internal-migrant at 26 percent. The predominance of these two patterns was consistent across both child cohorts. A notable proportion of the Younger Child Cohort had fathers as international migrants (13%) whereas among the Older Child Cohort mother-internal-migrant households (8%) were more prevalent. The percentage of both-parents-internal migrant (26%) was similar to the percentage of rural-to-urban migrant across adult population (25%) in 2013 according to the National Census Population Survey.[53]

2.5. CURRENT DESTINATIONS OF MIGRATION

UNDESA estimates 1.1 million Cambodians migrants were living and working in other countries, of which 62 percent or 680,000 were residing in Thailand.[54] Around 61 percent of migrant fathers and more than one half of migrant mothers migrated internationally cross-border to Thailand. Among those who migrated internally, Phnom Penh was the most preferred option, 22 percent and 28 percent respectively among migrant fathers and migrant mothers.

53. National Institute of Statistics & Directorate General for Health, Cambodia. Cambodia Demographic and Health Survey 2014. Available from <https://dhsprogram.com/pubs/pdf/FR312/FR312.pdf>.

54. International Migration Report, United Nations, Department of Economic and Social Affairs (UNDESA) 2017). Available from <https://www.un.org/development/desa/publications/international-migration-report-2017.html>.

TABLE 13— DETAIL OF CURRENT MIGRANT DESTINATIONS OF PARENTS

(Father N= 1085; Mother N= 1051)	Father-migrant	Mother-migrant
Thailand	60.93	51.07
Phnom Penh	21.53	28.00
Provincial town in another province	7.06	7.10
Village in other provinces	4.34	5.99
Village in the same province	2.54	3.23
Provincial town in the same province	1.70	1.81
Malaysia	0.93	0.91
South Korea	0.62	0.03
Other	0.24	0.33
Vietnam	0.10	1.16
Japan	0.03	0.37

2.6. MIGRATION DURATION

Migrant fathers and mothers both spent on average one-half of the index child's lifetime away (approximately 1.5 years among Younger Child Cohort, and 7 years in the Older Child Cohort). Around half of parents had migrated over five years but less than nine years. The second most common duration of migration was less than one year (18% of migrant fathers and 22% of migrant mothers).

TABLE 14— AVERAGE YEARS OF MIGRATION DURATION (FATHER N= 1,085; MOTHER N= 1,062)

Average years	Younger child cohort	Older child cohort
Duration of father migration Mean (SD)	1.54 (0.91)	7.39 (4.86)
Duration of mother migration (mean, SD)	1.39 (1.19)	7.11 (4.5)
	Internal-migrant	International-migrant
Duration of father migration (mean, SD)	4.81 (5.44)	4.20 (4.1)
Duration of mother migration (mean, SD)	4.75 (5.15)	4.43 (4.06)

Table 2.2.4 further provides the migration duration among the two child age cohorts. It is understandable that parents of children in the older age cohort were more likely to have a longer migration history, with 36 percent of migrant fathers and 32 percent of migrant mothers having 10 years migration experiences or even longer. In terms of migration destinations, fathers or mothers who migrated internally were more likely to have a prolonged history of migration above 10 years than those migrated internationally.

TABLE 15— DURATION OF PARENTAL MIGRATION BY CHILD AGE GROUPS AND MIGRATION DESTINATIONS (FATHER N= 1,085; MOTHER N= 1,062)

Duration of migration	Younger age cohort	Older age cohort	Internal migration	International migration
Father-migrant				
< 1 year	29.16	5.72	16.84	17.72
1-4 year	70.33	35.06	50.78	54.80
5-9 year	0.51	23.63	11.74	11.77
10 years	0.00	35.59	20.64	15.71
Mother-migrant				
< 1 year	38.64	7.06	21.65	19.86
1-4 year	60.04	32.33	43.14	46.99
5-9 year	0.90	28.60	15.60	16.27
10 years	0.41	32.01	19.60	16.88

2.7. DOCUMENT FOR MIGRATION

2.7.a. Document and contract of migrants

Having the proper documentation including transit documents, visas and employment contracts are important aspects of safe regularized migration. Cambodian migrant workers use a variety of regular and irregular channels to go abroad. Over 71 percent of migrants predominantly use unlicensed brokers, migrating via friends and family, or independently. Only a small portion of migrants migrate through licensed private recruitment agencies and government agencies due cost and lengthy procedures.[55]

Most international migrants in this study (89%) reported having documents for migration while most internal migrants were not required to have documents (81%) (see Table 16). Among the internal-migrants, most migrants

55. Risks and rewards: Outcome of labour migration in South-East Asia, ILO-IOM 2017, available from <https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_613815.pdf>.

(72% and 69% for father and mother migrants, respectively) did not have an employment contract. Both fathers and mothers who migrated internationally had a similar likelihood of holding an employment contract (43% for fathers and 42% for mothers).

TABLE 16— DOCUMENT AND CONTRACT STATUS OF MIGRANT PARENTS BY MIGRATION DESTINATIONS

	Internal migration	International Migration	Total	p-value
Document status of father migration				<0.0001
Documented	7.66	88.48	58.55	
Undocumented	10.34	9.00	9.50	
No document required due to domestic migration	80.78	0.75	30.39	
Don't know	1.23	1.77	1.57	
Document status of mother migration				<0.0001
Documented	10.55	87.81	57.71	
Undocumented	8.93	9.61	9.34	
No document required due to domestic migration	79.39	0.94	31.50	
Don't know	1.12	1.64	1.44	
Contract type of migrant father				<0.0001
Formal contract	4.68	43.19	28.92	
No formal contract	14.51	33.04	26.18	
No formal contract due to domestic migration	72.41	0.84	27.35	
Don't know	8.40	22.93	17.55	
Contract type of migrant mother				<0.0001
Formal contract	10.59	41.52	29.47	
No formal contract	12.56	37.08	27.53	
No formal contract due to domestic migration	68.86	0.76	27.29	
Don't know	7.99	20.64	15.71	

Given the diversity and complexity of documentation for legal migration between Cambodia and Thailand, it is possible these figures do not accurately reflect the true documentation status, as the survey question was a global question rather than a series of details reflecting different types documentation commonly used in the region.

FIGURE 12— DIVERSE TYPES OF DOCUMENTATION FOR CROSS-BORDER MIGRATION IN THE CAMBODIAN CONTEXT

Documented Migrant worker	Undocumented Migrant worker
PASSPORT **Two year** Visa (with permission to seek employment) Certificate of Good Health Health insurance Work Permit Contract with Employer **BORDER PASS** Certificate of Good Health Health insurance Work Permit Immigration Permission to stay 30 days (per entry/only border province) Employer contract maybe not common (seasonal work)	**PASSPORT** No Passport, No visa, **No** work permit (illegal entry/no permission to stay or work) Or Passport with tourist visa but No work permit (legal entry/stay but no permission to work) No contract with employer **BORDER PASS** No Border pass, no work permit or permission to enter (illegal entry) Or Border pass, no work permit, no permission to stay more than 7 days Or Border pass with work permit and permission to stay 30 days but working outside border province

Source: https://www.migra-info.org/information-for-migrants/documents/

2.7.b. Payment required for migrants

For both internal and international migrants, family members were the main method for migrant father and mothers to find employment opportunities (33% and 38% respectively). The second and third important channels were neighbor/word of mouth, and friends among internal migrants. Among

international migrants, agents/brokers played more of an important role than friends: around 33 percent of migrant fathers and mothers found work opportunities through agents. Around one third of migrants reported required payments for arranging migration, similar between migrant mothers and father. Payment required for migration happened much more frequently among international migrants than internal migrants. Data from the qualitative study highlighted that some migrants paid agents for necessary documentation for international migration but were otherwise cheated by agents in the end.

TABLE 17— SOURCE OF INFORMATION ABOUT AND WHETHER PAYMENT REQUIRED FOR MIGRATION BY TYPE OF MIGRATION

	Internal	International	Total	p-value
Source of information about migration				
How did father find out about the work opportunity that father migrated for?				<0.0001
Agent/broker	0.69	33.45	21.32	
Friend	17.38	5.16	9.69	
Family member	38.07	30.45	33.27	
Neighbors/word of mouth	25.26	22.32	23.40	
Other	18.61	8.62	12.32	
How did mother find out about the work opportunity that mother migrated for?				<0.0001
Agent/broker	1.78	32.54	20.56	
Friend	12.43	4.48	7.57	
Family member	45.77	33.65	38.37	
Neighbors/word of mouth	25.90	22.92	24.08	
Other	14.12	6.41	9.41	
Whether payment required for migration				
Payment required for migrant-father	2.76	54.80	35.53	<0.0001
Payment required for migrant-mother	3.79	56.86	36.19	<0.0001

2.8. MAIN REASONS OF MIGRATION

The survey asked the main reasons for father's and mother's migration from both caregiver's as well as adolescent's perspectives. Overall, one of the main reasons given by caregivers for the parent(s)' migration was household debt, followed by the need to search for work, and family problems. These reasons are similar to results of IOM's survey which reported "No job", "Low income" and "Financial debt" as the three most cited reasons for migrants leaving Cambodia.[56] The pattern of reasons why the parent(s) migrate shows group difference by age cohorts. Among the Younger Child Cohort, the highest proportion of households reported that the father and the mother migrated for debt (44% and 47% respectively), followed by searching for work (24% and 26% respectively). According to caregivers of the Older Child Cohort, the main reasons for father and mother's migration was debt (36% of fathers and mothers), followed by family problems (20% and 19% respectively). Reports by caregivers and adolescents for the main reasons of parental migration were inconsistent: Children's education was not considered a main driver of parental migration according to caregiver reports, in comparison to adolescents who reported that as a top reason for both fathers (20%) and mothers (23%).

56. The role of debts in Southeast Asia migrations. IOM 2016 Survey available from: <https://thailand.iom.int/sites/default/files/document/publications/Debt%20and%20Migration.pdf>.

TABLE 18— REASONS OF MIGRATION BY CHILD AGE GROUPS

Main reasons of migration (%)	Younger Child Cohort	Older Child Cohort	Child report (Older Child Cohort only)
Reason of father's migration			
Child's future /education	1.44	4.98	19.95
Search for work	24.36	18.44	11.98
Job transfer/job opportunity	10.28	8.31	15.21
Debt	43.81	35.95	18.70
Family problems	9.61	20.22	10.80
Moved to join other family members	8.11	8.16	

TABLE 18— REASONS OF MIGRATION BY CHILD AGE GROUPS

Main reasons of migration (%)	Younger Child Cohort	Older Child Cohort	Child report (Older Child Cohort only)
Don't have enough land	0.54	2.55	0.15
Poor quality of land or depleted soil	0.00	0.27	
Health problems	0.00	0.25	0.03
Drought	0.00	0.20	
Low salary here	0.00	0.00	10.82
Other	1.86	0.66	1.52
Don't know	0.00	0.00	10.85
Reasons for mother's migration			
Child's future /education	2.49	3.53	23.05
Search for work	25.98	18.89	13.17
Job transfer/job opportunity	6.59	10.95	14.75
Debt	46.60	36.18	16.67
Family problems	7.46	18.99	11.63
Moved to join other family members	7.73	8.38	
Don't have enough land	1.92	1.26	0.38
Poor quality of land or depleted soil	0.00	0.21	
Health problems	0.00	0.19	0.03
Drought	0.00	0.16	0.16
Low salary here	0.00	0.00	10.50
Other	1.22	1.26	0.64

According to caregiver's reports, debt was the main driver for most migrants regardless of destination (see Table 19). Mothers were more likely to migrate internationally when they confronted family problems while they often migrated internally when they were for searching for work. Children's perception about why their parents migrated differed by migration destinations: children whose parents were international migrants considered debt as the main reason for migration, while children whose parents were internal migrants perceived their further education as the main driver for their parents' migration.

TABLE 19— REASONS FOR MIGRATION BY MIGRATION DESTINATIONS

Main reasons of migration (%)	Father-internal-migrant	Father-international-migrant	Mother-internal-migrant	Mother-international-migrant
Reason of migration (caregiver report)				
Child's future /education	2.49	3.53	4.67	3.88
Search for work	25.98	18.89	23.00	16.39
Job transfer/job opportunity	6.59	10.95	4.57	9.53
Debt	46.60	36.18	43.21	36.51
Family problems	7.46	18.99	9.03	20.58
Moved to join other family members	7.73	8.38	10.42	10.02
Don't have enough land	1.92	1.26	2.21	1.97
Poor quality of land or depleted soil	0.00	0.21	0.00	0.20
Health problems	0.00	0.19	0.00	0.19
Drought	0.00	0.16	2.89	0.73
Low salary here	0.00	0.00		
Other	1.22	1.26	4.67	3.88

TABLE 19— REASONS FOR MIGRATION BY MIGRATION DESTINATIONS

Main reasons of migration (%)	Father-internal-migrant	Father-international-migrant	Mother-internal-migrant	Mother-international-migrant
Reason of migration (child report)				
Child's future /education	20.97	19.55	22.25	20.60
Search for work	15.61	10.29	16.58	12.34
Job transfer/job opportunity	19.14	12.96	17.71	13.17
Debt	12.69	22.26	12.77	21.17
Family problems	8.28	12.26	9.71	13.80
Don't have enough land	0.28	0.09	0.31	0.10
Health problems	0.08	0.00	0.09	0.00
Low salary here	7.47	12.81	7.07	11.73
Other	2.81	0.32	0.56	0.00
Don't know	12.67	9.47	1.27	0.49

Insights from Qualitative Interviews

Financial reasons were for many families the main reason for migration. The grandparents were, in many instances, responsible for the childcare when their parents were gone. The decision that grandparents (often the grandmother) would take care of the children was in most cases a mutual, family-based decision.

Although financial and physical struggles may necessitate children to contribute to the household chores and income, priority was often given to education. School was frequently mentioned by the grandparents as being important and was one of the main activities that they spent money on.

Even when parents did not send sufficient financial remittances to cover their children's education (see the point on remittances below), some grandparents worked extra hard, and relied on additional loans, to make sure their grandchildren could go to school.

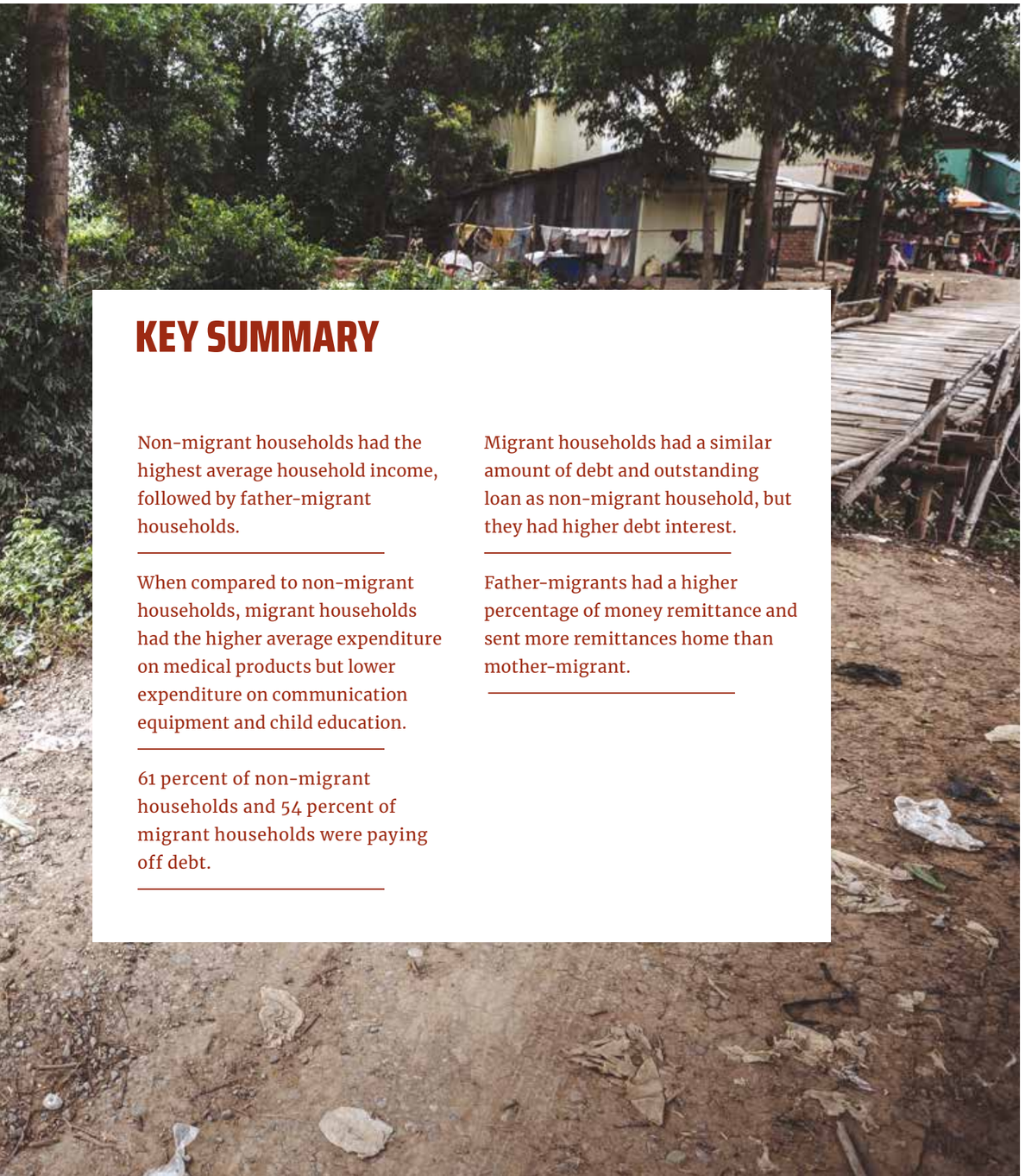
Caregiver's Voice

'We also raise chicken, ducks, to add more income to feed the grandchildren. Selling chickens earns 100,000 riels for grandchildren's study, such as their shoes, bags, school materials, and if we don't have money, we borrowed money . . . If we don't borrow money, how can we support them to go to school?'

Grandmother-caregiver,
age 67, in a mother-internal-migrant household

The next section explores the households' socio-economic dynamics including household debt and remittances more deeply.

3. Household Income, Debt and Remittance



KEY SUMMARY

Non-migrant households had the highest average household income, followed by father-migrant households.

When compared to non-migrant households, migrant households had the higher average expenditure on medical products but lower expenditure on communication equipment and child education.

61 percent of non-migrant households and 54 percent of migrant households were paying off debt.

Migrant households had a similar amount of debt and outstanding loan as non-migrant household, but they had higher debt interest.

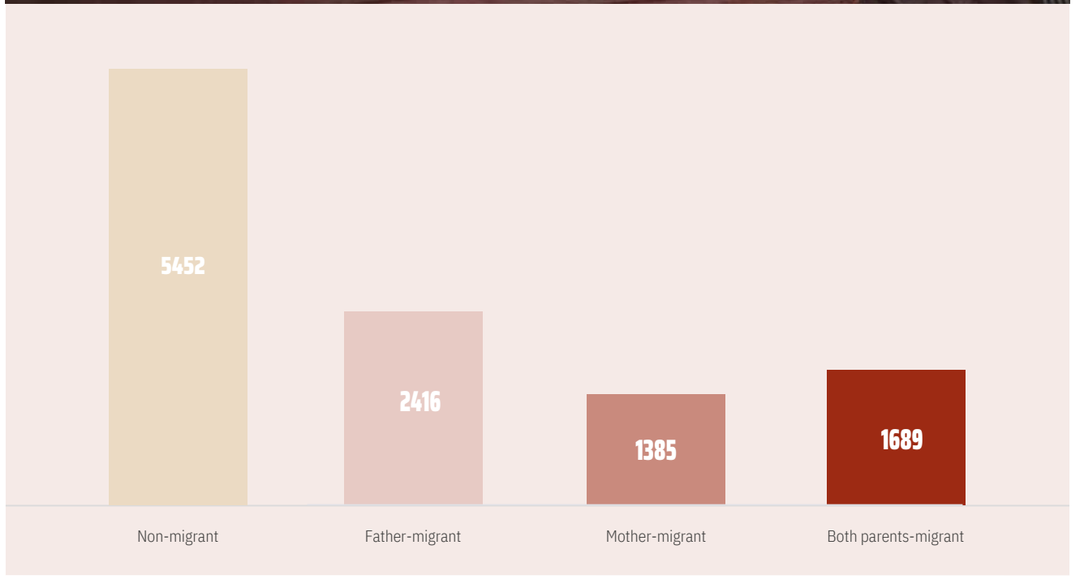
Father-migrants had a higher percentage of money remittance and sent more remittances home than mother-migrant.

3.1. HOUSEHOLD SOCIO-ECONOMIC INFORMATION

3.1.a. Household income and financial assistance

Within the 1,459 households, 83 percent of households reported income, not including remittances. Family income included income from household earning activities, and income and financial assistance from other resources. The amount of average annual income for non-migrant households was USD$5,452 (standard deviation = 9,941), which was significantly higher than the amount for the migrant households USD$1,762 (standard deviation = 5,074., $p < 0.0001$). Figure 13 shows the average household income by migration types of parents. Among migrant households, father-migrant households had the highest level of income and those with mother-migrants had the lowest level of income.

Figure 13— AVERAGE HOUSEHOLD INCOME IN THE LAST 12 MONTHS (USD)



The highest proportion of father-migrants were employed as construction workers (27%), followed by factory workers (17%); 24 percent of mother-migrants were garment workers and 17 percent of them were domestic workers. The type of occupation may be the main reason to cause lower levels of income for mother-migrants, CRUMP (2015) also reported that female migrants of Cambodia worked primarily as garment workers (32%) and they earned less money on average than male migrants.[57]

Table 20 presents the family income/assistance from other resources, in addition to salary and household production sales. The first two categories were only analyzed within migrant households as only migrant households were asked about remittances. Based on estimated values reported by respondents, cash and non-cash assistance from micro finance or loans played a significant role in the financial sources of households.

57. Zimmer, Z & Van Natta, M. A CRUMP Series Report. Migration and Left-Behind Households in Rural Cambodia: Structure and Socio-economic Conditions. Phnom Penh, Cambodia: UNFPA and National Institute of Statistics., 2015.

TABLE 20— INCOME AND FINANCIAL ASSISTANCE FROM OTHER RESOURCES

In the last 12 months did your family receive any income/assistance from the following sources? Mean (SD)	Estimated Earning (USD)		
	Income in Cash	Value of Non-Cash income	Total
Remittances from foreign country (only migrant households)	713.07 (1451.5)	10.45 (68.72)	723.6 (1466.26)
Remittances within home country (only migrant households)	407.06 (1343.36)	11.92 (57.53)	418.64 (1346.9)
Cash grants from International organization/NGO	1.77 (15.89)	0.39 (69.17)	3.68 (71.53)
Assistance from government (pensions, etcetera)	9.03 (104.67)	1.91 (12.26)	9.43 (108.35)
Collective saving/personal saving	21.85 (163.78)	5.41 (100.15)	27.27 (198.3)
Credit (micro finance/ loans)	1190.74 (2794.34)	18.51 (381.03)	1209.25 (2818.04)
Gifts (Rice and cash from others)	3.53 (44.65)	1.63 (39.57)	5.16 (59.76)

Note. S.D. = standard deviation

3.2. HOUSEHOLD PROPERTY

A higher proportion of migrant households reported having self-owned land, and free use of land. Among the 1,131 households who owned or operated agriculture land, 97 percent owned the land and 76 percent operated land for agricultural use. The proportion of land ownership among migrant households was not significantly different from non-migrant households, but the percentage of those operating agricultural land among migrant households was significantly lower than non-migrant households (75% vs 85%). The migrant households have significantly higher average house area than the non-migrant households.

TABLE 21— THE OWNERSHIP OF LAND AND AVERAGE HOUSE AREA BY MIGRANT STATUS OF HOUSEHOLDS

The type of land	Non-migrant household	Migrant household	Full sample	p-value
The land that house is on (%)				
Own	87.42	95.85	94.59	0.182
Free use of land	0	2.31	1.97	
Other	12.58	1.84	3.44	
Operating agriculture land (%)				
Owning	95.93	97.18	96.97	0.347
Operating	84.64	74.58	76.08	0.040
Average house area	872.72	1260.62	1202.74	<0.001

3.3. LIVESTOCK AND POULTRY RAISING ACTIVITIES

There was no group difference in owning water buffalo, cow/bulls, horse, donkey/mules, goat/sheep, elephant, pigs, chickens/ducks, others and none. Among the 62 households raising aquatic products, the question was asked regarding the ownership of their ponds. There was no group difference between migrant and non-migrant families in pond ownership.

3.4. EXPENDITURE

Family expenditure included food and non-food expenditure.[58] Main uses of cash across all households were on medical products and medical care. However, the average expenditure of medical products in non-migrant families was lower than migrant families. The average expenditure of communication equipment and child education in non-migrant families was higher than migrant families.

58. This section presents family non-food expenditure, while the information about family food expenditure will be presented in the section on household food security.

TABLE 22— NON-FOOD EXPENDITURE BY MIGRANT STATUS OF HOUSEHOLDS (USD)

	Non-Migrant household	Migrant household	Full sample	p-value
Non-food expenditure in last month Mean (SD)				
Medical care	22.1 (200.47)	20.85 (121.08)	21.04 (135.50)	0.930
Medical products	29.05 (59.09)	42.34 (108.53)	40.36 (102.98)	0.054
Tele communication and postal services	5.49 (5.94)	4.96 (9.57)	5.04 (9.13)	0.176
Total	56.69 (213.46)	68.15 (161.43)	66.45 (170.01)	0.502
Non-food expenditure in last 12 months USD (Average)				
Communication equipment	55.83 (141.87)	24.08 (64.12)	28.82 (80.97)	0.015
Education	88.35 (211.88)	69.5 (146.78)	72.31 (158.02)	0.196
Total amount	144.18 (265.75)	93.58 (165.04)	101.13 (183.96)	0.012

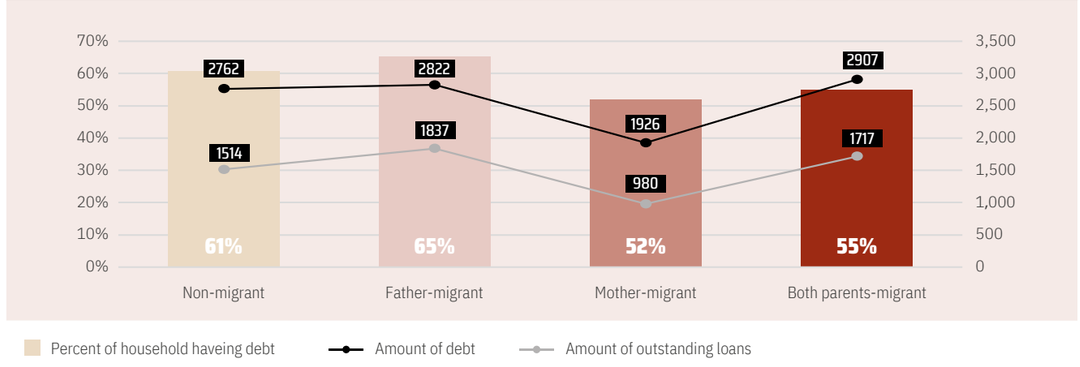
Note. S.D. = standard deviation

3.5. DEBT

3.5.a. Amount of debt and debt interest

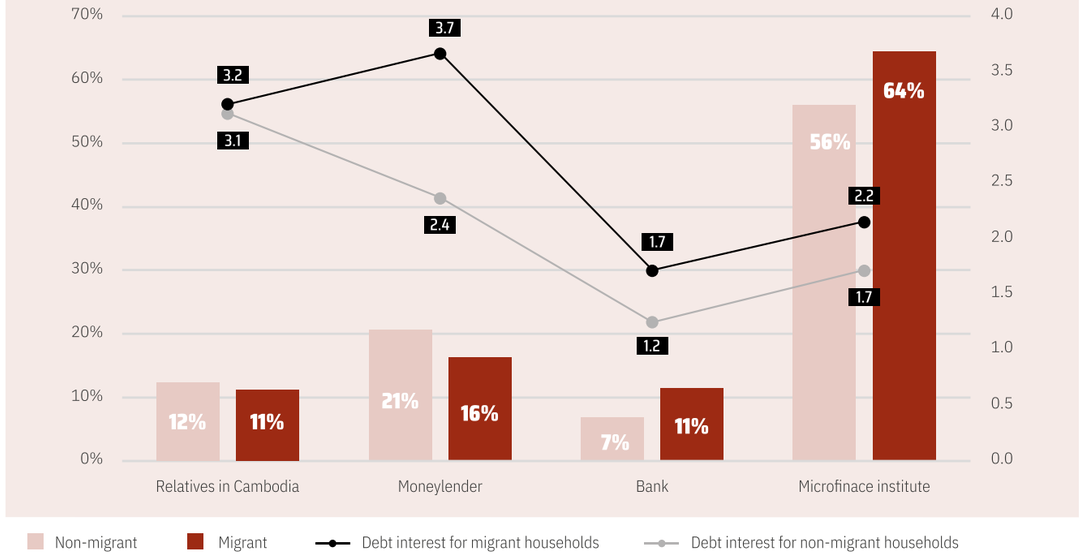
Among the households interviewed, 57 percent indicated that they were paying off household debts. Household debt was common among both migrant and non-migrant households, with 61 percent of non-migrant households and 54 percent of migrant households having debt. The average amount of debt and outstanding loan was USD$2,802 and USD$1,651. The average amount of debt and outstanding loans for non-migrant households was slightly higher than that of migrant households, but such differences were not statistically significant. Households with both parents-migrants had the highest average amount of debt and households with father-migrants had the highest average amount of outstanding loans.

Figure 14— PERCENTAGE OF HOUSEHOLDS WITH DEBT AND AMOUNT OF DEBT (USD)



Overall the major channels from which households obtained loans was microfinance institutions and moneylenders (63% and 17% respectively). The percentage of borrowing money from the bank or microfinance institutions among migrant households was significantly higher than the percentage in non-migrant households.

Figure 15— MAIN SOURCE OF DEBT AND DEBT INTEREST

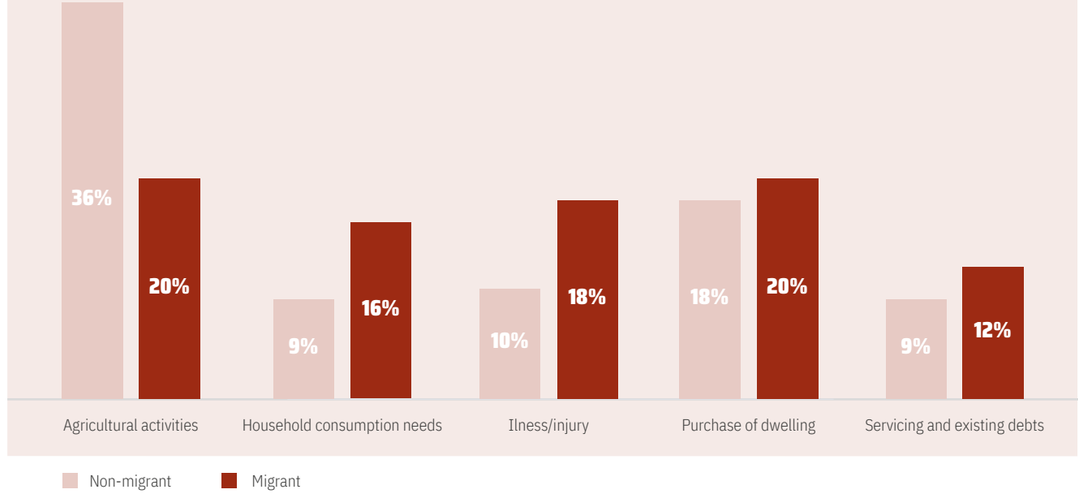


Although the main sources of debt for migrant households were similar to non-migrant families, migrant households tended to take out loans with higher interest compared to non-migrant households. This was likely due to the lenders compensating for a perceived risk of default on repayments, based on the fact the loans were predominantly taken out for expenses rather than for income generating activities. Longer-term loans also attracted higher interest rates.

3.5.b. Reasons for indebtedness

The top three reasons for a loan were agricultural activities (22%), purchase/improvement of dwelling (19%), and illness, injury (17%). The percentage of non-migrant households that borrowed money for agricultural activities was significantly higher when compared to migrant households (36% vs 20%), while migrant households had a significantly higher percentage of borrowing money for illness or injury (18%) than the prevalence among non-migrant households (10%).

Figure 16— THE PRIMARY REASONS FOR WHICH HOUSEHOLD BORROWED THE MONEY

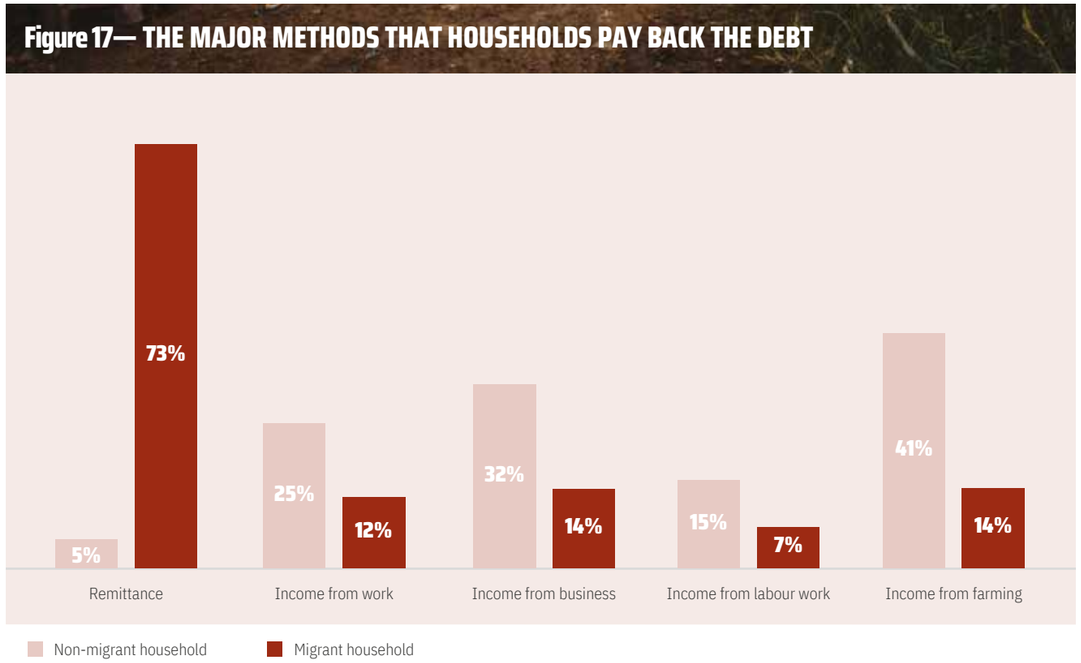


3.5.c. Methods of repayments

Overall, the top three main options for repaying debt were remittances (62%), income from farming (18%) and income from business (16%). A significant difference was observed in the method of repayments between non-migrant and migrant households (see Figure 17). Seventy-three percent of migrant households used remittances to pay back loans with the remaining house-

holds using income generating or business activities to make repayments. In contrast, non-migrant households exclusively used income generating activities and their business as the source of debt repayment.

Figure 17— THE MAJOR METHODS THAT HOUSEHOLDS PAY BACK THE DEBT

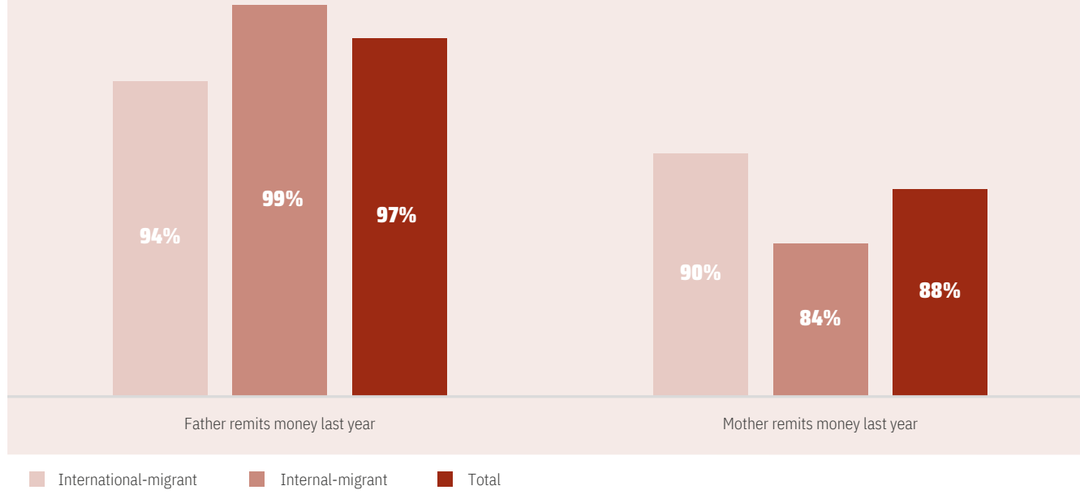


3.6. REMITTANCES FROM MIGRANT PARENTS

3.6.a. Regularity and amount of remittances

Among migrant households interviewed, the percentage of father-migrants who remitted money to the household during the past 12 months was 97 percent, which was noticeably higher than the prevalence among mother-migrants (88%). Father-international-migrants were more likely to send money with the rate as high as 99 percent while only 84 percent of mother-international-migrants remitted money.

Figure 18— PREVALENCE OF SENDING REMITTANCE IN THE LAST YEAR



Across all migrant-parent types, sending back remittances monthly was the predominant pattern (father-migrant: 69%; mother-migrant: 65%; both-parents-migrant: 76%).

TABLE 23— THE FREQUENCY OF SENDING REMITTANCES

The frequency of sending remittances (%)	Father-migrant households	Mother-migrant households	Both-parents-migrant households
Monthly	68.92	65.45	76.37
Every three months	13.39	21.84	12.07
Every 6 months	3.75	2.43	3.93
One a year	3.83	1.73	2.44
Other	11.1	8.56	5.2
Total	100	100	100

The average amount of remittances received for father-migrant households in the last year was USD$1,340, whereas the amount for mother-migrant and both-parents-migrant households was USD$750 and USD$1,096, respectively. Table 24 further breaks down remittances amount disaggregated by migration destinations. International mother- and both-parents-migrant groups sent a significantly higher amount of remittances compared to internal mother- and both-parents-migrant.

TABLE 24— AMOUNT OF REMITTANCE SENT IN THE LAST YEAR BY MIGRANT TYPES (USD)

Amount of remittance Mean (SD)	**Internal-migrant**	**International-migrant**	**Total**	**p-value**
Remittances from father-migrant	1265.48 (1425.73)	1421.85 (1693,75)	1341.85, (1616,63)	0.227
Remittances from mother-migrant	572.33 (548.33)	1033.06 (1534.45)	752.03 (1139.24)	0.001
Remittances from both-parents-migrant	673.09 (724.53)	1426.59 (1321.89)	1172.67 (1252.17)	<0.0001

Note. S.D. = standard deviation

3.6.b. Use of remittances

Participants were asked to select the top three main uses of the remittances. Remittances sent to families were often used for extra food (69%), more frequent or better-quality medical care (57%), and children's education (53%). There was a gender difference in use of remittances, with mother-migrant households they were 30 percent more likely than father-migrant households to use their funds for children's education. The ILO-IOM survey[59] also reported a higher percentage remittance use for children's education for female-migrant than males. A previous survey by UNICEF[60] found that the highest proportion of Thailand households used remittances on children's education (93%), food/clothes/household consumption (92%), and food for children (70%). The difference in the use of remittances between the two countries may reflect different economic profiles of general and migrant populations within the two countries, with Cambodian migrant households more likely to spend remittances on subsistence expenses as noted by common expenditure on extra food.

59. Risks and rewards: Outcome of labour migration in South-East Asia, ILO-IOM 2017, available from <https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_613815.pdf>.

60. Jampaklay, A., Vapattanawong, P., Tangchonlatip, K., Richter, K., Ponpai, N., & Hayeeteh, C. (2012). Children living apart from parents due to Internal Migration (CLAIM). Institute for Population and Social Research, Mahidol University, & UNICEF Thailand.

3.6.c. Perceived impact of migration and remittances

More than half of the households reported that their disposable income became much higher or higher when they were receiving remittances. Over 70 percent of children benefitted from parental migration by having higher school attendance. Remittances sent from migrants also contributed to a household's ability to afford food and diet. Further discussion on the potential positive impact of remittances on better dietary diversity for children in migrant households can be found in the following chapter.

Additionally, 66 percent of households perceived an increasing ability to afford medical care after receiving remittances. Remittances makes little change in saving money or investment but had a significant role in keeping children enrolled in school longer.

TABLE 25— PERCEIVED IMPACT OF MIGRATION AND REMITTANCES

Perceived impact of migration (%)	Disposable income	Children's school attendance	Number and value of household assets	Ability to afford food	How has your diet changed?	Ability to afford medical care / medication
Much higher	8.33	11.64	5.84	4.24	3.92	6.02
Higher	45.47	59.6	24.25	52.29	46.91	58.16
Same	39.02	25.39	65.63	39.14	45.46	29.29
Lower	6.8	2.97	3.37	3.94	3.32	5.89
Much lower	0.38	0.38	0.91	0.39	0.39	0.63
Total	100	100	100	4.24	3.92	6.02

Perceived impact of remittances (%)	Yes
Did anyone in your household open a bank/Microfinance Institute account specifically as a result of remittances?	4.49
Did anyone in your household open a store or small business, specifically as a result of remittances?	4.75
Have remittances enabled you to keep your child enrolled in school for longer?	83.76

Insights from Qualitative Interviews

Although this survey data showed that for many families their financial status had significantly improved due to parental migration, the qualitative interview findings with left behind caregivers and children in the villages indicated that migration did not necessarily alleviate a family's financial burden. Sufficient funds for basic needs may still be lacking in such families.

The qualitative interviews also highlighted how remittances were generally spent on food, medical needs, education and paying off debt, although the use of remittances varies within families. Although families often would spend remittances on children's education, some cases reported that they were not able to finish their study because of the financial challenges as illustrated below.

Caregiver's Voice

One grandparent described the continuing hardship in their family, despite the financial remittances they received:

"I spend [money] on rice, food, everything. No money left. It is not really enough for even the food. I spend on medicine for the grandchildren when they are sick, when seeing a doctor, and on clothes and for school".

Female Caregiver,
50 years old, Both-parents-international-migrant household

Another caregiver said that money sent back varies each month and their family still lacks sufficient food:

"Not at all, we still starve. . . Sometimes I owe the other money because I do not have money for the food. [It is] not enough, because the need never ends."

Female Caregiver,
56 years old, Both-parents-international-migrant household

4. Illness Profiles and Health Seeking Behaviors

KEY SUMMARY

The average number of family members who experienced any form of illness in the 30 days prior to the survey was higher among migrant families compared to non-migrant families.

During 30 days prior to the survey, more children reported being sick within the migrant households compared to children living in non-migrant households.

The percentage of family members injured in the past 12 months among migrant household was 9 percent, which was significantly lower than non-migrant households.

The general pattern of utilization of health care facilities was similar among non-migrant and migrant households: the private sector was more commonly used than public health services.

The costs associated with medical treatment for sick children were significantly higher in migrant households compared to non-migrant households, but there was no difference in cost for sick adults.

4.1. ILLNESS AND UTILIZATION OF HEALTHCARE SERVICE

4.1.a. Illness profiles of households

Around 88 percent of migrant household members had been sick in the 30 days prior to the interview, which was slightly higher than the prevalence in non-migrant households (84%). The average number of family members who experienced any form of illness in the 30 days prior to the survey was higher among migrant families compared to non-migrant families. Specifically, more children reported being sick within the migrant households, compared to children living in non-migrant households, in both age cohorts. The prevalence of illness reported by this study was much higher when compared to the prevalence of illness in the national sample (13%, DHS, 2014).[61] The percentage reported by DHS may be underrepresented as questions were asked only about household members residents in the past 24 hours from the time of the interview. Furthermore, secondary data specific to the age profiles in the current study is not available for direct comparison.

61. National Institute of Statistics & Directorate General for Health, Cambodia. Cambodia Demographic and Health Survey 2014. Available from <https://dhsprogram.com/pubs/pdf/FR312/FR312.pdf>.

TABLE 26— THE PREVALENCE OF ILL AND THE AVERAGE NUMBER OF SICK FAMILY MEMBERS

Illness profiles (In the last 30 days)	Non-migrant household	Migrant household	Full sample	p-value
Any member is sick in the household (%)	84.2	87.14	86.7	0.221
Average number of sick household members (mean)	2.12	2.48	2.43	0.001
Average number of sick adults (mean)	1.55	1.43	1.44	0.082
Average number of sick children (mean)	1.39	1.80	1.75	<0.0001
Younger child cohort	1.44	1.70	1.66	0.003
Older child Cohort	1.33	1.95	1.87	<0.0001

Note. The chi-square test applies to the categorical variable and t-test applies to the continuous variables.

4.1.b. Utilization of health care facilities when having an illness

Small differences in the patterns of health care use were observed, with the private sector used most often overall, followed by the public sector, and then the non-medical sector. In general, 87 percent of households that experienced illness sought medical services from the private sector at least once, while 21 percent of households used public medical resources. The percentage of utilization of non-medical services among migrant households was significantly higher (8%) than among non-migrant households (2%). Within the public sector, health centers were used most commonly for the treatment of adult illness (13%). Within the private sector, private pharmacies were most often visited for treatment among sick adults (31%), followed by private clinics (24%). Within the non-medical sector, shops or market and the traditional village healer were the main choices for a small percentage of sick adults.

TABLE 27— PREVALENCE AND TYPE OF TREATMENT AMONG SICK ADULTS BY HOUSEHOLD TYPES

Utilization of medical service among adults (%)	Non-migrant households	Migrant households	Full sample	p-value
Use public service	24.50	20.71	21.24	0.427
Use private service	91.34	86.17	86.89	0.222
Use non-medical service	1.71	8.10	7.21	0.006
Use overseas service	0.00	0.30	0.26	0.425
The place of treatment among adults (%)				
Public sector				
Health center	13.73	12.98	13.08	0.832
Provincial hospital	7.65	3.41	4	0.117
District hospital	4.21	3.06	3.22	0.595
Private sector				
Private pharmacy	35.97	29.98	30.82	0.149
Private clinic	27.8	23.49	24.09	0.218
Home/Office of trained health worker	16.99	21.47	20.84	0.06
Non-medical sector				
Other service	0.37	3.75	3.28	0.0004
Shop/market stall selling drugs	1.34	3.11	2.87	0.259
Traditional village healer	0	1.29	1.11	0.343

Note: Percentages could sum to greater than 100 because a person could use multiple types of treatment.

Services provided by the private sector were more commonly used (87%) than treatments provided by the public sector (24%) for sick children. No significant difference in the pattern of treatment types was observed between non-migrant and migrant households. Similar to adults experiencing illness, health centers were the first choice for treatment among the public sector, and private pharmacies were most commonly used among the private sector for children who were sick. The frequency of visiting the home/office of trained health worker (24%) was significantly higher among children from migrant households than among children from non-migrant families (13%). In summary, Cambodian households rely primarily on medical services provided by the private sector. This pattern was consistent with Cambodia DHS (2014)[62] data which showed that private sector providers were the first point of utilization for health care needs followed by government health system.

62. National Institute of Statistics & Directorate General for Health, Cambodia. Cambodia Demographic and Health Survey 2014. Available from <https://dhsprogram.com/pubs/pdf/FR312/FR312.pdf>.

TABLE 28— PREVALENCE AND TYPES OF TREATMENT AMONG SICK CHILDREN BY HOUSEHOLD TYPES

Utilization of medical service among children (%)	Non-migrant households	Migrant households	Full sample	p-value
Use public service	26.13	24.12	24.4	0.604
Use private service	83.45	88.05	87.41	0.194
Use non-medical service	6.42	7.64	7.47	0.474
The place of treatment among children (%)				
Public sector				
Health center	19.61	20.53	20.41	0.813
Provincial hospital	2.87	1.89	2.03	0.451
National hospital	2.75	0.86	1.12	0.039
District hospital	1.03	1.48	1.42	0.248
Private sector				
Private pharmacy	31.42	31.47	31.46	0.989
Private clinic	26.13	25.73	25.78	0.911
Home/Office of trained health worker	13.34	23.98	22.52	<0.0001
Non-medical sector				
Other service	3.45	4.65	4.49	0.418
Shop/market stall selling drugs	2.84	2.44	2.5	0.734
Traditional village healer	0.13	0.57	0.51	0.159

4.2. EXPENDITURES FOR HEALTH CARE

The overall average cost of medical treatment for sick adults and child(ren) in the households in the last 30 days was USD$27 and USD$61, respectively. There was no significant difference between the average medical expenditure for sick adults, however the costs associated with medical treatment for sick children were significantly higher in migrant than in non-migrant households (USD$28 vs USD$17).

This study also asked about how health expenditure for sick adults/children in the household had been financed as health care in Cambodia is largely fee-based. For non-migrant households, the two major sources of money spent on health care were wages or income and savings, similar to DHS data.[63] For migrant households, remittances were a main source of medical care expenditure. Migrant households had a slightly higher prevalence of taking out a loan than non-migrant households. Migrant households may increase dependence on loans if someone falls ill. Only around 2 percent of migrant households used money from a health equity fund, less than non-migrant households (3 and 4 percent for adults and children, respectively).

63. National Institute of Statistics & Directorate General for Health, Cambodia. Cambodia Demographic and Health Survey 2014. Available from <https://dhsprogram.com/pubs/pdf/FR312/FR312.pdf>.

TABLE 29— SOURCES OF MEDICAL CARE EXPENDITURE BY MIGRANT STATUS OF HOUSEHOLDS

How were health care expenditures for the sick adult(s) financed? (%)	Non-migrant households	Migrant households	Full sample	p-value
Health equity fund	3.65	2.03	2.26	0.138
Wage/income of family member	94.94	45.07	52.03	<0.0001
Remittance	13.22	55.02	49.18	<0.0001
Loan	7.38	10.95	10.45	0.282
Savings	94.96	94.97	94.97	0.994
How were health care expenditures for the sick child(ren) financed? (%)				
Health equity fund	2.58	2.2	2.25	0.717
Wage/income of family member	91.08	28.32	36.95	<0.0001
Remittance	24.56	70.09	63.82	<0.0001
Loan	8.22	11.54	11.09	0.345
Savings	93.97	97.54	97.05	0.004

Note: The categories are not mutually exclusive as respondents could select multiple responses.

4.3.
INJURY AND UTILIZATION OF HEALTHCARE SERVICE

4.3.a. Injury profiles of households

The percentage of family members injured in the previous 12 months prior to the survey among non-migrant households (14%) was significantly higher than among migrant families (9%). The proportions of different types of accident can be found in the Appendix (Table 4). Road accidents account for the greatest proportion of accidental injuries in both non-migrant and migrant households. This result is consistent with the finding of DHS (2014):[64] 7 in 10 injuries or deaths in Cambodia were attributed to road accidents. Beyond this similarity, there are differences in terms of the type of accidents between the non-migrant and migrant households. Within migrant families, 12 percent of injuries were the result of a fall from tree or buildings, while no similar case occurred among the non-migrant households. Five per cent of injuries among the non-migrant households were caused by violent assault, whereas there were only a few such cases in migrant households. There were only 13 households who reported the cost of the medical treatment for injured family members. The average medical cost for these few cases was USD$746, a high sum especially considering local economic conditions.

64. National Institute of Statistics & Directorate General for Health, Cambodia. Cambodia Demographic and Health Survey 2014. Available from <https://dhsprogram.com/pubs/pdf/FR312/FR312.pdf>.

Insights from Qualitative Interviews

The qualitative interviews provided further insight about how parents' migration may facilitate better access to health care and treatment, which supports the idea that higher expenditures on health services will be observed within households of migrants.

Children's Voice

Interviewer: *Your grandma always takes care of you and other grandchildren, how is her health?*
Child: *She was always sick before, but she is well now*
Interviewer: *She was sick before, now she is well!*
Child: *Before, younger sister and I always got sick too, but now we are well*
Interviewer: *You were sick together?*
Child: *We got cold*
Interviewer: *Oh, every time, you got sick, did grandma call your mother?*
Child: *Yes. She did. My mother sent money to buy medicine. We took medicine, we didn't get an injection*
Interviewer: *Did your mother come back when you got sick?*
Child: *When she came to visit, if we get sick, she brought us to a hospital for giving an injection*

Girl,
12 years old, Kandal, Both-parents-internal-migrant

5. Household Food Security

KEY SUMMARY

Nearly 6 percent of interviewed households reported experiencing moderate to severe hunger.

Migrant households had higher consumption-based coping strategies scores (CSI), indicating more frequent and severe coping strategies used to tackle food insufficiency, defined as a period when the household faced a food shortfall or insufficient money to purchase food in the past seven days.

Children in migrant households were more likely to borrow food and reduce the number of meals or reduce portion size of meals when their households had insufficient food.

The general pattern of using livelihood coping strategy in non-migrant and migrant households was similar, but migrant households were more likely to withdraw their children from school temporarily or sell their household goods due to food insufficiency.

5.1. HOUSEHOLD HUNGER SCORE

According to classification method mentioned in the above section, households were further classified into three groups: little to no hunger, moderate hunger, and severe hunger. Overall, only 6 percent of sampled households experienced moderate hunger, and less than 1 percent suffered from severe hunger. Table 30 describes the status of household hunger by migrant status of households. The percentage of households that reported little to no hunger were around 94 percent for both non-migrant and migrant households.

TABLE 30— HOUSEHOLD HUNGER BY HOUSEHOLD TYPES

Hunger (%)	Non-migrant households	Migrant households	Full sample	p-value
Little to no hunger	93.84	94.04	94.01	
Moderate hunger	5.9	5.59	5.64	0.929
Severe hunger	0.26	0.37	0.36	

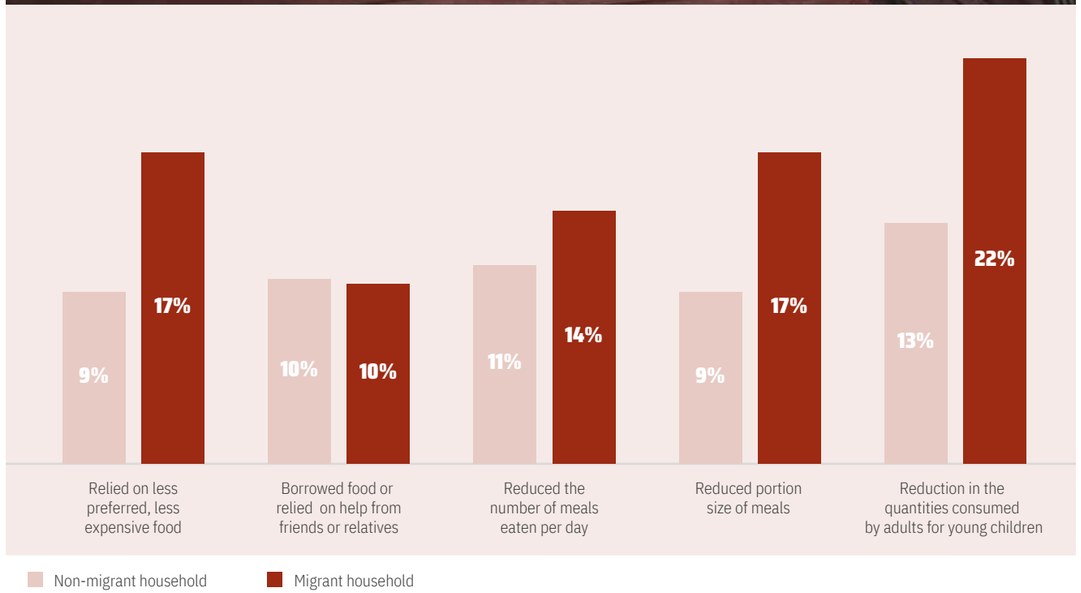
5.2. CONSUMPTION-BASED COPING STRATEGY

The Coping Strategy Index (CSI) was used to measure how households maintained access to food or reduced food consumed when households were not able to have sufficient food. A higher CSI score indicated a higher utilization of consumption-based coping strategies. Migrant households had significantly higher CSI scores than non-migrant households ($t = -2.26$, $p = 0.029$), while both parents-migrant households had the highest CSI score.

As shown in Figure 19, the most prevalent coping strategy used was reduction in quantities consumed by adults to allow more food for young children (21% of households), followed by relying on less preferred or less expensive food (16% of households) and reducing portion size of meals (16% of households).

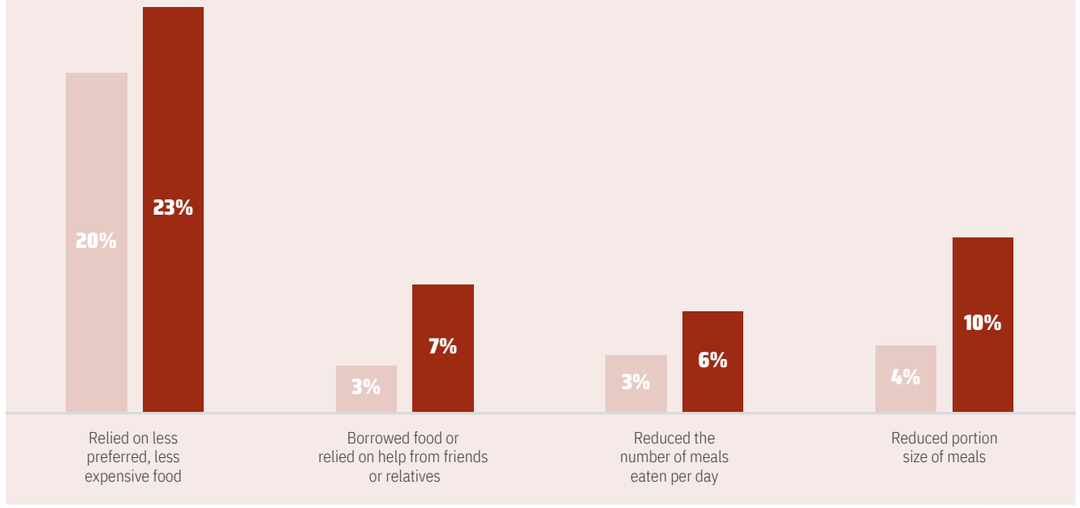
Migrant households tended to reduce portion size of meals or reduced adult portion sizes to accommodate feeding young children. When compared to non-migrant households, migrant households were more likely to use the coping strategies mentioned above.

Figure 19— ADULTS-INVOLVED CONSUMPTION-BASED COPING STRATEGY



Children were also involved in the specific consumption-based coping strategy in a few households. Figure 20 compares the prevalence of child-involved strategies in non-migrant and migrant families. The most common consumption-based coping strategy was relying on less preferred or less expensive food for both non-migrant and migrant households. Children in migrant households tended to receive borrowed food, reduced number of meals or reduced portion size of meals more so than their counterparts in non-migrant households. In summary, adults and children were more vulnerable to food insecurity in migrant households with noted increase in the frequency of consumption-based coping strategies used.

Figure 20— CHILDREN-INVOLVED CONSUMPTION-BASED COPING STRATEGY



5.3. LIVELIHOOD COPING STRATEGY

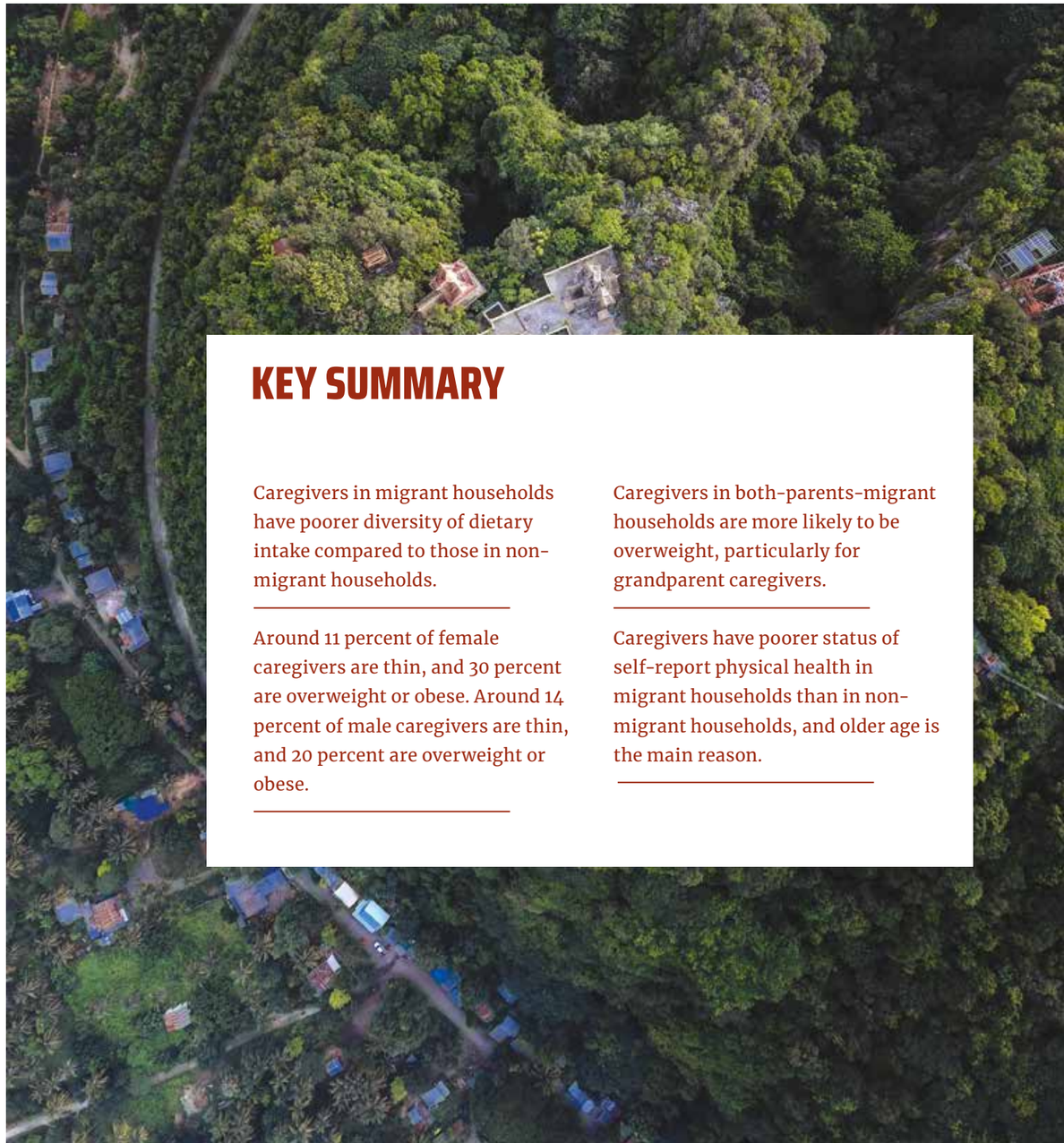
Livelihood coping strategy refers to the household's experiences with livelihood stress and asset depletion in the past 30 days prior to the survey. All strategies were classified into three groups: stress, crisis and emergency strategies (see details in Chapter 1 Introduction). Overall, when the household experienced food insufficiency, around 36 percent of the households adopted a stress livelihood coping strategy including spending savings or borrowing money, while 27 percent of households sold their productive assets such as household goods. Only three percent of households used emergency strategies which could have longer-term negative effects on their future financial security and productivity (e.g. selling land). The distribution of strategies for migrant families was similar to that for non-migrant households.

The most frequently used strategies included borrowing money, reducing essential-non-food expenditures, or spending savings for both non-migrant and migrant households. In the circumstance of facing food insufficiency, migrant households had higher likelihood to withdraw their children from school temporarily or sell their household goods.

5.4. HOUSEHOLD FOOD EXPENDITURE

There are two categories of household food expenditure, oil and fat, as well as sugar, salt and spice condiments, including those purchased in cash, personal production, wages in-kind, gift, and free collections (see details in Table 5 in the Appendix). The total food expenditure for migrant households, specifically the cost on sugar, salt and spices condiment, was significantly higher than the expenditure for non-migrant households in the past 30 days.

6. Nutritional Status and Physical Health of Adult Caregivers



KEY SUMMARY

Caregivers in migrant households have poorer diversity of dietary intake compared to those in non-migrant households.

Around 11 percent of female caregivers are thin, and 30 percent are overweight or obese. Around 14 percent of male caregivers are thin, and 20 percent are overweight or obese.

Caregivers in both-parents-migrant households are more likely to be overweight, particularly for grandparent caregivers.

Caregivers have poorer status of self-report physical health in migrant households than in non-migrant households, and older age is the main reason.

6.1.
CAREGIVER'S DIETARY DIVERSITY

The Dietary Diversity Scale was used to measure the quality of diet by assessing the range ('diversity') and volume of food consumed in the 24 hours prior to the survey. Examples of food groups: cereals and tubers (e.g. rice), pulses and legumes (e.g. bean sprouts), green leafy vegetables and animal and fish protein. Dietary diversity scores were calculated by adding the number of food groups consumed by the individual respondent over the 24-hour recall period. Individual dietary diversity scores aimed to reflect the macro and micro nutrient adequacy of the diet.

Overall, caregivers in migrant households had lower scores of dietary diversity when compared to those in non-migrant households ($p < 0.0001$) (a detailed table for mean scores of caregiver's dietary diversity by gender and age groups can be found in the Table 6 in the Appendix). After adjusting for caregiver age and gender (see details in Table 7 in the Appendix) caregivers in either father-migrant, mother-migrant, and both-parents-migrant households were more likely to have poorer dietary diversity ($\beta = -0.54$, $p < 0.0001$; $\beta = -0.53$, $p = 0.003$; $\beta = -0.58$, $p < 0.0001$, respectively). Whilst remittances may lead to greater purchasing power and greater diversity of household food baskets, this did not automatically translate to better dietary diversity for all left behind members of migrant household. The elderly caregivers did not appear to be consuming diverse food groupings reflecting macro and micro nutritional deficits. This is reflected in the next section on nutritional status.

6.2.
CAREGIVER'S NUTRITIONAL STATUS

Overall, 11 percent of caregivers were classified as thin, 30 percent as overweight or obese. Figure 21 reports the nutritional status by caregivers' age groups. The percentage of overweight and obese caregivers aged below 60 were both significantly higher in migrant households than in non-migrant households. Gender differences were observed in nutritional status: female caregivers were more likely to be overweight than male caregivers. Caregivers aged below 60 showed a significantly lower percentage of being thin but higher prevalence of being overweight than elderly caregivers above 60. The prevalence of thinness among females aged 18 to 49 years old (8%), noticeably lower when compared to the rate among women aged 15 to 49 years (14%) reported by the DHS (2014).[65] However, the prevalence of those overweight was more consistent.

65. National Institute of Statistics & Directorate General for Health, Cambodia. Cambodia Demographic and Health Survey 2014. Available from <https://dhsprogram.com/pubs/pdf/FR312/FR312.pdf>.

Figure 21— NUTRITIONAL STATUS OF CAREGIVER BY AGE GROUPS

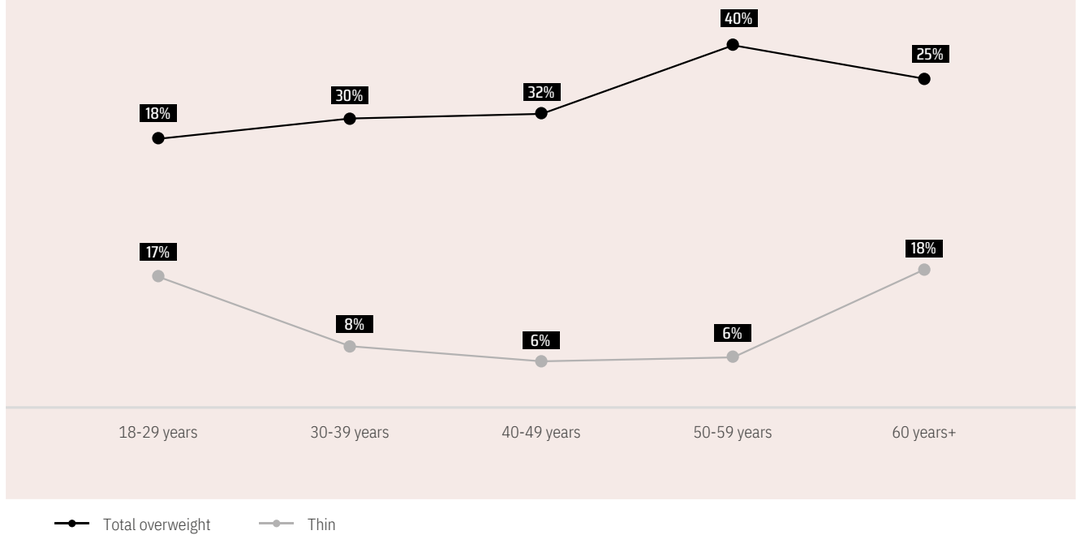


TABLE 31— CAREGIVER'S NUTRITIONAL STATUS BY GENDER AND AGE GROUPS IN NON-MIGRANT AND MIGRANT HOUSEHOLDS

Nutritional status (%)	Non-migrant households	Migrant households	Total	p-value
Thinness				
Total	8.42	11.74	11.25	0.301
Gender				
Female	8.62	11.52	11.08	0.365

TABLE 31— CAREGIVER'S NUTRITIONAL STATUS BY GENDER AND AGE GROUPS IN NON-MIGRANT AND MIGRANT HOUSEHOLDS

Nutritional status (%)	Non-migrant households	Migrant households	Total	p-value
Male	1.17	15	13.85	NA
Age groups				
18-59	7.23	8.25	7.99	0.749
60 and above	57.09	17.12	17.54	NA
Total overweight (overweight or obese)				
Total	22.89	31.08	29.86	0.026
Gender				
Female	23.52	31.58	30.35	0.033
Male	0	21.95	20.13	NA
Age groups				
18-59	23.45	35.02	32.47	0.007
60 and above	0	25	24.73	NA

After adjusting for caregivers' age and gender there was no significant association between migration and thinness of caregivers (see results in Table 8 in the Appendix). However, migration of both parents was still significantly associated with a higher prevalence of overweight (Odds ratio = 1.83, p = 0.07), particularly for grandparent caregivers in both-parents-migrant households (Odds ratio = 2.02, p = 0.005). Overweightness and obesity as forms of malnutrition were associated with several non-communicable diseases, which required public attention.

6.3. CAREGIVERS' PHYSICAL HEALTH

Caregivers' physical health was measured by the SF-12 Physical Health and Mental Health Scale. The SF-12 is a widely used quality of life instrument and the health component can capture a person's perceived health status, physical function, bodily pain and general health perceptions. Higher scores represent better self-reported health outcomes.

TABLE 32— CAREGIVER'S PHYSICAL HEALTH BY GENDER AND AGE GROUPS IN NON-MIGRANT AND MIGRANT HOUSEHOLDS

Physical health	Non-migrant households	Migrant households	Total	p-value
Total	43.73	39.67	40.28	<0.0001
Gender				
Female	43.83	39.64	40.28	<0.0001
Male	40.11	40.14	40.14	NA
Age groups				
18-59 years	43.59	41.13	41.68	0.002
60 and above	49.54	37.40	37.52	NA

Note. Given the sample size of males who were elderly above 60 in non-migrant households was small (n < 10), the test of group difference was not applicable to these two groups.

Caregivers in migrant families had significantly poorer self-reported health outcomes compared to caregivers in non-migrant families. There was no gender difference. Since caregivers in migrant households were significantly older than caregivers in non-migrant families, further analysis using adjusting for other factors such as age and gender was conducted (see results in Table 9 in the Appendix). Once this calibration was performed there was no significant difference in self-report physical health status of the caregivers. Overall, older age was the main risk factor associated with poorer physical health status.

Insights from Qualitative Interviews

While some elderly caregivers may be too fragile to work and earn their own living, others may still work on rice fields and raise chickens and other animals, making them breadwinners and caregivers at once. In many cases, grandparents had a hard time providing for the whole family, now that their grandchildren has become part of the household.

Caregivers' Voice

"Liv[ing] with my grandchildren [is] more difficult than when I lived only with my wife . . . since I have grandchildren, more eating, more clothes to wash, and more thing[s] to clean in the house . . . "

Grandfather Caregiver,
65 years old, Mother-internal-migrant, Battambang

"Looking after grandchildren is difficult, difficult to ask them for help, always shout at them. . . I am getting older and older cannot do anything and want their mum to return back; when I get older cannot cook rice and cannot do anything."

Grandmother Caregiver,
76 years old, Mother-international-migrant, Siem Reap

7. Child Growth and Development

KEY SUMMARY

Around 70 percent of children aged 6 to 23 months were receiving nutritional adequacy above the minimum for dietary diversity.

For the Younger Child Cohort aged 0 to 3, 19 percent were stunted, 9 percent were wasted, and 14 percent were underweight; for the Older Child Cohort aged 12 to 17, 25 percent were stunted and 11 percent were wasted.

Boys show disadvantages in nutritional status compared to girls, with a significantly higher rate of stunting in the Younger and the Older Child Cohort and higher prevalence of wasting in the Older Child Cohort.

For the Younger Child Cohort, children in migrant households were more likely to have higher scores of dietary diversity and early development, and better nutritional status compared to their peers in non-migrant households.

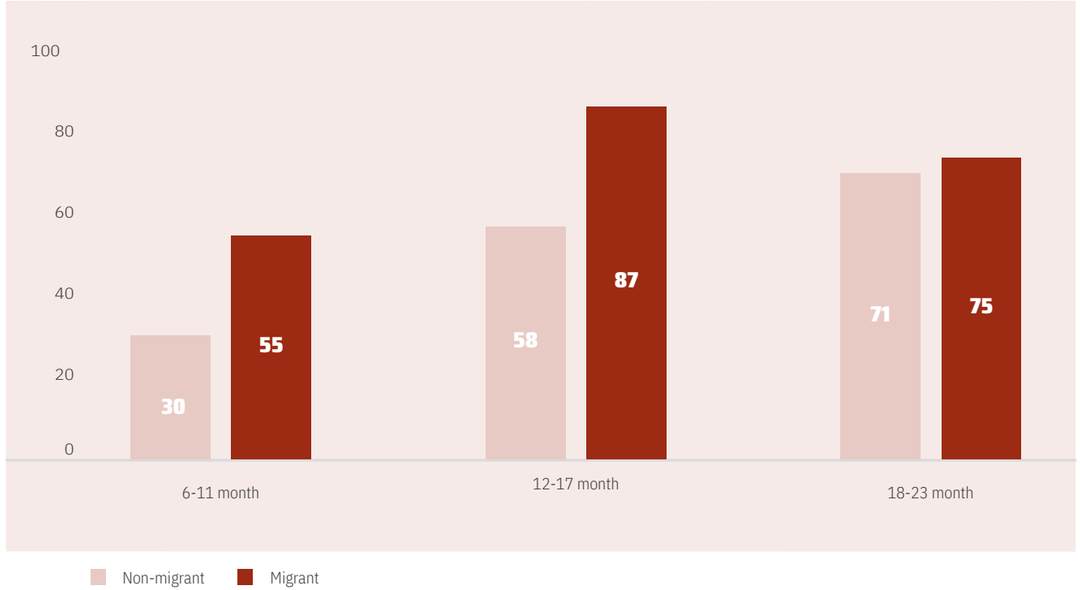
For the Older Child Cohort, children in migrant households had lower scores of dietary diversity: however, they were not worse off on other nutritional status measures compared to children in non-migrant households.

7.1.
CHILDREN'S DIETARY DIVERSITY

The Dietary Diversity Scale measures the quality of diet by assessing the range ('diversity') and volume of food eaten in the 24 hours prior to the survey. Dietary diversity scores were calculated by adding the number of food groups consumed by children according to their caregivers' recall.

Children's dietary diversity was measured by the Dietary Diversity Scale, but a different assessment method was applied for the Younger and Older Child Cohort. According to the Assessing Infant and Young Child Feeding Practices, scores of dietary diversity for infants 6 to 23 months of age were coded as a dichotomous indicators to indicate that infants were below or above the minimum dietary diversity cut-off, while continuous scores of the *Dietary Diversity Scale* were used as indicators of dietary diversity for the Older Child Cohort.

Figure 22— THE PERCENTAGE OF CHILDREN ABOVE MINIMUM DIETARY (6-23 MONTHS)



Overall, 70 percent of children's dietary intake was above minimum dietary diversity among the 0 to 3 years old. Children in migrant households showed a significantly higher proportion of minimum dietary diversity (75%) compared to those in non-migrant households (46%). There was no gender difference in terms of dietary diversity. Children in migrant households show advantages in dietary diversity among those aged 6 to 11 months. Adjusting for children's age and gender, children with both-parents-migrant or father-internal-migrant were more likely to have better dietary diversity. Detailed tables by gender and other adjusted factors were in the Appendix (Table 10).

For the Older Child Cohort, children in migrant households were more likely to have lower scores of dietary diversity. Specifically, girls and children aged 12 to 14 years old had significantly lower scores of dietary diversity when compared to their counterparts in non-migrant households. Multivariable regression models that adjust for children's age and gender show that having a non-parental caregiver (a grandparent or kinship caregiver) in both-parents-migrant and mother-migrant households was associated with children's lower scores of dietary diversity (see details in Table 11 in the Appendix).

The study highlights the importance of taking a child age into account when discussing the migration impact on children's dietary intake.

While the Younger Child Cohort appeared to benefit from parental migration, the Older Child Cohort showed disadvantages in dietary diversity.

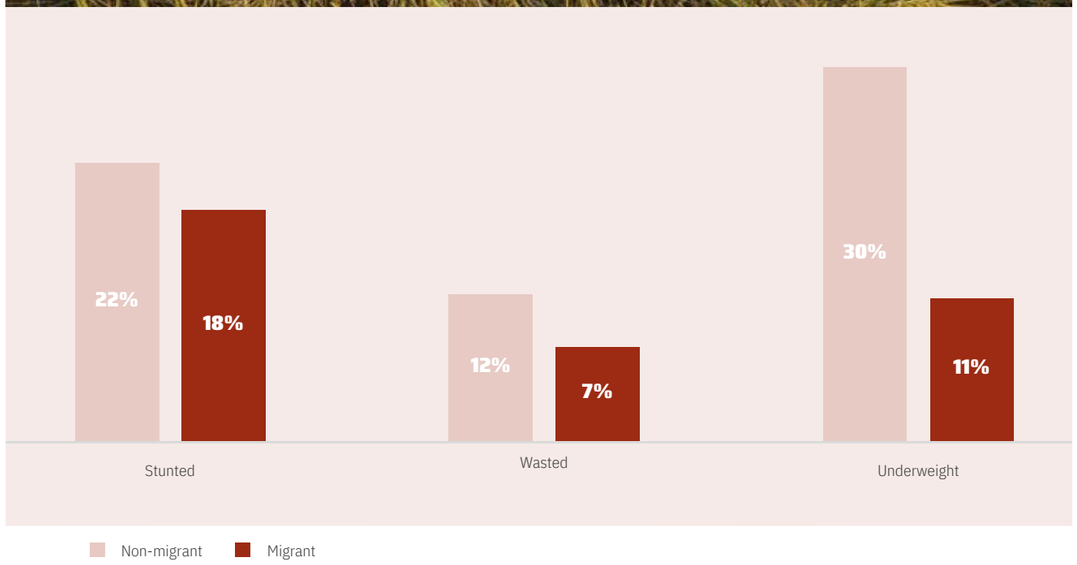
Female adolescents in migrant households were particularly vulnerable to nutritional inadequacy.

Whether the mother was involved in migration was a key determining factor in children's dietary diversity.

7.2.
CHILDREN'S NUTRITIONAL STATUS

Overall, 19 percent of sampled children under age three were stunted, nine percent were wasted, and 14 percent were underweight. In general, stunting increases with the age of the child, rising from 4 percent among children age 0-11 months to 26 percent among children age 24-35 months while wasted and underweight show a declining trend with age. Girls have a significantly lower percentage of stunting than boys (14% vs 23%). Children in migrant households were less likely to be underweight compared to those in non-migrant households (11% vs 30%).

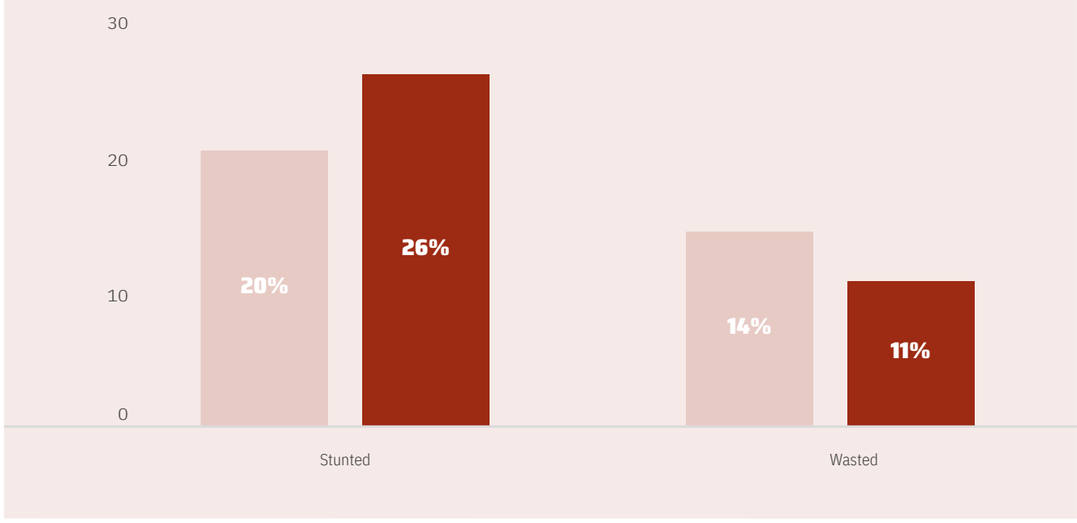
Figure 23— NUTRITIONAL STATUS OF CHILDREN BY HOUSEHOLD MIGRANT STATUS (0 TO 3 YEARS)



Multiple regression analysis accounting for children's age and gender highlights that children whose mother or both parents migrated were less likely to suffer from stunting and underweight (see details in Table 12 in the Appendix). In terms of migration destination, children of both-parents-international-migrant and father-internal-migrant were less likely to be stunted.

For children aged 12 to 17 years, the percent of stunting and wasting were 25 and 11, respectively. Boys in the older age cohort were more likely to experience stunting and wasting than girls. There were no significant differences in prevalence of stunting and wasting by migrant status of households (see details in Table 13 in the Appendix).

Figure 24— NUTRITIONAL STATUS OF CHILDREN BY HOUSEHOLD MIGRANT STATUS (12 TO 17 YEARS)

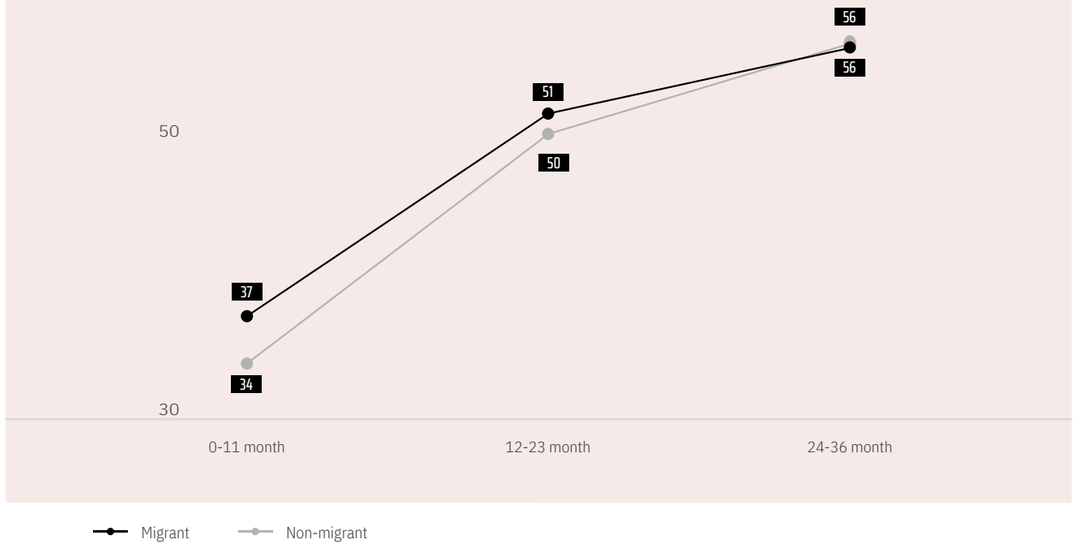


Adjusting for children's age and gender highlights that children in father-international-migrant households were more likely to suffer from stunting. Results regarding nutritional status show a similar pattern with findings of dietary diversity: children of migrant households in the Younger Child Cohort seem to show better nutritional status, while children of father-migrant households in the Older Child Cohort were more likely to be worse off on nutritional indicates.

7.3. CHILDREN'S EARLY DEVELOPMENT (YOUNGER CHILD COHORT)

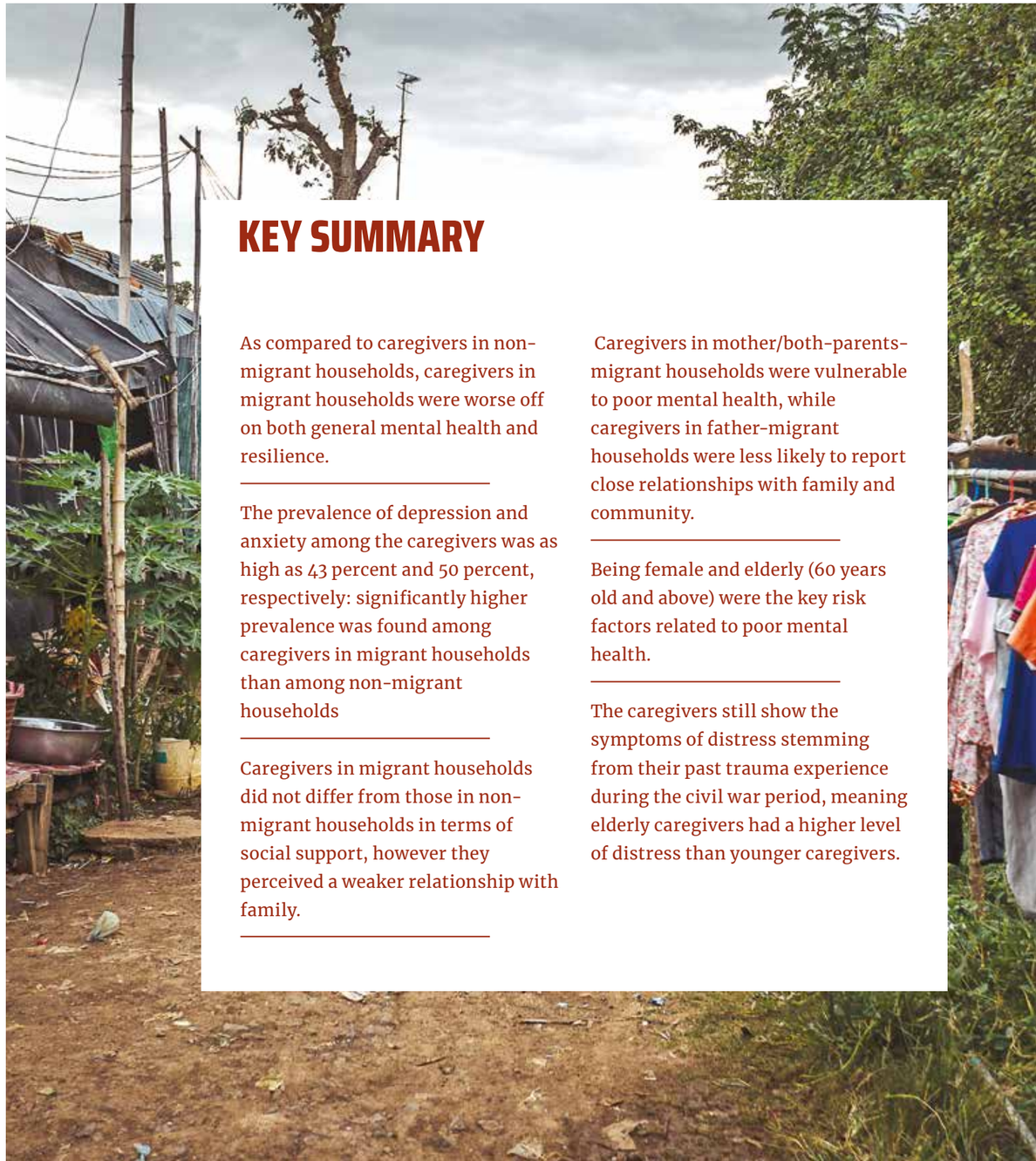
Caregiver-Reported Early Development Instruments (CREDI) Short-form measured children's early development status, including motor, cognitive, and socioemotional skills. A norm-referenced standardized score was generated based on the age-specific reference. Higher scores of CREDI indicate a better overall developmental status of children.

Figure 25— NUTRITIONAL STATUS OF CHILDREN BY HOUSEHOLD MIGRANT STATUS (0 TO 3 YEARS)



Children in migrant families had significantly higher scores of early development ($p < 0.0001$, details in Table 14 in the Appendix). Migration may offer benefits to infants below two years old, however, by age two these benefits were not apparent. Adjusting for child age and gender highlights that both-parents-migration and mother-migration were associated with higher scores of early development while father-migration was associated with better early development only when children were cared for by their mothers.

8. Mental Health and Social Support of Caregivers



KEY SUMMARY

As compared to caregivers in non-migrant households, caregivers in migrant households were worse off on both general mental health and resilience.

The prevalence of depression and anxiety among the caregivers was as high as 43 percent and 50 percent, respectively: significantly higher prevalence was found among caregivers in migrant households than among non-migrant households

Caregivers in migrant households did not differ from those in non-migrant households in terms of social support, however they perceived a weaker relationship with family.

Caregivers in mother/both-parents-migrant households were vulnerable to poor mental health, while caregivers in father-migrant households were less likely to report close relationships with family and community.

Being female and elderly (60 years old and above) were the key risk factors related to poor mental health.

The caregivers still show the symptoms of distress stemming from their past trauma experience during the civil war period, meaning elderly caregivers had a higher level of distress than younger caregivers.

Previous reports and studies of migration and its impacts in Cambodia mainly focused on the household's social-economic status with little emphasis on the impact on mental health in the context of parents' migration. Moreover, the conditions of caregivers of left behind children were not specifically addressed in previous migration studies in Cambodia. The literature review of past studies on migration and its impacts on mental health of left behind households showed negative impacts of international migration on general health issues and well-being of left behind families.[66,67] Grandparent caregivers and other-relative-caregivers showed higher odds of having common mental disorders in some Southeast Asia countries[68] and grandparent-caregivers might be especially vulnerable to anxiety and stress if they faced challenges of providing grandchild care.[69] Given the mixed results, this study examined whether or not the specific type of caregiver in migrant households (mother stay behind, grandparents/other-relative-caregivers) were vulnerable to poor mental health and decreased social support within the Cambodian context. To examine whether older age was a risk factor for caregivers' mental health and social support, mean scores were disaggregated by age cohorts (18 to 50 years or 60 years and above).

8.1. MENTAL HEALTH INDICATORS

8.1.a. General Mental health (SF-12)

Caregivers' general mental health was measured by the Mental Health Component of SF-12 Health Survey Version One (SF-12). A higher score indicates a better status of general mental health. There was a statistically significant difference between the means of general mental health, with significantly lower scores for caregivers in migrant households ($t = 3$, $p = 0.004$). No gender difference was observed. Elderly caregivers aged 60 years and above had poorer mental health than those below 60 years old ($t = -2.65$, $p = 0.01$).

After adjusting for caregiver age and gender, mother-migration, especially mother-internal-migration, was associated with poor mental health (see details in Table 15 in the Appendix). Specifically, mother-caregivers who stayed behind in father-migrant households and kinship-caregiver in mother-migrant households were more likely to have poor mental health ($\beta = -2.05$, $p = 0.043$; $\beta = -3.24$, $p = 0.015$, respectively).

66. Siriwardhana C, Adikari A, Pannala G, Siribaddana S, Abas M, Sumathipala A, Stewart R. Prolonged internal displacement and common mental disorders in Sri Lanka: the COMRAID study. PLoS One. 2013;8(5):e64742.

67. De la Garza, R. (2010) Migration, Development and Children Left Behind: A Multidimensional Perspective, UNICEF, Policy, Advocacy and Knowledge Management, Division of Policy and Strategy, New York.

68. Graham, E., Jordan, L.P. ,and Yeoh, B.S.A. (2015). Transnational family practices and the mental health of those who stay behind to care for children in South-East Asia. Social Science and Medicine 132: 225-235.

69. Knodel, John E., and Napaporn Chayovan. 2009. Population Ageing and the Well-Being of Older Persons in Thailand: Past trends, current situation and future challenges. UNFPA Thailand.

Qualitative interviews also found that caregiving may have had negative impacts on caregivers' mental wellbeing. The main themes regarding their feelings about caregiving experiences were "stress" and "difficult". One grandmother said:

"I am too tired to look after my grandchildren. Sometimes I feel I am fine to look after them, but sometimes I feel I am tired... When their parents are around here, I feel better. Once they get back to work, I have to look after their children."

Female Grandmother,
63 years old, Both parents-internal-migrant household

8.1.b. Anxiety and Depression Symptoms (Hopkins Symptoms Checklist - 25)

The Hopkins Symptoms Checklist-25 (HSCL) was used to evaluate whether interviewed caregivers were depressive or anxious. The prevalence of depression and anxiety for caregivers in migrant households was 45 percent and 53 percent respectively, which were significantly higher than among caregivers in non-migrant households. Female caregivers had a significantly higher prevalence of being depressed and anxious than male caregivers. Caregivers aged 60 and above were more vulnerable to depression and anxiety compared to those younger older caregivers. The prevalence of anxiety and depression reported by the Cambodian Mental Health Survey of RUPP in 2011 was 27.4 percent and 16.7 percent, respectively. It is possible there was an increasing trend in the prevalence of mental illness among Cambodian adults, which would require further study to better understand. Respondents of RUPP Survey were younger than the interviewed caregivers of this study, therefore older age (60 years and above) could be a risk factor for poor mental health observed in this study.

After adjusting for caregiver age and gender, mother-migration was associated with a higher prevalence of anxiety (adjusted odds ratio = 2.04, p = 0.001, see details in Table 16 in the Appendix) while only mother-internal-migration was associated with a higher risk of depression (adjusted odds ratio = 2.56, p = 0.001). Again, old age was found to be associated with the risk of being anxious.

Insights from Qualitative Interviews

Qualitative interviews revealed that grandparents expressed their worries about the household financial status, and wellbeing of their children who were migrant workers as well as their grandchildren.

Caregiver's voice

"Yes, I always worry if I died, who will take care [of] my grandchildren. If their mother takes care of them, how can she go to work and earn money to support the living? If . . . the eldest grandchildren stop the study and take care [of the] younger kid, what would be her future? I think about it every day. I hope my life could stay a bit longer until some of them grow up a bit, [then] I would be happy."

Female Grandmother,
63 years old, Mother-international-migrant household

8.1.c. Cambodian cultural symptoms of distress (Baksbat)

In order to account for the cultural-historical context, this study paid attention to culture-specific stress that caregivers' might have experienced during the civil war in Cambodia. Caregivers in migrant households, who mostly experience at least one traumatic event, had much higher scores on psychological distress than caregivers in non-migrant households ($t = 9.11$, $p < 0.0001$). The caregivers still show the symptoms of distress stemming from their past trauma experience, and this can partially contribute to their vulnerability and to the current poor mental health among ageing caregivers. After adjusting for caregiver age and gender, caregivers in mother-migrant and both-parents-migrant, particularly internal-migrant, continued to display higher levels of distress (mother-migrant: $\beta = 3.97$, $p = 0.039$; both-parents-migrant: $\beta = 3.29$, $p = 0.016$, see details in the Table 17 in the Appendix).

Insights from Qualitative Interviews

Qualitative interviews also highlighted the lasting effects of traumatic experiences on elderly caregivers. A few caregivers mentioned that physical and mental health issues stem from the Pol Pot regime.

One grandfather said that he suffered from stomach pain as a result of food deficiency and contracted malaria during the Pol Pot regime. Furthermore, his parents and siblings were killed during the atrocities, which, in his own words, "is still appearing in my mind",suggesting a need for ongoing treatment for post-traumatic stress disorder (PTSD) among some elderly.

Male Grandfather,
65 years old, Father-international-migrant household

8.1.d. Resilience

Resilience, as an indicator reflecting a positive aspect of caregivers' wellbeing, was measured by the 10-item Connor-Davidson Resilience Scale (CD-RISC). The mean score of resilience for caregivers in non-migrant households was statistically significantly higher than caregivers in non-migrant families ($t = 3.03$, $p = 0.011$). Elderly caregivers showed a significantly higher level of resilience when compared to younger caregivers below 60 years old ($t = -2.4$, $p = 0.021$). A similar pattern emerged after adjusting for caregivers' age and gender as for culture-specific trauma: caregivers in mother-migrant and both-parents-migrant had lower scores on resilience ($\beta = -1.66$, $p = 0.017$; $\beta = -1.07$, $p = 0.036$, respectively, see details in Table 18 in the Appendix). In particular, caregivers in international-mother/both-parents-migrant households were more likely to be worse off on resilience.

8.1.e. Social support

Three items selected from the Social Provisions Scale[70] evaluated the level of social support caregivers received. The level of social support did not differ by caregiver gender, age group, from migrant household or not. After adjusting for caregiver age and gender, other relative-caregivers in both-parents-migrant households were more likely to have decreased social support ($\beta = -0.79$, $p < 0.0001$, see details in Table 19 in the Appendix)

8.1.f. Relationship with family, community, and significant others

Respondents rated a Relationship Scale to describe how close were their relationships with family, community and significant other used in other similar studies in Cambodia. Respondents specified the significant other in their life. Caregivers in migrant households had significantly lower scores on the relationship with family than those in non-migrant households ($t = -2.44$, $p = 0.019$). When compared to males, females perceived a weaker relationship with the community ($t = -2.42$, $p = 0.019$) but a closer relationship with significant others ($t = 3.92$, $p < 0.0001$). After adjusting for caregiver age and gender, caregivers in father-migrant households display weaker relationships with family ($\beta = -0.26$, $p = 0.007$) as well as the community ($\beta = -0.49$, $p = 0.005$). Caregivers in mother-internal-migrant households and other relative caregivers in both-parents-migrant households were more likely to have weaker ties with the community ($\beta = -0.48$, $p = 0.007$; $\beta = -0.35$, $p = 0.022$).

70. Cutrona, C. E., & Russell, D. W. (1987). The provisions of social relationships and adaptation to stress. Advances in personal relationships, 1(1), 37-67.

Insights from Qualitative Interviews

The impacts on caregivers described were diverse, with some reporting increased stress and burden, others decreased conflict and arguments. Some caregivers also discussed positive social impacts of having a migrant child.

Caregivers' Voice

One grandmother described how the relationship with her migrated daughter had improved:

"Because she [migrated daughter] saw me take care of her kid . . . she loves me more than before."

She further described how her social status in the village also improved, as neighbors tended to admire her daughter, because she always brought back something for them.

Female Caregiver,
70 years old, Mother-internal-migrant household

Grandparents also discussed getting practical, financial, or emotional help from neighbors, who provided them with instrumental support such as transfers to the hospital, as well as emotional support. However, some caregivers also expressed worries about being stigmatized by others when they felt sad/upset about the circumstances, and one grandmother, a 72-year-old taking care of children of two international-migrant parents described how she was dependent on other people's generosity, so she did not want to display her stress.

9. Mental Health of Children (Older Child Cohort)

KEY SUMMARY

Based on child reports, children left behind were not worse off in terms of psychological well-being measured by the Strengths & Difficulties Questionnaire. In fact, children in father-migrant households exhibited more prosocial behaviors.

Based on caregiver reports, mother-internal-migration was associated with poor psychological wellbeing with increased total difficulties scores and reduced prosocial behaviors.

Parental migration, particularly international/cross-border migration, was associated with lower scores of child resilience.

Girls showed advantages on prosocial behaviors and resilience compared to boys.

9.1. CHILDREN'S WELL-BEING

Children's psychological wellbeing was measured by using the Strengths and Difficulties Questionnaire (SDQ), which was based on both children's and caregivers' rating.[71] The SDQ-total difficulties score was used to evaluate children's difficult dimensions while the score of pro-social behavior was used to indicate children's strengths.

There are no significant differences between the average total difficulties scores between children in migrant and non-migrant households (see details in Table 21 in the Appendix). After adjusting for children's age and gender children who were cared for by kin (other than grandparents) in father-migrant households were more likely to report lower levels of total difficulties (β = -2.7, $p < 0.0001$, see details in Table 22 in the Appendix). Results based on caregiver reports show a different pattern: mother-internal-migration was associated with higher scores of total difficulties (β = 1.84, $p = 0.012$), while mother-international-migration was associated with reduced total difficulties (β = -1.97, $p = 0.003$).

Mean scores of prosocial behavior subscale reported by children and caregivers for all children were similar (6.82 and 6.79, respectively, see details in Table 23 in the Appendix). According to children's reports, girls were more likely to have higher prosocial scores than boys ($t = 4.94$, $p < 0.0001$) but no significant difference was found by migrant status of households. However, caregivers' reports suggested that children in migrant households have more prosocial behaviors than their peers in non-migrant households for boys and children aged 15 to 17 years. After taking into account child gender and age (see details in Table 24 in the Appendix), children in father-migrant households, particularly those cared for by their mothers, displayed more prosocial behaviors regardless of who reported (Child report: β = 0.57, $p = 0.016$; Caregiver report: β= 0.74, $p = 0.015$, respectively). Children in both-parents-internal-migrant households were more likely to report prosocial behaviors (β = 0.48, $p = 0.047$). Despite differences between child and caregiver reports, in general children in migrant households were more likely to have higher scores on the prosocial subscales.

71. Goodman, R. 2001. Psychometric Properties of the Strengths and Difficulties Questionnaire. Journal of the American Academy of Child & Adolescent Psychiatry, Volume 40, Issue 11, 1337 – 1345.

9.2.
CHILDREN'S RESILIENCE

The Connor-Davidson Resilience Scale (CD-RISC 10) is the 10-item scale used to measure the resilience of children. Overall children in non-migrant households had higher scores of resilience compared to children in migrant households, and this was especially the case for girls and children aged 12 to 14 years (see details in Table 25 in the Appendix). Girls showed clear advantages in resilience over boys ($t = 3.19$, $p = 0.003$).

After adjusting for children's age and gender the destination of parental migration matters to children's resilience (see results in Table 26 in the Appendix): children in both-parents-migrant and father-migrant households were less resilient ($\beta = -0.85$, $p = 0.049$; $\beta = -1.92$, $p = 0.029$, respectively). Taking destination into account, children's resilience was worse off only when their mothers migrate internationally ($\beta = -2.83$, $p = 0.002$). Within both-parent-migrant households, children cared for by relatives rather than their grandparents showed disadvantages in resilience (other relative-caregivers: $\beta = -1.24$, $p = 0.029$).

Insights from Qualitative Interviews

Among the interviews with children 12 to 17 in the villages, the theme of worry about the health and well-being of their migrant parents and also about their grandparent caregivers was common.

Children's Voice

Child: I worry about my father who is sick, my grand-mother who has heart failure.

Boy,
14 years old, Battambang, Father-international-migrant

Interviewer: What do you worry about [your grandpa]?

Child: I am worried about his health.

Interviewer: Do you worry about your mom who travels a lot?

Child: I am worried about the traffic [accident]

Boy,
13 years old, Siem Reap, Both-parents-internal migrants

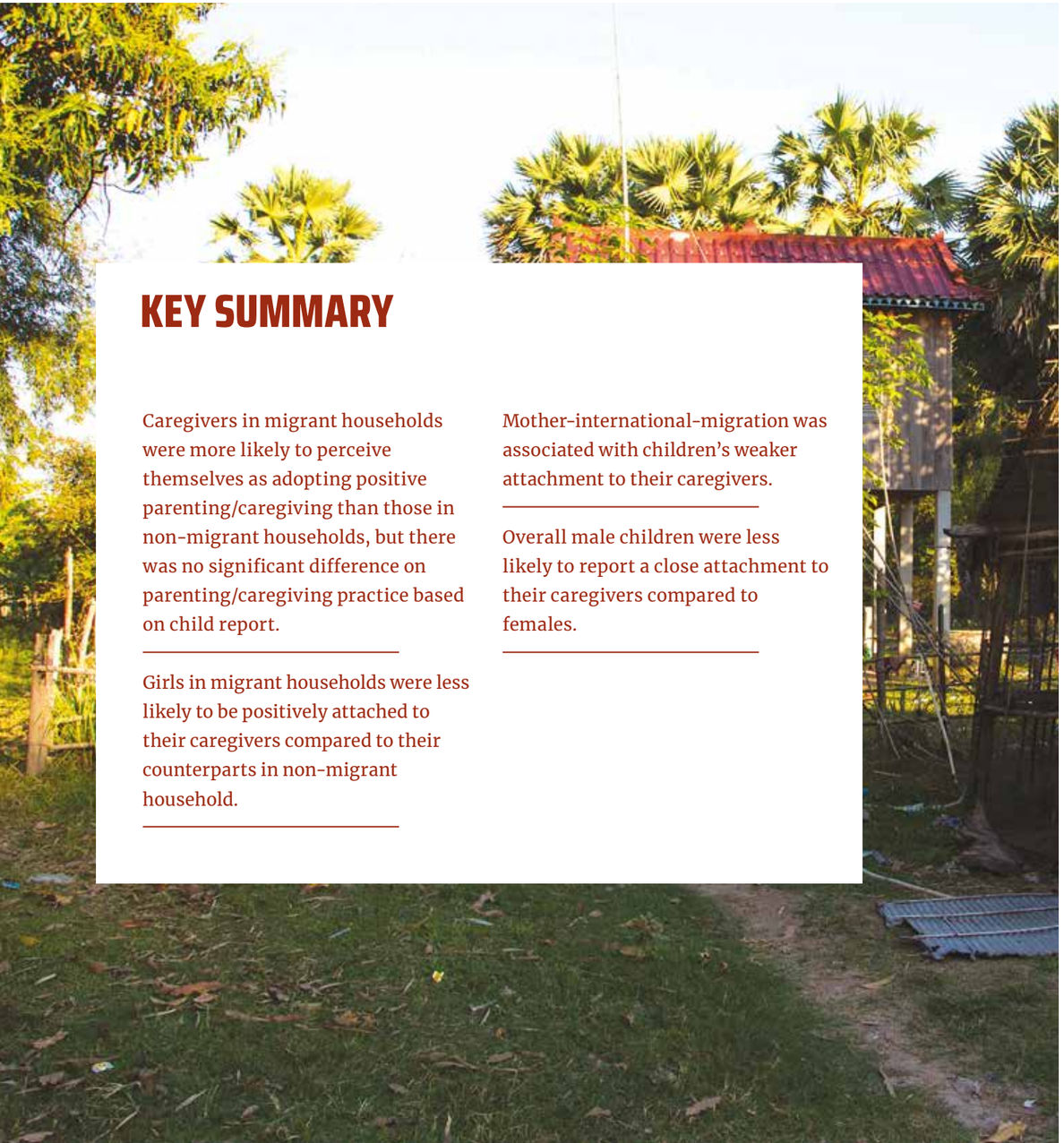
Child: I worry if he got sick and nobody looks after him.

Interviewer: Does he live alone there?

Child: Yes

Girl,
16 years old, Siem Reap, Both-parents-internal

10. Family functioning of children (older child cohort)



KEY SUMMARY

Caregivers in migrant households were more likely to perceive themselves as adopting positive parenting/caregiving than those in non-migrant households, but there was no significant difference on parenting/caregiving practice based on child report.

Girls in migrant households were less likely to be positively attached to their caregivers compared to their counterparts in non-migrant household.

Mother-international-migration was associated with children's weaker attachment to their caregivers.

Overall male children were less likely to report a close attachment to their caregivers compared to females.

10.1. PERCEPTION OF PARENTING PRACTICE

The family as a microsystem of individual development is an important determinant of child wellbeing. Migration can change family structure, dynamics and functioning, altering children's relations with their family members. Given the important role of family in child development, this study addresses the question of whether migration influences family functioning including parenting practice and children's attachment.

Parenting/caregiving practice was measured using the Alabama Parenting Questionnaire (APQ-9) based on caregivers' rating and children's self-report. The mean scores of positive parenting perceived by children in non-migrant and migrant households were similar (see results in Table 27 in the Appendix). Caregivers in migrant households, however, were more likely to perceive themselves as adopting positive parenting compared to those in non-migrant households ($t = 2.1$, $p = 0.041$).

After adjusting for children's age and gender, kinship caregivers in mother-migrant households and grandparents in both-parents-migrant households were more likely to report positive parenting ($\beta = 1.05$, $p = 0.008$; $\beta = 0.68$, $p = 0.038$, respectively, see details in Table 28 in the Appendix).

10.2. ATTACHMENT TO CAREGIVERS

Children's attachment to caregivers was measured by a subscale adapted from People in My Life (PIML) instrument.[72] Overall girls reported a stronger attachment to caregivers than boys ($t = 2.94$, $p = 0.005$, see details in Table 29 in the Appendix). Close attachment with caregivers of girls in migrant households was less common compared to those in non-migrant household ($t = -2.85$, $p = 0.007$). After adjusting by child age and gender (see results in Table 30 in the Appendix), only mother-international-migration was associated with a weaker attachment ($\beta = -2.83$, $p = 0.04$).

72. Cutrona, C. E., & Russell, D. W. (1987). The provisions of social relationships and adaptation to stress. Advances in personal relationships, 1(1), 37-67.

Insights from Qualitative Interviews

The qualitative interviews suggested that when parents migrate during the very early years of a child's life, the child may experience the grandparents as their 'father' and 'mother'.

Caregiver's Voice

"S/he still didn't know as s/he was so small [less than one year old] but then s/he lived with me for long time [so] s/he calls me "dad" and grand-mum "mum"."

Grandfather,
65 years old, Father-international-migrant, Battambang

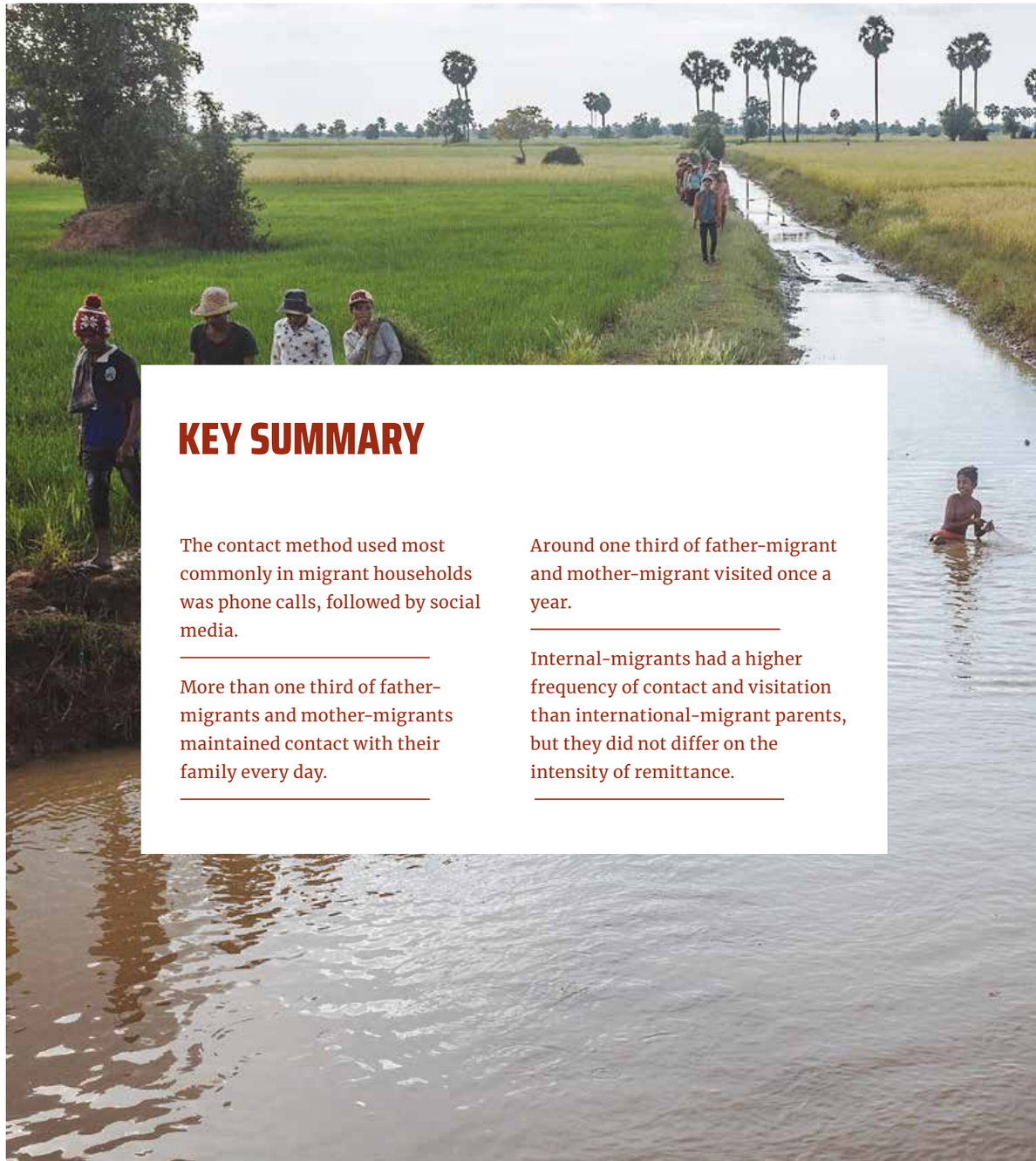
While some elderly caregivers may be too fragile to work and earn their own living, others may still work on rice fields and raise chickens and other animals, making them breadwinners and caregivers at once. Some grandparents therefore had a difficult time managing to provide for diverse needs which could influence the relationships between children and their caregivers.

Caregiver's Voice

"Liv[ing] with my grandchildren [is] more difficult than when I lived only with my wife . . .since I have grandchildren, more eating, more clothes to wash, and more thing[s] to clean in the house . . . "

Grandfather,
65 years old, Father-international-migrant, Battambang

11. Contact and Communication



KEY SUMMARY

The contact method used most commonly in migrant households was phone calls, followed by social media.

More than one third of father-migrants and mother-migrants maintained contact with their family every day.

Around one third of father-migrant and mother-migrant visited once a year.

Internal-migrants had a higher frequency of contact and visitation than international-migrant parents, but they did not differ on the intensity of remittance.

11.1. METHODS OF CONTACT

Communication between migrant parents and families left behind is an important component of understanding children's and other family members' well-being. Lacking face-to-face contact with migrant parents may constrain parent-child intimacy.[73] Maintaining frequent contact can encourage children who stay behind to feel engaged emotionally with their migrant parents.[74] Information and communications technology (ICTs) can facilitate long-distance communication through regular contact.[75] This study asked caregivers to report how migrant parents maintain contact with families left behind in the past six months.

Most households maintained contact in the six months prior to the interview: 97 percent for both father- and mother-migrant households. The most prevalent contact method was phone calls, followed by social media such as email, Facebook or WhatsApp, for both father- and mother-migrants. The pattern of contact methods showed a statistically significant divergence between the two different migration destinations: the percentage using social media as the medium of contact among father/mother-international-migrants was 31%, while the portion of using social media was very low among father/mother-internal-migrants.

TABLE 33— METHODS OF CONTACT WITH MIGRANT WORKERS BY MIGRATION DESTINATION

How father contact family (%)	Internal-migrant	International-migrant	Total	p-value
Mobile phone/cell phone	97.52	68.23	78.99	<0.0001
Social media	2.21	30.91	20.37	
friends/family who visit	0.26	0.58	0.47	
Other	0	0.28	0.18	
How mother contact family (%)				
Mobile phone/cell phone	97.39	68.15	78.86	<0.0001
Social media	2.29	30.81	20.36	
friends/family who visit	0.32	0.71	0.57	
Other	0	0.34	0.21	

73. Boccagni, P. (2012) Practising Motherhood at a Distance: Retention and Loss in Ecuadorian Transnational Families, Journal of Ethnic and Migration Studies, 38:2, 261–277, DOI: 10.1080/1369183X.2012.646421Laurie, 2008); Laurie K. (2008). Gender and transnational migration: Tracing the impacts home, Atlantis Center Working Paper Series, 17.

74. Dreby J. (2007). Children and power in Mexican transnational families. Journal of Marriage and Family, 69(4), 1050–1064.

75. Haagsman K., & Mazzucato V. (2014). The quality of parent–child relationships in transnational families: Angolan and Nigerian migrant parents in the Netherlands. Journal of Ethnic and Migration Studies, 40(11), 1677–1696. 10.1080/1369183X.2013.871491; Peng Y., & Wong O. M. (2013). Diversified transnational mothering via telecommunication intensive, collaborative, and passive. Gender and Society, 27(4), 491–513. 10.2307/23486647.

76. Jordan, LP, Dito, B, Nobles, J, Graham, E. Engaged parenting, gender, and children's time use in transnational families: An assessment spanning three global regions. Popul Space Place. 2018; 24:e2159. <https://doi.org/10.1002/psp.2159>.

11.2. FREQUENCY OF CONTACT

Overall, the majority of migrant parents maintained contact with their families frequently: 37 percent of father-migrant and 38 percent of mother-migrant households reported contact every day. Compared to families of internal-migrants, families of international-migrants report having contact with less frequency: the highest prevalence reported for internal-migrants was every day (father-migrant: 50%; mother-migrant: 53%), while a few times each week was the highest proportion reported for international-migrants (father-migrant: 32%; mother-migrant: 33%). The main reason for not having contact with families was the expensive cost.

11.3. FREQUENCY OF VISIT

The majority of father-migrants and mother-migrants visited their families occasionally. When parents migrated internationally, the frequency of visit, as expected, was significantly less compared to those parents who were internal-migrants. The percentage reporting several visits every year was the highest among internal-migrants (40% and 48% for father-migrant and mother-migrant, respectively), while visiting once a year was the most predominant situation reported by international-migrants (46% and 44% for father-migrant and mother-migrant, respectively). Notably, around 22 percent of international-migrants had never visited home at the time of this survey.

11.4. ENGAGED PARENTING

Following a recent study, a measure of engaged parenting—those who called back at least weekly, who visited home annually or more frequently, and who sent remittances at least twice in the last six months was created.[76] Internal-migrant-parents had a higher likelihood of having engaged parenting compared to international-migrant-parents (father-migrant: 43% vs 16%; mother-migrant: 43% vs 4%). In particular, fathers and mothers who migrated internationally were less likely to have frequent contact and visits than those

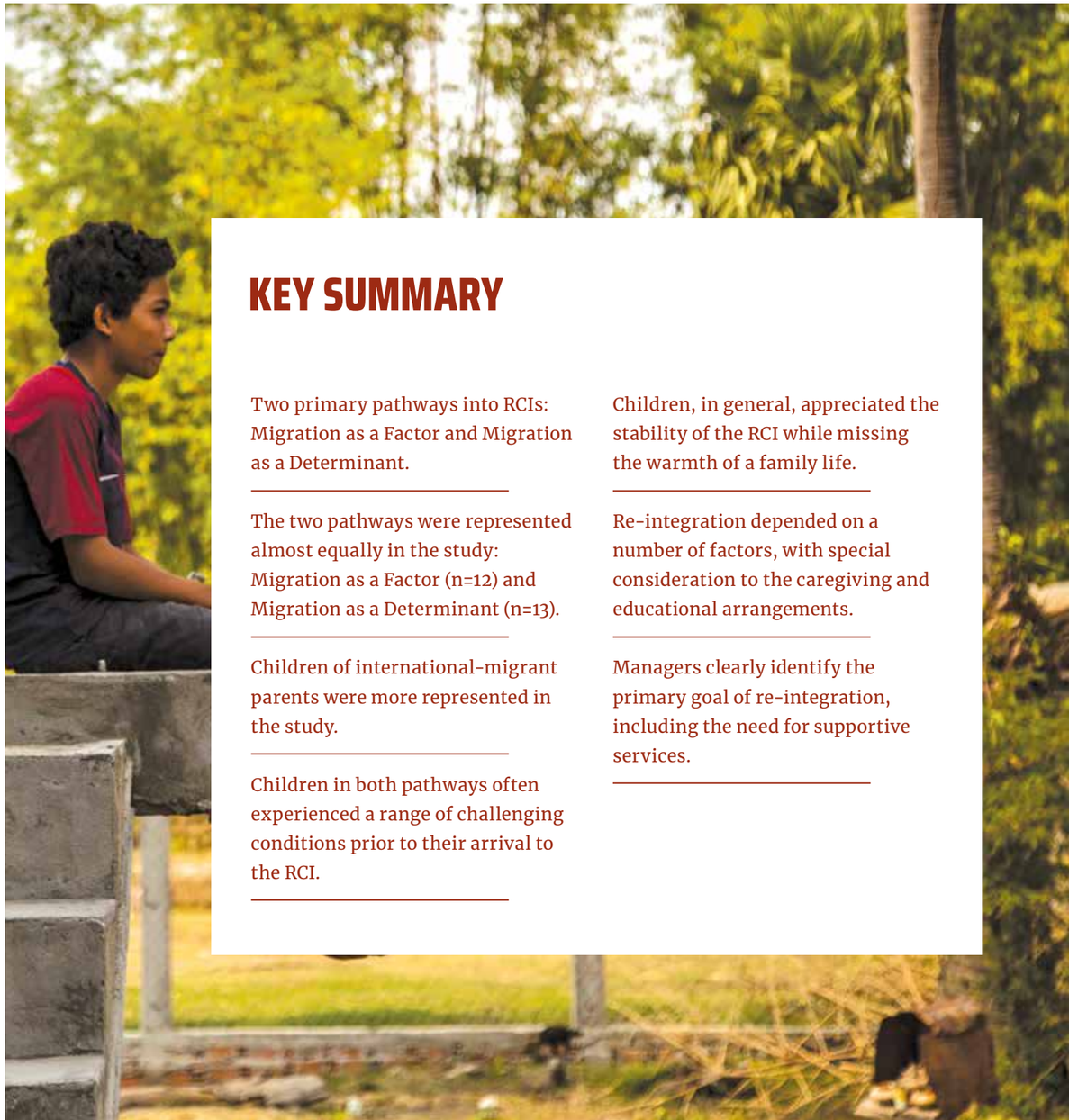
internal-migrant-parents. Note the behavior of remitting did not differ in frequency between migration destinations for either fathers or mothers.

TABLE 34. THE PREVALENCE OF FREQUENT CONTACT/VISIT/REMITTANCE AND ENGAGED PARENTING

	Internal- migrant	International-migrant	Overall	p-value
Father-migrant				
Frequent contact	82.29	71.87	75.72	<0.0001
Frequent visit	90.53	60.39	70.93	<0.0001
Frequent remittance	92.86	91	91.67	0.302
Engaged parenting	69.41	42.18	51.44	<0.0001
Mother-migrant				
Frequent contact	86.55	73.26	78.50	<0.0001
Frequent visit	91.50	57.18	69.81	<0.0001
Frequent remittance	91.35	90.09	90.6	0.494
Engaged parenting	72.92	40.61	52.4	<0.0001

Note: Frequent contact is defined as at least one time per week; frequent visit is defined as at least one time per year; frequent remittance is defined as at least twice in the past six months; Engaged parenting is defined as satisfying all the previous three simultaneously.

12. Pathways into Residential Care Institutions (RCIs)



KEY SUMMARY

Two primary pathways into RCIs: Migration as a Factor and Migration as a Determinant.

The two pathways were represented almost equally in the study: Migration as a Factor (n=12) and Migration as a Determinant (n=13).

Children of international-migrant parents were more represented in the study.

Children in both pathways often experienced a range of challenging conditions prior to their arrival to the RCI.

Children, in general, appreciated the stability of the RCI while missing the warmth of a family life.

Re-integration depended on a number of factors, with special consideration to the caregiving and educational arrangements.

Managers clearly identify the primary goal of re-integration, including the need for supportive services.

12.1. CHILDREN'S TRAJECTORIES TO RCIs

A small body of evidence suggests that family poverty and a lack of educational opportunities are major factors which contribute to the institutionalization of children, especially older children in LIC and LMICs including in Cambodia.[77]

12.2. CHARACTERISTICS OF QUALITATIVE SAMPLE FROM RESIDENTIAL CARE INSTITUTIONS

The qualitative sample consists of 25 children who were living in eight RCIs for more than six months prior to the time of the interview, eight directors/managers of those institutions and nine caregivers who provided daily care for children within the facilities.

The average age of sampled children was 14.64 (targeted age range: 12 to 17 years old). Eleven of them were from both-parents-migrant households, nine from mother-migrant households and the remaining three from father-migrant households. The distribution of the sample was similar to the household survey which had a majority of both-parents-migrant households. However, the children from RCIS included in the study were more likely to be from mother-migrant households than the household survey data indicated would occur in the general population covered by the sample survey frame.

Table 35 reports detailed characteristics of interviewed children. To explore possible difference in outcomes and trajectories between children who were institutionalized and left behind children cared by families, 37 children and their primary caregivers from migrant families in the village survey sample were interviewed as a comparison group. The comparison sample was selected from the provincial area where the sampled RCIs were located as preliminary field work suggested that many children resident in RCIs were from surrounding areas.

77. Stark L, Rubenstein BL, Pak K, et al National estimation of children in residential care institutions in Cambodia: a modelling study BMJ Open 2017;7:e013888. doi: 10.1136/bmjopen-2016-013888; Petrowski N., Cappa, C. and Gross, P. 2017. Estimating the number of children in formal alternative care: Challenges and results, Child Abuse & Neglect,Volume 70,Pages 388-398, ISSN 0145-2134, <https://doi.org/10.1016/j.chiabu.2016.11.026>.

TABLE 35— CHARACTERISTICS OF CHILDREN INTERVIEWED IN RCIS (N=25)

Research site	Child age	Child gender	Who migrate(s)	Migration destination	Migration as a factor or determinant
Banteay Meanchey	13	Male	Both parents	International	Determinant, following family care (grandmother)
Banteay Meanchey	14	Female	Both parents	International	Determinant, following Thai arrest
Banteay Meanchey	14	Female	Both parents	International	Determinant, following Thai arrest
Banteay Meanchey	14	Female	Both parents	Internal	Factor
Banteay Meanchey	15	Male	Father	International	Determinant, following Thai arrest
Banteay Meanchey	16	Male	Father	Internal	Factor
Banteay Meanchey	13	Female	Mother	International	Determinant, following family care (aunt)
Banteay Meanchey	16	Female			Factor (unclear)
Battambang	16	Female	Both parents	International	Determinant, following Thai arrest
Battambang	17	Male	Both parents	International	Determinant, following Thai arrest
Battambang	13	Male	Both parents	International	Factor
Battambang	14	Male	Both parents	International	Determinant (following check-up at the hospital)
Battambang	17	Male	Mother	International	Determinant, following Thai arrest
Battambang	16	Male	Mother	Internal	Factor
Battambang	14	Female	Mother	International	Determinant, following family care (child was abused by uncle she lived with)
Battambang	16	Female	Mother	Internal	Factor
Phnom Penh	13	Female	Father	International	Factor
Phnom Penh	14	Female	Mother	International	Factor

TABLE 35— CHARACTERISTICS OF CHILDREN INTERVIEWED IN RCIS (N=25)

Research site	Child age	Child gender	Who migrate(s)	Migration destination	Migration as a factor or determinant
Phnom Penh	16	Female			Factor
Siem Reap	17	Male	Both parents	Internal	Factor
Siem Reap	16	Male	Both parents	International	Determinant, following other RCI and family care (aunt + uncle)
Siem Reap	13	Female	Both parents	International	Determinant, following other RCI and family care (grandmother and aunt + uncle)
Siem Reap	13	Male	Mother	Internal	Determinant, following Thai arrest
Siem Reap	12	Male	Mother	Internal	Factor
Siem Reap	14	Female	Mother	Internal	Factor

12.3. PATHWAYS TO INSTITUTIONALIZATION

The study identified two primary pathways into RCIs in the study. The first was Migration as a Factor (n=12). In this instance, when families face numerous challenges including poverty, insufficient educational opportunities in combination with migration, children may end up coming into an RCI. Family separation and continuous family structure transitions, such as divorce and domestic abuse also appeared to be a very common push-factor that was present in the lives of the children who were being sent to RCIs. On the other hand, the accessibility of RCIs and the opportunities that they offer for the children, appeared to be an important pull-factor for many families. The dire financial situation of the families was the main reason for the child moving to an RCI.

An example of divorce and poverty as push-factors for institutionalization

Child: *My dad was sent into prison because he beat my mom while he was drunk. My mom called the police. I was at my grandma's house at that time, my grandma tells me to visit my dad at pagoda. Immediately, I cannot find my dad.*

Interviewer: *Why do you move to live in the center?*

Child: *While my mom was collecting the scraps, she met someone who know about that, then se ask about the information of that center and she sent me to live in the center.*

Male,
13 years old, parents divorced, mother-internal-migrant worker

In some instances, extended family members recommended to the child's mother that the child should stay at an RCI. In other cases, children themselves realize that their families are poor, and so asked their family for permission to come to the RCI.

An example of being institutionalized voluntarily due to poverty

Interviewer: *Why did they [the child's mother and step-father] decide to bring you and your sibling to live in this center?*

Child: *Because they are so poor and I couldn't study, so I asked them. I heard that other people brought their children to RCI. My parents then asked the others about this and brought me here.*

Interviewer: *And, when your parents brought you here, you wanted to come by yourself or have they talked [to] you about this?*

Child: *I just wanted to come by myself. That's why I asked them to bring me.*

Male,
17 years old, Both-parents-internal-migrant workers

The second pathway was Migration as a Determinant (n=13). In this instance family poverty was a push factor influencing the family to migrate to Thailand together. The child ends up migrating to Thailand and engaging in informal work, for example street begging and was arrested and detained by the Thai authorities. When a child was repatriated to Cambodia s/he then enters the RCI system. Most children interviewed stayed in a Thai center for a couple of months (ranging from around two months to a year, based on the children's own accounts), before the centers sent them to an RCI. In some cases, parents went to Thailand with the whole family and were arrested with the child.

An example of migration as a determinant:

A girl was left behind by her parents who were working in Thailand and cared for by her aunt before living in the RCI. The girl's mother took her to Thailand and they were caught begging on the street. Her mother was arrested and the girl stayed in a Thai center for around nine months before transferring to a RCI in Cambodia. As the police could not find any other relatives of the child at that time the child was sent to the RCI.

Female,
14 years old, Both-parents-international-migrant workers

12.4. CHILDREN'S EXPERIENCES IN RCIs

Although the majority of children were relatively positive about their lives in RCIs (i.e. they state that they get enough food, clothes, they can now study, there was some time to relax and play with other children), this appreciation also seems to stem from the sheer contrast with the harsh and complicated lives they had lived outside the RCI. They may have experienced a life consisting of family break-ups, abuse, (several) residential moves, hard labor, being arrested, poverty, and daily uncertainties whether they would have access to food, clothes, education, and other basic needs. Therefore, many of the children recognized that they had no other choice than to accept their fate, and make the best of being away from their families, while living in an RCI. For others, despite the hardships of life outside the RCI, they still longed for the warmth of their family: "I felt warm when I lived with my mom even I don't have the opportunity to study."

Children's voice about experiences in RCIs:

"I feel that I miss them [parents] but I have no choice since they live far and [are] poor. I have to stay here to get more knowledge so that they won't feel disappointed with me... If comparing living together before and now, here [in RCI] I live in more comfortable but I don't feel warm as I lived with family. At that time, I was hit sometimes, but I still felt warm living together with family."

Male,
16 years old, Both-parents-international-migrant workers

"At first, I felt nervous, and I didn't want to leave my mother. I told her that I didn't want to go, but when I stayed here for a long time, I feel happy because I can study... I feel happy, and l love and respect her (the caregiver) as my mother."

Male,
17 years old, Mother-internal-migrant worker)

12.5.
FAMILY STRUCTURE AND FAMILY DYNAMICS OF CHILDREN LIVING IN RCIs

Family characteristics of the qualitative sample were consistent with quantitative results. The majority of caregivers interviewed reported extended family structure, grandparents, sometimes aunt/uncles take the responsibilities to take care of children left behind. Among the RCI sample, children often lived with various family members and in various locations before moving to the RCI. Parental divorce was reported in most of the cases, and often the mother had remarried. Hence, the children came from complex family formations (i.e. step-families, divided families, single-parent families, extended-family care). In the RCIs, some children lived together with their siblings, but in most instances, siblings had different care arrangements.

Overall, children go through traumatizing events and experienced hardship when their families split up, and diverse factors contributed to them being sent to a RCI. There may have been instances of abuse, parents who suffered from alcohol addiction or other mental health issues. In another extreme case, the mother of a child had to escape from a family that wanted to kill her, due to disputes over land and money.

Children's Voice

Child: *. . . I have stayed here [at RCI] for a half year, my parents divorced for a half year, and someone [new is] engaged with my mother. . . When he [my father] was drunk, he hit my mother. My mother went to the police officers asking for a divorce.*
Interviewer: *When your father was in Cambodia, did he also drink alcohol like that?*
Child: *No. My father just drank when he had money.*
Interviewer: *Was that when he got money from working in Thailand?*
Child: *Yes*

Female, *13 years old, Both-parents-international-migrant workers)*

Excerpt of the interview with a girl who was institutionalized after her uncle abused her, and her aunt reported the incident to the police:

Interviewer: *Did he [uncle] threaten you when he abused you?*
Child: *Threaten*
Interviewer: *What did he threaten you?*
Child: *Didn't tell anyone otherwise kill [me] and threw me in the water*
Interviewer: *Where were the incident happen?*
Child: *At home*
Interviewer: *At that time, where was your aunt?*
R: *Aunt went to farm for others.*

Female,
14 years old, Mother-international-migrant worker

A similar pattern of family structure was found among children who lived in villages. Some of the interviewed children living in the village had received support from social service organizations predominately for study materials and clothes. Some of the organizations set out eligibility criteria for service provision such as poverty and without parents (see details in Table 36). Whether the presence of such services acted as a protective factor enabling children to remain with their families cannot be determined from the current study, however, further exploration and mapping of services in villages could offer deeper insight into this in the future.

TABLE 36— SERVICES IN VILLAGE COMMUNITIES FOR CHILDREN

NGO	Provision by NGO	Eligibility for assistance
First to Sight NGO	Extra classes, bags, books, study materials, clothes	Poverty card, without father
World Vision	Rice, canned fish and oil	Not mentioned
Organization of Fresh to Shine	Study material, clothes, and monthly salary to support study	Not mentioned
Room to Read	Study materials	Girls who are orphaned

12.6. FACTORS FOR REINTEGRATION TO COMMUNITY

Although children in RCIs were loved and cared for by staff, their eventual reintegration into the community was expected. This might involve reunification with parents, relatives or legally adoptive parents.

"Reintegrated children are happy to meet their parents, [but] when they do not have enough food to eat and meet us, they want to come back to the center."

Director, *Battambang A*

Reintegration was not always a clean and problem-free process and solution, as difficult circumstances or family conflicts may still be exist.

"First, we have to do an assessment on the children's families and their relatives, whether they can take care of the children or not."

Director, *Battambang A*

"If we reintegrate without assessment, children can be at high-risk."

Director, *Battambang B*

The study identified factors that may facilitate Reintegration, with the major factor being suitable and available caregiving arrangements. From the RCI managers' perspective, assessments of caregiving arrangements were multi-faceted, considering factors such as extended family, degrees of acquaintance/familiarity with caregivers, children's agency, and risk/protective factors on the community level (e.g. security in the community, Case 95).

Suitability was primarily conceptualized as whether the RCI managers/staff were convinced that the children will be well cared for. Establishing suitability through assessment was vital.

"Sometimes the relatives facilitate [reintegration] because the children's parents are in Thailand and cannot come. So, the relatives try to reintegrate children. So, we facilitate and reintegrate accordingly. If the children do not want to go, we do not force them. But some children do not know the relatives at the beginning, so the mothers have to facilitate to allow children to know and trust the relatives. We are worried that the children will be trafficked [a] second time, so we have home visit with the family that wants to accept the children by collaborating with the Department of Social Affairs and village chief to assure that they are good people and they can take care of children, and they are not cruel with children when they accept the children. We reintegrate while we have clear information, and the mother cannot lie to us or traffic the children again. Sometimes, the mother lies to us, then she brings her children back to Thailand."

Director, *Banteay Meanchey B*

The return of migrant parent(s) was a factor for re-integration. Migration cessation was sometimes an important antecedent for reintegration of children with parents. This was a consideration in mitigating risks for child re-trafficking, but also an indicator that parents were "capable".

"They come back when they are capable of raising their children."

Director,
Battambang A

"The goal of this care center is that we don't want to raise children just for their parents to take them back to work in Thailand."

Director,
Battambang C

Whether families were better off financially was also an important consideration, not only was this an indicator that they could provide materially for their children, but also that they could fulfil their parental duties.

"When the family finance is better, parents would come back to get their children ...when we reintegrate children, their parents come back and stop migrating. Some families go to Thailand, just to earn some capital to run a business in Cambodia."

Director,
Battambang A

Mental stability of children was also an important factor for reintegration. RCI managers express concern for children's social, emotional and psychological adjustment during the reintegration process.

"If we follow the steps, children, families and relatives get along together, they live happily and it is successful. Hence, we can close the cases."

Director,
Battambang A

One NGO particularly mentioned about their assessment about available social networks to support children with a history of abuse and violence.

"We look at their internal feelings, whether they are strong, do not isolate themselves from others, [that] their feelings do not go down easily, and they have support of parents in the community... when we can see their support network to make them trust, and their parents understand their role."

Director,
Phnom Penh A

RCIs may also see their responsibility as ensuring—as much as possible—a continuity in the community for children's wellbeing after reintegration. This included parent education and providing resources, among others. For example:

"We work with families more closely than before. We provide awareness on parenting skills to their parents, mental state of children who used to be raped, and how to intervene for children when their children's feelings are down. We always teach parents to prepare a safe plan for their children and how they can seek services, like public services. We do not encourage them to be silent. [That] means that they [would] go to authorities when they have any issues."

Director,
Phnom Penh A

This RCI manager also acknowledged that institutionalization over long periods may be detrimental to well-being:

> *"'In some cases, there are small children, we try to mentally rehabilitate them, we do not keep them [for a] longer time because separation from their parents is not so good for them."*

Director,
Phnom Penh A

A RCI would ensure that children had access to equitable education after their reintegration to community. While many children received education in/through the RCIs, RCIs also viewed education from the perspective of reintegration and building continuity. Depending on the type of services a RCI provided and was contracted for, they could offer different types of supportive services for reintegration.

> *"When we work with them to rehabilitate their mental health, we ask about their future plans. Most of them want to study. For small children that we work with, we provide a one-year scholarship package to them when we reintegrate them, including bicycle, study materials, uniforms and $30 per month. We try to work with their families in order to allow [them] to learn how to save and support their children's study."*

Director,
Phnom Penh A

04

Summary of key findings, intervention for policy and practice

This chapter provides a summary of the key findings from the study and is organized by research questions (Table 3.1). A discussion of relevant Cambodian policies is offered, when applicable, and specific interventions to strengthen areas of resilience and mitigate areas of vulnerability among children and caregivers are suggested. Many of these recommendations were initially developed during a series of dissemination meetings held in the first quarter of 2019 in Phnom Penh and they reflect local expertise and knowledge.

The chapter concludes with the introduction of a comprehensive intervention framework that can guide the development of future policy and practice going forward.

1. Health trajectories

Research question

1- To explore the specific health vulnerabilities and those factors that enable positive health outcomes and resilience for children, caregivers and spouses in migrant households

1.1. HEALTH TRAJECTORY OF CHILDREN

RQ 1.1 : Do children in migrant households have worse nutrition status than their peers in non-migrant households?

The health dividends on children were mixed for this study. Younger children of migrants appear to benefit, especially nutritionally, while older children did not show similar nutritional advantage. For the Younger Child Cohort, children in migrant households were more likely to have higher scores

of dietary diversity while those in the Older Child Cohort had lower scores of dietary diversity when compared to their counterparts. For the Younger Child Cohort, the percentage of underweight children in migrant households was 11, which was significantly lower than the prevalence among children in non-migrant households (30%). For the Older Child Cohort, children in migrant households were not better or worse off in terms of nutritional status compared to those in non-migrant households.

The National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) states 'there should be zero stunted children less than two years of age.' (Pillar 2: Zero stunned children less than two years of age). The National Policy on Early Childhood Care and Development (2010) further contends that all Cambodian children under six years old shall be provided with care and development services including health education services, adequate immunization and nutrition, early learning' (Objective 2: All children have their births registered, are provided with care, regular health check-up, adequate immunization and nutrition, and early learning).

While existing policy interventions target reducing malnutrition among children under five years of age, age-specific interventions are also required for those in older age group. Interventions to ensure nutritionally adequate food for children should include providing school feeding programs for poor communities, improving access to child health services, and education for caregivers on the diversification of diet for children of all ages up to age 18. Community-level health workers and child protection/welfare workers can be mobilized at the village level to support migrant households identified by the village chief/administrator to develop a nutritional plan for caregivers during absence of parent/s.

RQ 1.2: Do children in migrant households show vulnerabilities in terms of physical health?

The study found there was a greater burden of illness in children in the left behind migrant households. When compared to children living in non-migrant households, more children reported being sick within the migrant households during 30 days prior to the survey. Additionally, the overall medical expenditure for sick children left behind in-migrant families was significantly higher. The general pattern of utilization of health care facilities was similar among non-migrant and migrant households: the private sector was more commonly used than public health service. Understanding the higher burden of illness in left behind children requires further investigation.

Existing policy frameworks such as the National Policy on Early Childhood Care and Development (2010) clearly state that all Cambodian children age six years old and younger shall be provided with care and development services including health education services, adequate immunization and early learning (Objective 2: All children have their births registered, are provided with care, regular health check-up, adequate immunization and nutrition, and early learning). Early-childhood, adolescent and youth health programs at the national level, relevant agencies working within this space including donor agencies, needs to graft migration as a key determinant of child-health outcomes.

Mainstreaming migration health is critical. At the sub-national level, the village commune council for women and children (CCWC) could establish mechanisms to identify families with vulnerable children and coordinate with relevant health providers and welfare officers to support case-management plans for left behind children. Policy interventions should concentrate on enhancing social health protection schemes (e.g. Health Equity Fund) to increase the inclusion of young people – especially in rural areas and reduce indebtedness for high out-of-pocket health expenditure. The barriers and costs to the fund need to be addressed to ensure greater uptake, including educating prospective migrant workers on the importance of social and health insurance schemes. Health diplomacy in the form of bi-lateral agreements with labor receiving countries to encourage employer groups in destination countries to provide social protection for workers and families may be facilitated by the Ministry of Foreign Affairs, Trade, Labor and the Ministry of Health.

RQ 1.3: Do children aged 0 to 3 in migrant household show disadvantages on early development (motor, cognitive, and socioemotional skills)?

The study found children from migrant families showed advantages in terms of early development at very early stage of life (below two years old). The mechanism under which parental migration may boost their children's early development needs further study. A higher post-migration socioeconomic status can be one protective factor on child early development.

The National Policy on Early Childhood Care and Development (2010) provides guidance on fulfilment of Cambodian children age under six years right to be provided with care and development services including health educa-

tion services, adequate immunization and nutrition, early learning (Objective 2: All children have their births registered, are provided with care, regular health check-up, adequate immunization and nutrition, and early learning). The Education Strategic Plan 2014-2018 of Cambodia can be leveraged to focus on expansion of Early Childhood Education to ensure children from birth to school entry achieve positive physical and psychosocial development in the home and community (Policy Early Childhood Education-Objective 1: Increased enrolment of children from 0 to 6 years old, especially for poor, ethnic minorities, and children with disabilities with priority to community pre-school and home based care services). Early childhood development was included in UN's Sustainable Development Goals in 2015 to ensure that all girls and boys have access to quality early childhood development (SDG 4: Quality Education). It is critical to increase public awareness about the importance of early education and invest in family-friendly policies. Based on UNICEF'S program guidance for early childhood development, the Cambodian government can invest in early childhood development by providing quality child care, ensuring adequate nutrition, and encouraging positive parenting. Investing in birth-to-five early childhood education, particularly for early years (before three years of age), has the greatest efficiency and effectiveness to promote child development. Early childhood resources, such as home visits, workshops on parenting skills, and community centers for early learning, should be provided to those disadvantaged children and families.

RQ 1.4: Is parental migration associated with children aged 12 to 17 year old's psychological wellbeing and resilience?

The study finds children left behind were not worse off on psychological well-being measured by the Strengths & Difficulties Questionnaire (SDQ). In fact, children in father-migrant households were more likely to show prosocial behaviors. Parental migration, especially when the mother migrates abroad, is linked with lower levels of child resilience. Challenges faced by left behind children may not meet a threshold of psychological ill health, but nonetheless may have a negative impact and decrease their resilience. Low levels of resilience reflect an individual's ability to confront adverse situations, which can lead to increase levels of mental distress and hinder children from being able to flourish in the long-term.

Children and their caregivers perceived parenting/caregiving practices differently. While caregivers from migrant households had positive views of parenting/caregiving, the children in these families seemed not to feel the same way. A previous study conducted by the Royal University of Phnom Penh (RUPP) on the impacts of past trauma on parenting across three generations highlighted that grandparents were more likely to use a negative parenting style,[78] which may be in contradiction to the current study. Perhaps in the context of migration where grandparents perform the caregiving role in exchange for remittance from migrant parents, harsh discipline can be less likely to occur. In addition, according to common Cambodian belief, a caregiver who cares for grandchildren, the third generation, can more easily adopt a positive parenting style compared to when they are caregiving their own children, the second generation.

To date there is a lack of specific policies targeting adolescents and youth in Cambodia. There is no specific policy addressing adolescents but there are a few relevant strategic plans such as the National Strategic Plan 2014-2018, which mentioned adolescent and reproductive health, as part of the national strategy for reproductive and sexual health. This is an important area of future policy development.

The policy for migrant workers should also include their families left behind. Early intervention and prevention are needed to avoid later mental health challenges, and promote child resilience, particularly to enable children to cope with migration-related stress. It is essential to improve access to child mental health services on the community level. School-based programs can be conducted for identifying children at risk of mental health risk.

The UN's Sustainable Development Goals place a strong emphasis on resilience (SDG 3: Good Health and Well-being). A focus on strengthening resilience can protect positive development gains and ensure individuals have the resources and capacities to better adapt to stress and adversities. Low levels of resilience reflect an individual's ability to confront adverse situations, which can lead to increase levels of mental distress and hinder children from be flourishing in the long-term. Policy makers and health-care workers should have a greater awareness of potential mental health risk when children are left behind without parental caregivers. A strength-based approach, for example, the Positive Youth Development framework[79] could be explored and integrated with cultural-specific needs in Cambodia to foster child resilience by enhancing their internal assets (e.g. positive values and identity, social competencies,) and external resources (e.g. positive family relations, and caring community environment).

78. Schunert, T., Khann, S., Kao, S., Pot, C., Sauoe, B. L., Lahar, J. C., Sek, S., & Nhong, H. (2012). Cambodia mental health survey. Royal University of Phnom Penh, Department of Psychology

79. Benson, P. L., Scales, P. C., Hamilton, S. F., & Sesma, A. (2006). Positive youth development: Theory, research, and applications. Handbook of child psychology.

Despite grandparent's willingness to be involved in caregiving of grandchildren in migrant households of Cambodia, caregiving for the third generation still can be challenging. Services focusing on parenting skills and support can encourage responsible caregivers to reframe their perceptions of parenting, learn parenting skills and provide respite from the demands of caregiving. Parenting education, such as the Triple P-Positive Parenting Program,[80] can be considered to improve the wellbeing of children and their family relationships. To enhance caregivers' knowledge and skills of positive parenting, guidance and support from professionals could be beneficial. Interventions can focus on providing parenting resources for all caregivers on the community level, and group-based workshops for caregivers who face challenges of caring for children with behavioral or emotional difficulties.

RQ 1.5: Are there gendered differences of vulnerabilities and resilience profiles among children of migrant parents?

The study found a consistent risk for boys, though not specific to parental migration. Boys showed disadvantages in nutritional status compared to girls, with a significantly higher rate of stunting in the Younger Child Cohort aged 0 to 3 (23%) and higher prevalence of stunting (33%) and wasting (16%) in the Older Child Cohort aged 12 to 17. No gender difference was found on children's dietary diversity. Results highlight the gendered difference of nutritional indicators. Further research is required to address any specific nutritional needs of boys in Cambodia.

According to children's report on SDQ, girls aged 12 to 17 were more likely to have higher prosocial scores than boys. Girls showed advantages in resilience over boys in both non-migrant and migrant households. Girls furthermore reported a stronger attachment to caregivers than boys in both non-migrant and migrant households.

As highlighted in Section 1.1 policies such as the National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) and the National Policy on Early Childhood Care and Development (2010) apply to these gendered nutritional risks for children (Objective 2: All children have their births registered, are provided with care, regular health check-up, adequate immunization and nutrition, and early learning). The results further draw attention to adolescent boys' vulnerability to poorer psychological well-being in Cambodia. A weaker attachment reported by boys can be one reason behind this. Interventions recommended in Section 1.4 apply. Policy makers should further develop mechanisms to assess gender specific interventions, in particular to address the risk for boys among the general population (both migrant and non-migrant). Interventions to promote resilience could be developed based on the advantage observed in girls in this study and assess if/how skills could be transferred to boys in the Cambodian context. All youth interventions should pay attention to gender dimensions of resilience and focus on differentiated resources of social support by gender.

80. Sanders, M. R. (2008). Triple P-Positive Parenting Program as a public health approach to strengthening parenting. Journal of family psychology, 22(4), 506.

1.2. HEALTH TRAJECTORY OF CAREGIVERS

RQ 1.6: Do caregivers in migrant households have worse nutritional status than those in non-migrant households?

The study finds that caregivers in migrant households had poorer diversity of dietary intake compared to those in non-migrant households. Caregivers in migrant households showed risk of malnutrition, with a significantly higher rate of being overweight (31%) compared to caregivers in non-migrant households (23%).

Cambodia has recently recognized in the National Aging Policy 2017-2030 that Cambodian elderly are living longer and healthier lives. However, as people grow older, their vulnerability increases. They are at an increased risk of challenges including a fragile health status. They face a growing risk of morbidity which may include weakening defense against infectious diseases, such as flu; and increased risk of non-communicable diseases such as diabetes and hypertension. Also, older persons are more prone to terminal illnesses like cancers and organ function failures which call for long-term care. Moreover, the older one gets, so too does the risk of incurring a disability that requires increasing assistance in daily functions. The incidence of disability rises with age among both males and females. Objective 2.1: To promote healthy ageing and expand preventive health care.) This in conjunction with the current National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) provides a strong platform for evidence-based interventions (Pillar 1: 100% Equitable access to adequate, nutritious, and affordable food all year round). Recommendations outlined in Section 1.1 highlighted the need for migrant

households identified by village chiefs/administrators to be visited by health, social services and social welfare officers to develop a care-giving plan for children. This same assessment plan should include the caregiving capacity for the caregivers in the household, noting any chronic disease or disability. Efforts should be made to formulate a strategy not only for child wellbeing but also in ensuring respite and health and spiritual needs for caregivers.

RQ 1.7: Do caregivers in migrant households show vulnerabilities in terms of physical health?

The study found caregivers had poorer status of self-report physical health in migrant households than in non-migrant households, and older age is the main reason.

The National Health Care Policy and Strategy for Older People, 2016 (Objective 3: To promote an age-friendly environment through multi-sector collaboration in regards to prevention, care and support services and Objective 4: To strengthen the health system to meet the health needs of older people through an integrated approach of adequate preventive, treatment, rehabilitation and palliative care services at all levels) and the National Aging Policy 2017-2030 (Objective 2.1: To promote healthy ageing and expand preventive health care) provide a platform for targeting well-being of the elderly Cambodians. These findings highlighted the importance of 'Caring for the Caregiver'. Interventions to support elderly care provision can include: providing respite for elderly caregivers (e.g. by establishing social support networks at village level); greater acknowledgement of the elderly by community (e.g. in the form of 'caring for caregiver' day); public education for the improvement of elderly's nutrition knowledge and dietary behaviors; and, efforts to make health care more equitable for older people, especially those in rural areas. The demands of caregiving and time consumed in care of left behind children may limit the access of elderly caregivers to routine physical activities, as well as other activities, for example their religious/spiritual practices such as attendance of Buddhist temples. Providing support for elderly caregivers to participate in spiritual development is an important cultural and religious engagement and forms a key part of 'healthy' aging in Cambodian life.

RQ 1.8: Is migration associated with caregiver's mental health, resilience and social support?

The prevalence of depression and anxiety among sampled caregivers was as high as 43 percent and 50 percent, respectively: significantly higher prevalence was found among caregivers in migrant households than those in non-migrant households. Caregivers in migrant households also had lower levels of resilience and perceived their social support from family members to be weaker than those in non-migrant households.

The study also highlighted the culture-specific mental health needs of Cambodia's elderly population who experienced the Khmer Rouge period. The caregivers showed the symptoms of distress stemming from their past traumatic experience during the civil war period, as elderly caregivers had a higher level of distress than younger caregivers.

Employment-driven out-migration among the younger generation leaves an increasing number of older people outside the traditional safety net in which they are cared for by their children, furthermore it even poses additional burdens for them in the form of taking care of their grandchildren. The main features of a mental health policy have been included in the Mental Health and Substance Misuse Plan 2011-2015: to ensure universal access to mental health and substance abuse services for all Cambodians. Policy makers and health-care professionals should have an increased awareness to this vulnerable population. It is important at the policy level to consider mental health issues among caregivers left behind, especially the female elderly who often take the responsibility for child care.

In addition to the Recommendation 1.7 above, to support a large population of elderly citizens especially in rural communities, the interventions to support elderly mental care provision could be specifically targeted. The service sectors including health workers, social workers, and other professionals working in elderly care should be trained to identify and treat the common psychological distress among elderly. To reach out to the most needed and vulnerable group of elderly that are fully occupied with childcare and household chores due to the migration of parents. Community-based awareness raising on mental health and home visits should be strengthened. Beside working with targeted vulnerable groups of elderly, home visits should also reach out to the family members of migrant household including, father, grandfather, and other relatives in order to involve them as supporting

resources for elderly. Psychoeducation and cognitive-behavior therapy (CBT) can be provided to elderly caregivers to reduce trauma-related stress. Taking into account the specific cultural context of Cambodia, where Buddhist practice such as meditation may offer spiritual healing.

The Quality Assurance Office under the Department of Hospital Services, Department of International Cooperation and Department of Mental Health and Substance Abuse have been established to clarify the Ministry of Health's roles in strengthening system-wide quality improvement in health care services and development cooperation and in addressing increased burden of mental illness, and mental health related drug use. In addition to ensuring the inclusion of caregivers within the services mentioned above, future research is needed to provide evidence to national policies with regards to special needs of caregivers in migrant households.

RQ 1.9: Are there gendered differences of vulnerabilities and resilience profiles among caregivers?

The study found gender differences in the nutritional status of female caregivers, who were more likely to be overweight than male caregivers. There was no gender difference found on dietary diversity and self-reported physical health. Being female was also a key risk factor related to poor mental health, as female caregivers had a significantly higher prevalence of being depressed and anxious than male caregivers. When compared to male caregivers, females perceived a weaker relationship with the community, but a closer relationship with significant others, suggesting different resources of social support for female and male caregivers.

When assessing the physical health scores, nutritional status and dietary diversity as a whole, it was clear that the female elderly caregivers (grandmothers) of left behind children were the most vulnerable. It is important at the policy level to consider mental health issues among caregivers left behind, especially the female elderly who often take the responsibility for child care. There should be a different focus on enhancing social support by gender: services can be provided to strengthen family support for male caregivers; female caregivers should be encouraged to be engaged in community activities to enhance their resources at the community level. From the service sector, health workers, social workers, and other professionals working in the elderly care sector must be aware of the potential mental health and nutritional needs of and how they may vary by gender and be trained to support and treat them.

2. The Role of Remittances

Research question

1 - To understand the extent of contribution by remittances to health, educational and social protection of the families left behind

RQ 2.1: How often do migrant parents remit money?

Migrant parents most commonly send remittances monthly (father-migrant: 69%; mother-migrant: 65%; both-parents-migrant: 76%). The father-migrants had a higher likelihood of remitting money and remitted a higher amount of money home than mother-migrants. The total amount of remittances sent from both-parents-international-migrant was the highest.

RQ 2.2: What is the role of remittances in migrant households?

Remittances sent to families were often used for extra food (69%), more frequent or better-quality medical care (57%), and children's education (53%). More than half of the households reported that their disposable income became much higher or higher when they were receiving remittances. Over 80 percent of children could be enrolled in the school longer as a result of remittances. Around 66 percent of households perceived an increasing ability to afford medical care after receiving remittances. Although this survey data showed that for many families the financial status had significantly improved due to parental migration, migrant households still faced a financial burden when compared with the comparison households. The reasons for this vary, and are related to: 1) inconsistent employment opportunities for some migrant workers, including those working in exploitative working conditions where remittance flows may be ad-hoc; 2) the need to pay-off debts/loans; 3) personal issues (including family struggles); and, 4) the general cost of living (including, for example, additional health care expenditures, or economic factors such as the increasing price of rice).

Household debt was common among both migrant and non-migrant households, with 61 percent of non-migrant households and 54 percent of migrant households having debt. Seventy-three percent of migrant households used remittances to pay back loans with the remaining households using income generating or business activities to make repayments. In contrast, non-migrant households exclusively use income generating activities and their business as the source of debt repayment. The study highlights the importance of remittances in facilitating access to medical care, children's education, and paying off debt.

The Labor Migration Policy (LMP) provides a framework for addressing diverse migrant needs. The policy includes provisions on the development of financial services to ease remittances transfer and support productive investments in the communities of origin (Policy Goal 15: The Government works with financial institutions in Cambodia and destination countries to enable access to safe, efficient and cheaper remittance and financial services for migrant workers. The impact of remittances on development is enhanced through support services provided to migrants and their families, including gender-sensitive financial literacy training, a broader range of financial services and products, and dialogue and tools for diaspora engagement).

To develop a comprehensive and effective labor migration governance framework that protects and empowers women and men throughout the migration cycle, ensures that migration is an informed choice, and enables a positive and profitable experience for individual workers, their families and communities, that also contributes to the development of Cambodia.

Governments can support families in making a decision to migrate through information campaigns in areas with high levels of migration. For instance, by creating Migrant Resource Centers (MRCs). Such centers can provide access to information and facilitate informed choice in migration by facilitating partnerships with local job-network providers or domestic processing zones. MRCs can also conduct budgeting workshops (organized by Ministry of Labor in partnership with other relevant partners) on better utilization of remittances.

According to the ILO-IOM survey, the service fee is 2.4 percent for remitting money.[81] The Government can facilitate making remittance transfers more affordable and offering credit schemes to support migrant families. It would be helpful to formalize, digitize and customize products to better fit the needs of migrant workers and families in Cambodia who are dependent on regular remittances through forming stronger linkages between international remittances and local financial services in Cambodia. Efforts are being made by mobile providers to reduce costs of remittance transfers and better financial securities for migrant workers.[82]

There are several companies and ventures establishing mobile financial services, such as mobile money payment and transfer applications that enable individuals to transfer money across the country using USSD messages. Some companies have partnered with several foreign companies to expand these services to Cambodian migrant workers aboard offering wallet-to-wallet remittance services for migrant workers abroad.[83]

Public sector actors can explore regulatory guidelines to enable partnership models and non-bank institutions to accelerate product innovation. Private sectors can identify and support innovative solutions, including strengthening digital delivery channels, launching mobile wallet apps and developing remittance-linked savings. Pre-departure orientation information through social media platform to inform aspirant and out–ward bound migrant workers and families on formal remittance products available to ensure a gradual transitioning from informal to formal remittance products and a more inclusive financial market.

81. Risks and rewards: Outcome of labour migration in South-East Asia, ILO-IOM 2017, available from <https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_613815.pdf>.

82. Wing2World is Wing's international money transfer services cater towards serving Cambodians locally and worldwide. Wing opens up to a world of possibilities, providing access to thousands of migrant workers and their beneficiaries, as well as expats residing in the country. Find out at: <https://www.wingmoney.com/en/wing2world/>.

83. Fintechnews Singapore, 2018. Cambodia Sees Growing Mobile Payment Industry, available from <http://fintechnews.sg/23022/mobilepayments/cambodia-mobile-payment-industry-growing/>.

3. Specific Vulnerabilities and Protective Factors of Households

Research question

3 - To understand specific vulnerabilities and protective factors of households with either male or female single migrant parent or of households with two migrating parents (parenting styles, attachment and communication issues)

RQ 3.1: Whether who migrates in the households matters to children's development?

Among the Younger Age Cohort (0 to 3 years old) children in both-parents-migrant households appeared to benefit from migration: they were more likely to have better dietary diversity, early development, and less likely to suffer from stunting and being underweight, after adjusting for children's age and gender.

Among the Older Age Cohort living in a both-parents-migrant and father-migrant households were associated with children's lower levels of resilience. Children from father-migrant households were more likely to have poor nutrition and reduced resilience. The underlying mechanism through which father- or mother- migration affects various aspects of child development may be different. Father-migrant, rather than mother-migrant, can create more benefits in terms of family wealth, which may lead to better nutrition and education for young children. On the other hand, however, the literature suggests that father-migrants were less likely to maintain parent-child intimacy over distance than mother-migrants.[84] A key intervention recommendation is to provide support for father-migrants to adjust their fathering roles accordingly to better fulfil children's emotional needs.

RQ 3.2: Whether who is the caregiver in migrant households matters to children's development outcomes?

Among both child cohorts, having a mother-caregiver in father-migrant households or a grandparent-caregiver in both-parents-migrant household can be a protective factor for child development. Among the Younger Child Cohort aged 0 to 3 having a father-migrant was associated with better early development when children were cared for by their mothers. For the Older Age Cohort, having a mother-caregiver may protect children from having lower levels of resilience and promote children's prosocial behaviors. On the other hand, when both parents of the children migrate and children are cared for by relatives other than their grandparents, these children are more likely to have disadvantages in resilience.

84. Dreby J. (2007). Children and power in Mexican transnational families. Journal of Marriage and Family, 69(4), 1050–1064.

RQ 3.3: Whether migration destination (internal or international migration) matters to children's development outcomes?

The results regarding whether internal or international differentially influence child development were complex. Among the Younger Age Cohort, children of both-parents-international-migrants and father-internal-migrants were less likely to be stunted. Among the Older Age Cohort, children in mother-migrant households were more likely to be less resilient and have a weaker attachment to their caregivers, however, this was only when mothers migrated internationally.

RQ 3.4: Which type of caregiver in migrant households were most vulnerable in terms of health?

In general, caregivers in both-parents-migrant households showed disadvantages in health: after adjusting for age and gender, grandparent-caregivers were more likely to be overweight and have a higher level of psychological distress, while other relative-caregiver (e.g. mainly mother's sister) had poorer self-reported physical health and lower levels of resilience.

This study especially highlighted the mental health vulnerability of female caregivers in mother-migrant and both-parents-migrant households. The absence of the mother-migrant appeared to remove an important source of social support for elderly caregivers which was not being supplemented. Interventions to support elderly caregivers can include: public education for changing traditional gender ideology regrading roles of females in housework, child care centers that can offer respite for caregivers, as well as community centers that provide a space for elderly to relax and build peer support.

RQ 3.5: Whether migration destination (internal or international migration) matters to caregiver's health outcomes?

Caregiver's health did not differ based on the destination of father-migrants. However, a mother's migration operates differently: within both-parents-migrants and mother-migrant households, international migration was associated with caregiver's lower levels of resilience.

To reach out to most the needed and vulnerable group of elderly that are fully occupied with childcare and household chores due to the migration of parents- the migration of women in particular-community-based awareness raising on mental health and home visits could be strengthened. Beside working with targeted vulnerable group of elderly, home visits could also reach out to the family members of migrant households including, father, grandfather, and other relatives in order to involve them as supporting resources for caregivers.

RQ 3.6: Whether the migration destination (internal or international migration) matters to the pattern of communication?

Internal-migrants had higher frequency of communication contact and visitation with the families in origin communities compared to international-migrants. International-migrants rely more on social media for communication.

Although communication technologies offer new opportunities for migrant families to maintain intimacy across the distance, high costs were still considered as the major obstacle hindering communication. Lowering telecommunications costs and related technological barriers could enable migrants to connect more frequently and through multiple modes (calling, texting, social media, video-calling) with their families left behind.

Frequent contact had a critical role in building parental support and family cohesion. Parenting workshops can be provided to migrant parents to set up a regular communication schedule and develop a long-distance parenting plan, and elderly caregivers could receive support to learn how to use advanced communication technologies to facilitate communication between children and their parents.

4. Linkage between Migration and Children's Institutionalization

Research question

4 - To understand the linkages, if any, between migration and institutionalization of children of migrant worker.

RQ 4.1: What are the pathways that lead the left behind children of migrant workers towards institutionalization?

The current study offers insight into risk and protective factors which were associated with entry to RCIs. Children of migrant parents who lived in RCIs often had experienced a number of challenging situations in their family lives, including extreme poverty, domestic violence, parental alcoholism and caregiving instability. The findings specifically offered further evidence of the salience of family poverty—a push factor—and educational opportunities – a pull factor—along the pathway to the RCI. One of the unique contributions of the current study was to debate about how migration specifically contributed to these trajectories. The study suggested how migration was one of several factors which contributes to a child's entry to institutional care.

One of the primary routes into RCIs among the sample was as a result of migration with parents to Thailand, leading to repatriation and institutionalization.

Further large-scale research is needed in order to examine in detail the larger populations of children in RCIs, especially to consider how prevalent of a factor migration is to children's entry to RCIs. This small-scale qualitative study was unable to provide any type of estimation about prevalence.

RQ 4.2: How do the experiences of the children in RCIs differ from children who remain in the village when their parents migrate?

Children of migrants in villages also experienced a wide range of challenging situations and instability within their families. However, the availability of alternative caregiving was a crucial factor that enabled these children to remain living with their families. Children who remain in the village were much less likely to have the experience of migrating with their parents to Thailand, although one grandparent spoke specifically of ensuring that this did not happen to her grandchild, suggesting that it was recognized as a risk for children of cross-border migrants in rural villages.

RQ 4.3: What are the factors that enable re-integration of children of migration to the community?

As demonstrated by the perspectives of managers from RCIs was the desire to reintegrate children, while highlighting the challenges that were faced regarding assessment and assurance of positive conditions for the children following reintegration.

> *"The ministry wants fewer children to live in the center. But we do not have a choice. Some children cannot be reintegrated or left at some places because sometimes they are vulnerable to different risks."*
>
> **Director,**
> *Battambang*

The government has clearly signaled its support for family and kinship care as well as community-based care over residential, institutional care with a series of policy reforms. Starting in 2006 the government issued a Policy on Alternative Care for Children (2006)[85] to ensure that children without a family home receive alternative care. This was followed by the release of the Minimum Standards on Alternative Care for Children in Residential Care (2006) and for Children in the Community (2008). In 2016 the Action Plan for Improving Child Care set forth the specific guidelines to safely return 30 percent of children in residential care to their families over the period of 2016-2018.

The factors uncovered in the study do offer possible pathways for intervention. Family poverty and family instability appear as the important determinants along the path to institutionalization for children. Community interventions to support strengthening family functioning and to address risky behaviors including domestic violence, alcohol and drug abuse, could help to support families and children to remain in the community, within their families, or in kinship or other foster care.

Consideration of different structural interventions regarding accessibility to secondary schools for children living in more remote rural areas could be considered, as accessibility to secondary school/vocational training may be an additional risk factor for some families. A lack of viable employment opportunities within communities also may contribute to family poverty, thus further consideration about how to address such structural barriers deserves attention. If parents need to migrate in order to pursue sustainable livelihood opportunities, communities could seek to offer planning support to facilitate positive alternative caregiving arrangements for children to remain in local communities, and/or build partnerships with national allies to facilitate safe family migration to areas where employment opportunities are available so that children can come with their parents.

There is a need for the identification of best practices in strengthening community-based care in rural areas, including rigorous evaluation of interventions in order to facilitate scaling up across the country. Thoughtful considerations of required resources and costings are crucial for any future success of interventions to support primary prevention of children from entering RCIs as well as successful reintegration programs. The findings from the current study offer a number of points of potential interventions on the individual, family, community, institutional and government level.

85. Policy on Alternative Care for Children 2006. Available at: <http://www.cncc.gov.kh/userfiles/image/download/Policies%20&%20Standards-E2%20Policy%20on%20Alternative%20Care%20for%20Children-En.pdf>.

TABLE 37— SUMMARY OF THE KEY FINDINGS ORGANIZED BY RESEARCH QUESTIONS
1 - To explore the specific health vulnerabilities and those factors that enable positive health outcomes and resilience for children, caregivers and spouses in migrant households

	Research questions	Study Findings	Relevant Policies	Recommended Interventions
	Children			
1.1	Do children in migrant households have worse nutrition status than their peers in non-migrant households?	The health dividends on children were mixed. Youngest children appeared to benefit. Older children showed no difference between migrant and non-migrant.	National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) National Policy on Early Childhood Care and Development (2010)	Interventions to ensure nutritionally adequate food for children should include: school feeding programs for poor communities, improving access to child health services, and education for caregivers on the diversification of diet for children. Community-level health workers and child protection/welfare workers can support migrant households to develop a nutritional plan for caregivers during absence of parent/s.
1.2	Do children in migrant households show vulnerabilities in terms of physical health?	Greater burden of illness in children in the left behind migrant households. Overall medical expenditure for sick children left behind in-migrant families was significantly higher. All household use the private sector more commonly than public health service.	National Policy on Early Childhood Care and Development (2010)	Early-childhood, adolescent and youth health programs at national level, relevant agencies need to mainstreaming migration and health. Village commune council for women and children (CCWC) could establish mechanisms to support case-management plans for left behind children. Enhance social health protection schemes (e.g. Health Equity Fund) to increase the inclusion of people. Bilateral agreements with labor receiving countries may be facilitated by the Ministry of Foreign Affairs, Trade, Labor and Ministry of Health.
1.3	Younger Child Cohort: Do children in migrant households show disadvantages on early development (motor, cognitive, and socioemotional skills)?	Children of migrants had better early development below two years old.	National Policy on Early Childhood Care and Development (2010) The Education Strategic Plan 2014-2018 of Cambodia	Increase public awareness about the importance of early education and invest in family-friendly policies. Early childhood resources, such as home visits, workshop for parenting skills, community centers for early learning, should be provided to those disadvantaged children and families.
1.4	Older Child Cohort: Is parental migration associated with children's psychological wellbeing and resilience?	Children left behind were not worse off on psychological well-being. Children in father-migrant households had more prosocial behaviors. International-parental migration, was linked with lower levels of child resilience.	No specific policies	It is essential to improve access to child mental health services on the community level. School-based programs can be conducted for identifying children at risk of mental health risk. A strength-based approach, such as Positive Youth Development framework (Hamilton, Hamilton, & Pittman, 2003) could be integrated with cultural-specific needs in Cambodia to foster child resilience by enhancing their internal assets (e.g. positive values and identity, social competencies,) and external resources (e.g. positive family relations, and caring community environment). Services focusing on parenting skills and support can encourage responsible caregiver to reframe their perceptions of parenting, learn parenting skills and provide respite from the demands of caregiving.

1.5	Are there gendered differences of vulnerabilities and resilience profiles among children of migrant parents?	Boys were disadvantaged in nutritional status compared to girls: higher rate of stunting in ages 0 to 3 (23%); higher prevalence of stunning (33%) and wasting (16%) in ages 12 to 17. Girls were more likely to express pro-social norms than boys. Girls showed advantages in resilience over boys in both non-migrant and migrant households. No gender difference was found on children's dietary diversity.	National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025): there should be zero stunted children less than two years of age. National Policy on Early Childhood Care and Development (2010)	Recommended Interventions 1.2, 1,3, 1.4 apply. In addition, policy makers should develop mechanisms to assess gender specific interventions, in particular to address risk of boys among the general population (migrant and non-migrant) as well among children of migrants. Interventions to promote resilience could be developed based on the advantage observed in girls in this study and assess if/how skills could be transferred to boys in the Cambodian context.
	Caregivers			
1.6	Do caregivers in migrant households have worse nutrition status than those in non-migrant households?	Poor dietary diversity of caregivers in migrant households. Higher rate of being overweight (31%) among caregivers in migrant households compared to caregivers in non-migrant households (23%).	National Aging Policy 2017-2030 National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025)	Community-level health workers can support migrant households to develop a nutritional plan for caregivers. Efforts should be made to formulate a strategy not only for child wellbeing but also in ensuring respite and health and spiritual needs for caregivers.
1.7	Do caregivers in migrant households show vulnerabilities in terms of physical health?	Caregivers had poorer self-report physical health in migrant households than in non-migrant households: older age was the main reason.	National Health Care Policy and Strategy for Older People, 2016 National Aging Policy 2017-2030	'Caring for the caregiver' to guide interventions to support elderly caregivers. Providing support for elderly caregivers to participate in spiritual development is an important as cultural and religious engagement forms a key part of 'healthy' aging in Cambodian life.
1.8	Is migration associated with caregiver's mental health, resilience and social support?	Prevalence of depression and anxiety for caregivers was as high as 43% and 50%, respectively: Higher prevalence among caregivers in migrant households. Caregivers in migrant households had lower levels of resilience. Oldest caregivers showed the symptoms of distress stemming from their past trauma experience during the civil war period.	Mental Health and Substance Misuse Plan 2011-2015: to ensure universal access to mental health and substance abuse services for all Cambodians National Aging Policy 2017-2030	Policy should address mental health issues among caregivers left behind, especially the female elderly. Service sectors in elderly care can be trained to identify and treat the common psychological distress among elderly. Psychoeducation and cognitive-behavior therapy (CBT) can be provided to elderly caregivers to reduce trauma-related stress. Taking into account the specific cultural context of Cambodia, Buddhist practice such as meditation may offer spiritual healing. Quality Assurance Office under the Department of Hospital Services, Department of International Cooperation and Department of Mental Health and Substance Use can provide support.
1.9	Are there gendered differences of vulnerabilities and resilience profiles among caregivers?	Gender differences in nutritional status: female caregivers were more likely to be overweight than male caregivers. No gender difference was found on dietary diversity and self-report physical health. Being female was a key risk factor related to poor mental health: female caregivers had a higher prevalence of depression and anxiety	Mental Health and Substance Misuse Plan 2011-2015: to ensure universal access to mental health and substance abuse services for all Cambodians National Aging Policy 2017-2030	Recommended Interventions 1.5, 1.6, 1,7 apply.

2- To understand the extent of contribution by remittances to health, educational and social protection of the families left behind

	Research questions	Study Findings	Relevant Policies	Recommended Interventions
2.1	How often migrant parents remit money?	Most parents sent remittances monthly. Father-migrants remitted more frequently and more money. International-migrant remitted the highest amount.	The Labor Migration Policy (LMP): The policy includes provisions on the development of financial services to ease remittances transfer and support productive investments in the communities of origin; To develop a comprehensive and effective labor migration governance framework that protects and empowers women and men throughout the migration cycle, ensures that migration is an informed choice, and enables a positive and profitable experience for individual workers, their families and communities, that also contributes to the development of Cambodia.	Governments can support families by creating Migrant Resource Centers (MRCs) to provide access to information and facilitate informed choice in migration by facilitating partnerships with local job-network providers or domestic explore processing zones.
2.2	What is the role of remittances in migrant households?	Remittances were often used for extra food, more frequent or better-quality medical care and children's education. Household debt was common among all households. Seventy-three percent of migrant households used remittances to pay back loans with the remaining households using income generating or business activities to make repayments. Non-migrant households exclusively used income generating activities and their business as the source of debt repayment.		Government can make remittance transfers more affordable and offering credit schemes to support migrant families. Public sector actors can explore regulatory guidelines to enable partnership models and non-bank institutions to accelerate product innovation. Private sector actors can identify and support innovative solutions, including strengthening digital delivery channels, launching mobile wallet apps and developing remittance-linked savings.

3 - To understand specific vulnerabilities of households with either male or female single migrant parent or of households with two migrating parents (parenting styles, attachment and communication issues)

	Research questions	Study Findings	Relevant Policies	Recommended Interventions
Children				
3.1	Whether who migrates in the households matters to children's development?	Children 0 to 3 of both-parents migrant had better dietary diversity, early development and were less likely to be stunted and underweight. Children 12 to 17 of both-parents-migrant and father-migrant had less resilience. Children 12 to 17 of father-migrants had poorer nutritional status.	National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) National Policy on Early Childhood Care and Development (2010)	Recommendations 1.1, 1.4 apply. Services could be designed is to support father-migrants to adjust their fathering roles as migrants and accordingly to fulfil children's emotional needs.
3.2	Whether who is the caregiver in migrant households matters to children's development outcomes?	Children 0 to 3 with mother and grandparent caregivers had better children development. Children 12 to 17 of both-parent-migrant who were cared for relatives other than grandparents showed disadvantages in resilience.	National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) National Policy on Early Childhood Care and Development (2010)	
3.3	Whether migration destination (internal or international migration) matters to children's development outcomes?	Destination mattered for child development. Younger children 0 to 3 were less likely to be stunted when both-parents migrated internationally, or fathers migrated internally. Older children 12 to 17 of mother-migrants had less resilience. Older children 12 to 17 of mother-international-migrants had less attachment to caregivers.	National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) National Policy on Early Childhood Care and Development (2010)	Recommendations 1.1, 1.4 apply.

Caregivers				
	Which type of caregiver in migrant households were most vulnerable in terms of health?	Caregivers in both-parents-migrant households showed disadvantages in health: more likely to be overweight and had higher level of psychological distress. Other relative-caregiver (e.g. mainly mother's sister) had poorer self-report physical health and lower levels of resilience.	National Health Care Policy and Strategy for Older People, 2016 National Aging Policy 2017-2030	Recommendation 1.7 applies. Interventions to support elderly caregivers can include: public education for changing traditional gender ideology regrading roles of females in housework, child care centers that can offer respite for caregivers, as well as community centers that provide a space for elderly to relax and build peer support.
	Whether migration destination (internal or international migration) matters to caregiver's health outcomes?	Within father-migrant households, caregiver's health did not differ by internal of international migration. Within both-parents-migrant and mother-migrant households, international migration was associated with caregiver's lower levels of resilience.		Recommendation 1.7 and 1.8 applies. Interventions can include community-based awareness raising on mental health and home visits should be strengthened. In addition to working with the targeted vulnerable group of elderly, home visits should also reach out to the family members of migrant household including, father, grandfather, and other relatives in order to involved them as supporting resources for caregivers.
	Whether the migration destination (internal or international migration) matters to the pattern of communication?	Internal-migrants had a higher frequency of communication contact and visitation than international-migrant. International-migrants rely more on social media for communication.		Government can encourage strategies to lower telecommunications costs and related technological barriers to enable migrants to connect more frequently with their families left behind. Parenting workshops can be provided to migrant parents to set up a regular communication schedule and develop a long-distance parenting plan. Elderly caregivers could receive support to learn how to use advanced communication technologies to facilitate communication between children and their parents.

4 - To understand the linkages, if any, between migration and institutionalization of children of migrant worker

	Research questions	Study Findings	Relevant Policies	Recommended Interventions
4.1	What are the pathways that lead the left behind children of migrant workers towards institutionalization?	Two primary pathways into RCIs: Migration as a Factor and Migration as a Determinant. Children of internation-al-migrant parents were represented more in the study Children appreciated the stability of the RCI while missing the warmth of a family life.	Policy on Alternative Care for Children (2006) Minimum Standards on Alternative Care for Children in the Community (2008)	Recommendations 2.1 about migrant parent remittances apply. Community interventions to support family functioning and to address risk behaviors including domestic violence, alcohol and drug abuse. Different structural interventions regarding accessibility to secondary schools for children living in more remote rural areas and increasing accessibility to secondary school/vocational training.
4.2	How do the experiences of the children in RCIs differ from children who remain in the village when their parents migrate?	Children in village had not participated in cross-bor-der migration with their parents. Children in village had a caregiver who worked to keep the children in the village—strong support from caregivers.	Policies in 1.6 to 1.8 apply	Recommendations 1.6 to 1.8 to support caregivers well-being apply.
4.3	What are the factors that enable reintegration of children of migration to the community?	Supportive services. Return migration. Stable caregiving. Educational opportunities. Child mental stability.	Minimum Standards on Alternative Care for Children in the Community (2008)	Recommendations 1.6 to 1.8 to support caregivers well-being apply. Recommendations on 2.1 about migrant parent remittances apply.

5. Intervention Framework

As indicated in Chapter 1, very few studies have specifically explored the health impact on migrant families in Cambodia despite the relatively large migrant worker flows both internally within Cambodia, and across its borders – for instance in 2013 alone, nearly 25 percent of the Cambodian population had changed their location of residence and an estimated 1.1 million worked as inter-national migrant workers (National Institute of Statistics 2013; UNDESA 2017).

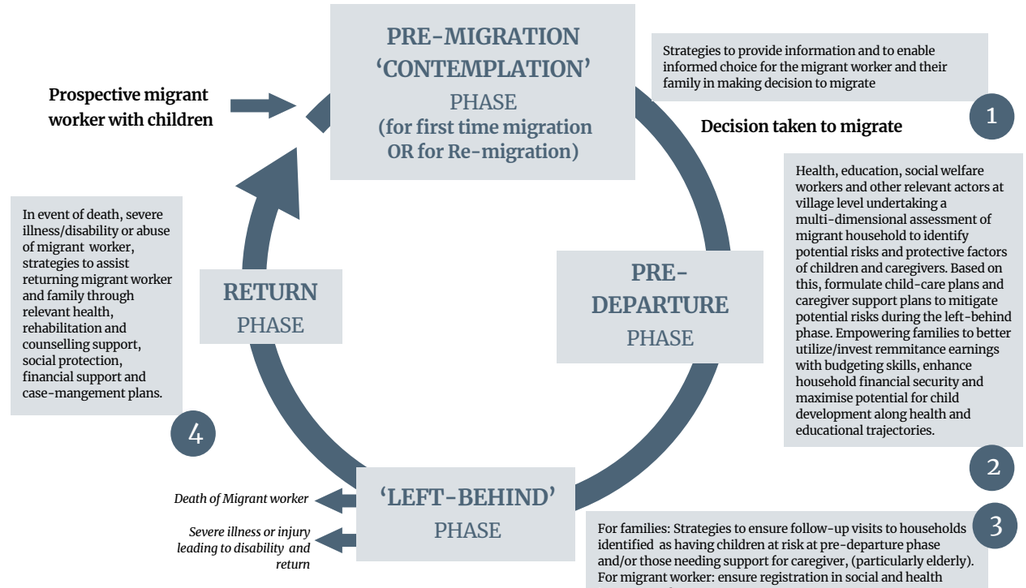
The MHICCAF research study therefore presents the most comprehensive baseline assessment hitherto of the health and wellbeing of members of mi-grant households in Cambodia. While the current study provides arguably a most comprehensive picture, there were several others that have also been presented exhibiting their impact on the existing evidence-base (Section 3.6).

To address health impacts to migrants and their left behind families IOM recommends a multi-dimensional intervention framework across all stages of migration (see Figure 26) adopting the social determinants of health approach.[86] Proposed actions may include establishing or enhancing: policy and legal formulary, service management and delivery programs/projects; reform of existing case-management practice, better data management practices and research. An intervention framework needs to be calibrated upon:

- the best available evidence, considering the strength of the evidence and gaps.
- local internal, cross-border and international migration dynamics.
- clarity in determining who the recommendations are for (e.g. practitioners, policy makers, researchers); by sector (e.g. public, private, voluntary organizations); and by setting/context.
- local resource realities and capacities considering the feasibility, acceptability, cost (resource use) and health equity of proposed interventions.
- meaningful consultations with key stakeholders (including migrants, their families) and defining mechanisms to address these.
- assessing existing domestic legal and policy framework, examining gaps, policy coherence, policy conflict, opportunities for enhancing existing policies or need to establish dedicated policies.

86. Wickramage K, Siriwardhana C, Peiris S. (2015) Promoting the well-being of left behind children of asian labour migrants: evidence for policy and action. <http://www.migrationpolicy.org/research/promoting-health-leftbehind-children-asian-labour-migrants-evidence-policy-and-action> Migration Policy MPI Publications, Washington DC.

FIGURE 26— A MULTI-DIMENSIONAL INTERVENTION FRAMEWORK TO PROMOTE WELL-BEING OF MIGRANTS AND THEIR FAMILIES ACROSS THE PHASES OF MIGRATION



87. Ibid, Wickramage K, Siriwardhana C, Peiris S. (2015).

88. IOM (2017) Migration health research to advance evidence-based policy and practice in Sri Lanka. IOM publications, Geneva, 2017.

IOM recommends a multi-sectoral intervention formulary driven through a process that engages the relevant organs of government (such health, social services and social welfare, foreign affairs, child protection, immigration, labor, including governance conduits at regional and local level), industry and employer groups, civil society, NGOs, development partners and migrants themselves.[87]

The importance of tailoring policy recommendations and programmatic interventions to existing realities, along with financial resources, existing technical capacities, social and political capital are also emphasized in IOM's guidance in addressing health impacts of labor migration through sustainable and durable solutions. Not all recommendations may be feasible in the short to medium term, and therefore it is suggested that a tiered approach to interventions be adopted at the country level to ensure progressive realization. Facilitating knowledge exchanges with labor sending countries in the South-Asian region that have formulated policy and program approaches by using this inter-sectoral framework is also useful.[88]

5.1.
METHODS USED TO FORMULATE POSSIBLE INTERVENTION STRATEGY

Findings of the research were first shared with the MHICCAF research project's collaborating agencies and feedback was obtained on possible intervention formulary. IOM, Louvain foundation and HKU researchers then facilitated seminars with a broader group of stakeholders in Cambodia to share research findings. The research team then facilitated workshops with these stakeholders on exploring sustainable and durable solutions based on existing evidence and harnessing the experience of practitioners and agencies involved. Stakeholders that participated in the intensive workshop and seminars included representatives from the Cambodian government - across health, foreign affairs, social and welfare, mental health domains, civil society organizations, researchers, NGOs (both local and international), national child protection and welfare networks, United Nations agencies and development partners. IOM's multi-dimensional intervention framework described above was used as an anchoring point to facilitate discussion.

Recommended interventions across policy, service and research action areas can be presented in different formats. Tables in Section 3 are presented alongside each evidence node/strand. It is important to note that these proposed actions are calibrated to reference a broad intervention approach rather than a prescriptive action based on the valency and weight of each research finding. For instance, evidence node in part of Table 1.5 indicates that boys in migrant households were disadvantaged in nutritional status compared to girls - with higher rate of stunting in ages 0 to 3 (23%); higher prevalence of stunning (33%) and wasting (16%) in ages 12 to 17, with boys less likely to express prosocial norms than girls. Recommendations however stopped short of suggesting specific actions to target male children, rather focusing on implementing a risk assessment plan.

Here the recommended interventions are categorized across the phases of migration as per the IOM framework. The targeted beneficiaries for intervention include migrant workers, their left behind children and caregivers of these children, while key stakeholders needed to advance interventions include health, child protection, education and elderly welfare workers working at village/commune level within government and non-governmental sectors.

5.2.
EXAMPLE OF INTERVENTION STRATEGIES ACROSS THE PHASES OF MIGRATION

5.2.a. Pre-migration contemplation phase:

Aim: *Empowering migrants and their families with information and knowledge to promote safe migration and joint planning for their migration journey*

Qualitative interviews of migrant household members indicated some felt disenfranchised in the decision made to migrate for work. While many viewed migration as a positive enabler for the household, some responders felt the decision to migrate was best made through a consultative process involving the potential migrant worker, spouse and other members of household. Planning to address child-care support needs was highlighted as a critical step in this 'pre-contemplation phase'. Intervention scope within this phase may focus on providing information, counselling and guidance to migrants and their families through Migrant Resource Centers (MRCS) established in heavy out-migration districts and along key border areas in Cambodia. Utilizing culturally appropriate communication methods, community campaigns and other communication platforms such social media platforms may also be considered. During the study, the study team found the village chief (the local administrative head of each village) to have a sound understanding on the migration intent of many within the village catchment. Providing targeted training to such conduits with information may therefore be useful.

Several MRCs have already been established in Cambodia - operated by Government agencies, trade unions as well as community support organizations.[89] The purpose of the MRCs is to provide information, counselling, and legal assistance to visitors, and to conduct outreach to schools, training institutions, and communities. However, stakeholder feedback during workshops indicated information modules relating to health risks, vulnerabilities and health protection strategies were poorly defined or non-existent in the range of services provided at existing MRCs. An IOM supported MRC in the border district of Poi Pet in Banteay Meanchey province undertook health care services, community-based health promotion and prevention programs, with a focus on diseases such as tuberculosis and malaria for migrant workers and communities. Action is needed to ensure tailored, evidence-informed

89. ILO (2014) Migrant Worker Resource Centre operations manual. ILO Regional Office for Asia and the Pacific. – Phnom Penh: ILO. Link: <http://www.oit.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_312456.pdf

education and training material are developed and requisite investments in coordination, material and module development and training programs are implemented in MRCs across the country. MRCs provide opportunity to facilitate informed choice in migration trajectory.

5.2.b. Pre-departure phase:

Aim: *Empowering and supporting migrants and their families in assessing potential risks to health and wellbeing during the migration journey and developing strategies to mitigate those risks.*

A multi-dimensional assessment of migrant household to identify potential risks and protective factors of children and caregivers of the migrant household at pre-departure phase can be undertaken by health, education, social welfare workers and other relevant actors at village level. Based on this assessment child-care plans and caregiver support plans to mitigate potential risks during the left behind phase can be formulated. An example of this coordinated care plan approach to identify at risk families that may progress toward negative trajectories is currently been implemented in Sri Lanka.[90] It is important to emphasize that it is not to inhibit migration but to better manage and mitigate the potential risks that the assessment should aim for. The development of such a rapid assessment tool should be implemented through an inter-sectoral effort as described in introduction to this section.

The importance of 'caring for the caregiver' was highlighted in the research study, as the impact on health vulnerabilities were greatest within this group. Interventions to support elderly care provision includes:

- Importance of ensuring a case-management plan for left behind adults prior to migration through information and counselling provided by migrant resource centers or by village level social support workers.
- Providing respite for elderly caregivers (e.g. by establishing social support networks with other seniors at the local pagoda – place of worship at village level). Demands of caregiving and time consumed in care of left behind children may limit the access of elderly caregivers in their religious/spiritual practices such as attendance to Buddhist temples. Providing support for elderly caregivers to participate in spiritual development is an important as cultural and religious engagement forms a key part of 'healthy' aging in Cambodian life.
- Greater acknowledgement and recognition of the role elderly play in Cambodia's labor migration by community campaigns (e.g. in the form of 'caring for caregiver' day) and other culturally appropriate means of recognizing the role of elderly.
- Interventions should include improving management of non-communicable diseases including psychosocial and mental health services at the primary care level.
- A key finding from the stakeholder consultative workshop was the poor inclusion of elderly as a key beneficiary group as part of village development, health and welfare programs by NGOs, civil society organizations at village level.
- Efforts to make health care more equitable for older people, especially those in rural areas (through effective implementation of Cambodia's health equity scheme) and enhancing outreach elderly care support service plans (as stipulated under the National Health Care Policy and Strategy for Older People, 2016 and the National Aging Policy 2017-2030).

Several countries within the Asia-Pacific region have implemented programs and practices aimed at supporting the health welfare needs of transnational families. These include: pre-departure migrant workers orientation programs that is inclusive of migrant family members; enabling affordable and portable health insurance and migrant family welfare fund schemes; direct credit facilities and savings schemes for migrant households. The Government of Thailand permits migrants irrespective of their irregular status to access Thailand's social welfare and medical systems. Requirement from the Thai authorities is for migrants to register, undertake a health assessment and obtain a work permit.[91]

Existing pre-departure registration processes focus exclusively on the migrant worker, with little or no engagement of their families. While recognizing the predominant outflow of workers from Cambodia is through irregular routes, pre-departure orientation program that may be delivered at MRCs may help migrants and their families better understand of labor migration-related processes and risks. Engagement of village chief in referring migrant households to such orientation may be crucial. Empowering the caregivers of the left behind children in planning for case-management of child through another example of action that may be provided at such a pre-departure orientation at the MRC. Child-rearing and care strategies such as food preparation, educational support and recreational needs form a vital part of preparedness. Financial planning and investment advice to maximize the use of remittances may also be provided to heads of households within such pre-departure orientation programs, potential at MRC sites. Empowering families to better utilize/invest remittance earnings with budgeting

90. Ibid, Wickramage K, Siriwardhana C, Peiris S. (2015).

91. The Cambodian Ministry of Labor and Vocational Training (MLVT) provide services to ensure migrant workers register to enable access to health services in Thailand. The MLVT also facilitate with employer and industry groups safety training courses for laborers in a bid to cut down on potential accidents in the workplace.

skills, enhance household financial security and maximize potential for child development along health and educational trajectories is critical for development gains.

5.2.c. Left behind phase:

Aim: *to ensure follow-up visits to households identified as having children at risk at pre-departure phase and/or those needing support for caregivers (particularly those elderly).*

Research evidence from the current study and others[92] indicated that elderly caregivers who acquired child-care responsibilities within left behind families were afflicted with adverse health conditions, including mental health. Implementation of respite care programs for elderly caregivers at the community level and wider recognition of their services through supportive partnerships between employment agencies, civil-society groups, religious/spiritual organizations, NGOs, media and community volunteers may contribute to reducing the psychological burden of care.

Ensuring community-level health workers, child protection officers, education officers and other welfare workers at village level have capacity, resources and support to provide effective case-management and referral services to at-risk migrant households.

5.2.d. Return phase:

Aim: *to assist within return and integration – for instance, in the event of death, severe illness, disability or abuse of migrant worker, strategies to assist returning migrant worker and family through relevant health, rehabilitation and counselling support, social protection, financial support and case-management plans.*

Families face significant vulnerability and hardship especially in situations where the migrant worker incurs major injury, disability or abuse, or dies during employment abroad. Financial support, counselling and welfare support should be facilitated for members of such families, including children and elderly caregivers, with adequate provision for insurance payments and other livelihood support. Ensuring support to migrant workers who have been subjected to severe abuse during their labor migration experience or are survivors of trafficking or smuggling operations form a critical intervention at return phase.[93]. Psychosocial and mental health programs from important arms to family re-integration. Re-adjustment to traditional parental and/or spousal roles may also become difficult for the returning migrant, especially after long periods of absence.

92. Thapa, D.K., Visentin, D., Kornhaber, R. and Cleary, M., 2018. Migration of adult children and mental health of older parents 'left behind': An integrative review. PloS one, 13(10), p.e0205665.

93. IOM Cambodia continues to protect Cambodian victims of trafficking stranded abroad by facilitating voluntary repatriation. Provide immediate direct assistance and reintegration support upon victims' return to Cambodia with an expanded focus on adult male victims of forced labour. This includes screening for victims of trafficking at the main international border point in Poi Pet at the Migrant Resource Centre Complement the provision of direct assistance, also focusing on capacity building, such as training in victim identification, psychosocial first aid, and case management to Government and NGO service providers, including community leaders raise awareness about risks of human trafficking, and promote behavior change models in key migrant sending areas. Link: <https://www.iom.int/sites/default/files/country/docs/cambodia/IOM-SDG-BROCHURE-WEB.pdf>.

94. Alonso-Coello P, Schünemann HJ, Moberg J, Brignardello-Petersen R, Akl EA, Davoli M, et al. GRADE (Grading of Recommendations, Assessment, Development and Evaluations) Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well-informed healthcare choices. 1: Introduction. BMJ. 2016;353.

95. The National Institute for Health and Care Excellence (NICE), UK (2012) Methods for the development of NICE public health guidance (third edition) Link:<https://www.nice.org.uk/process/pmg4/chapter/developing-recommendations#formulating-research-recommendations >.

96. Wickramage K, MOsca D and Peiris, S (2017) Migration health research to advance evidence-based policy and practice in Sri Lanka. IOM Publications, Geneva. 2017: Link: <https://publications.iom.int/books/migration-health-research-advance-evidence-based-policy-and-practice-sri-lanka>.

5.2.e. Future action

While the study team adopted an evidence-to decision approach in guiding the recommended interventions, a more rigorous iterative consensus process is required by authorities and stakeholders. The recommendations provided in this report are therefore conditional and presented as progenitor actions. Methods such as those described by GRADE (Grading of Recommendations, Assessment, Development and Evaluations)[94] and The National Institute for Health and Care Excellence (NICE)[95] are useful in this regard. Important considerations such as feasibility analysis, financial assessments, potential effects of intervention; resource requirements, implications for health and welfare systems; cost-effectiveness and acceptability for each proposed action need to be assessed through extensive stakeholder consultations facilitated through for instance an inter-sectoral committee on migration health as exemplified in Sri Lanka.[96]

The interventions prosed provide the initial progenitor framework to catalyse debate and discussion. The Cambodian Migration Health Policy Process led by the Ministry of Health currently underway may provide a robust inter-sectoral mechanism to lead such discussions on policy and intervention formulary.



LIMITATIONS

Two major limitations should be highlighted for this study regarding the survey. One is the dichotomous choice of two cohorts, 0 to 3 and 12 to 17 years old only, which may oversimplify the complicated role played by age in the process and neglect the change of trend between these two age groups. The rationale for selecting the two age cohorts were outlined in the Methodology section (2.3), namely to ensure calibration with early childhood development assessment tools (CREDI) for early child cohort, and anchoring of the psychometric assessments such as the SDQ, Alabama Parenting for the older child cohort. Much of the rationale was also based on resource and time factors. For instance, the study was able to readily enable eliciting of information about adolescent children's own perspectives on parental migration, family relationships and their well-being. This enabled the comparison and cross-validation between the results obtained from youth and caregivers. While child-centered research approaches to elicit such responses within the younger age groups is possible, this would have taken considerable resources, training and expertise that would have far exceeded the project period. Future studies conducting follow-up survey can certainly track the youngest cohort within this study and map developmental and nutritional outcomes through the childhood years.

The provinces with the highest net migration were included in the survey sample. The provinces included (13 out of 25) resulted in national coverage of over 50% of the migrant origin areas for both internal and international migrants over age 18. Due to the constraints of time and budget, it was not feasible to cover each province, thus making the systematic choice of 13 among them with the biggest share of migration. The survey thus offers good coverage of major migrant sending areas across the country.

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APPENDIX 1— SAMPLE PROTOCOLS

The study implemented a PPS (probability proportional to size) multi-stage cluster sample of 1,500 migrant families and 400 non-migrant families stratified by province and district. All provinces with a threshold of having 1% or higher migrant households in the province population were selected into the sample. In each province, all districts that contributed at least a 1% share of the domestic or international migrant population were selected. This resulted in a sample of 56 districts in 13 provinces. Within each district 26 households were selected using multi-stage PPS cluster sampling. Stage one randomly selected communes with probabilities proportionate to the size of total over-18 migrant population from the commune. Stage 2 randomly selected villages using the same criteria. In stage 3 a list of migrant families in the village procured from local government was randomly ordered and households were approached in this random order (a simple random sample –SRS).

Because the study team could not anticipate in advance any fixed number of available migrant families per village, a 'filling-the-bucket' approach was used at the village level. That is, within each district, a complete list of communes and villages was produced that was randomly ordered using probabilities proportional to size. The study team proceeded down the list, attempting to get 5 families (4 migrant and one comparison) per village vis SRS until the district quota was met. Of course, for the last village surveyed in each district the sample was in general smaller, and that SRS was on average smaller than villages in the district that were sampled earlier. However, because the first village in each district represented, on average, a larger proportion of the migrant population than the last village, this approach still produces a random PPS sample that, when appropriately weighted, is representative of the migrant family population of Cambodia.

The result of this approach is a stratified sample, because the number of households per district has been fixed at 26. Hence, the sample size for each province is a function of the number of districts that meet the 1% threshold. However, for the purposes of obtaining the population weights the stratification is incidental, because the study sampled every district in Cambodia that met the 1% province threshold and the 1% district threshold. Analytically, the sample can be seen as a multi-stage PPS cluster sample of village households in 56 districts. Probability weights were calculated for each village in the sample, with probabilities proportionate to the village population's contribution to the total migrant population. For the total migrant population, if each village proportion of the total migrant population was p_v_i, the weight for each village = where the denominator represents the sum of all of these village proportions in the sample. Multiplying village means times these weights and summing over the sample will produce an unbiased estimate of the migrant population mean. Separate weights were calculated in like fashion for the domestic and international migrant populations.

We had a target sample size of 1,500 based on the project timeline, work-plan and minimum sample size for adequate sample power (see Table 1). A sample size of 1,500 allows for a confidence interval of +/- 2.5 percentage points around proportions; $\{\}^2$ = 1,537. The numbers are currently adjusted to 1,456 to allow for consistency of target number (household n=26) across the number of districts (more detail in Table 2 below). Multi-stage cluster sampling has to balance between cluster coverage and a sufficient sample size within cluster to represent each cluster with sufficient precision. Sampling 26 households per district allowed inclusion of all districts meeting the 1% threshold with a within district sample size ample for precise multi-level modeling of district level demographic and policy effects.

While the population number of international to domestic migrants varies, the distribution of this ratio among our target group (parents of children under age 18) is not known precisely, thus we are adopting an equal probability: the target ratio of domestic to international households ratio will be 1:1. Our sample is also adopting a 1:4 ratio for comparison households to combined (domestic/international) migrant household.

TABLE 1— TARGET SAMPLE

	Domestic	International	Comparison	
Share of sample	~40%	~40%	~20%	Total Col
Ages 0-3	300	300	150	750
Ages 12-17	300	300	150	750
Total Row	600	600	300	1500

Many of the selected sites have both types of migrants, although this will not be true in all cases. See below for the protocol for sampling households.

Household Selection

The Fieldwork Supervisor (FS), Team Leader , or designated other will coordinate with the Village Chief/Head in advance of enumerators arriving to the location (commune/villages) to obtain the listing of the migrant households with children in the target age groups (ages 0-3 and 12-17). The gold standard is to obtain two separate lists for (1) Domestic and for (2) International Households with children ages (3) 0-3 and/or (4)12-17 under each of the two types of migrants. Households will then be screened to compile the roster of eligible households. From this listing households will be randomly selected:

TABLE 2— WITHIN DISTRICT SAMPLE SIZES FOR TARGET HOUSEHOLDS (TARGET TOTAL: 1,456)

	Domestic	International	Comparison	**Row Total**
Ages 0-3	5	6	2	**13**
Ages 12-17	5	6	2	**13**
Col Total	10	12	4	26

The comparison households should be diversified across the sample and matched by age and gender to children within each district sample. Ideally the comparison households should be matched at the lowest level of administration (within same Village). However, if this is not possible for some reason, you will follow the general procedure below for reaching the target within the district to build the matched comparison sample. With four comparison households per district, you should aim to have 1 male & 1 female age 0-3 and 1 male and female age 12-17. These can then be matched with the different migrant age group households for comparison.

We selected 26 households within each of the 56 districts as above in Table 2. Table 3 is referred to in the procedure that follows to illustrate the process. Detailed notes to the study team about how to sample within each village follow.

TABLE 3: BATRAY DISTRICT WITHIN KAMPONG THOM PROVINCE

District	Commune	Village	VillGis	dist	com	Vill Chief Int	HHs matching criteria (randomly selected)	HHs inter-viewed	Com-ments
Mongkol Borei	Chamnaom	Chamnaom Lech	1020304	1	9				
Mongkol Borei	Chamnaom	Say Samon	1020318	1	9				
Mongkol Borei	Chamnaom	Rongvean Kaeut	1020303	1	9				
Mongkol Borei	Chamnaom	Rongvean Lech	1020302	1	9				
Mongkol Borei	Chamnaom	Roung Kou Daeum	1020306	1	9				
Mongkol Borei	Chamnaom	Ta Sal	1020310	1	9				
Mongkol Borei	Chamnaom	Roung Kou Kandal	1020307	1	9				
Mongkol Borei	Chamnaom	Dang Trang	1020313	1	9				
Mongkol Borei	Chamnaom	Ta Bun	1020316	1	9				
Mongkol Borei	Chamnaom	Roung Kou Chong	1020308	1	18				
Mongkol Borei	Soea	Boeng Touch	1021107	1	18				
Mongkol Borei	Soea	Buor	1021104	1	18				

1 - Within each District select the first Commune from the (randomly ordered) list.

2 - Go to the first village on the (randomly ordered) village list and recruit up to 5 households per Village (4 migrant, 1 Comparison). (In example above this is District: BARAY; Commune: CHOLONG; Village: BOS SBAENG)

3 - If there are fewer than 4 migrant households OR no comparison households, then continue to the next Village on the list for Commune 1 (example above: District: BARAY; Commune: CHOLONG; Village: Village: TUOL TUMPING)

4 - Continue in order of listing to next village(s) within commune until you have met the target sample sizes for the district (as above in Table 2).

5 - If not possible to complete within the villages within Commune 1, continue to Commune 2 and so on following same process until reach target size. (In example above this District: BARAY; Commune: TRIEL; Village: ROPEAK PEN). I have provided an 'exhaustive list' which means there should be more than enough villages to fulfil the quota. However, this does not mean you will necessarily go to all of the communes nor villages. You should fill the quota up to 5 households per Village and then move onto the next Village on the list within that Commune until you have the final 26 for that District.

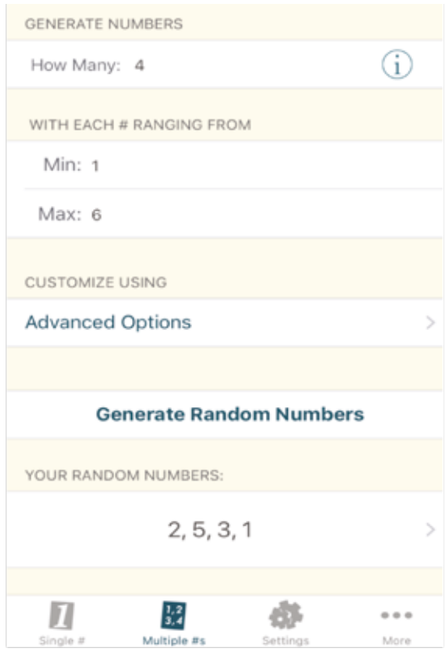
The goal is to balance the migrant composition (a balance of international and domestic households) over all of the districts and ultimately across the national sample. As the proportion varies within districts, some districts may have more domestic while others have more international. We will keep track of this during the field period, and may make adjustments to the suggested approach for selecting households if necessary. When possible we will aim to balance the sample by type of migration (domestic/international) and age group of child (0-3 and 12-17).

The target number is 1,456 which is slightly less than the current fieldwork plan (1,500). This number was selected to provide an overall balance for the sample composition. If we choose 5 households per Village, and each Village has eligible households, then we would visit 6 Villages (example above would be choosing 5 households from the first 5 Villages and 1 more from Village 6 to meet the quota of 26. In the example above this means we would only go to the first Commune: BARAY.

Within each village which has eligible households beyond the required number (4 Migrant; 1 Comparison) you will randomly select using a simple Random Number Generator App (Android RNG or IPhone Random #). For example, you complete the screening of listing of households, the given village has 6 eligible households for Domestic migrant parents with children aged 0-3 years old and 4 households non-migrant (i.e. comparison in age 0-3). Consulting Table 2 you recall you need to select up to 4 migrant (domestic or international) households per village, and 1 comparison. So you should select 4 migrant households and 1 comparison. You should randomly select the 4 migrant households as below. Example using Random # IPhone you enter:

4 for How many
1 for Min
6 for Max

Press Generate Random Numbers (every time you press it will be different)



You then would select the households according to the numbers generated. In the example here it is households:

2,5,3,1
You should choose the households associated with these numbers from the list. Afterwards move to the next village and start the process again for selecting households. This process should be documented in the field for later review if necessary and discussion amongst the team about fieldwork progress and quality.

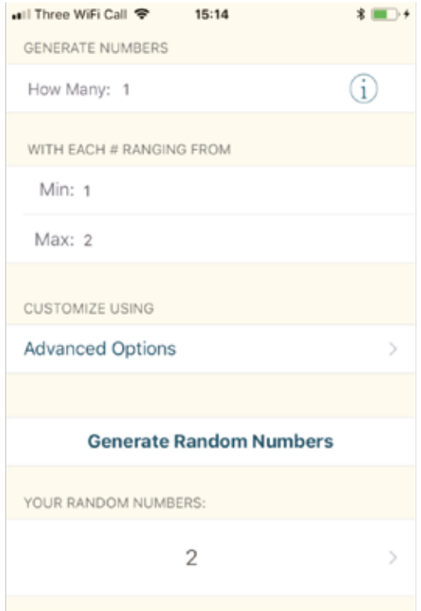
Selection of Children in Household

In the event there is more than one child per eligible age group in the household, do a simple random selection using the same procedure as above. For household with 2 eligible children:

1 for How many
1 for Min
2 for Max

Press Generate Random Numbers (every time you press it will be different)

In this example it is **Child 2** we select.



In the event there is an eligible younger (0-3) and older (12-17) child in the same household, the team should purposefully select the child in the older child age group (12-17) since we anticipate there are fewer of these households. Thus you would apply the random process only if there are two or more children within the same age age group, but not to select between the older and younger age groups.

A note about comparison households. If there is no comparison household in the village, then seek to locate a comparison household within the next highest level of aggregation where you are sampling (next village in Commune for example). To the best extent possible we would like to have 4 comparison households per District (one male and female in age group). If this is not possible, then seek to match within Province.

APPENDIX 2— FIGURES AND TABLES

TABLE 1— DISTRIBUTION OF PRIMARY CAREGIVER'S AGE AND GENDER BY MIGRANT STATUS OF HOUSEHOLDS

Characteristics of primary caregiver	Non-Migrant household	Migrant household	Full sample[1]	p-value
Average age	35.49	53.41	50.74	<0.0001
Age groups (%)				<0.0001
18-29 years	26.66	7.46	10.33	
30-39 years	43.14	10.11	15.04	
40-49 years	23.63	14.5	15.86	
50-59 years	4.2	28.67	25.02	
60 and above	2.37	39.26	33.75	
Gender (%)				0.043
Female	97.32	94.8	95.18	
Male	2.68	5.20	4.82	

TABLE 2— AGE OF INDEX CHILD'S PARENTS BY MIGRANT STATUS OF HOUSEHOLDS

Characteristics of parents	Non-Migrant household	Migrant household	Full sample	p-value
Average age of father	37.34	34.29	34.77	< 0.0001
Age groups (%)				
18-29	20.75	25.25	24.58	
30-39	41.46	44.65	44.17	0.102
40-49	26.51	19.08	20.18	
50 and above	11.28	11.03	11.07	
Average age of mother	34.72	32.12	32.52	<0.0001
Age groups (%)				
18-29	31.53	35.49	34.90	
30-39	41.31	49.99	48.69	<0.0001
40-49	22.67	11.78	13.40	
50 and above	4.48	2.75	3.01	

[1] Full sample refers to date from sample including both migrant and non-migrant households

TABLE 3— DISTRIBUTION OF MIGRANT'S AGE BY MIGRATION TYPES OF PARENTS

Age groups of migrants	Non-migrant households		Both-parent-migrant households		Father-migrant households	Mother-migrant households	Total	
	Father	Mother	Father	Mother			Father	Mother
Age 18-29	20.75	31.53	27.63	36.48	26.44	23.76	26.33	34.45
Age 30 - 39	41.46	41.31	47.13	50.04	52.37	59.97	47.01	49.44
Age 40 - 49	26.51	22.67	20.98	12.28	14.95	15.95	20.96	14.42
Age 50 and above	11.28	4.48	4.26	1.19	6.24	0.31	5.7	1.68

TABLE 4— PREVALENCE OF INJURY BY MIGRANT STATUS OF HOUSEHOLDS

Injury profile in the last one year	Non-migrant households	Migrant household	Full sample	p-value
Any member is injured in the household (%)	14.18	8.97	9.75	0.015
Average number of injured members (mean)	1.11	1.12	1.12	0.91
Types of injury				
Road accident	72.98	55.78	59.59	
Other	17.21	19.48	18.98	
Fall from tree/building	0	12.06	9.39	
Snake/animal bite	2.97	7.84	6.76	
Violent assault	4.92	0.93	1.81	
Fire/burning	1.91	1.95	1.95	
Poisoning	0	1.38	1.07	
Gunshot/weapon	0	0.59	0.46	

TABLE 5— FOOD EXPENDITURE BY MIGRANT STATUS OF HOUSEHOLDS

Proportion of food expenditure in the last one month	Purchase in cash	Own production, wages in kind, gifts, free collections	Total amount
Oil and fats	2.87	0.15	3.02
Sugar, salt and spices condiment	8.42	0.45	8.87
Total	11.29	0.6	11.89

Food expenditure	Non-Migrant household	Migrant household	Full sample	p-value
Oil and fats	2.74	3.04	3.02	
Sugar, salt and spices condiment	7.82	9.05	8.87	0.009
Total	10.56	12.12	11.89	0.006

TABLE 6— MEAN SCORES OF CAREGIVER'S DIETARY DIVERSITY BY GENDER AND AGE GROUPS

Average scores of dietary diversity	Non-migrant households	Migrant households	Total	p-value
Total (mean, S.D.)	7.11 (1.68)	6.55 (1.7)	6.62 (1.71)	<0.0001
Gender				
Female	7.12	6.51	6.64	<0.0001
Male	6.67	6.61	6.61	NA
Age groups				
18-59 years	7.14	6.55	6.64	<0.0001
60 and above	6.06	6.52	6.477	NA

Note: Given the sample size of males and elderly above 60 in non-migrant households is small (n < 10), the test of group difference is not applicable to these two groups.

S.D. = standard deviation

TABLE 7— REGRESSION OF TYPES OF MIGRANT ON CAREGIVER'S DIETARY DIVERSITY

Migration information	Coef.	S.E.	p-value	95% CI	
Model 1 **Diverse types of migration on caregiver's dietary diversity**					
Non-migrant household (Reference group)					
Father-migrant	-0.54	0.14	0.000	-0.83	-0.25
Mother-migrant	-0.53	0.17	0.003	-0.86	-0.19
Both-parents-migrant	-0.58	0.15	0.000	-0.89	-0.28
Caregiver age	0.00	0.00	0.969	-0.01	0.01
Caregiver gender-being male	-0.12	0.20	0.559	-0.53	0.29
Constant	7.25	0.22	0.000	6.80	7.70
F	4.98				
R-square	0.01				
Model 2 **Diverse types migration pertaining to migration destination on caregiver's dietary diversity**					
Non-migrant (Reference group)					
Both-parents-internal-migrant	-0.61	0.19	0.002	-0.99	-0.24
Both-parents-international-migrant	-0.55	0.15	0.001	-0.85	-0.24
Father-internal-migrant	-0.30	0.15	0.053	-0.60	0.00
Father-international-migrant	-0.72	0.19	0.000	-1.10	-0.33
Mother-internal-migrant	-0.61	0.22	0.008	-1.06	-0.17
Mother-international-migrant	-0.42	0.18	0.021	-0.77	-0.07

TABLE 7— REGRESSION OF TYPES OF MIGRANT ON CAREGIVER'S DIETARY DIVERSITY

Migration information	Coef.	S.E.	p-value	95% CI	
Caregiver age	0.00	0.00	0.968	-0.01	0.01
Caregiver gender-being male	-0.15	0.20	0.469	-0.56	0.26
Constant	7.27	0.23	0.000	6.81	7.74
F	3.13				
R-square	0.02				
Model 3 **Diverse types of migration pertaining to care arrangement on caregiver's dietary diversity**					
Non-migrant					
Father-migrant/mother-caregiver	-0.43	0.15	0.007	-0.74	-0.12
Father-migrant/kinship-caregiver	-1.08	0.35	0.004	-1.79	-0.37
Mother-migrant,/kinship-caregiver [2]	-0.67	0.20	0.002	-1.08	-0.26
Both-parents-migrant/grandparents-caregiver	-0.73	0.19	0.000	-1.11	-0.34
Both-parents-migrant/other relative-caregiver	-0.49	0.16	0.004	-0.81	-0.16
Caregiver age	0.005	0.004	0.185	0.00	0.01
Caregiver gender-being male	-0.13	0.21	0.550	-0.56	0.30
Constant	7.07	0.24	0.000	6.58	7.56
F	3.46				
R-square	0.02				

[2]. Only 5 cases that have fathers as caregivers when their mothers migrate. They are omitted in the regression analysis of model 3.

TABLE 8— LOGISTIC REGRESSION OF TYPES OF MIGRANT ON CAREGIVER'S NUTRITIONAL

	Thinness				
Migration types	**OR**	**S.E**	**p-value**	**95% CI**	
Father-migrant	1.34	0.54	0.469	0.59	3.03
Mother-migrant	1.12	0.53	0.806	0.44	2.90
Both-parents-migrant	1.08	0.49	0.869	0.43	2.72
Child age	1.02	0.01	0.066	1.00	1.05
Child gender-being male	1.13	0.33	0.679	0.63	2.02
Constant	0.03	0.02	0.000	0.01	0.12
F	1.03				
Caregiver types					
Father-migrant/mother-caregiver	1.57	0.66	0.284	0.68	3.64
Father-migrant/kinship-caregiver	0.72	0.47	0.619	0.20	2.67
Mother-migrant,/kinship-caregiver [3]	1.04	0.51	0.944	0.38	2.81
Both-parents-migrant/grandparents-caregiver	0.96	0.47	0.935	0.35	2.60
Both-parents-migrant/other relative-caregiver	1.09	0.65	0.884	0.33	3.65
child age	1.03	0.02	0.073	1.00	1.06
child gender (1 = Female; 2 = Male)	1.18	0.34	0.573	0.66	2.12
Constant	0.02	0.02	0.000	0.01	0.11
F	0.75				
Destinations					
Both-parents-internal-migrant	1.17	0.58	0.750	0.43	3.20
Both-parents-international-migrant	1.11	0.52	0.818	0.43	2.88
Father-internal-migrant	1.24	0.55	0.637	0.50	3.02
Father-international-migrant	1.43	0.63	0.422	0.59	3.50
Mother-internal-migrant	1.59	0.84	0.383	0.55	4.59
Mother-international-migrant	0.68	0.37	0.487	0.23	2.04
child age	1.02	0.01	0.104	1.00	1.05
child gender (1 = Female; 2 = Male)	0.98	0.30	0.946	0.53	1.80
Constant	0.04	0.03	0.000	0.01	0.15
F	0.97				
Total Overweight (overweight + obese)					
Migration types	**OR**	**S.E**	**p-value**	**95% CI**	
Father-migrant	1.26	0.30	0.341	0.78	2.05
Mother-migrant	1.24	0.32	0.423	0.73	2.10
Both-parents-migrant	1.83	0.39	0.007	1.19	2.83
Child age	0.99	0.01	0.302	0.98	1.01
Child gender-being male	0.56	0.12	0.012	0.36	0.87
Constant	0.66	0.19	0.155	0.37	1.18
F	2.88				
Caregiver types					
Father-migrant/mother-caregiver	1.25	0.32	0.394	0.74	2.10
Father-migrant/kinship-caregiver	1.36	0.68	0.539	0.50	3.72

[3] Only 5 cases that have fathers as caregivers when their mothers migrate. They are omitted in the regression analysis of model 3.

Mother-migrant,/kinship-caregiver [4]	1.37	0.39	0.276	0.77	2.44
Both-parents-migrant/grandparents-caregiver	2.02	0.48	0.005	1.25	3.27
Both-parents-migrant/other relative-car-egiver	1.58	0.42	0.097	0.92	2.71
child age	0.99	0.01	0.128	0.98	1.00
child gender (1 = Female; 2 = Male)	0.58	0.13	0.020	0.37	0.91
Constant	0.71	0.20	0.236	0.40	1.26
F	2.12				
Destinations					
Both-parents-internal-migrant	1.63	0.29	0.009	1.13	2.33
Both-parents-international-migrant	1.93	0.47	0.010	1.18	3.15
Father-internal-migrant	1.33	0.36	0.298	0.77	2.28
Father-international-migrant	1.21	0.39	0.556	0.63	2.33
Mother-internal-migrant	1.08	0.31	0.784	0.61	1.91
Mother-international-migrant	1.38	0.46	0.344	0.70	2.71
child age	1.00	0.00	0.416	0.99	1.01
child gender (1 = Female; 2 = Male)	0.55	0.12	0.011	0.35	0.86
Constant	0.64	0.18	0.122	0.36	1.13
F	1.86				

[4] Only 5 cases that have fathers as caregivers when their mothers migrate. They are omitted in the regression analysis of model 3.

TABLE 9— REGRESSIONS OF MIGRATION ON CAREGIVER'S PHYSICAL HEALTH

Migration information	Coef.	S.E.	p-value	95% CI	
Model 1 **Diverse types of migration on caregiver's physical health**					
Non-migrant (Reference group)					
Father-migrant	-0.95	0.82	0.257	-2.61	0.72
Mother-migrant	-1.08	1.05	0.312	-3.20	1.05
Both-parents-migrant	0.43	0.87	0.625	-1.32	2.18
Caregiver age	-0.23	0.02	0.000	-0.27	-0.18
Caregiver gender-being male	1.38	1.32	0.301	-1.28	4.05
Constant	50.24	1.48	0.000	47.26	53.22
F	25.70				
R-square	0.10				
Model 2 **Diverse types migration pertaining to migration destination on caregiver's physical health**					
Non-migrant (Reference group)					
Both-parents-internal-migrant	0.46	1.07	0.671	-1.71	2.63
Both-parents-international-migrant	0.68	0.87	0.439	-1.07	2.43
Father-internal-migrant	-1.32	0.91	0.155	-3.16	0.52
Father-international-migrant	-0.68	1.03	0.515	-2.76	1.40
Mother-internal-migrant	-0.23	1.25	0.853	-2.75	2.28
Mother-international-migrant	-2.27	1.35	0.098	-4.99	0.44

TABLE 9— REGRESSIONS OF MIGRATION ON CAREGIVER'S PHYSICAL HEALTH

Migration information	Coef.	S.E.	p-value	95% CI	
Caregiver age	-0.22	0.02	0.000	-0.27	-0.18
Caregiver gender-being male	1.41	1.36	0.306	-1.33	4.15
Constant	50.17	1.51	0.000	47.12	53.22
F	16.37				
R-square	0.09				
Model 3 **Diverse types of migration pertaining to care arrangement on caregiver's physical health**					
Non-migrant					
Father-migrant/mother-caregiver	-1.50	0.88	0.096	-3.27	0.28
Father-migrant/kinship-caregiver	1.52	1.46	0.303	-1.42	4.46
Mother-migrant,/kinship-caregiver [5]	-1.65	1.16	0.160	-3.98	0.68
Both-parents-migrant/grandparents-caregiver	-0.13	1.04	0.902	-2.22	1.97
Both-parents-migrant/other relative-caregiver	2.30	1.01	0.027	0.27	4.34
Caregiver age	-0.21	0.03	0.000	-0.27	-0.16
Caregiver gender-being male	1.03	1.40	0.466	-1.79	3.85
Constant	50.18	1.50	0.000	47.15	53.20
F	24.51				
R-square	0.10				

[5] Only 5 cases that have fathers as caregivers when their mothers migrate. They are omitted in the regression analysis of model 3.

TABLE 10— LOGISTIC REGRESSION OF TYPE OF MIGRANT ON CHILDREN'S DIETARY DIVERSITY (6 – 23 MONTHS)

	O.R.	S.E.	p-value	95% CI	
Model 1 **Diverse types of migration on children's dietary diversity**					
Non-migrant (Reference group)					
Father-migrant	1.95	0.75	0.088	0.90	4.24
Mother-migrant	3.95	1.95	0.008	1.46	10.68
Both-parents-migrant	3.13	0.99	0.001	1.65	5.94
Child age	2.20	0.67	0.014	1.18	4.08
Child gender (1 = Female; 2 = Male)	0.97	0.22	0.898	0.62	1.53
Constant	0.40	0.21	0.089	0.14	1.16
F	4.47				
R-square	0.00				
Model 2 **Diverse types of migration pertaining to migration destination on Children's dietary diversity**					
Non-migrant (Reference group)					
Both-parents-internal-migrant	2.79	0.92	0.004	1.43	5.44
Both-parents-international-migrant	3.18	1.10	0.002	1.58	6.39
Father-internal-migrant	2.75	1.29	0.038	1.06	7.11
Father-international-migrant	1.59	0.65	0.267	0.69	3.62
Mother-internal-migrant	2.80	1.45	0.053	0.99	7.95
	1.00	(empty)			
Child age	2.31	0.68	0.007	1.27	4.19

TABLE 10— LOGISTIC REGRESSION OF TYPE OF MIGRANT ON CHILDREN'S DIETARY DIVERSITY (6 – 23 MONTHS)

	O.R.	S.E.	p-value	95% CI	
Child gender (1 = Female; 2 = Male)	0.91	0.20	0.680	0.58	1.43
Constant	0.42	0.22	0.104	0.15	1.20
F	3.06				
R-square	0.01				
Model 3 **Diverse types of migration pertaining to care arrangement on children's dietary diversity**					
Non-migrant					
Father-migrant, mother caregiver	1.90	0.72	0.100	0.88	4.10
Father-migrant, kinship caregiver	8.85	11.66	0.105	0.62	126.23
Mother-migrant, kinship caregiver [6]	3.93	1.93	0.008	1.46	10.60
Both-parents-migrant, grandparents carer	2.98	0.93	0.001	1.59	5.59
Both-parents-migrant, other relative carer	8.62	6.69	0.008	1.80	41.22
Child age	2.22	0.68	0.012	1.20	4.13
Child gender (1 = Female; 2 = Male)	0.97	0.22	0.907	0.61	1.54
Constant	0.39	0.21	0.083	0.14	1.13
F	3.83				
R-square	0.00				

[6] Only 5 cases that have fathers as caregivers when their mothers migrate. They are omitted in the regression analysis of model 3.

TABLE 11— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S DIETARY DIVERSITY (OLDER AGE COHORT)

	Coef.	S.E.	p-value	95% CI	
Model 1 Diverse types of migration on children's dietary diversity					
Non-migrant (Reference group)					
Father-migrant	-0.48	0.22	0.034	-0.92	-0.04
Mother-migrant	-0.60	0.21	0.008	-1.03	-0.17
Both-parents-migrant	-0.47	0.15	0.003	-0.78	-0.17
Child age	-0.09	0.03	0.009	-0.16	-0.02
Child gender (1 = Female; 2 = Male)	0.17	0.14	0.253	-0.12	0.46
Constant	8.53	0.51	0.000	7.50	9.56
F	5.25				
p-value	0.001				
R-square	0.02				
Model 2 Diverse types migration pertaining to migration destination on children's dietary diversity					
Non-migrant (Reference group)					
Both-parents-internal-migrant	-0.56	0.17	0.002	-0.90	-0.21
Both-parents-international-migrant	-0.45	0.16	0.008	-0.77	-0.12
Father-internal-migrant	-0.30	0.26	0.263	-0.83	0.23
Father-international-migrant	-0.60	0.31	0.063	-1.22	0.03
Mother-internal-migrant	-0.70	0.18	0.000	-1.07	-0.33
Mother-international-migrant	-0.45	0.43	0.300	-1.32	0.42

TABLE 11— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S DIETARY DIVERSITY (OLDER AGE COHORT)

	Coef.	S.E.	p-value	95% CI	
Child age	-0.09	0.04	0.012	-0.17	-0.02
Child gender (1 = Female; 2 = Male)	0.16	0.15	0.275	-0.13	0.45
Constant	8.54	0.54	0.000	7.45	9.63
F	3.97				
p-value	0.002				
R-square	0.02				
Model 3 Diverse types of migration pertaining to care arrangement on children's dietary diversity					
Non-migrant					
Father-migrant, mother caregiver	-0.46	0.26	0.080	-0.97	0.06
Father-migrant, kinship caregiver	-0.54	0.37	0.144	-1.28	0.19
Mother-migrant, kinship caregiver [7]	-0.57	0.21	0.011	-1.00	-0.14
Both-parents-migrant, grandparents carer	-0.46	0.15	0.004	-0.76	-0.15
Both-parents-migrant, other relative carer	-0.54	0.22	0.018	-0.99	-0.10
Child age	-0.09	0.03	0.010	-0.16	-0.02
Child gender (1 = Female; 2 = Male)	0.16	0.14	0.283	-0.13	0.45
Constant	8.52	0.51	0.000	7.49	9.56
F	3.75				
p-value	0.004				
R-square	0.02				

[7] Only 5 cases that have fathers as caregivers when their mothers migrate. They are omitted in the regression analysis of model 3.

TABLE 12— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S NUTRITIONAL STATUS (YOUNGER CHILD COHORT)

	Stunt				
Migration types	O.R.	S.E.	p-value	95% CI	
Father-migrant	0.50	0.20	0.084	0.23	1.10
Mother-migrant	0.41	0.17	0.034	0.18	0.93
Both-parents-migrant	0.48	0.17	0.041	0.23	0.97
Child age	2.68	0.33	0.000	2.09	3.44
Child gender (1 = Female; 2 = Male)	1.81	0.36	0.005	1.21	2.71
Constant	0.03	0.02	0.000	0.01	0.08
Adjusted-F	1.78				
p-value	0.108				
Caregiver types					
Father-migrant, mother caregiver	0.50	0.21	0.111	0.21	1.18
Father-migrant, kinship caregiver	0.50	0.29	0.240	0.15	1.61
Mother-migrant, kinship caregiver	0.42	0.17	0.038	0.18	0.95
Both-parents-migrant, grandparents	0.48	0.17	0.047	0.23	0.99
Both-parents-migrant, kinship caregiver	0.39	0.19	0.058	0.14	1.03
Child age	2.69	0.34	0.000	2.09	3.46
Child gender (1 = Female; 2 = Male)	1.81	0.36	0.005	1.21	2.71
Constant	0.03	0.02	0.000	0.01	0.08
Adjusted-F	1.89				
p-value	0.086				
Destinations					

TABLE 12— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S NUTRITIONAL STATUS (YOUNGER CHILD COHORT)

	Stunt				
Both-parents-internal-migrant	0.48	0.19	0.078	0.22	1.09
Both-parents-international-migrant	0.45	0.17	0.037	0.21	0.95
Father-internal-migrant	0.21	0.07	0.000	0.10	0.43
Father-international-migrant	0.73	0.33	0.490	0.29	1.82
Mother-internal-migrant	0.55	0.26	0.205	0.21	1.41
Mother-international-migrant	0.26	0.15	0.026	0.08	0.85
Child age	2.68	0.33	0.000	2.09	3.44
Child gender (1 = Female; 2 = Male)	1.74	0.35	0.008	1.16	2.61
Constant	0.03	0.02	0.000	0.01	0.09
Adjusted-F	2.72				
p-value	0.016				
Wasted					
Migration types	O.R.	S.E.	p-value	95% CI	
Father-migrant	1.36	0.61	0.501	0.55	3.37
Mother-migrant	0.66	0.34	0.431	0.23	1.89
Both-parents-migrant	0.88	0.41	0.792	0.35	2.26
Child age	0.41	0.08	0.000	0.28	0.60
Child gender-being male	1.24	0.34	0.435	0.72	2.15
Constant	0.22	0.12	0.011	0.07	0.69
Adjusted-F	1.77				
p-value	0.110				

TABLE 12— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S NUTRITIONAL STATUS (YOUNGER CHILD COHORT)

	Stunt				
Caregiver types					
Father-migrant, mother caregiver	1.44	0.65	0.427	0.58	3.57
Father-migrant, kinship caregiver	1.00	-	-	-	-
Mother-migrant, kinship caregiver	0.63	0.32	0.372	0.22	1.78
Both-parents-migrant, grandparents	0.86	0.39	0.743	0.35	2.14
Both-parents-migrant, kinship caregiver	0.63	0.73	0.695	0.06	6.60
Child age	0.44	0.08	0.000	0.30	0.64
Child gender (1 = Female; 2 = Male)	1.23	0.34	0.453	0.71	2.15
Constant	0.21	0.12	0.010	0.06	0.67
Adjusted-F	2.66				
p-value	0.018				
Destinations					
Both-parents-internal-migrant	0.66	0.34	0.419	0.24	1.84
Both-parents-international-migrant	1.08	0.54	0.881	0.40	2.93
Father-internal-migrant	1.31	0.72	0.618	0.44	3.94
Father-international-migrant	1.47	0.72	0.438	0.55	3.96
Mother-internal-migrant	0.61	0.38	0.426	0.17	2.12
Mother-international-migrant	1.02	0.80	0.984	0.21	5.00
Child age	0.37	0.06	0.000	0.27	0.52
Child gender (1 = Female; 2 = Male)	1.39	0.37	0.232	0.80	2.39
Constant	0.20	0.12	0.010	0.06	0.66

TABLE 12— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S NUTRITIONAL STATUS (YOUNGER CHILD COHORT)

	Stunt				
Adjusted-F	1.66				
p-value	0.137				
Underweight					
Migration types	O.R.	S.E.	p-value	95% CI	
Father-migrant	0.44	0.18	0.049	0.20	1.00
Mother-migrant	0.19	0.10	0.004	0.07	0.57
Both-parents-migrant	0.27	0.10	0.001	0.13	0.56
Child age	0.99	0.14	0.944	0.75	1.30
Child gender-being male	1.23	0.25	0.312	0.82	1.87
Constant	0.31	0.13	0.009	0.13	0.73
Adjusted-F	3.49				
p-value	0.004				
Caregiver types					
Father-migrant, mother caregiver	0.50	0.21	0.112	0.21	1.18
Father-migrant, kinship caregiver	0.09	0.05	0.000	0.03	0.29
Mother-migrant, kinship caregiver	0.19	0.10	0.003	0.06	0.55
Both-parents-migrant, grandparents	0.28	0.10	0.001	0.14	0.57
Both-parents-migrant, kinship caregiver	0.05	0.06	0.009	0.01	0.46
Child age	1.05	0.15	0.737	0.79	1.39
Child gender (1 = Female; 2 = Male)	1.25	0.26	0.301	0.81	1.92
Constant	0.28	0.13	0.007	0.12	0.69

TABLE 12— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S NUTRITIONAL STATUS (YOUNGER CHILD COHORT)

	Stunt				
Adjusted-F	3.69				
p-value	0.003				
Destinations					
Both-parents-internal-migrant	0.25	0.09	0.001	0.12	0.54
Both-parents-international-migrant	0.28	0.12	0.004	0.12	0.65
Father-internal-migrant	0.50	0.24	0.163	0.19	1.34
Father-international-migrant	0.40	0.20	0.074	0.14	1.10
Mother-internal-migrant	0.07	0.06	0.004	0.01	0.42
Mother-international-migrant	0.41	0.23	0.121	0.13	1.28
Child age	0.99	0.13	0.923	0.75	1.29
Child gender (1 = Female; 2 = Male)	1.23	0.25	0.321	0.81	1.86
Constant	0.31	0.14	0.012	0.13	0.76
Adjusted-F	1.48				
p-value	0.193				

TABLE 13— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S NUTRITIONAL STATUS (OLDER CHILD COHORT)

	Stunt				
Migration types	O.R.	S.E.	p-value	95% CI	
Father-migrant	2.90	0.83	0.001	1.63	5.17
Mother-migrant	1.15	0.33	0.635	0.64	2.05
Both parents-migrant	1.32	0.29	0.209	0.85	2.05
Child age	1.03	0.08	0.688	0.88	1.21
Child gender (1 = Female; 2 = Male)	2.36	0.37	0.000	1.73	3.23
Constant	0.04	0.05	0.007	0.00	0.40
Adjusted-F	1.85				
p-value	0.095				
Caregiver types					
Father-migrant, mother caregiver	3.51	1.12	0.000	1.85	6.67
Father-migrant, kinship caregiver	1.73	0.62	0.133	0.84	3.56
Mother-migrant, kinship caregiver	1.19	0.35	0.542	0.67	2.14
Both-parents-migrant, grandparents	1.29	0.28	0.243	0.83	2.00
Both-parents-migrant, kinship caregiver	1.45	0.50	0.287	0.72	2.93
Child age	1.03	0.08	0.697	0.88	1.21
Child gender (1 = Female; 2 = Male)	2.41	0.38	0.000	1.76	3.30
Constant	0.04	0.05	0.006	0.00	0.39
Adjusted-F	0.49				
p-value	0.873				
Destinations					

TABLE 13— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S NUTRITIONAL STATUS (OLDER CHILD COHORT)

	Stunt				
Both-parents-internal-migrant	1.15	0.29	0.583	0.69	1.92
Both-parents-international-migrant	1.42	0.33	0.129	0.90	2.26
Father-internal-migrant	1.94	0.76	0.098	0.88	4.27
Father-international-migrant	3.67	1.43	0.002	1.68	8.04
Mother-internal-migrant	1.50	0.49	0.222	0.78	2.90
Mother-international-migrant	0.75	0.33	0.514	0.31	1.80
Child age	1.04	0.08	0.602	0.90	1.21
Child gender (1 = Female; 2 = Male)	2.29	0.36	0.000	1.66	3.15
Adjusted-F	1.62				
p-value	0.148				
Wasted					
Migration types	O.R.	S.E.	p-value	95% CI	
Father-migrant	1.10	0.35	0.758	0.58	2.11
Mother-migrant	0.69	0.30	0.397	0.28	1.66
Both parents-migrant	0.71	0.23	0.294	0.37	1.36
Child age	1.09	0.08	0.262	0.94	1.27
Child gender (1 = Female; 2 = Male)	2.62	0.44	0.000	1.86	3.69
Constant	0.01	0.01	0.000	0.00	0.09
Adjusted-F	0.97				
p-value	0.483				
Caregiver types					

TABLE 13— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S NUTRITIONAL STATUS (OLDER CHILD COHORT)

	Stunt				
Father-migrant, mother caregiver	1.29	0.50	0.510	0.59	2.81
Father-migrant, kinship caregiver	0.72	0.37	0.520	0.26	2.01
Mother-migrant, kinship caregiver	0.71	0.31	0.445	0.29	1.73
Both-parents-migrant, grandparents	0.77	0.25	0.418	0.40	1.48
Both-parents-migrant, kinship caregiver	0.49	0.21	0.108	0.20	1.18
Child age	1.09	0.08	0.248	0.94	1.28
Child gender (1 = Female; 2 = Male)	2.63	0.44	0.000	1.87	3.69
Constant	0.01	0.01	0.000	0.00	0.09
Adjusted-F	0.68				
p-value	0.720				
Destinations					
Both-parents-internal-migrant	0.87	0.32	0.706	0.41	1.84
Both-parents-international-migrant	0.59	0.21	0.137	0.29	1.19
Father-internal-migrant	1.25	0.53	0.596	0.54	2.93
Father-international-migrant	1.02	0.48	0.964	0.40	2.62
Mother-internal-migrant	0.98	0.47	0.965	0.37	2.59
Mother-international-migrant	0.33	0.22	0.104	0.09	1.27
Child age	1.09	0.09	0.277	0.93	1.29
Child gender (1 = Female; 2 = Male)	2.68	0.49	0.000	1.86	3.87
Adjusted-F	0.76				
p-value	0.656				

TABLE 14— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S EARLY DEVELOPMENT (YOUNGER CHILD COHORT)

	Coef.	S.E.	p-value	95% CI	
Non-migrant (Reference group)					
Father-migrant	1.06	0.50	0.041	0.05	2.07
Mother-migrant	2.44	0.56	0.000	1.30	3.57
Both-parents-migrant	2.47	0.48	0.000	1.51	3.43
Child age	9.43	0.20	0.000	9.03	9.83
Child gender (1 = Female; 2 = Male)	-0.15	0.26	0.555	-0.67	0.36
Constant	32.28	0.65	0.000	30.97	33.59
F	473.27				
p-value	0.000				
R-square	0.81				
Non-migrant (Reference group)					
Both-parents-internal-migrant	2.41	0.51	0.000	1.38	3.44
Both-parents-international-migrant	2.49	0.52	0.000	1.44	3.55
Father-internal-migrant	0.30	0.56	0.594	-0.83	1.43
Father-international-migrant	1.61	0.58	0.008	0.45	2.77
Mother-internal-migrant	2.59	0.66	0.000	1.26	3.91
Mother-international-migrant	2.16	0.55	0.000	1.04	3.27
Child age	9.44	0.19	0.000	9.05	9.83
Child gender (1 = Female; 2 = Male)	-0.19	0.26	0.481	-0.72	0.34

TABLE 14— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S EARLY DEVELOPMENT (YOUNGER CHILD COHORT)

	Coef.	S.E.	p-value	95% CI	
Constant	32.32	0.66	0.000	30.99	33.65
F	341.88				
p-value	0.000				
R-square	0.81				
Non-migrant					
Father-migrant, mother caregiver	1.10	0.51	0.037	0.07	2.14
Father-migrant, kinship caregiver	0.70	0.76	0.363	-0.83	2.22
Mother-migrant, kinship caregiver	2.45	0.57	0.000	1.31	3.59
Both-parents-migrant, grandparents	2.45	0.48	0.000	1.49	3.42
Both-parents-migrant, other relative carer	2.43	0.66	0.001	1.10	3.77
Child age	9.45	0.21	0.000	9.03	9.87
Child gender (1 = Female; 2 = Male)	-0.15	0.26	0.551	-0.67	0.36
Constant	32.26	0.66	0.000	30.93	33.58
F	349.16				
p-value	0.000				
R-square	0.81				

TABLE 15— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S MENTAL HEALTH

	Coef.	S.E.	p-value	95% CI	
Model 1 **Diverse types of migration on caregiver's mental health**					
Non-migrant (Reference group)					
Father-migrant	-1.54	1.03	0.142	-3.61	0.53
Mother-migrant	-3.13	1.23	0.015	-5.60	-0.65
Both-parents-migrant	-0.69	1.06	0.516	-2.83	1.44
Caregiver age	-0.08	0.02	0.000	-0.12	-0.04
Caregiver gender (1 = Female; 2 = Male)	1.99	1.09	0.074	-0.20	4.19
Constant	45.95	1.47	0.000	42.98	48.92
F	13.33				
R-square	0.02				
Model 2 **Diverse types of migration pertaining to migration destination on caregiver's mental health**					
Non-migrant (Reference group)					
Both-parents-internal-migrant	-1.38	1.13	0.227	-3.66	0.90
Both-parents-international-migrant	-0.09	1.10	0.936	-2.31	2.13
Father-internal-migrant	-1.75	1.25	0.169	-4.27	0.77
Father-international-migrant	-1.40	1.21	0.252	-3.83	1.03
Mother-internal-migrant	-4.43	1.35	0.002	-7.15	-1.72
Mother-international-migrant	-1.28	1.40	0.364	-4.10	1.54
Caregiver age	-0.08	0.02	0.000	-0.12	-0.04

TABLE 15— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S MENTAL HEALTH

	Coef.	S.E.	p-value	95% CI	
Caregiver gender (1 = Female; 2 = Male)	1.48	1.07	0.174	-0.68	3.65
Constant	46.50	1.47	0.000	43.54	49.46
F	9.67				
R-square	0.03				
Model 3 **Diverse types of migration pertaining to care arrangement on caregiver's mental health**					
Non-migrant (Reference group)					
Father-migrant/mother-caregiver	-2.05	0.98	0.043	-4.04	-0.07
Father-migrant/kinship-caregiver	0.90	1.91	0.641	-2.96	4.75
Mother-migrant/kinship-caregiver	-3.24	1.28	0.015	-5.82	-0.66
Both-parents-migrant/grandparents-caregiver	-0.65	1.18	0.581	-3.02	1.72
Both-parents-migrant/other relative-caregiver	-0.02	1.51	0.992	-3.06	3.03
Caregiver age	-0.08	0.03	0.002	-0.14	-0.03
Caregiver gender (1 = Female; 2 = Male)	1.71	1.11	0.131	-0.53	3.94
Constant	46.44	1.64	0.000	43.12	49.75
F	10.87				
R-square	0.03				

TABLE 16— LOGISTIC REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S DEPRESSION AND ANXIETY

	Depression				
	Odd ratio	S.E.	p-value	95% CI	
Model 1 **Diverse types of migration on caregiver's depression prevalence**					
Non-migrant (Reference group)					
Father-migrant	1.18	0.27	0.480	0.74	1.86
Mother-migrant	1.63	0.49	0.109	0.89	2.98
Both-parents-migrant	1.11	0.22	0.613	0.74	1.67
Caregiver age	1.02	0.00	0.000	1.02	1.03
Caregiver gender (1 = Female; 2 = Male)	0.79	0.20	0.348	0.48	1.30
Constant	0.27	0.07	0.000	0.16	0.46
F	18.15				
R-square	0.04				
Model 2 **Diverse types of migration pertaining to migration destination on caregiver's depression prevalence**					
Non-migrant (Reference group)					
Both-parents-internal-migrant	1.23	0.28	0.372	0.78	1.94
Both-parents-international-migrant	1.03	0.21	0.871	0.69	1.56
Father-internal-migrant	0.73	0.22	0.310	0.40	1.35
Father-international-migrant	1.61	0.46	0.102	0.91	2.84
Mother-internal-migrant	2.56	0.70	0.001	1.47	4.46

TABLE 16— LOGISTIC REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S DEPRESSION AND ANXIETY

Depression

	Odd ratio	S.E.	p-value	95% CI	
Mother-international-migrant	0.93	0.37	0.847	0.42	2.05
Caregiver age	1.02	0.00	0.000	1.01	1.03
Caregiver gender (1 = Female; 2 = Male)	0.90	0.22	0.670	0.55	1.47
Constant	0.24	0.06	0.000	0.14	0.41
F	12.24				
R-square	0.05				

Model 3
Diverse types of migration pertaining to care arrangement on caregiver's depression prevalence

Non-migrant (Reference group)					
Father-migrant/mother-caregiver	1.42	0.34	0.158	0.87	2.30
Father-migrant/kinship-caregiver	0.50	0.19	0.069	0.23	1.06
Mother-migrant/kinship-caregiver	1.69	0.53	0.102	0.90	3.18
Both-parents-migrant/grandparents-caregiver	1.15	0.27	0.545	0.72	1.84
Both-parents-migrant/other relative-caregiver	0.73	0.22	0.308	0.40	1.35
Caregiver age	1.02	0.01	0.000	1.01	1.04
Caregiver gender (1 = Female; 2 = Male)	0.84	0.21	0.490	0.51	1.38
Constant	0.25	0.08	0.000	0.13	0.46

TABLE 16— LOGISTIC REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S DEPRESSION AND ANXIETY

Depression

	Odd ratio	S.E.	p-value	95% CI	
F	11.98				
R-square	0.04				

Anxiety

	Odd ratio	S.E.	p-value	95% CI	

Model 1
Diverse types of migration on caregiver's anxiety prevalence

Non-migrant (Reference group)					
Father-migrant	1.11	0.22	0.588	0.75	1.66
Mother-migrant	2.04	0.41	0.001	1.37	3.05
Both-parents-migrant	1.45	0.25	0.035	1.03	2.04
Caregiver age	1.02	0.00	0.000	1.01	1.03
Caregiver gender (1 = Female; 2 = Male)	0.39	0.09	0.000	0.24	0.62
Constant	0.63	0.21	0.166	0.33	1.22
F	22.14				
R-square	0.04				

Model 2
Diverse types of migration pertaining to migration destination on caregiver's anxiety prevalence

Non-migrant (Reference group)					
Both-parents-internal-migrant	1.49	0.29	0.050	1.00	2.21
Both-parents-international-migrant	1.40	0.25	0.064	0.98	2.02
Father-internal-migrant	0.94	0.29	0.844	0.51	1.75

TABLE 16— LOGISTIC REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S DEPRESSION AND ANXIETY

	Depression				
	Odd ratio	S.E.	p-value	95% CI	
Father-international-migrant	1.26	0.26	0.279	0.83	1.91
Mother-internal-migrant	1.73	0.44	0.037	1.04	2.88
Mother-international-migrant	2.60	0.80	0.004	1.39	4.85
Caregiver age	1.02	0.00	0.000	1.01	1.03
Caregiver gender (1 = Female; 2 = Male)	0.40	0.10	0.000	0.25	0.65
Constant	0.61	0.21	0.149	0.31	1.20
F	12.90				
R-square	0.05				
Model 3					
Diverse types of migration pertaining to care arrangement on caregiver's anxiety prevalence					
Non-migrant (Reference group)					
Father-migrant/mother-caregiver	1.25	0.28	0.312	0.80	1.96
Father-migrant/kinship-caregiver	0.64	0.23	0.218	0.31	1.31
Mother-migrant/kinship-caregiver	2.04	0.40	0.001	1.37	3.03
Both-parents-migrant/grandparents-caregiver	1.40	0.25	0.068	0.97	2.00
Both-parents-migrant/other relative-caregiver	1.29	0.31	0.284	0.80	2.09
Caregiver age	1.02	0.01	0.000	1.01	1.04
Caregiver gender (1 = Female; 2 = Male)	0.41	0.10	0.001	0.24	0.67
Constant	0.56	0.18	0.079	0.29	1.07
F	17.44				
R-square	0.05				

TABLE 17— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S DISTRESS (CAN PUT IN THE APPENDIX)

	Coef.	S.E.	p-value	95% CI	
Model 1 **Diverse types of migration on caregiver's distress**					
Non-migrant (Reference group)					
Father-migrant	-0.47	1.55	0.762	-3.60	2.66
Mother-migrant	3.97	1.87	0.039	0.21	7.74
Both-parents-migrant	3.29	1.31	0.016	0.64	5.94
Caregiver age	0.42	0.04	0.000	0.35	0.50
Caregiver gender (1 = Female; 2 = Male)	-4.41	1.11	0.000	-6.65	-2.17
Constant	-5.44	2.11	0.013	-9.70	-1.19
F	57.76				
R-square	0.18				
Model 2 Diverse types of migration pertaining to migration destination on caregiver's distress					
Non-migrant (Reference group)					
Both-parents-internal-migrant	4.63	1.50	0.003	1.62	7.65
Both-parents-international-migrant	2.17	1.39	0.125	-0.63	4.98
Father-internal-migrant	-1.13	1.08	0.299	-3.31	1.04
Father-international-migrant	0.04	2.23	0.984	-4.45	4.54
Mother-internal-migrant	6.59	2.50	0.012	1.54	11.64
Mother-international-migrant	0.44	1.83	0.810	-3.24	4.12
Caregiver age	0.42	0.04	0.000	0.34	0.50

TABLE 17— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S DISTRESS (CAN PUT IN THE APPENDIX)

	Coef.	S.E.	p-value	95% CI	
Caregiver gender (1 = Female; 2 = Male)	-3.34	1.10	0.004	-5.56	-1.13
Constant	-6.47	2.14	0.004	-10.78	-2.15
F	46.05				
R-square	0.19				
Model 3 Diverse types of migration pertaining to care arrangement on caregiver's distress					
Non-migrant (Reference group)					
Father-migrant/mother-caregiver	0.47	1.72	0.788	-3.00	3.93
Father-migrant/kinship-caregiver	-4.86	2.06	0.023	-9.00	-0.71
Mother-migrant/kinship-caregiver	4.15	1.94	0.038	0.24	8.06
Both-parents-migrant/grandparents-caregiver	3.71	1.51	0.018	0.67	6.74
Both-parents-migrant/other relative-caregiver	0.93	1.64	0.575	-2.38	4.24
Caregiver age	0.42	0.05	0.000	0.31	0.52
Caregiver gender (1 = Female; 2 = Male)	-4.33	1.14	0.000	-6.63	-2.03
Constant	-5.42	2.59	0.042	-10.65	-0.20
F	43.99				
R-square	0.18				

TABLE 18— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S RESILIENCE

	Coef.	S.E.	p-value	95% CI	
Model 1 **Diverse types of migration on caregiver's resilience**					
Non-migrant (Reference group)					
Father-migrant	-0.46	0.60	0.447	-1.67	0.75
Mother-migrant	-1.66	0.67	0.017	-3.01	-0.31
Both-parents-migrant	-1.07	0.49	0.036	-2.06	-0.07
Caregiver age	-0.02	0.01	0.320	-0.05	0.02
Caregiver gender (1 = Female; 2 = Male)	0.53	0.77	0.491	-1.01	2.08
Constant	15.42	1.02	0.000	13.36	17.48
F	4.70				
R-square	0.01				
Model 2 Diverse types of migration pertaining to migration destination on caregiver's resilience					
Non-migrant (Reference group)					
Both-parents-internal-migrant	-1.01	0.58	0.086	-2.18	0.15
Both-parents-international-migrant	-1.04	0.51	0.048	-2.06	-0.01
Father-internal-migrant	-0.69	0.91	0.455	-2.53	1.16
Father-international-migrant	-0.28	0.50	0.570	-1.29	0.72
Mother-internal-migrant	-0.35	0.69	0.618	-1.74	1.04
Mother-international-migrant	-3.37	0.75	0.000	-4.88	-1.85
Caregiver age	-0.02	0.01	0.276	-0.05	0.01
Caregiver gender (1 = Female; 2 = Male)	0.66	0.82	0.426	-0.99	2.31
Constant	15.33	1.06	0.000	13.19	17.47

TABLE 18— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S RESILIENCE

	Coef.	S.E.	p-value	95% CI	
F	4.84				
R-square	0.01				
Model 3 Diverse types of migration pertaining to care arrangement on caregiver's resilience					
Non-migrant (Reference group)					
Father-migrant/mother-caregiver	-0.25	0.65	0.701	-1.56	1.06
Father-migrant/kinship-caregiver	-1.41	0.99	0.161	-3.41	0.58
Mother-migrant/kinship-caregiver	-1.49	0.71	0.042	-2.91	-0.06
Both-parents-migrant/grandparents-caregiver	-1.03	0.59	0.090	-2.22	0.17
Both-parents-migrant/other relative-caregiver	-1.39	0.45	0.004	-2.30	-0.48
Caregiver age	-0.02	0.02	0.420	-0.05	0.02
Caregiver gender (1 = Female; 2 = Male)	0.79	0.85	0.358	-0.93	2.51
Constant	15.16	1.09	0.000	12.97	17.34
F	3.86				
R-square	0.01				

Note. Given the sample size of males and elderly above 60 in non-migrant households is small (n < 10), the test of group difference does not apply to these two groups.

TABLE 19— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S SOCIAL SUPPORT

	Coef.	S.E.	p-value	95% CI	
Model 1 **Diverse types of migration on caregiver's social support**					
Non-migrant (Reference group)					
Father-migrant	0.27	0.18	0.147	-0.10	0.64
Mother-migrant	0.08	0.18	0.672	-0.29	0.44
Both-parents-migrant	-0.11	0.14	0.411	-0.39	0.16
Caregiver age	0.00	0.00	0.474	-0.01	0.01
Caregiver gender (1 = Female; 2 = Male)	-0.08	0.19	0.673	-0.45	0.30
Constant	9.73	0.26	0.000	9.21	10.25
F	1.77				
R-square	0.01				
Model 2 **Diverse types of migration pertaining to migration destination on caregiver's social support**					
Non-migrant (Reference group)					
Both-parents-internal-migrant	-0.07	0.18	0.707	-0.43	0.29
Both-parents-international-migrant	-0.13	0.14	0.357	-0.40	0.15
Father-internal-migrant	0.29	0.26	0.274	-0.24	0.81
Father-international-migrant	0.26	0.19	0.189	-0.13	0.64
Mother-internal-migrant	0.22	0.22	0.324	-0.22	0.65
Mother-international-migrant	-0.11	0.19	0.548	-0.49	0.26
Caregiver age	0.00	0.00	0.488	-0.01	0.01

TABLE 19— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S SOCIAL SUPPORT

	Coef.	S.E.	p-value	95% CI	
Caregiver gender (1 = Female; 2 = Male)	-0.05	0.19	0.814	-0.44	0.34
Constant	9.70	0.27	0.000	9.16	10.23
F	1.11				
R-square	0.01				
Model 3 **Diverse types of migration pertaining to care arrangement on caregiver's social support**					
Non-migrant (Reference group)					
Father-migrant/mother-caregiver	0.36	0.18	0.053	0.00	0.72
Father-migrant/kinship-caregiver	-0.09	0.37	0.813	-0.84	0.66
Mother-migrant/kinship-caregiver	0.27	0.19	0.153	-0.10	0.65
Both-parents-migrant/grandparents-caregiver	0.16	0.15	0.299	-0.15	0.47
Both-parents-migrant/other relative-caregiver	-0.79	0.20	0.000	-1.19	-0.39
Caregiver age	0.00	0.00	0.342	-0.01	0.00
Caregiver gender (1 = Female; 2 = Male)	-0.05	0.19	0.783	-0.43	0.33
Constant	9.96	0.25	0.000	9.46	10.47
F	5.75				
R-square	0.03				

TABLE 20— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S RELATIONSHIPS WITH FAMILY, COMMUNITY AND SIGNIFICANT OTHERS

	The relationship with family			The relationship with community			The relationship with significant others		
	Coef.	S.E.	p-value	Coef.	S.E.	p-value	Coef.	S.E.	p-value
Model 1 **Diverse types of migration on caregiver's relationships**									
Non-migrant (Reference group)									
Father-migrant	-0.26	0.09	0.007	-0.49	0.16	0.005	-0.15	0.11	0.162
Mother-migrant	-0.03	0.11	0.800	-0.25	0.16	0.132	-0.04	0.11	0.731
Both-parents-migrant	-0.04	0.07	0.541	-0.20	0.10	0.050	-0.07	0.08	0.376
Caregiver age	0.00	0.00	0.113	0.01	0.00	0.000	0.00	0.00	0.171
Caregiver gender (1 = Female; 2 = Male)	0.15	0.09	0.092	0.40	0.19	0.041	-0.64	0.15	0.000
Constant	6.48	0.13	0.000	4.03	0.23	0.000	6.73	0.19	0.000
F	3.72			6.53			5.00		
R-square	0.01			0.02			0.01		
Model 2 **Diverse types of migration pertaining to migration destination on caregiver's relationships**									
Non-migrant (Reference group)									
Both-parents-internal-migrant	0.00	0.08	0.980	-0.12	0.11	0.255	-0.04	0.11	0.703
Both-parents-international-migrant	-0.05	0.07	0.500	-0.25	0.11	0.030	-0.05	0.08	0.542
Father-internal-migrant	-0.35	0.14	0.018	-0.53	0.21	0.014	-0.48	0.16	0.004

TABLE 20— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S RELATIONSHIPS WITH FAMILY, COMMUNITY AND SIGNIFICANT OTHERS

	The relationship with family			The relationship with community			The relationship with significant others		
	Coef.	S.E.	p-value	Coef.	S.E.	p-value	Coef.	S.E.	p-value
Father-international-migrant	-0.19	0.09	0.048	-0.47	0.20	0.026	0.09	0.11	0.426
Mother-internal-migrant	0.04	0.14	0.770	-0.48	0.17	0.007	0.00	0.13	0.979
Mother-international-migrant	-0.11	0.17	0.533	0.04	0.26	0.880	-0.07	0.17	0.657
Caregiver age	0.00	0.00	0.088	0.01	0.00	0.000	0.00	0.00	0.227
Caregiver gender (1 = Female; 2 = Male)	0.16	0.09	0.074	0.42	0.19	0.033	-0.63	0.15	0.000
Constant	6.48	0.13	0.000	4.01	0.24	0.000	6.73	0.18	0.000
F	2.11			4.70			4.20		
R-square	0.01			0.02			0.02		
Model 3 **Diverse types of migration pertaining to care arrangement on caregiver's relationships**									
Non-migrant (Reference group)									
Father-migrant/mother-caregiver	-0.23	0.10	0.024	-0.42	0.19	0.032	-0.15	0.12	0.203
Father-migrant/kinship-caregiver	-0.42	0.15	0.008	-0.81	0.25	0.002	-0.15	0.16	0.326
Mother-migrant/kinship-caregiver	-0.07	0.11	0.538	-0.20	0.18	0.269	-0.04	0.12	0.729
Both-parents-migrant/grandparents-caregiver	-0.07	0.07	0.291	-0.17	0.10	0.109	-0.06	0.09	0.524

TABLE 20— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CAREGIVER'S RELATIONSHIPS WITH FAMILY, COMMUNITY AND SIGNIFICANT OTHERS

	The relationship with family			The relationship with community			The relationship with significant others		
	Coef.	S.E.	p-value	Coef.	S.E.	p-value	Coef.	S.E.	p-value
Both-parents-migrant/other relative-caregiver	-0.04	0.10	0.662	-0.35	0.15	0.022	-0.12	0.13	0.361
Caregiver age	0.00	0.00	0.302	0.01	0.00	0.009	0.00	0.00	0.285
Caregiver gender (1 = Female; 2 = Male)	0.14	0.09	0.123	0.47	0.17	0.007	-0.67	0.16	0.000
Constant	6.45	0.14	0.000	3.97	0.22	0.000	6.77	0.20	0.000
F	2.52			4.93			3.74		
R-square	0.07			0.02			0.01		

TABLE 21— MEAN SCORES OF CHILDREN'S SDQ-TOTAL DIFFICULTIES SCORE

Total difficulties score (child report)	Non-migrant household	Migrant household	Full sample	T	p-value
Total	12.78	12.65	12.66	0.29	0.776
Gender					
Female	12.49	12.58	12.57	-0.16	0.880
Male	13.07	12.72	12.77	0.47	0.640
Age groups					
12-14 years	12.43	12.56	12.54	-0.21	0.833
15-17 years	13.65	12.99	13.12	0.96	0.340
Total difficulties score (caregiver report)					

TABLE 21— MEAN SCORES OF CHILDREN'S SDQ-TOTAL DIFFICULTIES SCORE

Total	12.16	12.22	12.21	-0.12	0.904
Gender					
Female	12.39	12.18	12.21	0.33	0.750
Male	11.94	12.25	12.21	-0.44	0.660
Age groups					
12-14 years	12.32	12.13	12.16	0.33	0.740
15-17 years	11.78	12.55	12.40	-1.02	0.310

TABLE 22— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S SDQ-TOTAL DIFFICULTIES

	Child report					Caregiver report				
	Coef.	S.E.	p-value	95% CI		Coef.	S.E.	p-value	95% CI	
Model 1 Diverse types of migration on children's total difficulties										
Non-migrant (Reference group)										
Father-migrant	0.15	0.55	0.785	-0.96	1.27	1.02	0.78	0.198	-0.56	2.60
Mother-migrant	0.10	0.70	0.888	-1.30	1.50	0.21	0.55	0.700	-0.90	1.33
Both-parents-migrant	-0.17	0.48	0.726	-1.14	0.80	-0.04	0.49	0.935	-1.03	0.95
Child age	0.09	0.14	0.529	-0.19	0.36	0.13	0.20	0.520	-0.28	0.55
Child gender (1 = Female; 2 = Male)	0.20	0.31	0.531	-0.43	0.82	-0.02	0.34	0.943	-0.72	0.67
Constant	11.25	1.93	0.000	7.35	15.15	10.32	2.92	0.001	4.43	16.21

TABLE 22— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S SDQ-TOTAL DIFFICULTIES

	Child report					Caregiver report				
	Coef.	S.E.	p-value	95% CI		Coef.	S.E.	p-value	95% CI	
F	0.29					0.75				
R-square	0.00					0.006				
Model 2 **Diverse types of migration pertaining to migration destination on children's total difficulties**										
Non-migrant (Reference group)										
Both-parents-internal-migrant	-0.47	0.56	0.403	-1.59	0.65	-0.01	0.56	0.981	-1.14	1.11
Both-parents-international-migrant	0.05	0.49	0.925	-0.94	1.03	-0.02	0.51	0.972	-1.05	1.01
Father-internal-migrant	0.35	0.88	0.691	-1.42	2.12	0.44	0.65	0.506	-0.88	1.76
Father-international-migrant	0.02	0.62	0.971	-1.23	1.28	1.39	1.10	0.210	-0.82	3.61
Mother-internal-migrant	0.71	0.77	0.363	-0.85	2.26	1.84	0.70	0.012	0.43	3.25
Mother-international-migrant	-0.65	0.92	0.482	-2.51	1.20	-1.97	0.63	0.003	-3.25	-0.69
Child age	0.13	0.14	0.379	-0.16	0.42	0.13	0.19	0.506	-0.25	0.50
Child gender (1 = Female; 2 = Male)	0.18	0.32	0.571	-0.46	0.82	-0.08	0.34	0.806	-0.76	0.60
Constant	10.70	2.03	0.000	6.61	14.79	10.52	2.71	0.000	5.05	15.99
F	0.64					2.21				

TABLE 22— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S SDQ-TOTAL DIFFICULTIES

	Child report					Caregiver report				
	Coef.	S.E.	p-value	95% CI		Coef.	S.E.	p-value	95% CI	
R-square	0.01					0.03				
Model 3 Diverse types of migration pertaining to care arrangement on children's total difficulties										
Non-migrant										
Father-migrant/ mother-caregiver	1.23	0.65	0.065	-0.08	2.53	1.22	0.87	0.170	-0.54	2.97
Father-migrant/ kinship-caregiver	-2.70	0.68	0.000	-4.08	-1.32	0.49	0.85	0.568	-1.23	2.21
Mother-migrant/ kinship-caregiver	0.18	0.71	0.800	-1.25	1.61	0.31	0.56	0.582	-0.83	1.45
Both-parents-migrant/ grandparents-caregiver	-0.26	0.49	0.596	-1.25	0.73	-0.06	0.50	0.902	-1.07	0.94
Both-parents-migrant/ other relative-caregiver	0.21	0.68	0.758	-1.16	1.58	0.05	0.67	0.939	-1.30	1.41
Child age	0.08	0.14	0.572	-0.20	0.37	0.13	0.21	0.520	-0.28	0.55
Child gender (1 = Female; 2 = Male)	0.29	0.32	0.367	-0.35	0.92	-0.01	0.35	0.971	-0.71	0.68
Constant	11.21	1.96	0.000	7.25	15.17	10.30	2.91	0.001	4.43	16.18
F	4.38					0.61				
R-square	0.02					0.006				

TABLE 23— MEAN SCORES OF CHILDREN'S SDQ-PRO SOCIAL SCORE

Mean scores of pro social (child report)	Non-migrant household	Migrant household	Full sample	T	p-value
Total	6.67	6.95	6.91	-1.640	0.109
Gender					
Female	7.20	7.21	7.21	-0.050	0.958
Male	6.14	6.67	6.59	-1.810	0.077
Age groups					
12-14 years	6.77	6.93	6.90	-0.700	0.489
15-17 years	13.65	12.99	6.92	0.960	0.344
Mean scores of pro social (caregiver report)					
Total	6.55	6.90	6.85	-1.650	0.106
Gender					
Female	6.74	6.97	6.93	-0.630	0.534
Male	6.36	6.83	6.76	-2.150	0.037
Age groups					
12-14 years	6.42	6.76	6.71	-1.280	0.207
15-17 years	6.86	7.46	7.34	-2.110	0.041

TABLE 24— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S SDQ-PROSOCIAL BEHAVIOR

	Child report					Caregiver report				
	Coef.	S.E.	p-value	95% CI		Coef.	S.E.	p-value	95% CI	
Model 1 Diverse types of migration on children's prosocial behaviour										
Non-migrant (Reference group)										
Father-migrant	0.57	0.23	0.016	0.11	1.04	0.74	0.29	0.015	0.15	1.33
Mother-migrant	0.48	0.24	0.053	-0.01	0.96	0.37	0.27	0.176	-0.17	0.91
Both-parents-migrant	0.22	0.18	0.234	-0.15	0.58	0.33	0.22	0.150	-0.12	0.78
Child age	0.05	0.04	0.295	-0.04	0.14	0.08	0.06	0.197	-0.04	0.20
Child gender (1 = Female; 2 = Male)	-0.63	0.13	0.000	-0.88	-0.37	-0.18	0.17	0.295	-0.53	0.16
Constant	6.95	0.66	0.000	5.61	8.29	5.69	0.88	0.000	3.92	7.46
F	5.89					1.52				
R-square	0.04					0.01				
Model 2 Diverse types of migration pertaining to migration destination on children's prosocial behaviour										
Non-migrant (Reference group)										
Both-parents-internal-migrant	0.48	0.23	0.047	0.01	0.95	0.37	0.29	0.200	-0.20	0.95
Both-parents-international-migrant	0.07	0.18	0.695	-0.30	0.44	0.28	0.22	0.214	-0.17	0.72

TABLE 24— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S SDQ-PROSOCIAL BEHAVIOR

	Child report					Caregiver report				
	Coef.	S.E.	p-value	95% CI		Coef.	S.E.	p-value	95% CI	
Father-internal-migrant	0.23	0.32	0.477	-0.42	0.89	-0.01	0.51	0.988	-1.03	1.02
Father-international-migrant	0.79	0.31	0.015	0.16	1.43	1.22	0.31	0.000	0.58	1.85
Mother-internal-migrant	0.54	0.28	0.065	-0.03	1.11	0.77	0.30	0.014	0.17	1.38
Mother-international-migrant	0.39	0.31	0.222	-0.24	1.02	-0.22	0.36	0.531	-0.94	0.49
Child age	0.04	0.05	0.421	-0.06	0.13	0.04	0.06	0.473	-0.08	0.17
Child gender (1 = Female; 2 = Male)	-0.60	0.13	0.000	-0.86	-0.34	-0.15	0.17	0.379	-0.49	0.19
Constant	7.03	0.69	0.000	5.64	8.43	6.14	0.88	0.000	4.38	7.91
F	5.69					2.73				
R-square	0.04					0.02				
Model 3 Diverse types of migration pertaining to care arrangement on children's prosocial behaviour										
Non-migrant										
Father-migrant/ mother-caregiver	0.71	0.28	0.014	0.15	1.26	0.86	0.35	0.019	0.15	1.56
Father-migrant/ kinship-caregiver	0.21	0.31	0.500	-0.41	0.83	0.42	0.34	0.221	-0.26	1.10

TABLE 24— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S SDQ-PROSOCIAL BEHAVIOR

	Child report					Caregiver report				
	Coef.	S.E.	p-value	95% CI		Coef.	S.E.	p-value	95% CI	
Mother-migrant/ kinship-caregiver	0.53	0.24	0.032	0.05	1.01	0.46	0.26	0.089	-0.07	0.99
Both-parents-migrant/grand-parents-caregiver	0.18	0.18	0.325	-0.18	0.54	0.47	0.23	0.043	0.01	0.93
Both-parents-migrant/other relative-caregiver	0.37	0.27	0.169	-0.16	0.91	-0.27	0.29	0.363	-0.85	0.32
Child age	0.05	0.05	0.300	-0.04	0.14	0.09	0.06	0.158	-0.03	0.21
Child gender (1 = Female; 2 = Male)	-0.62	0.13	0.000	-0.88	-0.36	-0.21	0.17	0.222	-0.55	0.13
Constant	6.93	0.68	0.000	5.57	8.30	5.64	0.85	0.000	3.92	7.36
F	4.46					3.69				
R-square	0.04					0.03				

TABLE 25— MEAN SCORES OF CHILDREN'S RESILIENCE

Resilience	Non-migrant households	Migrant households	Full sample	T	p-value
Total	16.26	15.18	15.34	2.36	0.023
Gender					
Female	17.46	15.72	15.97	3.65	0.001
Male	15.09	14.59	14.67	0.67	0.509
Age groups					
12-14 years	16.45	15.00	15.19	2.81	0.007
15-17 years	15.81	15.85	15.84	-0.05	0.958

TABLE 26— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S RESILIENCE

	Coef.	S.E.	p-value	95% CI	
Model 1 **Diverse types of migration on children's resilience**					
Non-migrant (Reference group)					
Father-migrant	-1.92	0.85	0.029	-3.64	-0.21
Mother-migrant	-1.13	0.73	0.130	-2.60	0.35
Both-parents-migrant	-0.85	0.42	0.049	-1.69	0.00
Child age	0.33	0.14	0.021	0.05	0.60
Child gender (1 = Female; 2 = Male)	-1.34	0.41	0.002	-2.17	-0.52
Constant	13.67	2.03	0.000	9.57	17.77
F	4.21				
R-square	0.03				

TABLE 26— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S RESILIENCE

	Coef.	S.E.	p-value	95% CI	
Model 2 Diverse types of migration pertaining to migration destination on children's resilience					
Non-migrant (Reference group)					
Both-parents-internal-migrant	-0.22	0.57	0.704	-1.36	0.93
Both-parents-international-migrant	-1.16	0.41	0.008	-1.99	-0.32
Father-internal-migrant	-1.17	1.07	0.282	-3.33	0.99
Father-international-migrant	-2.41	1.10	0.034	-4.62	-0.19
Mother-internal-migrant	0.10	0.77	0.899	-1.45	1.65
Mother-international-migrant	-2.83	0.96	0.005	-4.76	-0.90
Child age	0.28	0.14	0.046	0.00	0.56
Child gender (1 = Female; 2 = Male)	-1.32	0.40	0.002	-2.13	-0.52
Constant	14.26	2.07	0.000	10.09	18.43
F	4.52				
R-square	0.04				
Model 3 Diverse types of migration pertaining to care arrangement on children's resilience					
Non-migrant					
Father-migrant/mother-caregiver	-2.48	1.08	0.026	-4.66	-0.31
Father-migrant/kinship-caregiver	-0.39	0.78	0.617	-1.97	1.18
Mother-migrant/kinship-caregiver	-0.83	0.71	0.248	-2.26	0.60
Both-parents-migrant/grandparents-caregiver	-0.75	0.47	0.117	-1.69	0.19
Both-parents-migrant/other relative-caregiver	-1.24	0.55	0.029	-2.34	-0.13

TABLE 26— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON CHILDREN'S RESILIENCE

	Coef.	S.E.	p-value	95% CI	
Child age	0.34	0.14	0.016	0.07	0.62
Child gender (1 = Female; 2 = Male)	-1.46	0.39	0.000	-2.24	-0.68
Constant	13.62	2.04	0.000	9.51	17.72
F	5.02				
R-square	0.04				

TABLE 27—MEAN SCORES OF POSITIVE PARENTING

Positive parenting (child report)	Non-migrant households	Migrant households	Total	t	p-value
Total	10.09	10.10	10.10	-0.06	0.953
Gender					
Female	10.78	10.41	10.46	1.34	0.188
Male	9.41	9.77	9.71	-1.10	0.277
Age groups					
12-14 years	10.40	10.20	10.23	0.75	0.455
15-17 years	9.31	9.73	9.65	-0.89	0.380
Positive parenting (caregiver report)					
Total	9.49	10.12	10.03	-2.10	0.041
Gender					
Female	10.00	10.23	10.20	-0.83	0.411
Male	8.98	10.00	9.84	-1.87	0.068
Age groups					
12-14 years	9.80	10.16	10.11	-1.12	0.270
15-17 years	8.71	9.96	9.72	-1.73	0.091

TABLE 28— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON POSITIVE PARENTING PRACTICE

	Child report					Caregiver report				
	Coef.	S.E.	p-value	95% CI		Coef.	S.E.	p-value	95% CI	
Model 1 Diverse types of migration on children's prosocial behaviour										
Non-migrant (Reference group)										
Father-migrant	-0.46	0.51	0.368	-1.49	0.56	-0.34	0.50	0.498	-1.35	0.67
Mother-migrant	0.03	0.49	0.953	-0.96	1.02	1.01	0.37	0.008	0.27	1.75
Both-parents-migrant	0.02	0.23	0.923	-0.43	0.48	0.67	0.30	0.033	0.05	1.28
Child age	-0.07	0.07	0.277	-0.20	0.06	-0.04	0.10	0.673	-0.24	0.16
Child gender (1 = Female; 2 = Male)	-0.74	0.23	0.002	-1.20	-0.28	-0.34	0.17	0.048	-0.67	0.00
Constant	12.22	1.22	0.000	9.76	14.67	10.60	1.39	0.000	7.79	13.40
F	2.79					3.07				
R-square	0.02					0.02				
Model 2 Diverse types of migration pertaining to migration destination on children's prosocial behaviour										
Non-migrant (Reference group)										
Both-parents-internal-migrant	0.31	0.25	0.231	-0.20	0.82	0.68	0.33	0.043	0.02	1.33
Both-parents-international-migrant	-0.13	0.24	0.588	-0.62	0.35	0.64	0.32	0.054	-0.01	1.29

TABLE 28— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON POSITIVE PARENTING PRACTICE

	Child report					Caregiver report				
	Coef.	S.E.	p-value	95% CI		Coef.	S.E.	p-value	95% CI	
Father-internal-migrant	0.78	0.49	0.114	-0.20	1.76	0.01	0.54	0.983	-1.07	1.09
Father-international-migrant	-1.26	0.69	0.074	-2.65	0.13	-0.57	0.68	0.407	-1.94	0.80
Mother-internal-migrant	0.52	0.41	0.213	-0.31	1.36	1.09	0.46	0.023	0.16	2.03
Mother-international-migrant	-0.64	0.74	0.393	-2.14	0.86	0.89	0.40	0.033	0.07	1.71
Child age	-0.08	0.06	0.207	-0.21	0.05	-0.05	0.09	0.574	-0.24	0.13
Child gender (1 = Female; 2 = Male)	-0.68	0.22	0.003	-1.12	-0.25	-0.33	0.17	0.058	-0.68	0.01
Constant	12.26	1.14	0.000	9.96	14.57	10.73	1.27	0.000	8.17	13.29
F	3.3					2.27				
R-square	0.04					0.03				
Model 3 Diverse types of migration pertaining to care arrangement on children's prosocial behaviour										
Non-migrant										
Father-migrant/ mother-caregiver	-0.53	0.63	0.413	-1.81	0.76	-0.71	0.58	0.225	-1.88	0.45

TABLE 28— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON POSITIVE PARENTING PRACTICE

	Child report					Caregiver report				
	Coef.	S.E.	p-value	95% CI		Coef.	S.E.	p-value	95% CI	
Father-migrant/ kinship-caregiver	-0.29	0.49	0.556	-1.28	0.70	0.67	0.40	0.099	-0.13	1.48
Mother-migrant/ kinship-caregiver	0.06	0.50	0.907	-0.95	1.07	1.05	0.37	0.008	0.29	1.80
Both-parents-migrant/grandparents-caregiver	0.00	0.23	0.996	-0.47	0.48	0.68	0.32	0.038	0.04	1.32
Both-parents-migrant/other relative-caregiver	0.11	0.36	0.759	-0.61	0.83	0.63	0.37	0.100	-0.12	1.38
Child age	-0.07	0.07	0.285	-0.20	0.06	-0.04	0.10	0.685	-0.24	0.16
Child gender (1 = Female; 2 = Male)	-0.75	0.24	0.004	-1.24	-0.25	-0.38	0.17	0.028	-0.72	-0.04
Constant	12.21	1.22	0.000	9.75	14.68	10.63	1.38	0.000	7.85	13.40
F	2.95					2.56				
R-square	0.02					0.03				

TABLE 29— MEAN SCORES OF ATTACHMENT TO CAREGIVERS

Attachment	Non-migrant households	Migrant households	Total	t	p-value
Total	21.16	20.88	20.93	0.44	0.663
Gender					
Female	23.46	21.24	21.56	2.85	0.007
Male	18.89	20.50	20.25	-1.88	0.067
Age groups					
12-14 years	20.90	20.63	20.67	0.42	0.676
15-17 years	21.81	21.87	21.86	-0.05	0.961

TABLE 30— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON ATTACHMENT TO CAREGIVERS

	Coef.	S.E.	p-value	95% CI	
Model 1 Diverse types of migration on attachment					
Non-migrant (Reference group)					
Father migration	-0.81	1.14	0.479	-3.11	1.48
Mother migration	-0.46	0.87	0.602	-2.22	1.30
Both parents migration	-0.01	0.63	0.992	-1.28	1.27
Children's age	0.41	0.20	0.050	0.00	0.83
Children gender-being male	-1.36	0.45	0.005	-2.27	-0.44
Constant	17.36	3.01	0.000	11.28	23.44
F	3.02				

TABLE 30— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON ATTACHMENT TO CAREGIVERS

	Coef.	S.E.	p-value	95% CI	
R-square	0.02				
Model 2 **Diverse types migration pertaining to migration destination on attachment**					
Non-migrant (Reference group)					
Both-parents-internal-migrant	0.86	0.74	0.251	-0.63	2.34
Both-parents-international-migrant	-0.50	0.69	0.472	-1.88	0.89
Father-internal-migrant	1.13	1.16	0.335	-1.21	3.46
Father-international-migrant	-2.06	1.90	0.285	-5.89	1.77
Mother-internal-migrant	1.26	1.12	0.265	-0.99	3.52
Mother-international-migrant	-2.83	1.36	0.044	-5.58	-0.08
Children's age	0.36	0.20	0.070	-0.03	0.76
Children gender-being male	-1.29	0.48	0.010	-2.26	-0.33
Constant	17.94	2.87	0.000	12.15	23.74
F	4.32				
R-square	0.04				
Model 3 **Diverse types of migration pertaining to care arrangement on attachment**					
Non-migrant					
Father-migrant, mother caregiver	-0.29	1.51	0.847	-3.34	2.75
Father-migrant, kinship caregiver	-2.23	1.18	0.064	-4.61	0.14
Mother-migrant, kinship caregiver	0.08	0.80	0.917	-1.52	1.69
Both-parents-migrant, grandparents caregiver	0.16	0.65	0.811	-1.15	1.46

TABLE 30— REGRESSIONS ABOUT SPECIFIC TYPES OF MIGRATION ON ATTACHMENT TO CAREGIVERS

	Coef.	S.E.	p-value	95% CI	
Both-parents-migrant, other relative caregiver	-0.66	0.89	0.463	-2.45	1.14
Children's age	0.43	0.20	0.038	0.03	0.84
Children gender-being male	-1.43	0.44	0.002	-2.32	-0.54
Constant	17.19	2.99	0.000	11.16	23.21
F	2.74				
R-square	0.03				

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International Organization for Migration (IOM) & Thida KIM

Migration impacts on Cambodian children and families left behind

REPORT 2019

This research investigates health and social consequences on children left behind and the family members of low-skilled migrant workers. It also looks at the links between these migrations and the institutionalization of children of migrant workers. From the key issues identified by the research, a multi-dimensional intervention framework for policy and practices is suggested across the phases of migration to deliver appropriate, culturally and contextually relevant interventions in Cambodia.