



ARE WE FAILING OUR CHILDREN?

The need to prioritize children in poverty reduction in Nepal

As demonstrated in the MDG Summit and other recent fora, Nepal is making progress in poverty reduction and is on track to achieve MDGs 2, 4 and 5. But the MDG Summit was also a time to reflect and deepen our analysis of the challenges and disparities remaining – including more refined disaggregation of available data by age, gender, geography, caste, ethnicity and other vectors of inequity.

In Nepal, sharpening our analysis by age shows that children are disproportionately poor – when the national poverty incidence was 31% in 2003/4, for children the incidence was 36%.¹ When a multidimensional approach is applied, the stark reality is that 69% of Nepal’s children – tomorrow’s parents, workers and leaders – are severely deprived of at least one of seven basic necessities (see Table 1).

The most worrying indicators concern malnutrition and sanitation. Every second child under five (49%) in Nepal is stunted or has a low height for age; a result of chronic undernourishment. Over half of Nepal’s children between the ages 0-17 years have no access to a toilet of any kind.

Urgent action is required. Severe deprivation during an individual’s first few years can cause irreparable damage, perpetuating poverty cycles over generations. Everything from cognitive development to employment potential is laid down within these formative years. Investing in children’s well-being is not only a social and moral imperative, it is an economically sound investment strategy for the future.

The many faces of child poverty and deprivation in Nepal

Poverty is more than insufficient income for meeting consumption needs. Whether a child lives in poverty depends on access to public goods and services such as safe water, health care, education and protection from risks associated with physical

work and abuse. Globally it is understood that only by applying a definition of child poverty that captures its many faces – in other words, that is multidimensional – can one understand the true nature of deprivations faced by millions of children. One such multi-dimensional measure is the ‘Bristol’ methodology (Table 1).

Table 1: Bristol Child Deprivation Index

Deprivation	Criteria for Severe Deprivation
Sanitation	Children (0-17 years) with no access to a toilet of any kind.
Information	Children (3-17 years) with no access to a radio or television or telephone or newspaper or computer (i.e., all forms of media).
Shelter	Children living in a dwelling with 5 or more people per room or with no floor materials.
Water	Children using surface water such as rivers, ponds, streams and dams, or those for whom it takes 30 minutes or longer to collect water
Malnutrition/ Food	Children (under 5) who are more than minus 3 standard deviations below the international reference population for underweight (weight for age).
Education	Children (7-17 years) of schooling age who have never been to school or who are not currently attending school.
Health/ Immunization	Children who did not receive immunization against any diseases or who did not receive treatment for a recent illness involving an acute respiratory infection or diarrhea.

Source: Gordon *et.al* 2003.



The methodology, developed by the Townsend Centre for International Poverty Research at the University of Bristol, UK, uses thresholds that are extremely strict – more than some of the MDG indicators.² Hence the results of the severe deprivation analysis are cause for urgent attention as it presents the scale of absolute and chronic poverty. In short, the worst case scenario of child poverty.

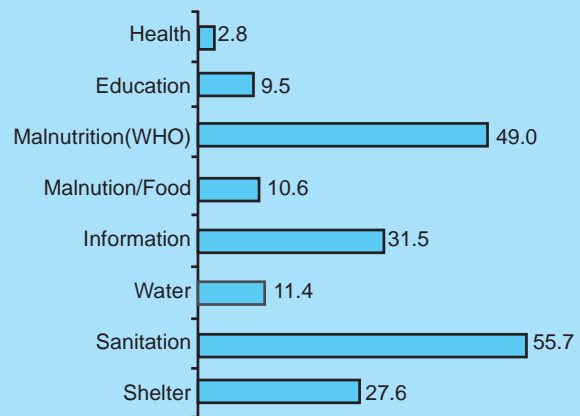
It should be noted that the Bristol method is one of a number of methodologies used to measure poverty and deprivation. Others include the Millennium Development Goals (MDGs) and the new Multidimensional Poverty Index (MPI).³ Such methodologies encourage poverty analysis from a multidimensional, human development perspective.

Given its focus on children, the Bristol methodology was adopted by UNICEF in its global initiative on Child Poverty and Disparities launched in 2007.⁴ This Child Poverty Brief is based on the findings of the Nepal study on Child Poverty and Disparities, which aims to strengthen the profile of children in national policymaking and to encourage better resource allocation in the best interests of children.

The scale of child poverty and deprivation in Nepal

Child poverty in Nepal is demonstrated in both income/consumption measures and multidimensional indices such as the Bristol methodology. When comparing the 1995/96 and 2003/04 data for Nepal, the national income/consumption poverty incidence decreased from 42% to 31%, but child poverty declined from 44% to 36% over the same period. When applying the Bristol multidimensional measure, 69% of children in Nepal are severely deprived of at least one of the seven indicators and 38% are severely deprived of at least two of the indicators – considered a measure of absolute poverty.

Figure 1: Prevalence of severe deprivation in 2006 (%)



Primary source: New Era based on NDHS 2006.

Note: The WHO malnutrition indicator (height for age) represents the percentage of children (0-4 years) who are more than minus two standard deviations from the international reference population. The Bristol Malnutrition/Food indicator (weight for age) represents the percentage of children (0-4 years) who are more than minus three standard deviations from the international reference population.

Diseases caused by unclean water and bad sanitation are responsible for 70 deaths per day of children under five:

According to WHO it is estimated that diarrhoeal disease and acute respiratory infection (ARI) account for 18% of deaths among children under five years. Recent calculations by WHO estimates about 13,000 children under five years die each year in Nepal from diarrhoeal diseases and a further 13,000 from ARI (UNICEF 2006). Both of these conditions are caused and aggravated by poor sanitation, inadequate personal hygiene and a lack of access to quality water. The mode of excreta disposal plays a major role in the spread of diarrhoea. According to household surveys, only 15% of the rural population disposed of children's stools hygienically as compared with 47% in urban households.



Over half of Nepal's children lack access to a toilet of any kind: The most widespread severe deprivation faced by Nepal's children is sanitation (Figure 1). Measured by lack of access to a toilet of any kind, over half (55.7% or 6.4 million) of Nepal's children defecate in open spaces with obvious implications for the spread of diseases. Children living in the western mountains, mid-western hills, and central *terai* suffer disproportionately (over 70% defecate in open spaces), while those in rural areas are three times worse off than their urban counterparts (61% vs. 21%).

Poor sanitation is compounded by the fact that 11.4% or 1.3 million children in Nepal lack safe and adequate access to water supply. The mountain and hill regions are the worst off, with double the national proportion of children (20%) lacking access to safe water. The multiplier effect caused by bad sanitation and unclean water raises particular concerns including: worm infestations which affect some 1.3 million children; typhoid caused by drinking water or eating food contaminated by the faeces of infected individuals, which affected over 200,000 children in 2003/2004 (UNICEF 2006); and vector-borne diseases such as Japanese encephalitis and Malaria which are responsible for many deaths each year (UNICEF 2006).

Every second child under five in Nepal is malnourished: Alongside sanitation, child malnutrition is one of the most severe problems affecting children in Nepal – 49% of children under five years are stunted (low height for age) and 39% are underweight (low weight for age) (NDHS 2006). The Bristol indicator (percentage of children who are more than minus three standard deviations below the international reference population for weight for age) shows the most severe scenario of 11% malnutrition.

Rural children fare significantly worse than their urban counterparts (51% vs. 36% stunting, 41% vs. 23% underweight). Important influences on

nutrition standards also include mother's education (Table 2). NDHS 2006 data shows that children of uneducated mothers are three times more likely to be underweight than children of educated (SLC and above) mothers. Analysis also reveals interventions to address malnutrition are needed, not just for the poorest children, but across all wealth quintiles in Nepal (Table 2).

Table 2: Nutritional status of children disaggregated by various characteristics, 2006

	Underweight	Stunted
Mothers' education:		
No education	46.6	52.7
Primary	31.1	46.3
Some secondary	24.0	29.7
SLC and above	11.0	15.6
Wealth quintiles:		
Lowest	47.0	61.6
Second	46.0	54.9
Middle	41.7	50.4
Fourth	31.0	39.8
Highest	18.8	30.9

Source: MOHP et al., 2007.

Malnutrition is a serious obstacle to the survival, growth and development of children. One may hear the benign expression, "*we have always been small*". What is less known is that a child born anywhere in the world, given an optimum start in life, has the potential to develop to within the same range of height and weight.

Malnutrition in early childhood can have deleterious long-term effects. When children's cognitive development is impaired, particularly before the age of two, the effects may be irreversible. Such children find learning more difficult. They can fail to obtain crucial skills thereby constraining their future employment opportunities. Undernourished girls face higher risks of maternal and child mortality. They also



have a greater probability of low birth-weight and stunting in their own children, problems that are compounded by an earlier start to childbearing among poor women (IPC 2004).

Lack of access to information is a significant deprivation in Nepal: Although not often high in the agenda when fighting poverty, it may come as a surprise to learn that the second leading cause of child deprivation in Nepal is the lack of access to information – a vital tool for mental stimulation and the nurturing of intellectual potential. Thirty two percent, close to 3 million children between the ages of 3-17 years, have no access whatsoever to any form of media. The mountain and *terai* (especially eastern and central *terai*) regions are worst off, with above average incidence of information deprivation among children.

Millions of children live in cramped conditions: Measured by children living in dwellings with 5 or more people per room or with no floor material, the Nepal study findings show that close to a third (27.2%) of Nepal's children live in such cramped conditions. The problem is particularly severe in the eastern and central mountains, eastern hills, and central and western *terai*. Unlike sanitation and information, shelter deprivation is equally bad in urban and rural areas (urban=23%, rural=28%) owing to the high population density.

Statistical analysis also shows significant positive correlations between sanitation, shelter and information deprivation. This means that a child that is deprived of sanitation is also likely to be deprived of acceptable shelter conditions and have no access to media/information. This underscores the point that interventions that address one or another deprivation in isolation are unlikely to improve the wellbeing of children.

Education gains are shared inequitably: Increasing school enrolment has been a top priority in Nepal and considerable progress has been made in the last decade – primary school net enrolment rates (NER) rose to 87% in 2006, up from 73% in 2001.⁵

Table 3: Net primary enrolment by characteristic (2006)

Characteristic	Net primary enrolment rate (%)
Wealth quintile	
Richest	94.5
Poorest	80.6
Caste/ethnicity/religion*	
Brahmin/Chhetri	92.3
Dalit	80.7
Janjati	83.2
Terai/madhese caste	90.7
Newar	88.0
Muslim	62.4

Sources: MOHP et al., 2007, *New ERA estimates based on NDHS 2006

Nevertheless, many of the gains have been at primary level (rather than in early childhood and secondary education) and 9.5% children of school going age still have not been to school. Worse, the gains even in primary education are inequitably distributed along social lines. As seen in Table 3, net primary enrolment is lowest among children from the poorest wealth quintile and among Muslim and Dalit households. The disparity is chiefly attributed to economic poverty of households. While public primary schools are free for tuition, significant direct and indirect costs (e.g., books, clothes, transport) act as a significant barrier for poorer households to send their children to school.

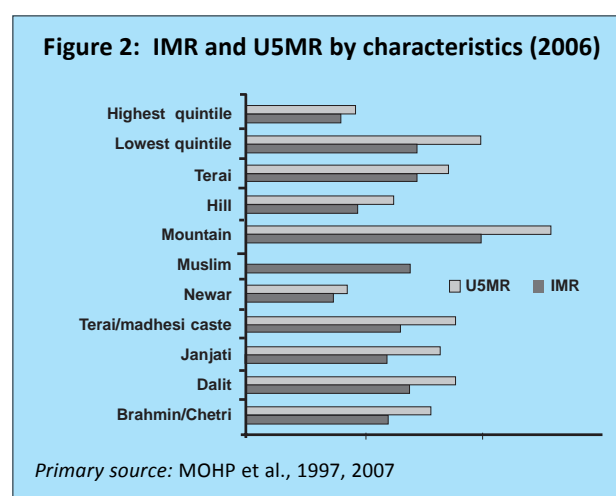
The opportunity cost of sending a child to school vis. a vis. engaging in some economic activity at farm and household levels is also a deterrent. A special monitoring project by the Ministry of Education and UNICEF since early 2009 has found that the globally induced food, fuel and financial crises have resulted in already poor rural families needing children for work and being less able to pay for school related fees and expenses.



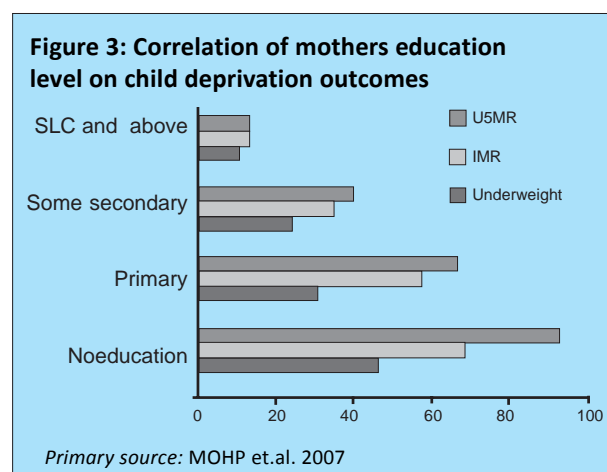
Good health a privilege of the 'haves': Nepal has made significant strides in improving its health indicators for children. In 1996, 20% of children (0–2 years) did not receive any immunization or treatment for illnesses such as Acute Respiratory Infection (ARI) or diarrhoea. By 2006, this was reduced to 2.8 per cent. Between 1996 and 2006, the Under Five Mortality Rate (U5MR) was reduced by almost half from 118 to 61 deaths per 1,000 live births, and the Infant Mortality Rate (IMR) by one-third from 78 to 48 deaths per 1,000 live births. These are remarkable achievements and can be attributed to effective mass immunization campaigns and improved delivery of basic health services.

Neonatal mortality, however, shows slower progress. Analysis of U5 deaths shows that the majority of children die in the first month of their lives; specifically, within 24 hours of birth. The current neonatal mortality in Nepal is 33 per 1,000 live births contributing to 54% of U5 mortality.

Moreover, progress is uneven across spatial and socio-economic lines. Figure 2 shows that U5MR and IMR for Muslim, Terai/Madhesi and Dalit groups are higher than for Newar and Brahmin/Chhetri groups. The gap between the richest and poorest wealth quintiles for U5MR and IMR is also significant; and IMR and U5MR rates are lowest in the hills followed by the *terai* and mountains.



The role of the mother: A clear correlation exists between a number of child deprivation outcomes and the education level of the mother. As seen in Figure 3, the main impact on child outcomes comes from secondary education level onwards, although there is improvement between mothers with no education and those with primary education. The impact is particularly strong in the U5 MR where the rates drop by a third for women with primary education.



According to the NDHS 2006, more than half of Nepal's women aged 15–49 years were illiterate in 2006 – posing a significant challenge to efforts aimed at improving child deprivation outcomes.

Policy implications: child poverty requires a multipronged endeavor

This policy brief has shown that child poverty is multi-dimensional. The child that goes to school cannot be expected to perform if she is sick every week due to diarrhoea caused by unclean water. The child that has been immunized will still not grow up healthy if he is malnourished due to lack of proper food and vitamins because his mother is unable to read the instructions provided by the community health centre.

Nepal's most valuable resource is its young people. Forty five percent of the population, close to 13 million, is under 18 and based on current



projections, will remain so for the next 20-25 years. If the children of today are the foundation of tomorrow, they must be equipped to reach their full potential. This has to start with policies that recognize the centrality of children for Nepal's future and begins to place children where they belong – at the forefront of national development. Following are some preliminary observations for policy making from the Nepal study on Child Poverty and Disparities.

Malnutrition needs to be tackled through multiple means: Stunting cannot be reversed.

Every second child under five in Nepal malnourished, implying that the next generation of parents and workers may lack the cognitive and intellectual capacities to take Nepal forward. Tackling malnutrition requires a multipronged effort – including improving infant and young child care practices and nutrition awareness. In Nepal, the most common forms of malnutrition are protein energy malnutrition, iodine deficiency disorders, and deficiencies of iron and vitamin A. Teaching hygienic/healthy feeding practices, awareness of locally grown foods and above all adult education/literacy programmes aimed at mothers and caregivers, will have exponential benefits.

Underage marriage and child bearing also needs to be actively discouraged given the evidence that underage mothers give birth to low birth weight babies. Literacy programmes for young women of child bearing ages (15-19 years) can increase awareness of health and nutrition. Existing programmes on micronutrients and supplementary foods for pregnant mothers and infants need to be expanded to cover excluded households.

Unclean water and poor sanitation need urgent action: There is a close link between environmental sanitation, hygiene and water supply. Evidence shows that interventions that combine all three elements are more effective at improving the health status of beneficiaries than single focus interventions (UNICEF 2006). Awareness raising programmes on good practices (e.g., washing hands, safe disposal of faeces) can have a huge impact – safe sanitation and hand washing can significantly reduce the incidence of diarrhoea and worm infestations as well as improve child growth (UNICEF 2006).

Address social exclusion in education: Despite improved enrolment rates, 723,000 children (9.5%), predominantly from marginalized groups, still lack access to education. Social exclusion barriers due to caste, ethnicity and language play a major role in spreading the rewards of education inequitably. The education system therefore has to bring marginalized groups within the net. For Nepal, much can be done to improve access to quality early childhood, primary and secondary education, as well as strengthen the scholarship and stipend schemes intended to reduce disparities in education.

Enhanced resource allocation to child sensitive social protection initiatives will bring exponential results:

The findings of the Child Poverty study clearly show that the burden of poverty is borne by families with children: national poverty in Nepal is 31%, but 36% for children. The country's poverty alleviation strategy therefore needs to give priority to families with children. A start has been made with the introduction of the Child Grant in late 2009.¹ Extending the child grant nationally would be a major step in supporting families with children. Currently, the proportion of non-contributory social transfers is only 3% of the budget – the bulk of social security spending (5% of the budget) goes on government pensions. Through a relatively low investment, child benefits can have very substantial returns.⁷

If Nepal is to change its tomorrow, placing children at the forefront of poverty reduction needs to happen today.



END NOTES

¹ The Nepal Child Poverty Study was undertaken with NDHS 2006, MOHP 2007, NLSS 2003/4 and other datasets. Nepal has recently announced national poverty at 25%; this brief reports the data available when the disaggregation for children according to the Bristol methodology was performed in 2009.

² The thresholds use 'no schooling' instead of 'non-completion of primary school' for education, 'no sanitation facilities in or near dwelling' instead of 'unimproved sanitation facilities' for sanitation, 'no immunization of any kind' instead of 'incomplete immunization' and most important – especially for Nepal – 'children under five years who are below minus three standard deviations from the mean weight of the international reference population' for Food instead of the WHO standard which uses minus two standard deviations as the cut off for defining underweight. IPC March 2004, www.undp.org/povertycentre

³ See www.ophi.org.uk for more details on the MPI

⁴ The UNICEF Global Study on Child Poverty and Disparities was launched in 2007. The Nepal study on Child Poverty and

Disparities was conducted on behalf of UNICEF by New ERA Ltd. The full study is available from the UNICEF Nepal Country Office in Kathmandu and details and discussions on the Global Study can be viewed at <http://unicefglobalstudy.blogspot.com/>.

⁵ Recently published official data reports a national NER of 93.7% (compared to 91.9% in 2008). Source: Flash Report 2009/2010.

⁶ Under the child grant scheme, children aged less than five years (up to two children per family) from poor Dalit families across the country and all families in the Karnali Zone will be provided Nepali Rupees 200 per month per child.

⁷ See presentation by Dr. David Gordon at the Dhaka Regional Conference on *Achieving Child Well-Being and Equity in South Asia*, <http://sites.google.com/site/globalstudy7/dhakaconference-achievingchildwell-being> and article by Dr. Peter Townsend, *In Focus*, March 2004. www.undp.org/povertycentre

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