With the Best Intentions...

A STUDY OF ATTITUDES TOWARDS RESIDENTIAL CARE IN CAMBODIA

2011

ACKNOWLEDGEMENTS

We wish to acknowledge with great gratitude all those who supported this study.

We express deep appreciation to the research coordinator Camilla Jordanwood and assistant researcher Seng Suy Lim, for their commitment and dedicated hard work over an extended period of time, which ensured quality analysis of rich primary findings from a range of sources covering an under-researched area in Cambodia.

We extend our appreciation to the Provincial Departments of Social Affairs, Veterans and Youth Rehabilitation and District Offices of Social Affairs, Veterans and Youth Rehabilitation who participated in the initial meetings of the Research Reference Group, as well as interviews and focus group discussions.

We extend our thanks to International Cooperation Cambodia - Project Sky and its manager, Sarah Chhin, for allowing the integration into this study of their own baseline research, including invaluable primary data on attitudes of children, young people and directors in residential care, analysis of stakeholder groups and methodology, which was replicated in new locations for the purposes of this study. We would also like to acknowledge FELM for their financial support of the original ICC-Project SKY research.

Our appreciation is also extended to Friends International and other NGO partners, who contributed valuable support in developing direction and focus, quality control and finalization of the research study as part of the Research Reference Group.

A special word of thanks to all participants including children, young people, families, national and sub-national government officials, residential care directors, volunteers, tourists, key informants from NGOs and the tourism industry, and adults who had formerly lived in residential care who generously shared information on their lives and donated both their time and ideas to this project. We are humbled by their stories.

We express thanks to the UNICEF Cambodia Child Protection team for their technical guidance and support to realize this research study.

Last but not least, we wish to acknowledge USAID and the German National Committee for UNICEF for their generous financial support that made this study possible.

FOREWORD

Under the leadership of Samdach Hun Sen, Prime Minister of the Royal Government of Cambodia, the Kingdom of Cambodia has been progressing and has made achievements in all sectors, including child welfare. A Policy on Alternative Care for Children was adopted in 2006, which aims to ensure that children grow up in a family and in a community environment and promotes the principle that institutional care should be a last resort and a temporary solution for children. In 2006, Minimum Standards on Residential Care for Children were adopted, and in 2008 another set of Minimum Standards on Alternative Care for Children in the Community saw daylight. Both Minimum Standards set standards for residential and community-based care facilities and their care for children. In 2009, the implementation of the Policy on Alternative Care was further strengthened by the development on a draft Prakas on Procedures for Implementation of the Policy on Alternative care, which establishes a child welfare system in Cambodia.

The principle that institutional care should be a last resort and a temporary solution has not been fully engrained in the general mindset in Cambodia, where the number of institutions and children living in residential care continues to rise each year. The increasing trend of opening and placing children in residential care facilities is of great concern. International research demonstrates that institutionalization of children impacts negatively on social, physical, intellectual and emotional child development and that non-institutional care is recognized as providing children with a range of benefits compared to other forms of residential care. Moreover, institutionalization of vulnerable children when family and community-based options have not been explored, does not comply with the Royal Government of Cambodia 2006 Policy on Alternative Care for Children.

The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY), with technical support from UNICEF, conducted this research to understand prevailing attitudes among a wide range of stakeholders on residential care in Cambodia and to generate evidence for policy and advocacy purposes. I am pleased to present the findings from this study and convey MoSVY's commitment and recommendations to donors, families, alternative care providers and relevant institutions and organi-zations at the national and sub-national levels.

The Ministry gladly welcomes feedback to the commitments and recommendations and is working in partnership with others to further strengthen national capacity to build a child welfare system, to achieve common goals to provide care and protection for vulnerable children and to act in the best interest of the child.

Phnom Penh, 07 October, 2011

MINISTER

CONTENTS

ACKNOWLEDGEMENTS 3
FOREWORD 4
ACRONYMS 7
EXECUTIVE SUMMARY 8

1. A NOTE ON TERMINOLOGY 10

2. INTRODUCTION 12
2.1. Background 12
2.2. Rationale and objectives 13
2.3. Research methodology 14
2.3.1. Methods of conducting research 14
2.4. Limitations 17
2.5. Literature review on the physical and psychological impact of residential care on children 18
2.5.1. Introduction 18
2.5.2. Socio-emotional and cognitive development 20
2.5.3. Health 22
2.5.4. Abuse 24

3. FINDINGS 25
3.1. Attitudes of overseas donors 25
3.1.1. Key findings 25
3.1.2. Funding for residential care 25
3.1.3. Reasons overseas donors support residential care 30
3.1.4. Reasons donors are less likely to fund community-based care 31
3.2. Government attitudes towards residential care 33
3.2.1. Key findings 33
3.2.2. Registration of residential care facilities 34
3.2.3. Criteria for opening residential care centres 35
3.2.4. Residential care monitoring 35
3.2.5. The effectiveness of monitoring 36
3.2.6. Attitudes of DOSVY, commune council members and village chiefs 37
3.3. Attitudes of directors of residential care 38
3.3.1. Key findings 38
3.3.2. Advantages of residential care 38
3.3.3. Disadvantages of residential care 39
3.4. Attitudes of families 42
3.4.1. Key findings 42
3.4.2. Physical/societal factors contributing to families placing children in care 42
3.4.3. Attitudes that contribute to placing children in residential care 48

3.4.4. Attitudes that contribute to keeping children in the community ---- 56
3.5. Attitudes of young people to residential care ---- 57
3.5.1. Key findings ---- 57
3.5.2. Present ---- 58
3.5.3. Future ---- 59
3.6. The process of placing a child in residential care ---- 62
3.6.1. Key findings ---- 62
3.6.2. Children in the care of relatives ---- 62
3.6.3. Placing children into care ---- 62
3.7. Child protection issues ---- 64

4. CONCLUSION ---- 65

5. RECOMMENDATIONS AND COMMITMENTS ---- 67
5.1. Overseas donors ---- 67
5.2. Donors in Cambodia ---- 67
5.3. Families ---- 68
5.4. National Government ---- 68
5.5. Local Government ---- 69
5.6. Residential care ---- 69

REFERENCES ---- 70

ACRONYMS

BEIP	Bucharest Early Intervention Project
COSECAM	Coalition to Address Sexual Exploitation of Children in Cambodia
HOSEA	Helping Orphanages through Support, Education and Advice
HIV	Human Immunodeficiency Virus
ICC	International Cooperation Cambodia
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MoRD	Ministry of Rural Development
MoCR	Ministry of Cults and Religion
MoFA	Ministry of Foreign Affairs
MoI	Ministry of Interior
NGO	Non-Governmental Organization
NOVCTF	National Multi-sectoral Orphans and Vulnerable Children Task Force
DOSVY	District Office of Social Affairs, Veterans and Youth Rehabilitation
OVC	Orphans and Vulnerable Children
RGC	Royal Government of Cambodia
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund

EXECUTIVE SUMMARY

Since 2005, Cambodia has seen a 75 per cent increase in the number of residential care facilities, with 269 residential care facilities housing 11,945 children in 2010. Government statistics demonstrate that over the past five years, 44 per cent of children who were placed in residential care were brought there by their parents or extended family, and 61 per cent of children who left residential care were reunited with their parents or extended family[1]. This situation is in sharp contrast to government policy, which in its 2006 Policy on Alternative Care for Children and the 2008 Minimum Standards on Alternative are for Children (herein referred to as the Minimum Standards[2]) notes that family and community-based care are the best option for children, with institutional care being a last resort and a temporary solution.

Sixty years of global research details the adverse impacts of residential care on the physical and emotional development of children. This body of research has shown that residential care can result in clinical personality disorders, growth and speech delays, and an impaired ability to re-enter society later in life. Residential care has also been shown to place children at risk of physical and sexual abuse. Cambodia has a long tradition of caring for vulnerable children within kinship care, and to this day, the majority of Cambodia's orphans live within the extended family. The rapid increase in residential care facilities threatens to erode these existing systems, and places children at risk.

In response to this situation, the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) and UNICEF commissioned this study to understand attitudes and beliefs that are contributing to the increase in residential care facilities. A research team was established to conduct the study.

Residential care appears to be the first-stop solution of individual overseas donors who, with the best intentions, provide support and funding to children in orphanages, often unaware of community-based care options. Since almost all residential care centres are funded by individuals from overseas, many centres turn to tourism to attract more donors. In the worst cases this becomes the basis for an *"orphanage tourism"* business, in which children are routinely asked to perform for, or befriend donors, and in some cases to actively solicit the funds to guarantee the residential centres' survival. Residential centres have also turned to international volunteers in the hopes of raising money. As a result, short-term volunteers, who have not undergone background checks, are frequently given access to children, which poses a child protection risk.

A high turnover of caregivers has also been shown to negatively impact children in care, who must repeatedly try to form emotional connections with different adults. Many volunteers see it as their role to provide love, thus building strong emotional bonds with the children. However, when volunteers leave, these bonds are broken and the children are once again left alone.

The Government of Cambodia supports family- and community-based care, and views residential care as a last resort. MoSVY has taken a strong stance in the Policy on Alternative Care for Children and the Minimum Standards, enacting policies and frameworks that favour family- and community-based care over residential care, but these have not been adequately enforced. MoSVY continues to register a high number of residential care centres every

---

1 Ministry of Social Affairs, Veterans and Youth Rehabilitation, Alternative Care Database, 2005-2009.

2 Minimum Standards on Alternative Care for Children are comprised of Minimum Standards on Residential Care for Children (2006) and Minimum Standards Applicable to Alternative Care for Children in the Community (2008).

year and has described itself as powerless to redirect the trend. Meanwhile, at the local government level, residential care receives a great deal of support. In surveys with Commune Council members and Village Chiefs, 70.7 per cent of respondents believed that residential care was the best option for a child without parents. Commune Council members and Village Chiefs often persuade families to put their children into residential care in the absence of alternative support mechanisms.

In most cases the signature of the Village Chief is required to place a child into residential care. Although Village Chiefs support residential care, many are also open to the idea of community-based care, noting that it would help to keep children with their families. If Village Chiefs are made aware of the potential negative impact of residential care, and are linked with community-based care and support options, they could be instrumental in helping poor families keep their children at home.

An estimated 30.1 per cent of Cambodians live below the poverty line (World Bank, 2009), and most of the families interviewed for this study were living in poor conditions. Cambodia lacks a social welfare network to support poor families in need, and residential care often fills that gap.Poor families explain that they want to provide the best for their children, but are often unable to provide them with food and education. While an array of other socio-economic factors such as remarriage, single parenting, large families and alcoholism contribute to the likelihood of placing a child in care, the single largest contributing factor for placement in residential care is education. In surveys conducted in the course of this research study, 91.9 per cent of family members agreed/definitely agreed that a poor family should send a child to an orphanage for education if they cannot afford to pay for the child's education themselves. Primary school education fees account for 26.5 per cent of non-food spending among the poorest households (World Bank, 2005). Faced with this reality, with the best intentions families choose to place their children in residential care, in the hope that it will offer a path out of poverty to a better life. The MoSVY database confirms that over the past five years, 45 per cent of children currently in residential care have primarily been placed there because of poverty.

Children often suffer as a result of being placed in residential care. Young people living in residential care, directors of facilities, and key informants all describe the negative effects of residential care on children. Children miss their families, develop tendencies towards dependency and show symptoms of *"indiscriminate affection".* They feel that their basic needs are not sufficiently met, and complain of a lack of freedom. Children note the lack of adequate love or warmth, or the inequality of affection, and worry about their ability to find a place in society in the future. Some children do not even receive the education that they were promised. Whilst a child's right to education is a fundamental right, the United Nations Convention on the Rights of the Child also clearly states that the family, as the fundamental group of society, should be afforded the necessary protection and assistance so it can assume its responsibilities[3]. It further notes that the child, for the full and harmonious development of his/her personality, should grow up in a family environment. It is fundamentally wrong to deny children their rights in one arena in favour of achieving rights in another. Parents and children should never be placed in the position of having to decide between education and family life.

[3] United Nations Convention on the Rights of the Child, Preamble.

1 A NOTE ON TERMINOLOGY

In the interests of clarity and good practice the definitions used in this study are based on the Royal Government of Cambodia's Policy on Alternative Care for Children 2006 and the 2010 UN Guidelines for the Alternative Care of Children. By referencing both of these documents, MoSVY is attempting to establish a universal understanding and application of alternative care terminology to ensure harmonized approaches. The standard and consistent use of this terminology will ensure a common understanding amongst agencies concerned with children and their care, and will contribute to improved validity of research and recommendations.

Alternative care is defined in the Royal Government of Cambodia's Policy on Alternative Care for Children (2006) as *"care for orphaned and other vulnerable children who are not under the care of their biological parents".* It includes institutional or residential care and family and community-based care. It is further defined in the UN Guidelines for the Alternative Care of Children (2010) as signifying *"informal care: any private arrangement provided in a family environment, whereby a child is looked after on an on-going or indefinite basis by relatives or friends (informal kinship care) or by others in their individual capacity, at the initiative of the child, his/her parents or other person without this arrangement having been ordered by an administrative or judicial authority or a duly accredited body." [and] "formal care: all care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities whether or not as a result of administrative or judicial procedures"* [4].

Birth parent is a child's biological parent, who may or may not be looking after the child.

Child. A child means every human being below the age of 18 years.

Community-based care. Any kind of support given to families with vulnerable children that helps them to support their children within their families.

Foster care. The Royal Government of Cambodia Alternative Care Policy describes foster care as the formal or informal care of the child by a family unrelated to the child. This relates most closely to the UN Guidelines definition of kinship care (see above) and thus foster care as used in this report refers to *"situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family other than the children's own family, which is selected, qualified, approved and supervised for providing such care".*

Kinship care. The Royal Government of Cambodia Alternative Care Policy describes kinship care as the full-time care of a child by a relative or another member of the child's extended family[5]. The UN Guidelines extend this definition to include *"close friends of the family known to the child".* Kinship care can be informal, a private arrangement, or formal, ordered through a competent administrative body or judicial authority.

---

[4] United Nations General Assembly, Resolution adopted by the General Assembly, Guidelines for the Alternative Care of Children, A/Res/64/142, April 2010.

[5] Better Care Network, Adoption. Available from: http://www.crin.org/bcn/topic _ more.asp?topicID=1012&themeID=1012

Orphan is a child below the age of 18 who has lost one or both parents. A child who has lost both parents is referred to as a double orphan. A child who has lost his/her mother is a maternal orphan. A child who has lost his/her father is a paternal orphan.

Pagoda-based care. Buddhist monks, nuns and lay clergy provide children, usually boys, with food, shelter (accommodation), education etc. within the pagoda grounds.[6]

Residential care is a group living arrangement, in which renumerated adults provide care to children on a full-time basis.[7] In Cambodia this encompasses both short-term centres, including recovery or child protection centres, and longer-term residential care facilities such as orphanages. Residential care and institutional care are used interchangeably[8].

Residential care centre/facility are used interchangeably to describe a group living facility or centre in which remunerated adults provide care to children on a full time basis.

---

6 MoSVY.Policy on Alternative Care for Children, 2006, p.11.

7 MoSVY. Policy on Alternative Care for Children, 2006, p.9.

8 Adopting the terminology established in Tolfree's global study of separated children in the developing world, Roots and Roofs (1995).

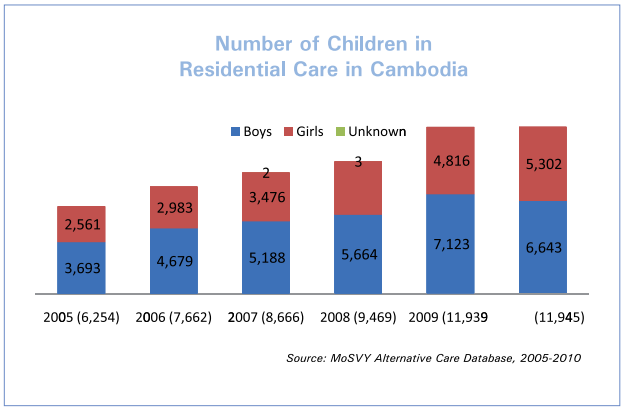
2 INTRODUCTION

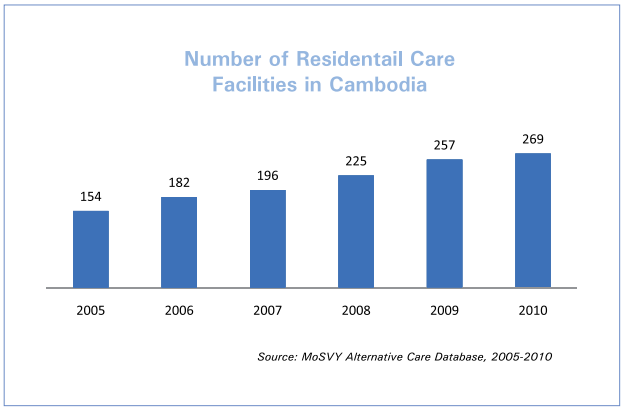
2.1. Background

Cambodia has an estimated 553,000 single and double orphans[9], accounting for 8.8 per cent of all children. In comparison, the child population in residential care facilities remains relatively small at 11,945 (2.2 per cent)[10]. However, the MoSVY database shows that the majority of children in residential care are not double orphans, but children with parents. These children have been placed in care for a variety of reasons, which are investigated within this study. Cambodia is not isolated in this aspect. A Save the Children Alliance report cited many countries in which the percentage of children in residential care with one or more parents was over 80 per cent (Csaky, 2009). However, the vast majority of children without parental caregivers are cared for through traditional community and extended family forms of alternative care. In fact, MoSVY's Alternative Care database notes that 44 per cent of children in residential care facilities are brought there by their parents or extended family, and 61 per cent of children leaving residential care are reunited with their parents or extended family.

Increasingly, these traditional forms of non-residential alternative care are being replaced by residential facilities. Since 2005 the number of children in residential care in Cambodia has increased sharply, with the number of children in state orphanages remaining stable and significant proliferation in NGO run orphanages. Statistics provided by the MoSVY Alternative Care Database indicate that numbers have increased in the last five years by 75 per cent from 154 institutional care facilities in 2005 to 269 in 2010. MoSVY also recognizes that since residential care facilities are increasing rapidly and not all facilities within their database are registered with MoSVY, but instead with other ministries including the Ministry of Foreign Affairs, the Ministry of Interior and the Ministry of Rural Development, the actual numbers of children in residential care could be much higher, as residential care is increasingly utilized as an alternative to parental, traditional community and extended family forms of care.

The increasing trend to place children in residential facilities is a concern and does not comply with the policy of the Royal Government of Cambodia. In 2006, MoSVY developed the Policy on Alternative Care for Children, which was then followed by the Minimum Standards on Alternative Care for Children in 2008. Together these documents offer guidance and a regulatory framework for forms of alternative care. The Policy on Alternative Care for Children states that residential care should be a last resort and a temporary solution.





9 NOVCTF. Orphans, children affected by HIV and other vulnerable children in Cambodia: a situation and response analysis. Cambodia: MoSVY/National AIDS Authority, 2008, p.15.

10 MoSVY Alternative Care Database, December 2010.

The increase in placement of children in residential care in Cambodia is not in accordance with the principles of care articulated at the Stockholm conference on Children and Residential Care and the 2010 UN Guidelines for the Alternative Care of Children. Moreover, it is in contravention of the United Nations Convention on the Rights of the Child (UNCRC) to which Cambodia is a signatory. Residential care withholds several rights granted to children in the UNCRC[11], which are summarized below:

- The child, for the full and harmonious development of his or her personality should grow up in a family environment (Preamble),
- In all actions concerning children…the best interests of the child shall be a primary consideration (Article 3),
- The child shall have the right to know and be cared for by his or her parents (Article 7),
- State parties shall ensure that a child shall not be separated from his or her parents, unless such a separation is in the best interests of the child (Article 9),
- The child has the right to be heard in any judicial proceedings affecting them (Articles 12, 13 and 14),
- Children within the care of any person have the right to protection from physical or mental violence, injury and abuse, neglect or negligent maltreatment (Article 19),
- A child deprived of his or her family environment shall be accorded special protection and assistance from the State (Article 20).

International research has indicated that family-based care is recognized as providing children with a range of benefits compared to other forms of residential care and avoids the risks associated with institutionalization, such as delays in social, physical, intellectual and emotional development.[12]

Despite government policy and negative outcomes for children, the number of residential care facilities continues to grow each year in Cambodia. MoSVY and UNICEF seek to address this issue by developing, in cooperation with relevant government agencies and NGOs, public awareness campaigns and corresponding advocacy materials to promote family-based care and encourage community-based family support over institutional care. This research study was developed to identify the attitudes amongst a wide range of stakeholders that influence the increase in residential care, and to use this information to feed into child welfare policy development, inform advocacy dialogue on de-institutionalisation and promote family and community-based forms of alternative care for children.

2.2. Rationale and objectives

This qualitative study seeks to understand prevailing attitudes towards residential care in Cambodia and build evidence for policy and advocacy purposes, particularly public awareness campaigns. This research is also important in light of the growing realization that a comprehensive social protection system is needed in Cambodia, with the provision of family and child welfare services being an important component. As residential care is perceived as one of the few services available to vulnerable families, it is essential to know the norms and attitudes that drive families, communities and donors to support residential care. This will help to target messages and plan appropriate community-based services in the future. Central research questions that directed the focus of this research were: *"What are the attitudes of families, communities, government, donors and providers towards residential care in Cambodia?" and "Could these attitudes be influencing the increase in residential care in Cambodia?"*

[11] This is the summary of a list originally compiled by Richard Carter, in Family Matters, 2005.

[12] This research is examined in detail in the literature review.

2.3. Research methodology

Primary and secondary qualitative research was conducted by the research team in 2009 on attitudes of families, national and local government, residential care directors, overseas donors and volunteers, key informants from NGOs and the tourism industry, and adults who had formerly lived in residential care as children. The research was conducted in five districts in Phnom Penh, Kampong Thom, Battambang and Siem Reap. Interviews were recorded by taking notes and the majority were also recorded digitally.

A second round of quantitative research was conducted by the research team in 2010 using surveys with three primary stakeholder groups: families, government officials and tourists.

Qualitative and quantitative research into the attitudes of children and residential care directors was conducted by the ICC-Project Sky research team in Phnom Penh in 2007 and in Kampong Thom and Battambang in 2009. Primary data were recorded by note-taking and integrated into the analysis of the final research study.

2.3.1. Methods of conducting research

Research was conducted through semi-structured interviews, focus group discussions, in-depth email questionnaires and secondary printed and online data sources. Semi-structured interviews were conducted with almost all stakeholder groups, allowing in-depth investigation of opinions and attitudes. Children, however, were not interviewed one-on-one because it was felt that they might feel uncomfortable with outside researchers or feel pressured to talk. Interviews were conducted with vulnerable families as well as randomly selected families from communities to get a sense of prevailing attitudes of the public. Donors and volunteers were interviewed when possible, but those who were overseas at the time of research were contacted through in-depth email questionnaires. All semi-structured interviews were conducted by the same researcher, accompanied by a translator. The interviews were recorded and translation was checked at a later date. The researcher introduced basic subject areas, and then built questions based on the participants' response.

Focus group discussions involved conversations, participatory games and drawings. A special effort was made to ensure that focus groups with children and young people were child-friendly.

Focus group discussions were thought to be a less invasive method of working with children and young people in residential care because they would be with their peers, and could choose more easily whether or not to speak. The research team also decided not to ask young people to discuss their past, or the benefits and disadvantages of living in residential care, since this may have been traumatic for young people who had no other options at the time.

The findings from the first round of research were used to design the second round of surveys. Printed and online publicity from residential care organizations were reviewed. This included promotional leaflets distributed via residential care centres, websites and volunteer weblogs[13].

Sample

This study was conducted in five districts within four provinces: one in Phnom Penh, one in Kampong Thom, two in Battambang and one in Siem Reap. Communities were chosen in consultation with MoSVY, local service providers, and UNICEF's child protection specialists. Provinces were identified using the following criteria:

[13] A weblog is a personal diary posted on the internet.

- Large numbers of residential care facilities and high numbers of children in residential care (Phnom Penh City, Battambang City, Siem Reap City).
- High levels of residential care tourism (Siem Reap City).
- A representative sample of rural and urban facilities (Kampong Thom and Reaksmei Sanghavillage in rural Battambang).

In total, 151 participants took part in semi-structured interviews, 992 participants took part in focus group discussions, six participants completed in-depth questionnaires, 1,798 par-ticipants completed surveys and 24 promotional documents were reviewed. These numbers are disaggregated below.

Children over the age of 15 in residential care
Focus group discussions: 634 participants. Surveys: 634[14] participants.

Children over 15 living in the community
Focus group discussions: 153 participants. Surveys: 153 participants.

Adults who had formerly been in residential care
Semi-structured interviews: 5 participants.

Families with children in residential care
Semi-structured interviews: 45 participants.

Families with vulnerable children living at home
Semi-structured interviews: 42 participants.

General families from communities
Focus group discussions: 153 participants. Surveys: 385 participants.

Residential care directors
Semi-structured interviews: 14 participants. Focus group discussions: 52 participants.

Government members
Semi-structured interviews: 16 participants (MoSVY: 3, DoSVY and Commune Councils: 9, Village Chiefs: 4). Surveys: 315 participants.

Donors to and volunteers in residential care
Semi-structured interviews: 6 participants. In-depth email questionnaires: 6 participants.

Residential care centre promotional documents
Leaflets: 10. Websites: 10. Weblogs: 4.

Tourists
Surveys: 311 participants.

Key informants from NGOs, civil society and the tourism industry
Semi-structured interviews: 23 participants.

[14] The same children and young adults took part in focus group discussions and completed surveys. All other participants took part in only one form of research.

Purposive sampling was used throughout the study, except with the general survey, in which random sampling was used. Children and young adults in residential care were contacted through the centres themselves, and children and young adults in the community were contacted through youth groups. Families with vulnerable children living at home, who took part in semi-structured interviews, were identified according to one or more of the following criteria:

- Identified as vulnerable by a local NGO and as a result were receiving some form of aid, usually in the form of a food subsidy;
- Had previously been approached by residential care centre staff who offered to place their child in residential care;
- Had previously been forced to place a child in the care of an extended family member.

The research team tried to ensure equal representation of men, women and elders within families, but was unable to achieve this. Fewer men were interviewed than women. Some facilitators argued that this was due to the fact that vulnerable children were more likely to come from families that did not have a father living at home, but others said it was due to the work schedule of men. The research team, however, did attempt to work around people's work schedules by conducting interviews on weekends or in the evenings when necessary. These interviews were conducted in order to compare the attitudes of families that had decided to place children in care, with those of families who considered placing children in families, but had decided against it.

Families with children in residential care were located through NGOs and residential care centres. The initial intention had been to interview an equal number of families with children in care, and families with vulnerable children living in the community in each district. However, it became clear that fewer families living in Phnom Penh put their children into residential care; children in residential care centres in Phnom Penh come almost entirely from the provinces.

Families with children from communities were contacted in order to identify prevailing attitudes of the local community towards residential care. Residential care directors were also took part in focus group discussions according to their availability.[15]

Interviews with government were specific to the location. In Phnom Penh, members of MoSVY were interviewed, and in the provinces members of DoSVY, Commune Councils and Village Chiefs were interviewed.

Donors and volunteers were contacted through key informants to take part in semi-structured interviews and in-depth email questionnaires. Multilateral donors, NGOs, civil society and members of the tourism industry were interviewed as key informants. Promotional documents were collected in Phnom Penh and Siem Reap. All websites and blog posts used for analysis were printed out and kept in research logs.

Ethical considerations

Consent

Consent was sought from all participants after informing them of the purpose and timescale of the research. Participants were informed that:

- They had the right not to participate;
- They had the right to discontinue at any time;
- All information would be confidential.

[15] For example, many residential care directors were willing to talk in Phnom Penh, whereas in Siem Reap some said they were too busy or preferred to voice their opinions in the focus group discussions. In Reaksmei Sangha there was only one residential care director.

Many participants were illiterate, and many were rightfully wary of signing papers. In these cases the consent form was read aloud, and verbal consent was given and recorded. Consent for surveys was emailed to the researcher. Consent for children and young people to take part in the research was sought from both residential care directors and from children and young people themselves. It was made clear that they could choose not to participate, but if they later changed their mind, they could join in the activity at any time.

It was also made clear to each group that if an individual decided not to be involved in an activity, noone would force them to join in. This gave children and young people freedom to be involved in activities they felt comfortable with, and to sit out of those they did not. This freedom is recorded in the results themselves, where full numbers in some activities cannot be accounted for, or where some parts of papers are left blank.

Research with children

The research team focused on children over the age of 15 due to the complex considerations of doing research with young children. A series of ethical safeguards were followed when working with children and young people, including a set of guidelines, which ensured no adult was alone with a child, adults treated children with respect, and children were free to stop at any time.

Children were contacted through residential care centres and youth groups, but all children in the centres who fitted the research age criteria were invited to participate in focus group discussions. This prevented staff from residential centres having to select child participants. Staff from residential centres were kept separate from focus group discussions so that they could not hear the children's conversations.

Materials for focus group discussions were designed to be child-friendly using child-centered participatory techniques, including drawing and games. All focus group materials were accessible to the illiterate.

Protecting participants from harm

All research records are confidential and no names or identifying information are used in the report, with the exception of documents already in the public domain, such as published documents available on the internet or leaflets distributed in public venues.

If participants became upset during an interview, they were asked if they wanted to stop. If participants had not previously heard about residential care facilities, the researcher was careful not to introduce them to such facilities.

Unrealistic expectations

The research team made it clear to all participants how the research would be used, and that it would not result in programmatic support from UNICEF or other development organizations at a later date.

2.4. Limitations

- This is a study of attitudes and therefore records what people report they think and believe. When investigating attitudes it is important to remember that people often shade the truth and offer an improved version of events, reflecting what they think the researcher wants to hear. However, many of the different groups in this research gave similar responses, which, for the most part, were in line with existing literature.
- During the research planning phase, it was decided to add Siem Reap to the list of target provinces, due to reports of thriving residential care tourism in the town. However, budget and time concerns meant that it was not possible for Project Sky to conduct focus group discussions with children and young people in Siem Reap.

- In order to involve government, local DoSVY staff helped organize the research plan. Many families who participated in this research were contacted through organizations that work closely with DoSVY. This may have influenced the sample selected and the responses they gave.
- Participants may have viewed the research coordinator as a possible donor. Although the research team was clear that participation in the research would not result in programmatic support, this prior belief may have influenced the answers participants gave.
- When conducting research with families, the research team made an effort to hear from an equal sample of mothers, fathers and elders. However, despite all efforts, the team was unable to find as many men to talk to as women. Some attributed this to the work schedule of men, whilst others said that when a father lived at home a child was less likely to bevulnerable, and that many vulnerable families did not have a father living in the house.
- The initial round of research contributed by Project Sky was conducted in 2007. It was therefore not conducted at the same time as the rest of the research and it limited the scope of inquiry of the second round of research.
- More focus group discussions with children were held in Phnom Penh than in other provinces and this may have prejudiced the data in terms of representing the views of children in urbanresidential care centres.
- Young people over the age of 15 living in residential care were contacted through residential care directors. Residential care staff facilitated bringing children to the research workshop and focus group discussions. This may have influenced the ability of the young people to speak freely. However, staff did not listen to discussions.
- All research was conducted and recorded in Khmer, then translated and analysed in English. It may be possible that nuances of participants' views were altered in the process of translation.
- Foursquare Children of Promise, an organization that runs over 100 residential care facilities in Cambodia, refused to allow any of their staff to take part in the research, although many other participants (for example families, government members and former staff) spoke about experiences with Foursquare.

2.5. A literature review of studies on the physical and psychological impact of residential care on children

2.5.1. Introduction

For more than sixty years and across every continent, the impact of residential care on children has been thoroughly researched. The majority of findings conclude that institutionalization prevents the healthy development of children, and that these effects can last long into adulthood. This review will evaluate studies that look at the impact of residential care on the social, emotional and cognitive development of children. It will also assess how residential care affects the health of children and the likelihood of children being victims of abuse.

While initial studies focused on residential care in developed countries of the West, there is a growing body of research on institutional care in developing nations. Given the volume of international studies, this review will focus on the most influential. It will begin by looking at the work of Goldfarb and Bowlby (Bowlby 1951; Goldfarb 1943) whose early studies described the negative impact that residential care can have on children and established the importance for young children of attachment to a parent. It will then look at the studies by Tizard (Tizard and Hodges, Tizard and Rees, 1975), which first characterized the behaviour disorder known as Reactive

Attachment Disorder, which is a common effect of residential care. Next, it will look at the long-term effects of residential care on emotional health and social skills by looking at the studies of Rutter and Quinton (Rutter and Quinton, 1984). Following this, it will summarize the findings of several studies from the ground-breaking Bucharest Early Intervention Project (2005 and 2007), which has found evidence of both the negative effect of institutionalization on the physical workings of the brain and cognitive development, particularly among children under the age of three.

Next, it will reference three large-scale studies, which looked at the impact of residential care centres in a diverse range of countries across the world. These studies took the debate out of Western Europe and into the wider world. In 1991, Save the Children conducted a global research study in more than 20 developing countries on issues concerning the care of separated children, both in residential care and in community alternatives (Tolfree, 1991). This influential study described in detail the negative effects of residential care on children in developing countries and advocated for a move towards preventing family separation. Family Matters, published by EveryChild in 2005, was a further comprehensive study of institutional childcare in Central and Eastern Europe and the former Soviet Union (Carter, 2005). Drawing on examples and studies from a large number of countries, this study reinforced the view that residential care has a negative impact on the health and development of children. In 2009, members of staff at Duke University in the United States conducted a study entitled *A Comparison of the Wellbeing of Orphans and Abandoned Children Ages 6-12 in Institutional and Community-Based Care Settings in Five Less Wealthy Nations* (Whetten et al., 2009). The study took place in six locations across five countries and randomly sampled 1,357 children living in institutions and 658 children who were either abandoned by both parents or double orphans living in the community, but not receiving external support from any organization. The study compared cognitive functioning, emotion, behaviour, physical health and growth.

Published research on residential care in Cambodia is scarce. Only four studies[16] on residential care have been published in the last decade. In 2001, Daigle and Dybdal conducted a survey of providers of alternative care in Cambodia, in which the research team conducted interviews with non-governmental and governmental staff of organizations providing alternative care for children. The study had some limitations, in that the results relied on the assertions of the organizations' staff and there was no independent observation of conditions. Nor were the opinions of children, the recipients of this care, included. The findings, therefore, may have been biased towards a positive view of care. However, the survey did produce many interesting findings, which are referred to later in this review. In 2002, International Cooperation Cambodia's (ICC) Helping Orphanages through Support, Education and Advice (HOSEA) Project conducted a survey of alternative childcare in Phnom Penh and Kandal Province, which looked at staff and service provision in residential care. Finally, in 2004 Vijghen produced a small desk study for the Coalition to Address Sexual Exploitation of Children in Cambodia (COSECAM) on child recovery centres and the discrepancy between intentions and realities in residential care in Cambodia.

In 2009, Roisin Boyle conducted a study entitled *My Heart is Here, Alternative Care and Reintegration of Child Trafficking Victims and Other Vulnerable Children in Cambodia.* This study focused on the wellbeing of children in shelters, the majority of whom had been trafficked, abused or were living on the street when they entered the shelter. Shelters for children who have been victimized by their families play a different role than residential care centres. Children in these shelters have a complex range of needs, and their relationships with their families are often different than those of other children. In these circumstances, reintegrating a child back into their own family could be dangerous if a parent had trafficked the child in the first place. Children who have been victimized by their families may need additional counselling and support. Additional research is needed on the role of rehabilitation shelters for children in Cambodia and whether there is a disproportionate reliance on residential care for child victims.

[16] Four studies known to the author.

2.5.2. Socio-emotional and cognitive development

Research into the emotional and social effects of residential care has a long history.[17] In 1943, Goldfarb conducted an observational study in the United States that compared 40 six-year old children in residential care with 40 six-year old children in foster care. The report recorded the children's behaviour against a series of behavioural markers. Those in residential care showed high levels of hyper-activity and mental retardation, among other symptoms. Based on his findings, Goldfarb developed the characterization of *"institutional syndrome",* which included hyperactivity and indiscriminate demand for affection.[18] Children showing *"indiscriminate demand for affection"* are unusually friendly towards others, including strangers. Goldfarb went on to conduct a number of studies throughout his career, focusing on the negative effect of residential care on social and emotional development.

The work of Goldfarb informed the influential monograph of Bowlby, *Maternal Care and Mental Health* (1951), which was published by the World Health Organization in 14 different languages. Bowlby argued that in order for children to develop normally, they require strong attachment to a *mother* figure early in life.[19] Subsequent studies have argued that the term *mother* is too limiting and that this attachment can be formed by other caregivers, such as fathers or grandparents (Ainsworth, 1974; Tolfree, 1995; Rutter, 1981).

Tolfree (1995) argues that the term *maternal* should be expanded to describe the range of family caregivers often found in developing countries. Tolfree (1995) and Rutter (1981) revisited Bowlby's work arguing that other forms of deprivation found in residential care, such as lack of stimulation from the environment, might also influence the effects of maternal deprivation that Bowlby described. However, Bowlby's premise that strong interpersonal relationships are crucial to a child's development is still widely accepted. Bowlby further argued that the need of children for a maternal figure could not be met in institutions, which suffer from a high staff turnover and a low ratio of staff to children.

In the 1960s, Tizard conducted research on children who had been placed in residential care in England (Tizard and Hodges, 1978; Tizard and Rees, 1975). She identified a group of 65 children who had been placed in residential care at birth. She first visited these children at age two and then returned when they were four years old. At this point only 26 remained in the institution; the rest had either been adopted or returned to their families. The 26 that remained were assessed, and eight were found to be emotionally withdrawn, ten displayed indiscriminate affection and the remaining eight had formed attachments to caregivers within the institution (Tizard and Rees, 1975). The findings of these studies formed the basis for the description of Reactive Attachment Disorder, which can manifest itself as being either emotionally withdrawn or indiscriminately social, and is recognized as a clinical disorder by the World Health Organization (1992).

Rutter and Quinton (1984) conducted a study that tracked women who had been in residential care as young children over a long period. In this study, 94 women who had been in group homes as children were followed by the researchers over a 20 year period and compared to 41 women who had never been in residential care. The study found that women who had been institutionalized had higher rates of personality disorders and marital issues than the control group, but also cautioned that both genetic and environmental factors may be at play. The study also demonstrated how positive experiences later in life could modify the effects of residential care.

---

[17] Starting with the early observational studies of Lowrey (1940) and Spritz (1945) that described the behaviours of institutionalized children. These studies are not included here because we decided for the sake of brevity to focus on studies that had the largest impact.

[18] This study built on the ideas of Lowrey's (1940) study that found children who had lived in institutions for significant periods of their childhood formed partial love attachments and showed over-affection and aggression.

[19] Kuhn et al. (1998) in *Response to Maternal Separation: Mechanism and Mediators* found that maternal deprivation in rats produced a decrease in enzymes and synthesis, among other abnormalities.

More recently, beginning in 2003, The Bucharest Early Intervention Project (BEIP) conducted a series of studies comparing the development of children in residential care facilities with non-institutionalized children and children who had left institutions for foster homes (2005, 2007). A random sample of 208 children with a mean age of 22 months took part in the study. Several studies have been released as a result of this project and a few are noted below.

Parker et al. (2005) looked at the impact of early institutional rearing on the brain. The study measured the ability to discriminate facial expressions of emotion, using event-related potentials, which measure electrical activity in the brain. In Bucharest, Romania, 72 children (aged 7-32 months) who had been living in residential care were compared with 33 children (aged 8-32 months) who had never been institutionalized. Differences between the two groups suggested that early institutionalization disrupts the neurocircuitry involved in the recognition of faces by young children. In other words, institutionalization is shown to have an effect on the physical workings of the brain.

Zeanah et al. (2005) examined the effect of institutions on attachment—the child's ability to bond with a significant caregiver—looking at 136 institutionalized children and 72 children living in the community (aged 12-31 months). The study assessed children using ratings of attachment behaviours and caregiver's descriptions. It found that children raised in institutions showed serious disturbances of attachment and established a correlation between quality of care giving and a child's ability to form attachments.

Nelson et al. (2007)[20] looked at cognitive recovery in children who had previously been placed in institutions. One hundred and thirty six children were assessed at the beginning of the study after which 68 were randomly selected and moved to foster care, leaving another 68 still in residential care. The study also looked at 72 children who had never been in care. Children were assessed using the Bayley Scales of Infant Development and the Wechsler Preschool Primary Scale of Intelligence, two widely recognized international assessment tools, and tracked through to 54 months of age. Children who had remained in residential care had markedly lower scores of cognitive development than the other two groups. Children who had been moved into foster care showed improvement in cognitive scores, with those who had moved at a younger age showing more improvement than those who had moved when they were older.

The study of Whetten et al. (2009) compared orphaned or abandoned children in institutions with similar children who lived in the community, but received no external aid or support. They found that children in institutions fared better in cognitive tests, presumably because children in institutions were more likely to have received school support. Again, the study by Whetten et al. implies that institutions can function as an avenue to forms of support, which improve children's lives, but it fails to evaluate the effect that this support could have had if given to children living in their communities. Moreover, the study looked at children aged six and above, who had been resident in institutions for three years. It was therefore unable to gauge the long-term impact of institutionalization on children.

Social factors can result in children who have been in residential care finding it difficult to adapt to society later in life. Save the Children's global research study, referenced earlier, confirmed that children in institutions in developing countries display the same inability to make and sustain relationships as those mentioned in the European studies above. However, it also noted that children in residential care in the developing world are seldom prepared to enter society upon leaving the institution. Significantly, the study found,

[20] All research with young children in institutions raises ethical concerns since the ability of children under the age of 10 or 11 to give informed consent is questionable, and in residential care the legal guardian of children is, in most cases, the organization being researched. The BEIP posed additional ethical concerns because it organized a foster care programme in order to be able to randomly assign children either to foster care or to let them remain in the institution. The project was cleared by ethical committees in government and in academia, however the fact remains that it intervened in the life of very young children in institutions.

"Institutionalized children are likely to face an uncertain future as young adults. Frequently denied opportunities for learning about the roles and skills needed for adult life, and deprived of the emotional experiences which are necessary for healthy social adjustment, they face the uncertainty of a future without the support of parents... it is no surprise to find that many of these young people are unable to cope successfully in society and may even seek refuge in dependency-creating environments such as prisons or psychiatric hospitals" (p.8).

These findings were echoed by Vijghen's (2004) small study entitled *Child Recovery Centres in Cambodia,* which found that although children graduating from these recovery shelters had some vocational training it was often inadequate or inappropriate for the job market, and that many were unable to support themselves once they had left the institution. The *Project Survey of Alternative Child Care in Phnom Penh and Kandal*, conducted by ICC/HOSEA in 2001, found that although most children in residential care received primary education, vocational skills training was inadequate. The training offered *"few opportunities to break away from traditional roles and jobs, (i.e. girls study sewing or cosmetology and boys study mechanics or woodworking), and that a lack of innovation in the subjects studied meant that young adults entered "an already saturated job market"* (p.15).

Boyle's (2009) study noted that while children perceived themselves as having greater educational opportunities within residential care, most did not study at a level appropriate to their age. She also found that staff were poorly trained and that children had very high expectations of employment once they left the centre, but seldom had corresponding levels of experience. ICC/HOSEA (2001) also found that high expectations were common amongst children in residential care centres, but did not match the reality of the Cambodian job market, in which family often plays a part in securing positions and orphans suffer discrimination. Boyle (2009) found that many children had remained at the centre after the age of 18 and said that most were unhappy about the thought of leaving the centre. Boyle interprets this as evidence that the shelter is fulfilling children's needs[21], but alternatively it can be interpreted as the failure of the shelter to plan for reintegration into the community for those over 18.

2.5.3. Health

Studies have found that children in residential care are more at risk of contracting or carrying infectious diseases. In their paper for *American Paediatrics*, Frank et al. (1996) cite several studies that found higher levels of infections in children who have been living in residential care. In an article for the medical journal *The Lancet,* Simasathien et al. (1980) in Thailand found that children in a residential care centre there had developed a resistance to ampicillin and chloramphenicolas, a treatment for *Haemophilu-sinfluenzae* type B. Frank et al. (1996) argue that children in close contact in any kind of institution are more likely to contract and spread disease. They reference the 1994 American Academy of Paediatrics *RedBook,* which states, "*Infants and young children who are brought together in groups for care have a higher rate of infection, greater severity of illness, and increased risk for acquisition of resistant organisms".*

Frank et al. (1996) argue that *"The three factors most consistently linked to infectious disease transmission in group care have been young ages of the children, institutional versus family day-care, and hours spent in the institutional setting"* (p.571), noting that all three are present in residential care. Using data about infection rates from day care centres they then go on to argue that children in residential care would be similarly, if not more at risk, of respiratory and gastro-intestinal infections. Moreover, they note that *"effective infection control policies (isolation...strict sterilization procedures for toys and eating)"* would be *"difficult to reconcile with the infant's*

[21] Boyle also attempted to assess emotional wellbeing. However, her study did not use an internationally recognized cognitive/social assessment method, and many of her interviews with children were conducted whilst residential staff members were present. Children were also selected by staff members which may have placed children under pressure to say they were happy to please staff.

psychological and developmental needs for frequent and intense interpersonal contact (pp.569-578). They note it would also be difficult in a residential care centre to isolate infectious children.

In Cambodia, Daigle and Dybdal's (2001) survey found that 90 per cent of government and 92 per cent of non-government residential care centres said they provided health care to the children. As noted earlier, this survey only included the views of residential care directors. The quality of health care provided and an evaluation of the health of the children in residential care were beyond the scope of the survey. It is therefore difficult to know how accurate these ascertains are.

Frank et al. (1996) also argue that residential care can have a negative effect on children's nutrition. Daigle and Dybdal's (2001) survey found, not surprisingly, that almost all residential care centres reported providing food to the children. Boyle (2009) noted that most children said they received more food than they previously did before coming to the shelter, but also noted evidence of food shortages amongst the shelters visited. Moreover, Frank et al. (1996) argue in their paper that even providing food may not be enough: *"The growth failure historically noted in institutionalized infants and young children did not necessarily reflect insufficient quantity and quality of available food, but too few caregivers to assure that the available food was fed to those too young to feed themselves"* (p.571). They also note that multiple caregivers feeding children have been shown to result in lower growth rates.

The recent study by Whetten et al. (2009) compared the nutritional health of orphans and abandoned children in residential care with children who were receiving no additional support and were living within the community. This study found that the health and physical growth of children in institutions were generally *better* than those of orphaned/abandoned children in the community. However, this study compared children who were in institutions, receiving support in terms of additional food and education, with children who were orphaned or abandoned but continued to live with their communities *without* receiving any additional aid or support. The study shows that children receiving this extra support have better health, but it fails to examine what would happen to children were they able to receive this support whilst living in their communities.

In Tolfree's (1995) study for Save the Children, he found that the reason most often given by parents for placing their children in care is poverty. This was also found to be true for Cambodia in Daigle and Dybdal's survey in 2001. Tolfree (1995) argued that poor parents assume the level of physical care given to their children will be higher than that which they could provide alone, and that their children will be better fed. However, according to the study, this was not necessarily the case. Although the physical care provided in most residential care centres in his study was *"at least of a minimally acceptable standard"* (p.84), it was not the case in every instance. In 2005, EveryChild (Carter, 2005) conducted an extensive study of institutional childcare in Central and Eastern Europe and the former Soviet Union. This study also found several instances in which children were malnourished, underfed, and unable to access medical care because of the remote location of the institution. In Cambodia, Boyle (2009) also noted instances of food shortages at the shelters visited during her study.

Existing studies offer contradictory conclusions on the impact of residential care on health and nutrition. Daigal and Dybdal (2001), Whetten et al. (2009), and Boyle (2009) suggest that many residential care facilities do meet basic nutrition and health needs. Tolfree (1995), Carter (2005) and Frank et al. (1996), note this is not always the case, and argue that residential care can place children at increased risk of disease and sickness. There has been no medical study of the health and nutrition situation within Cambodian residential care centres. It is an area that merits more research.

2.5.4. Abuse

Children living in residential care are potentially more vulnerable to abuse. Over the last 20 years, overwhelming evidence has been uncovered, which irrefutably links residential care to prolonged, systematic and institutionalized abuse of children. The *Report on the Commission to Enquire into Child Abuse in Ireland* investigated cases of physical and sexual abuse in residential facilities between 1914 and 2000 and identified 800 perpetrators. EveryChild (Carter, 2005 found several instances of reported abuse in its study of residential care in Eastern Europe. The *Alternative Report of Non-Governmental Organizations of Kazakhstan* (2002) found that 63 per cent of children in children's homes had been physically abused. Human Rights Watch reported on the abuse of children by staff in institutions in Russia, noting cases of extreme physical abuse and degrading punishment (Human Rights Watch, 1998). The report found sexual abuse of children by staff and noted that older children within the institutions bullied younger children. A survey of 3,164 children in residential care facilities in Romania found that nearly half reported that being beaten was a routine punishment (Stativa, 2000). This violation has affected many generations of children and has required governments and other service providers, including the Catholic Church, to make significant court ordered compensation payments to victims.

There is a duty on the State to provide care and protection for children without parents or whose parents cannot look after them appropriately[22]. Thus, most countries need to provide temporary substitute care until a permanent solution for a child to grow up in a family environment can be found. This is because research has consistently shown that children who grow up in residential care, no matter how good the conditions or how caring the staff, are at significant risk of harm in terms of *"attachment disorder, developmental delay and neural atrophy in the developing brain"* and that this *"neglect and damage caused by early privation of parenting is equivalent to violence to a young child"* (World Health Organization, 2005).

There has been less research on abuse in institutions in developing countries than is warranted, presumably because of the difficulty of conducting such research. Ethical considerations, the fact that children suffering abuse within institutions could be difficult to access, and might not feel free to speak about abuse at the hands of those running the institutions, are some of the possible explanations for this lack of research. Tolfree (1995) found anecdotal evidence of the physical, emotional and sexual abuse of children in institutions noting, *"That it is not surprising that firm evidence about its incidence is extremely difficult to find"* (pp.108-9). However, he felt that *"a sufficient number of allegations were encountered to suggest that abuses are far from being isolated occurrences"* (p.109). A study on child abuse in India in 2007 found that 52 per cent had been beaten (Kacker et al.). Recent reports from Iraq have found a high level of abuse and neglect, particularly among children with disabilities.[23] In Cambodia, Vijghen's desk study of 2004 found a few incidences of abuse, which it said had been appropriately handled. ICC/HOSEA (2001) found that residential care facilities reported a much higher use of abusive forms of punishment than more humane forms, such as a reduction of privileges or giving extra jobs. Boyle's (2009) study noted the use of degrading chores as punishment. There has been no in-depth research into incidences of abuse in Cambodian residential care facilities. However, research has been conducted into the safeguards within institutions that would help to protect children from abuse by staff. ICC/HOSEA (2001) found that many residential facilities did not require references from their staff upon hiring. Boyle's (2009) study found that some children felt uncomfortable talking to staff and that in some institutions the staff-to-child ratio was as low as 81:1, which might make it difficult for a child to find someone to report abuse to. Daigle and Dybdal (2001) argued that protective measures safeguarding children would include *"common rules that apply to the staff's responsibilities in the daily protection of children"* (p.109), which the survey found were lacking in facilities surveyed.

---

[22] As guaranteed in the UN Convention on the Rights of the Child, Article 20, to which Cambodia is a signatory.

[23] http://www.guardian.co.uk/world/2007/jun/20/iraq.simontisdall.

3 FINDINGS

3.1. Attitudes of overseas donors

3.1.1. Key findings

- Overseas donors are the main funders of residential care. Most donors have limited awareness of alternatives to residential care, such as community-based care.
- Many residential care centres have begun turning to tourism to attract funders, and in doing so are putting children at risk.

3.1.2. Funding for residential care

Overseas donors are core funders of residential care in Cambodia

While MoSVY does not keep records of the funding sources for residential care centres, government staff who register and monitor centres estimate that they are almost 100 per cent foreign funded[24]. Despite many efforts, the research team was unable to find any residential centres that were predominantly Khmer funded and was unable to locate any Cambodian donors. We were able to talk to Cambodians who had started residential care centres, but they survived on overseas support. We were also unable to find residential care centres that were funded by international or multilateral organizations. This may be because of the international movement away from institutionalization and towards family-based care. The anecdotal evidence collected during this research suggests that private overseas donors are the main source of funding for residential care. Moreover, even the large NGO residential care service providers in Cambodia solicit the bulk of their donations from private individuals through sponsorship and church donation programmes.

International volunteers also play an important role in funding residential care. The role of volunteers will be discussed in some detail below, however it is important to note that volunteers can grow to be core funders of residential care centres. Many volunteers retain a relationship with the organization after their visit, and may begin fundraising or donating their own money.

"I came out with a volunteer organization...later I made two more trips. I started teaching English but in the end I did all sorts of things...handling donors, sponsorship programmes etc...Now I'm back in the Netherlands so I'm not directly involved anymore but I raise money and donate bimonthly" (former volunteer, in-depth Internet survey).

"Without my help the orphanage would probably have had to close its doors a long time ago" (former volunteer, in-depth Internet survey).

"Some of these volunteers are young kids, but they can come from wealthy families, and when they go home they can lead to some pretty big donations" (residential care director, interview).

[24] Not all residential care centres are foreign funded. The Cambodian Government does contribute to funding 21 government residential care centres, with additional support from an overseas organization.

Residential care centres have uncertain or inadequate funding

Residential care centres often suffer from insecure or inadequate funds and a lack of long-term financial stability. As noted earlier, the majority of residential care centres raise funds from individual donors and churches, some relying on just one or two individuals. Directors explained that it was hard to engage in long-term planning because individual donors were fickle. One noted the effect of the global financial crisis on fundraising, explaining that it was getting harder to raise money.

"He [founder] *would tell us to buy land and then sell it, he would decide to build the perfect school then change his mind. It was always harder to get funding at the end of the year because he lived on an annual fixed endowment, and money got tight at the end of the year"* (interview, former residential care centre director).

This financial insecurity is exacerbated by the fact that so many residential care centres rely in some way on volunteers, some of whom have taken on essential roles such as book keeping or as board members. No volunteers described training Cambodian counterparts to build institutional knowledge. This places residential care centres in a vulnerable position when volunteers leave.

Shortage of money was a constant theme among interviewees.

"Countless times during my connection the orphanage has been down to the last kilo of rice and the bank account nearly empty...annulment was considered an option when financial problems got severe last year" (volunteer and donor, in-depth internet interview).

"The director of that orphanage called us and said 'Please intervene for us with the director (of our organization) at headquarters. The kids here cannot go to school because we have no money. The children here go to the rice fields to catch fish for the centre'" (MoSVY staff member, interview).

"There are lots of problems in the orphanage...the children do not have money for uniforms or stationary for school...the director is also a moto-dop driver" (Commune Council member, interview).

International studies have repeatedly shown that providing residential care is more expensive than caring for children in the community. In Eastern Europe and the Former Soviet Union, research has found that cost-per-user for residential care is six times more expensive than providing social services to vulnerable families or voluntary kinship carers and three times more expensive than professional foster care (Save the Children, 2009). Several studies in Africa have found that residential care costs at least four times more than placing a child in a foster home and as much as ten times more than aid to support children in their families in the community (Over and Ainsworth, 1997; Desmond and Gow, 2001; Prywes et al., 2004). Residential care is a costly option for the care of separated children, and individual donors seldom engage in long-term financial planning to meet this cost. The abrupt closure of a residential facility due to financial insecurity could place children in a very vulnerable situation.

Relationship between orphanage tourism and funding of residential care

As a result of their reliance on individual overseas donors, many residential care centres have established links with the tourism industry. For example, tuk-tuks[25] in Phnom Penh advertise tours to *"orphanages"*. Two key informants alleged that tuk-tuk drivers receive a commission for bringing volunteers to the residential care centre, although the researcher was unable to confirm this. In Siem Reap and Phnom Penh, flyers advertising *"orphanage tours"* are distributed in a large number of cafes and hotels.

---

[25] A tuk-tuk is a three wheel open-sided vehicle, used as an alternative to a taxi.

[26] Website: the lighthouse.co.uk, accessed June 2010.

"[The orphanage] does not receive any form of funding from official bodies, currently the only support comes from donation by locals and tourists. The money and food received is barely enough to keep the orphanage running" (residential care centre website).[26]

In many cases children are involved in fundraising for their own care and support. Almost all residential care facility contacted uses pictures of children in their promotional material. The use of images of vulnerable children is considered controversial for many reasons, not least because graduates of residential care often suffer from social stigma, which may be exacerbated by the breach of privacy involved in publishing their images and identities. However, while young children may be too young to understand that the use of photos for fundraising may be harmful, others may feel unable to complain since they rely entirely on those taking the photographs for food and shelter. Some residential care centres sell bracelets made by the children and even t-shirts with drawings of *"orphans"* on them.

Many residential care centres train the children to perform *apsara* dancing[27], which is often promoted on their flyers and websites. Whilst some residential care centres make an effort to limit this activity, others advertise performances every evening. In an article in the Phnom Penh Post newspaper, a residential care director admits that the children in his care sometimes practice dancing until 11pm.[28] Several people described children being asked to perform or fundraise late at night in dangerous situations. One residential care director explained that he sent children in his care out to hand out flyers at the Killing Fields and a key informant from the tourism industry said that children were regularly made to beg for funds in bars at night.

"We survive because we teach dance to children and earn money" (residential care director, focus group discussion).

"The charity show is the children's life" (promotional document).[29]

"The children present traditional Khmer dancing every Saturday...it's a show you won't want to miss" [30] (promotional document).

"All the orphanages in Siem Reap have children perform apsara to raise money, but we do it in the right way, in nice hotels... to publicize our project, while others send their children out at night"[31] (interview, residential care staff member).

"The children go through the Pub Street at ten at night, wearing a sign that says please support us, handing out flyers, playing instruments, they stop at every bar, there are all these drunk travellers, and they are handing out ten and twenty dollar bills, and clapping. These are seven year olds out at ten at night, basically begging. Would you want that for your own child?" (Key informant from the tourism industry, interview).

The majority of children in Cambodia's residential care centres do have living parents. However, the residential care centres do not ask parents for consent for children to be used in fundraising activities for the centres. One former volunteer described leaving a residential care centre because the children were spending so much time dancing that they were not able to study. Children were forced to dance whether they wanted to or not.[32]

---

[27] One director noted that the children in his centre offer kick-boxing performances.

[28] Scollay and Nara, Phnom Penh Post, 4-17 January 2002.

[29] Acodo Orphanage Siem Reap, promotional flyer, 30 October 2009.

[30] Acodo Orphanage Siem Reap, promotional flyer, 2009.

[31] One director in Siem Reap disputed this saying they did not require their children to dance.

[32] Interview on Aljezeera television, 8 November 2008: http://www.youtube.com/watch?v=emYIQf-7piA, accessed 30 November 2009.

Unmonitored funds

Residential care centres generate funds that are unaccountable or in some cases provide profit. The findings demonstrate that most residential care centres do not have to account to donors for money collected, either in large sums or in donation boxes by children walking down Pub Street at night or after a dance performance. One former volunteer described seeing a foreigner, who had visited a centre on a previous trip, hand $7,000 in cash to a director without asking for a receipt and with no intention to follow up on the use of the money. Those who donate in this way have no way of knowing where their money will actually go. There is no guarantee that the money raised from apsara performances goes towards the welfare of the children.

Several participants complained about the absence of financial accountability within residential care facilities. However, complaints were hard to substantiate because ministries and institutions including, MoSVY, do not operate systems to regulate NGO residential care centres.

"The accounting is not clear. This is part of the problem. The orphans have no salary; they are just provided with food and education" (former volunteer, quoted in a newspaper article).[33]

"We got thousands of dollars...but I don't know where the money went" (former residential care staff member quoted in the same article).[34]

"We had a falling out when I asked a question about where the donors money went. This resulted in the entire orphanage being called into a two and a half hour denunciation of me" (former volunteer, in-depth interview).

"[We] have had difficulties because of rumours of corruption and a lack of transparency, we have no corruption now, we had difficulties because of corruption in the past" (residential care director, focus group discussion).

There are several overseas organizations that charge volunteers money in return for finding them work placements in charity organizations, including residential care centres in Cambodia. These organizations charge as much as US$4,540 for a three-month placement, not including the flight.[35] However, according to key informants the organizations do not generally give money to the residential care centres they work with arguing that this would increase corruption. Some of these organizations ask that the residential care centres provide room and board to the volunteers, whilst others provide this separately. Although some of these companies are 'not-for-profit' others are run as businesses and it is in their interest to place as many volunteers as possible to maximize their profit. One former employee describes scrambling to find places for all the volunteers who had signed up.

One website of a faith-based organization offers donors the chance to start an "orphanage" and a church at the same time. The site explains that for US$2,000 a month an individual or an overseas church group can build and fund an orphanage that will be physically attached to a church. This suggests that children are being used as a way to fund the building of churches.

"The children receive Christian care and upbringing and the church realizes a debt free facility" (promotional document).[36]

The cost of relying on volunteers

Volunteers usually have few or no applicable skills to work in residential care facilities. The websites of for-profit volunteer organizations stress that volunteers do not need to have prior experience or specific qualifications.

---

[33] Scollay and Nara, Phnom Penh Post, 4-17 January 2002.

[34] Scollay and Nara, Phnom Penh Post, 4-17 January 2002.

[35] http://www.projects-abroad.org/prices/?content=prices-in-usd/, accessed 31 October 2009.

[36] http://www.foursquareorphans.org/about _ fcop.htm, accessed November 2009.

[37] http://www.foursquareorphans.org/about _ fcop.htm, accessed November 2009.

[38] http://www.projects-abroad.org/, accessed October 2009.

Some organizations give volunteers a brief training, but as one key informant explained, this can cause problems. She explained that due to the high turnover of volunteers, and the unchanging training curriculum, children in residential care centre schools find themselves singing *"Heads, Shoulders, Knees and Toes"* every Monday of the month.

"No skills are necessary. Our English teachers do not need Toefl" (promotional document).[37]

"I wasn't sure what to expect, but to be honest, I don't think she [the children's centre staff member] did either. She took me into one of the classrooms (where there were 50 four-year olds sat at their desks) and introduced me to all of the children. Then she told me I could teach. You can imagine the surprised look on my face as I hadn't prepared anything and wasn't expecting to have to teach" (Internet blog, former volunteer).[38]

"If you are a volunteer, the people and systems at the place where you work should be better when you leave. For example, if a volunteer just teaches English to kids, then when they leave, although the kids may have learnt something, the organization is the same, there is a void. Volunteers should teach teachers instead, so that when they leave, the organization can keep on teaching English without them. But many volunteers are more concerned with their own need to have fun as travellers, and it's more fun to teach kids" (key informant from the tourism industry, interview).

In other blogs,[39] volunteers describe being given large amounts of access to children, dressing them after baths, feeding them, and giving them hugs. Interviews and organization's websites suggest that the organizations do not conduct background checks on volunteers, which was confirmed by the HOSEA survey (2001). The open access of volunteers to children presents a significant child protection risk.

"A lot of visitors go there. A number of volunteers are completely unsupervised. You just walk in and play with the kids. No screening, no background checks. Come when you want, stay as many days as you want. They take anybody. I have seen male volunteers alone unsupervised with children, I have seen them upstairs on the floor where no one else is. They have rules against this, but it happens all the time" (former volunteer, interview).

Many promotional documents suggest the main role of volunteers is providing love. The researcher was often greeted at a residential care centre by children who ran up expecting hugs or to sit on her lap, asking questions in English. This behaviour is consistent with indiscriminate affection, a manifestation of RAD, a personality disorder associated with residential care, and discussed at length in the literature review. Residential care centres typically have a low ratio of staff to children, and children may not be receiving adequate adult attention and nurturing. This is one of the reasons residential care centres give for accepting volunteers. *"Our children need love,"* one director explained. However, many residential care centres accept volunteers for as little as one hour, and few volunteers described working at the centre for longer than three months. It has long been argued that a constant turnover of caregivers can have a detrimental effect on children's development (Bowlby, 1951).

"We know you may not be able to stay for very long but the children have so much energy and love to play everyday that any time you can spend is greatly appreciated…there is no need to call in advance, just show up!" (promotional document)[40]

"It is difficult to see the children repeatedly build up friendships with volunteers only for them to leave every few months. Sometimes the children were heart broken, after having been left at previous points in their lives" (former volunteer, in-depth Internet survey).

---

[39] http://www.projects-abroad.org/, accessed October 2009.

[40] http://www.lighthouseorphanage.co.uk/, accessed June 2010.

Volunteers arriving without skills can place a burden on both the residential care facility and the children within it. While they can provide attention to the children, this attention is not long-term or sustainable since they usually leave after a few months. They are given unsupervised access to the children, which poses a significant child protection risk. Nevertheless, open access for volunteers to residential care centres in Siem Reap, and to a lesser extent in Phnom Penh, continues to be the norm.

3.1.3. Reasons overseas donors support residential care

This research found that most residential care centres are started and/or supported by individuals trying to improve the situation of those less fortunate than themselves. Many foreigners had visited Cambodia and seen children who appeared to be homeless and they felt moved to help.

"I started out of a naive idea of wanting to do something for the world after high school... it was the idea of doing something for others" (former volunteer, in-depth Internet survey).

"The centre was started by [two foreigners] who visited Cambodia in the nineties. They saw the poverty here, and felt strongly that they wanted to help in some way" (key informant, interview).

Many overseas donors first became interested in residential care centres when they were working as volunteers. They chose to volunteer because they believed it would offer them a unique lifetime experience. This position was reinforced by promotional documents that presented volunteering as a form of adventure tourism.

"I wanted to do something special in the summer holidays before starting university. My first visit was curiosity... and a test of myself to see how I would cope in a difficult situation" (former volunteer, in-depth Internet survey).

"I wanted something meaningful, I wanted an experience like this and to see how people live" (former volunteer, in-depth Internet survey).

"You will be working on your own development... you are creating a special bond with the children, the country... a unique experience to never forget" (promotional document).[41]

Findings indicated that a proportion of donors also intended to promote Western culture through residential care centres. In some cases this took the form of a religious influence as noted in the text box below. In other instances residential care centres created an environment that was more in line with western society. In these centres, the buildings and conditions represented western norms and were usually better than those surrounding the centre.[42] The culture within these centres incorporated many non-Cambodian features into the education curriculum, recreational time (e.g. playing foreign sports) and language. In some centres, English was the dominant language and the children spoke only rudimentary Khmer. One centre had changed the names of the children, naming them after the American friends of the main donor[43].

---

[41] Pure Volunteering and Supporting Children in Cambodia, promotional leaflet, October 2009.

[42] It is important to note, however, that the material conditions in these residential care centres were unusual, and that most NGO foreign funded residential care centres do not meet the Minimum Standards.

[43] Residential care centres run by the Cambodian Government were often reported and observed to be providing a high level of material provision, including traditional Cambodian sports and cultural activities exceeding the Minimum Standards.

[44] The MoSVY database does not keep records of religious affiliation, but staff noted that most residential care centres were Buddhist and there was also one Muslim residential care centre. However, MoSVY does keep records of the organizations that run residential centres and the largest implementer of residential care facilities is a Christian organization which runs over 100 residential care centres in Cambodia. It also has a prosthelitizing mission, as noted on its website: www.foursquareorphans.org, accessed 30 November 2009, and http://berkleycenter.georgetown.edu/interviews/a-discussion-with-pastor-ted-olbrich-country-director-of-foursquare-children-of-promise-and-stephen-billington-co-founder-of-home-of-english-international-school, accessed 5 September 2010.

THE ROLE OF CHRISTIANITY IN RESIDENTIAL CARE IN CAMBODIA

Many Christian NGOs within Cambodia have been very active in promoting community-based care. World Vision has strongly articulated its policy in favour of community-based care in the document *"Analysis and Programming Suggestions for Community-based Care Models"* (2009). World Vision and Halo run large foster care and reintegration projects and ICC/HOSEA and Project Sky are both dedicated to reducing the number of children in residential care and promoting community solutions for separated children.

At the same time MoSVY statistics from 2008 indicate that more than a third of residential care centres are owned and managed by Christian faith-based organizations.[44] Many of these have a declared proselytizing mission whilst others are clear that their purpose is not converting children in their care.

"I am a Christian but the children are Buddhists. We take the kids to the pagoda and invite the monks in on Buddhist holidays. We want the kids to be part of their culture" (residential care director, interview).

"*It is their own decision, we do not force them but we organize a place to pray here"* (residential care director, interview).

"We proselytize everybody…we will never force a child to be a Christian, but we've never had one choose not to be one. They're like fish falling into a pond" (residential care founder, published interview).[45]

"I was at a conference and a colleague from another organization said to me, 'The only way to evangelize the next generation is to put them in orphanages to convert them" (key informant, interview).

MoSVY data indicate that the majority of Christian residential care centres promote converting the children to Christianity as part of their role. One director of a residential care centre for children affected by HIV had offered to accept some children from a Christian residential care centre that did not have adequate medical facilities. He recalled being told they would not transfer the children unless he could guarantee they would be raised as Christians. One large Christian NGO advertises on its website that every orphanage is literally part of the church (the two buildings are connected). It notes that all the children are raised with Christian care and keeps web visitors and donors up to date on the evangelizing activities of the young people. Many residential care facilities are run by a single organization that is openly hostile towards Buddhism, as noted on its website, quoted below.

"There is relative freedom to preach the Gospel of Jesus Christ with the exception of arbitrary government 'requirements'. These are not born of ideological beliefs as much as the greed and political pressure of the Buddhist majority."[47]

3.1.4. Reasons donors are less likely to fund community-based care

Lack of knowledge amongst donors

Some residential care centres are started by umbrella organizations with years of experience. However, as Greenfield noted in his PhD Thesis (2004), *The Gulf between Rhetoric and Reality*, residential care centres are often started by private individuals who have little or no previous experience working with NGOs or with children. This was also found in the research conducted for this study. Key informants and donors told stories of traveling in Cambodia, seeing children who appeared to be homeless, orphaned or abandoned and deciding to do something about it. In many cases there appeared to be a lack of assessment of the needs of the children involved, or of the organizations already offering services to these children (as illustrated in the text box below).

Tourists play a major role in funding residential care. However, when asked in surveys about the best option for children without parents, they overwhelmingly favoured living with a relative (65 per cent) above living in an orphanage (16 per cent). Tourists supported family-based care in theory, but in practice they donated funds to residential care. When asked if they would consider donating money to an orphanage, a combined 91.8 per cent answered yes, maybe or I already have.

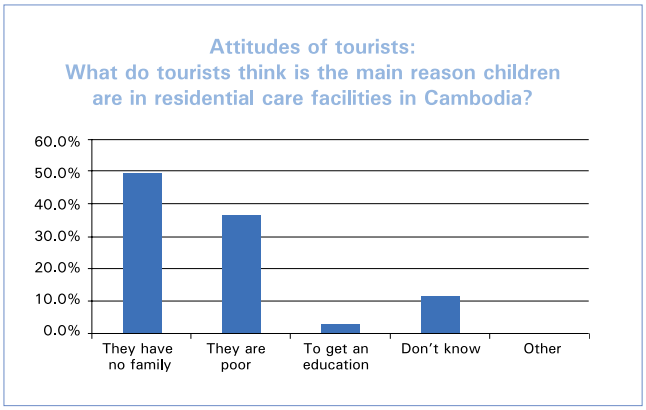
---

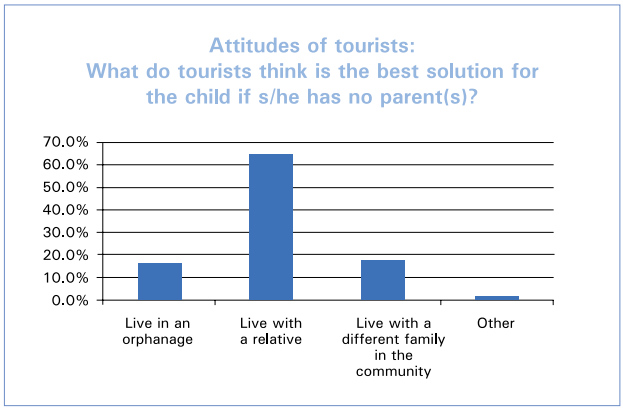
45 http://berkleycenter.georgetown.edu/interviews/a-discussion-with-pastor-ted-olbrich-country-director-of-foursquare-children-of-promise-and-stephen-billington-co-founder-of-home-of-english-international-school, accessed 5 September 2010.

47 http://www.foursquareorphans.org/about _ fcop.htm, accessed 30 November 2009.

Many tourists were unaware that the majority of children in residential care in Cambodia were not double orphans. Almost half (49.3 per cent) of tourists believed that the main reason children were in orphanages was because they did not have parents. Only 2 per cent believed that children were in residential care to receive an education, whereas 34 per cent of local government gave this as the main reason.

These findings indicate that overseas tourists are unaware of the real situation in Cambodian residential care centres and that they continue to fund them, in spite of their expressed belief in family-care options.





Fundraising

The results of this research demonstrate that overseas donors prefer to fund residential care centres because it is easier to raise funds to support them. Residential care centres frequently offer donors an ongoing relationship with a specific child, which in many cases acts as a surrogate parent-child relationship. The research also found that donors prefer to fund children because they are perceived as more innocent than adults.

"Impoverished and abandoned, they have no one to care for them...You can communicate with your sponsored child, get to know your sponsored child. That's what they hope for the most, to know that someone is out there—somewhere in the world—who knows them and cares about them" (promotional document).[48]

"It is hard to raise money...without something concrete...people want to see an impact in a picture, they are afraid to give money for a professors salary but are willing to give to sponsor a child because you can do this with photos...letters from children are very important...it's a pity...we prefer children to stay with their families" (residential care director, interview).

Mistrust of families

Findings indicate that a number of donors and residential care centre staff mistrust families. Some feel that money given to support children in families would be squandered. This opinion was not borne out by research, as discussed in more detail later. In fact, most of the extremely poor families who were being given monthly food support did send their children to school.

"I think the orphanage has more control, I really know where the money goes, all parents want their kids to go to school but there is a risk" (volunteer, interview).

"If I give the families money they will spend it on other things, not on the children" (residential care director, focus group discussion).

[48] http://www.foursquareorphans.org/about _ fcop.htm, accessed November 2009.

A RESIDENTIAL CARE DIRECTOR DESCRIBES OPENING A CENTRE

The director/founder of a rural residential care centre describes factors impacting his decision to open his centre and the difficult process of recruiting children:

*"I was an orphan myself. Years later I was working in business with a foreigner for a year in Poipet. He asked me one day "*What would you need to make your life better?' *I said I wanted to be a farmer and to start an orphanage. He didn't say anything at that time, but later he bought the farm and gave me a little money to start the orphanage. He wanted my dream to come true and even though it's difficult now, it came true.*

I spent a couple months just going around to find kids. It's quite difficult to find children, a lot of children don't want to come to the centre, the people they live with don't want to let the children come because the children make money. I am so tired sometimes… A lot of them only need money and when I ask them to let the children stay at the centre they say "no"…

But right now we have problems because we are running out of money. I asked them for money to start a farm project…so we don't have to buy food at the market so they gave me some money and we'll see what happens. I also want to buy a taxi to run a taxi service, which would mean next year I don't need to ask for money because I would have a business" (residential care director and founder, interview).

"I don't know if it's the consequence of the war, but here you take care of your own family first above all else, fostering here in Asia where people only care about their (own) families, and trafficking is a reality, without strong oversight, it could be a disaster" (donor, interview).

"The temptation to sell orphaned children by impoverished relatives is making family placements risky…the family system has been compromised by the selling of children, especially young girls, who can bring up to $700 when sold into the brothel system" (Internet website).[49] [50]

Family problems, including broken families, have been linked with the trafficking of children (Arensen, 2004). The research team was unable to locate any reports that suggest children have been or are likely to be trafficked from foster programmes. One review of a foster care programme noted isolated incidences of children feeling that they were not treated equally within the home. However, most children visited in the review spoke positively of their experiences (Vuthy et al., 2006). During this period there was a high profile media case of a child in foster care being exploited and abused.[51] There has, however, been little research undertaken into the potential for abuse in residential care in Cambodia, although international research referenced in the literature review suggests this is widespread. During the research period, there was also another media report of a child being severely physically abused in a residential care centre.[52]

3.2. Government attitudes towards residential care

3.2.1. Key findings

- MoSVY is committed to a policy that promotes family- and community-based care and monitors residential care facilities to improve conditions. However, there needs to be much stronger enforcement of policies already in place.
- Most residential care facilities require Village Chiefs to give their signature whenever a child is placed in care. The majority of Village Chiefs support residential care. Few had heard of community-based care options and, when the concept was introduced, they felt this would also be a good option.

---

[49] It is important to note that this extreme view point was not representative of most residential care organizations, although the organization expressing it does run a very large number of institutional centres in Cambodia.

[50] http://www.foursquareorphans.org/about _ fcop.htm, accessed November 2009.

[51] Loy, R. Phnom Penh Post, 3 December 2009.

[52] Chan Than, P. Cambodia Daily, 4 November 2009.

3.2.2. Registration of residential care facilities

Whilst NGOs are required to register in order to operate in Cambodia, not all register with the same ministry making thorough regulation and enforcement of minimum standards difficult. However, MoSVY is generally seen as the primary agency with responsibility for oversight of organizations providing care to children, and currently works to ensure all such organizations register with their ministry. Some key informants described MoSVY as having been biased towards residential care in the past. However, in recent interviews conducted for this research, the prevailing attitude of MoSVY staff in Phnom Penh was that residential care should be a last resort and a temporary solution after community care options have been explored and exhausted. As one official noted, our ideal is *"livelihood support to families so that a family can keep their children at home, providing basic needs."* The Ministry is also actively engaged in developing initiatives to support family-based care for children, including the introduction of a new Prakas[53] on Procedures to Implement the 2006 Policy on Alternative Care for Children, which places family-based care as its priority option and lays down procedures for family preservation, alternative care placement and permanency planning. However, despite MoSVY's expressed preference for family-based care, the population of children in residential care in Cambodia has increased by 75 per cent over fiveyears.[54]

As noted above, there is no legal requirement for organizations providing overnight accommodation to children under 18 to register with MoSVY. No data are available on the number of residential care centres that were either unregistered or registered with an alternative ministry, including the Ministry of Rural Development (MoRD), the Ministry of Cults and Religion (MoCR), the Ministry of Interior (MoI) and the Ministry of Foreign Affairs (MoFA). Some key informants believed that residential care centres avoided entering into agreements with MoSVY in order to avoid having to comply with the Minimum Standards. Most respondents, however, believed that the prevailing reason for non-registration was limited organization on the part of other ministries.[55]

There was however a report of an isolated incidence of good practice.

"On one occasion Foreign Affairs would not register an organization without a supporting letter from MoSVY" (MoSVY staff member, interview).

Unregistered residential care centres were described as posing a special threat to children's wellbeing. Most MoSVY staff said they did not have jurisdiction over residential centres that are not registered with them and, on some occasions, MoSVY personnel have been refused entry at unregistered facilities.

There is not yet a mechanism for conducting background checks on potential staff members and, as noted in the literature review, previous research has demonstrated that residential care centre staff lack training and adequate knowledge of early childhood development. Residential care centres therefore need a strong management structure in place to assure children's safety and wellbeing. The very fact that some residential care centres are unregistered suggests that they may be avoiding doing so because they are not taking adequate care of children. Unregistered residential care centres should be a primary target for investigation.

---

[53] A Prakas is a ministerial regulation.

[54] According to MoSVY's Alternative Care Database, which indicates that numbers have increased from 154 institutional care facilities in 2005 to 269 in 2010.

[55] Current regulations do not specify the need for a residential care facility to register with MoSVY if the centre has been registered with another Ministry.

[56] http://berkleycenter.georgetown.edu/interviews/a-discussion-with-pastor-ted-olbrich-country-director-of-foursquare-children-of-promise-and-stephen-billington-co-founder-of-home-of-english-international-school, accessed 5 September 2010.

REGISTRATION OF RESIDENTIAL CARE FACILITIES

Excerpts from a conversation between Ethan Carroll (EC) and Ted Olbrich (TO). Pastor Olbrich discusses the structure of Foursquare Cambodia. This interview was published on the website of Berkeley Center for Religion, Peace and World Affairs at Georgetown University[56]. The interview illustrates the difficulties that MoSVY faces in relation to alternative care.

EC: *"What is your relationship with the government?"*

TO: *"I would rather get a whole lot done and not have to mess with the government…We're not an international NGO. When they rubber stamped our Local NGO papers, they gave us permission to house orphans and teach the distinctives and practices of the Christian faith in our training centers. So, technically, they are not churches, they're training centers for the teaching of the distinctives and practices of the Christian faith."*

EC: *"So is that how the orphanages are registered?"*

TO: *"They're registered as churches with the Ministry of Cults and Religions, but technically, we're under three different ministries. We're the only NGO in the country that's under three ministries. We're under the Ministry of Interior, which is the one who gave us our original license. We're under the Ministry of Cults and Religions because of our church affiliation, and we're under the Ministry of Social Affairs, Veteran and Youth Rehabilitation because we have orphans."*

EC: *"How recent is that?"*

TO: *"That was about six, seven, eight years ago. They came in and they said, 'You've got more orphans than anybody in the country and you're not having anything to do with us. This is not right!'*

And we said 'Well, we're under the Ministry of Interior, so go fight with them.'

So they did and the Ministry of Interior said 'Well yeah, we're fine with them, what's your problem?'

Well then they came back and said 'Well you should be under us… we want to inspect you and make sure you meet our standards.'

I said, 'Well what are your standards?' So they gave me their list, and I went through it…I said… 'We're glad to cooperate with you.' But I said, 'There's two things we won't do.' One is, the second line was 'You will not proselytize,' and I said, 'We proselytize everybody,' so I said, 'No deal. Scratch it or we're not joining your club. We are a Christian organization'…Well then they got mad and left, and about two weeks or a month later they came back and said, 'Ok, we'll agree to what you want'. So we have a special memorandum of understanding where we're allowed to proselytize and we don't have to hire them."

3.2.3. Criteria for opening residential care centres

Regulations and requirements on opening residential care centres are unclear. As noted above, registration with the Ministry of Foreign Affairs and/or the Ministry of Interior is required to operate as an NGO. However, there is no specific guidance for children's service providers.

Experience in the field of childcare is not an official requirement of many residential care centres, nor is it a requirement of the Minimum Standards. The lack of background checks for both founders and staff places children at risk. Many participants alleged that those founding and working in residential centres had records of misconduct. It is important to note that these allegations are difficult to substantiate, although in at least two cases a current residential care centre director is reported to have served a prison term for offences against children, and a residential care founder was arrested for alleged sexual abuse.[57] A stringent set of enforceable guidelines for who can open residential centres could prevent such cases.

3.2.4. Residential care monitoring

MoSVY has developed a monitoring tool based on the Minimum Standards on Alternative Care for Children, which is used to monitor registered residential care centres. The Ministry provides annual training, development and orientation to the Provincial Department of Social Affairs. Following this, the Provincial staff undertake a

[57] The Straits Times, 23 October 2010: http://www.straitstimes.com/BreakingNews/SEAsia/Story/STIStory_594418.html, accessed January 2011.

EXAMPLE OF RESPONSE TO COMPLAINTS AGAINST AN ORGANIZATION

During the course of the research one specific organization that runs many residential centres was reported to be offering low standards of care. Commune Council members and other residential care directors in different districts mentioned the organization. A government staff member reported receiving a call from a director of one of the organization's residential centres requesting that the government pressure the NGO's head office in Phnom Penh to send more food for the children. He claimed the children had to spend their day fishing instead of attending school because the centre did not have enough money for food. This claim was echoed in a different province, in which a government official reported visiting the residential centre and finding no children. A staff member told him they were out working in the rice fields, transplanting seedlings to earn money instead of attending school.

In another district a Commune Council member noted he had just called a meeting with the local director of one of the organization's residential centres because the centre did not have enough money to send the children to school. He went on to describe that children and young people from the ages of 4-20 were sleeping in the same room on a single mat. All of these cases were described by either government or Commune Council members and had occurred over a one year period. When asked whether MoSVY could suspend this organization or force them to change their behaviours, MoSVY replied that they would ask them to change. When asked if they could prevent them from opening more residential care facilities until their current facilities met the Minimum Standards, a MoSVY official responded, *"We don't have the power to prevent them starting."*

monitoring exercise of all the residential care centres registered with MoSVY in their province. The data forms are then returned to Phnom Penh for inclusion in the Alternative Care Database and concerns raised with the Alternative Care and Inspection Office of the MoSVY Department of Child Welfare.

3.2.5. The effectiveness of monitoring

The Minimum Standards set clear guidelines for residential centres. The MoSVY database from 2008 estimates that 64 per cent of residential centres comply with the guidelines, explaining "Some minimum standards cannot be implemented, for example like ponds being fenced off, because of the expense." When residential centres fail to meet the Minimum Standards, MoSVY "asks them to improve and if they do not, this may lead to suspension," explained one MoSVY staff member. However, the same person could only think of two examples in which residential centres had been forced to close and explained that this was because the centres had housed only one or two children. In interviews with government staff members and key informants, no one offered examples of residential care centres being forced to close because of failure to meet the Minimum Standards.

Two key informants said that in the past year a residential care director had been accused of raping a child. Both MoSVY and the provincial authorities believed the other party had jurisdiction in this case. This confusion resulted in a delayed response. Eventually, the director in question was fired (it is unclear by whom) and the organization has reportedly begun to consider a child protection policy.

Some participants felt that cultural factors limited MoSVY's ability to act against residential care. There is a lack of critical assessment on the type of aid that is provided by donors to residential care and this was attributed to cultural beliefs.

"I have often witnessed the government not in a position to say 'no' to an NGO, the Ministry says 'Our donors come to Cambodia, they come and bring money, so we cannot change, we are bound by the donor" (key informant, interview).

Both Gourley (2009) and O'Leary and Nee (2001) describe the importance of the donor and the expectation that the donor should not be challenged by the recipient. These studies suggest that the government may feel pressured to acquiesce to the wishes of donors, who have been shown to favour residential care.

At the same time, participants gave examples of good practice on behalf of MoSVY. Several government residential care directors explained that MoSVY required them to make sure that children were not placed in residential care unnecessarily. They explained that when they were approached to take a child into residential care, they would first try to find an option within the community instead. This was not an unusual story. An NGO described working closely with a government residential care centre, so that when families approached them to place children in care, they were instead directed to the NGO that offered community-based support, keeping the children with their families. Families confirmed this. The government residential care directors were aware of the MoSVY position that residential care should be a last resort and were acting upon this. This was in contrast to non-government residential care directors who described actively soliciting children for their centres.

3.2.6. Attitudes of DoSVY, Commune Council members and Village Chiefs

Local Government

Commune Council members and Village Chiefs strongly supported residential care options. In surveys, 70.7 per cent said the best solution for a child with no parents was to live in an orphanage. Many residential care directors explained that Village Chiefs in the provinces would supply them with lists of the poor whom they approached when looking for children to place in their institutions. Village Chiefs confirmed that this was the case, with one noting he had helped the residential care director to register the centre and visited every group head in the village to promote it to vulnerable families. Like many other Village Chiefs, he explained that he wanted the children to go to the centre in order to study. Food and education were cited as the major benefits of residential care. A quarter (25 per cent) of Commune Council members and Village Chiefs said poverty was the main reason children went into residential care centres[58]. Poverty was frequently associated with child labour and one chief described trying to recruit children for the residential care centre. He said the children refused because they felt sorry for their families who relied upon their earnings.

EXAMPLE OF GOOD PRACTICE

The director of a government residential care centre explained that his centre only accepted children after an investigation of their circumstances and with MoSVY approval. A family had requested to place a child in residential care and, at the request of the ministry, he travelled to the child's home to investigate the family situation. The child and his three siblings were living with their aunt. Her husband had left her and she was unable to support her children with her business running a coffee shop. He spoke with the aunt and connected her with a programme that supported families in the community. He explained that she was happy because she did not want to send her children away.

"Children living in the community need to make money to support themselves, but they do not need to do this in the orphanage…there they have more time to study" (Village Chief, interview).

"Their relatives are also so poor, and cannot afford to take them" (Village Chief, interview).

Education was the most commonly given reason for placing children in residential care. Around a third (34.9 per cent) of Commune Council members and Village Chiefs surveyed believed it was the main reason children were placed in orphanages and 84.5 per cent agreed/definitely agreed that a very poor family should send a child to an orphanage for education if they cannot afford to pay for the child's education in the village. Moreover, 85.6 per cent agreed/definitely agreed that children in orphanages receive a better education than children in the village. Education was linked to development and described as the key to the future. Poor families were described as unable to pay for their children's education. The views of local government on education and poverty were very much in line with those of the families interviewed, which are examined in detail

[58] Poverty was the third most popular answer after education and no parents.

later in the report. Some Village Chiefs said that the community attempted to support children from poor families and orphans whenever possible, but that this was inadequate.

"The community can help but cannot help a lot. The community can provide little things, but this is not the same as parents taking care of their own children. The help is not enough though we try our best" (Village Chief, interview).

They explained that when children (orphans or otherwise) are sent to live with other relatives, this is done through informal channels. The Village Chief is not consulted or involved in these cases. The Village Chief is usually consulted, however, when a child is placed in residential care. Most facilities require the signature of the Village Chief and a member of the Commune Council before they will accept a child and most families confirmed this was common practice. This was particularly true for families who had placed children in government institutions or who had placed children in care recently. It appears that the process of placing a child in care is becoming more formalized.

Although most Village Chiefs described residential centres as appropriate and common options for orphans or vulnerable children, in deeper discussion more nuanced positions emerged. Many Village Chiefs had little or no knowledge of livelihood support programmes, which could support families to keep children at home. Others felt families were important to children.

"It is better to keep children with their relatives, but if there is no choice we have to send them to an orphanage" (Village Chief, interview).

Another said that the best solution for a child is support for an education, but that if support was given to families this would enable the children to study and help their parents to earn, having two good results.

3.3. Attitudes of directors to residential care

3.3.1. Key findings

- Residential care directors feel that there are strengths and weaknesses within their facilities. While they view residential care as providing many benefits for children, such as food, accommodation and education, they also recognize its failings. Many describe the negative impact of residential care on children, describing some children as lacking in emotional support, dependant and isolated from society.

3.3.2. Advantages of residential care

The findings demonstrated that residential care directors acknowledge there are both advantages and disadvantages to the type of care they offer. Most directors thought the main advantage of residential care was the provision of basic needs, such as food, accommodation, health care and education, which parents were sometimes unable to cover themselves.

"We provide a house, shelter, clothes, food and medical care. We offer a good education…Most families are very poor and don't have money to support their children…who will not have an opportunity to study" (residential care director).

Some directors also mentioned that the residential care centre also offered social benefits. They felt that it provided a moral education, was more modern, better organized and paid more attention to children. One noted that children in care were more confident, while another said that the children's relatives could be *"depressing"*.

"Residential care organizes children well, it has specific goals for them. It's more effective than living with relatives. Some families are good, but most don't pay attention to their children" (residential care director, focus group discussion).

Many directors said the environment in the community placed the children at risk of being victims of drugs, trafficking, gangs or domestic abuse.

"In the community they can be abused by their brothers or sisters, and other people. Living at home is more dangerous...they can ask the children to do something like child labour, and sometimes they [parents] hit them because there is no one to stop them. They can force the children" (deputy director of a residential care centre, interview).

Some directors said their residential care centres had a child protection policy, which prevented abuse within the residential care centre and so children were safer in the centre than in the villages. However, as noted in the literature review, child protection policies are absent in most residential care centres (ICC/HOSEA, 2001).

3.3.3. Disadvantages of residential care

Lack of provisions

The research found that directors were aware of the disadvantages of residential care. Some directors said that residential care facilities were not able to provide enough for children. This finding was in line with Boyle's (2010) study of shelters in Cambodia that found child-to-staff ratios in some cases were as high as 81:1. Other directors were conflicted and felt the advantage of residential care was that it provided material needs, however they also felt it was unable to meet all these needs.

"Children are not able to receive all they want" (residential care director, focus group discussion).

"The orphanage where I worked before lacked a lot. They lacked school stationary and uniforms. We had to ask permission from the teachers to send children without paying extra money and they weren't happy when they saw us. The children all slept together on a mat" (residential care director).

"It's difficult to give them enough attention when they study because there are so many children" (residential care director, interview).

"Children lack warmth from their caregiver because there are a lot of children" (residential care director, focus group discussion).

Children miss their families

Many directors said that children missed their families. They said it was difficult for the children to be separated from their parents and that they lacked family role models.

"[Children] do not have enough time to see how families are built" (residential care director, focus group discussion).

A few talked about the difficulty children have in forming relationships within the residential care centre, noting that older boys and girls were forbidden to form attachments and this was hard for them.

At the same time residential care directors had very mixed attitudes about contact with families. Some explained that their ideal project would support families to help them raise children at home. Others shared efforts they had made to keep children in the villages instead of bringing them to the centre. Some residential care centres also supported active community-based care projects and exercised good gate-keeping to ensure that residential care was in fact a last resort and a temporary solution. This was in stark contrast to some other directors who viewed children's families with suspicion.

As discussed later, most children visit their homes twice a year. Many residential care directors viewed this contact as positive, explaining it was good for children to get to know their communities. However, some directors did not approve of family visits and parents described being discouraged from visiting by directors, resulting in what Tolfree (2005) termed "a withering of ties".

TWO DIFFERING ATTITUDES TOWARDS RECRUITMENT, GATE-KEEPING, ASSESSMENT AND REINTEGRATION

One NGO had approximately 200 children in residential care and supported 800 children to live with their families in community-based care. The director explained that the organization would prefer to keep children at home and exercised strong gate-keeping practices to actively steer families towards the community-based care programme, though this was not always possible. He gave an example of a father who had bought a child to the centre a week before. The mother had recently died and both the father and the child were HIV positive. The father was in the military and lived in the barracks and his parents were also deceased. He said he had no living relatives. In this case, the director said they would accept the child. He also mentioned that the project continually reassessed children's condition, and worked to reintegrate them into the community as quickly as possible. *"Our hope is that the family situation is improved through grassroots organizations and LNGOS, where the family is supported to raise a child in a loving environment"* (residential care director, interview).

A second NGO ran a residential care centre that housed orphans, children with HIV, vulnerable children and children from the community. The deputy director explained that when the organization wanted to recruit more children, they visited the Commune Council members or Village Chiefs. The Village Chiefs then gave them information about who was poor in the community, "so we could choose and select children to live here." The children were usually living with relatives or single parents when the residential care centre contacted them.

The programme did not reassess the situation of children after they had been admitted, nor did it try to reintegrate children back into the village community. There were several adults age 18 and over living in the centre that had come as young children and did not have plans to leave.

"I used to visit a lot when she was young, but now she is older I don't go any more" (mother of a child in residential care, interview).

"I do not visit because I do not want to disturb his studies" (mother of a child in residential care).

"The orphanage does not allow children to visit parents, they try to cut the connection...when they [children] want to meet their parents they come secretly, the children sneak out of the orphanage without anyone knowing" (mother of a child in residential care).

Dependency of children in residential care

Many directors noted that children in their care suffered from a lack of motivation. Some described children as "lazy" or "dependant", saying that children were unwilling to take responsibility for themselves.

"They cannot solve problems by themselves because the manager provides everything for them, and they don't care anymore" (residential care director, focus group discussion).

Integration into society

Many residential care directors noted that children in their care lack exposure to the community. Several noted that they had a number of young people in their care who did not want to leave. Most of the directors viewed this as a problem. However some understood the role of the residential care centre to be caring for children, but not preparing them to live independently.

"Another child was nineteen years old. His friend called him and asked him to leave the orphanage. He went to work in a restaurant. Then he came back. He liked it better here and we are happy to take him back. He explained that outside there was no food or shelter...he will live here forever now" (residential care director, interview).

"They [the children] don't have communication with outsiders" (residential care director, focus group discussion).

"They look at life differently than children in society... they find it hard to adapt to society" (residential care director, focus group discussion).

Faced with the problem of many children staying on in residential care, many directors explained that they felt it was their responsibility to care for these children as long as they needed help.

"We want the children to think of the centre as a lifelong family, from which they can come and go" (residential care director, focus group discussion).

They said they also gave support to children once they had moved into the community. However, one adult who had formerly lived in care described being forced to leave without any support and a key informant said she had also seen this happen several times.

The Minimum Standards notes that residential care should be a "temporary solution". As noted earlier, a few residential care directors actively worked to re-integrate children into the community as soon as possible. However, most thought that their job was to provide for children until adulthood and had not considered re-integration. One key informant explained that she had worked with a residential care centre to help them re-integrate a girl with her family. Later, the centre revisited the family, decided the girl looked unhappy and took her back to the residential care centre against the parents' wishes.

Most directors said that their centres had prepared children to transition to the outside world through providing vocational skills training, although some admitted they had not planned ahead.

"My children are only 15, it's too soon to think about the future" (residential care director).

The research team made a concerted effort to explain the difference between vocational skills, which train people to do certain jobs, and life skills, which train people how to live in society. However, a great deal of confusion prevailed and when asked if the children in their care had learnt any life skills, most directors listed vocational skills instead. A few, however, did list some skills they would like to offer to the children including:

"Lessons in living independently"

"Choosing a mate"

"Relationships with family"

"How to love each other"

"How to love children"

(Residential care directors, focus group discussions)

Many directors showed that they were aware of issues faced by children in residential care. When directors described children as lacking love and warmth, being unmotivated and being unprepared to live in society, they were describing effects of residential care that have already been documented in research overseas. Bowlby (1951), Rutter (1972, 1979), Tizard and Hodges (1975) and Tizard and Rees (1975) all documented the devastating effects that lack of affection can have on the development of a child and Rutter and Quinton (1984) noted that previously institutionalized children can lack motivation and experience great difficulty in adapting to outside society. Directors know that children have these problems and, because they are unable to leave, many young people still end up living at their centres when they are over 20 years old. In their comments, directors described the negative effects of institutionalization. The awareness of these effects could be the first step in a process of effecting change.

3.4. Attitudes of families

3.4.1. Key findings

- Poverty places families in a vulnerable position, in which they are more likely to place a child into residential care for the sake of the child. However, when families are offered community-based care options, most prefer to keep their children at home.
- Families migrating for work often leave children in the care of elderly relatives and fear for the welfare of their children when the grandparents die or grow too old to provide for them. However, the elderly express a strong desire to live with and care for their grandchildren.
- Education is the primary reason why poor families place their children in care. Most residential care centres offer education and extra classes. However, most centres also send children to local state primary schools. Many children in residential care are not studying at grade level and some are illiterate.

3.4.2. Physical/societal factors contributing to families placing children in care

Poverty places children at risk

As the research was conducted in Phnom Penh, Kampong Thom, Battambang and Siem Reap, families came from a range of rural and urban backgrounds. Nevertheless, most families that were interviewed spoke about poverty in detail. This was true for both families with children in residential care and families with children at home. Almost all families with children in residential care said poverty had contributed towards their decision to place their children in care. Meanwhile, many of those still living with their children said they were afraid they would not be able to provide for their children due to poverty. Families repeatedly explained that poverty increases the vulnerability of their children.

Poverty is a major cause of admittance into residential care both in Cambodia and worldwide. In Brazil and Sri Lanka studies found that 50 per cent of children were reported to have been placed in residential care due to poverty (IPEA, 2004; Save the Children, 2005). In Tolfree's (1997) global study he also noted this as a significant contributing factor.

An estimated 30.1 per cent of Cambodians live below the poverty line.[59] The global economic crisis has impacted Cambodia[60] with a 3 per cent decrease in growth.[61] This has been coupled by an increase in the price of basic foodstuffs, such as rice, over the last four years as well as an increase in land prices.

Those families most likely to be faced with the decision about whether to place a child in residential care due to poverty are likely to be amongst the poorest in the country.

Most families interviewed lived in stark poverty. The majority lived in houses with walls made of palm grass, scavenged fabric or corrugated iron. Some had only one wall. Many of the families reported recent flooding of their homes, and in a few homes 'black' water, signifying untreated sewage, ran below or around the houses. In Kampong Thom, many of the houses were still flooded due to Typhoon Ketsana and reachable only by boat or by wading several hundred meters through water. In Reaksmei Sangha in Battambang, several houses were reachable only by walking through fields that had just been demined. The families explained that until this year they had carried

[59] This figure is based on the poverty headcount for Cambodia from the Cambodia Socio-Economic Survey 2007, published in 2009.

[60] UN inter-agency study on the impact of food prices on child labour and education in Cambodia, Phnom Penh, 2009.

[61] The CIA factbook, accessed December 2009: https://www.cia.gov/library/publications/the-world-factbook/geos/cb.html.

[62] A trailer that attaches to a bicycle for transporting goods.

the children or warned them to stay on the path. Some families owned their land and houses, some owned just the structures and others were renting their homes. One grandmother was squatting on land beside the train-tracks; another had only recently stopped living on pagoda land. Some participants had no building in which to live and one father of a child in residential care slept in the bicycle *remork*[62], which he used to transport goods for a fee during the day.

Many families described their difficulty surviving and talked about the problem of finding enough to eat. Some described living on a diet of porridge not rice, picking wild vegetables to sell, or catching crabs or fish to survive. Others talked about the problem of earning enough money. Many explained that they had no land on which to grow rice and they worked as hired labourers for others.

THE DEFINING ROLE OF POVERTY IN THE LIVES OF FAMILIES INTERVIEWED

Almost all parents interviewed described the struggle to survive. Several people became visibly upset whilst they spoke, describing the physical and emotional strain.

"I have no house, I have only my own body" (mother of a child in residential care, interview).

"We earn enough for the morning, but not for the evening" (comment made by several family members in different interviews and focus group discussions).

"The crops fail, we plant them but when it is time to harvest they are as small as your thumb, or have been spoiled by insects" (father caring for his child at home, focus group discussion).

"The price of rice is higher, the price of coal, [which she sells] is lower, people loan money and cannot pay it back" (mother caring for her child at home, focus group discussion).

"The government does not have enough factories for people to work here" (father caring for his child at home, focus group discussion).

"There are so many bike repair men, and so few customers" (father of child in residential care, interview).

"Most parents are unable to raise children, to support them to go to school, or to give them enough food" (Village Chief, interview).

"If I had money I would have kept my grandchildren because they would have been able to study harder here. Others who have enough money do not send their children" (grandmother of a child in residential care).

Factors which exacerbate poverty

Several factors exacerbate poverty, adding to the vulnerability of children within affected families. The findings demonstrated that the death of a parent, divorce and remarriage all contributed to a decision to place a poor child in residential care.

"My husband left me, and he might as well be dead. Now my children cannot receive higher education because I have no money" (interview, mother of child living in the community).

"When the father died, the mother remarried, and put the four children into an orphanage. She never comes back" (grandmother of a child living in the community, interview).

The research also concluded that alcohol abuse, the death of a child, illness, and a large number of children were contributing factors.

"I lost my thinking when my children died…I sent the other child to the orphanage. That child is still alive". (mother of a child in residential care, interview).

"I had an abdominal operation and now I can't do anything. I could not find money to support my children because I was so sick and they were too young to support themselves" (mother of a child in residential care, interview).

"In the community when children are sick…the parents go into debt…In the orphanage they have money for treatment" (Village Chief, interview).

Many of the families interviewed said they did not own land, and those that did, often owned only their own housing plots. The Khmer language has different words for land used to farm rice and land used to farm crops for sale. Rice land is viewed as necessary for survival since many subsist on rice they grow for their own consumption.

"If my children had stayed I would have had to sell my land, but now, when they leave the orphanage they will have land, can get a job and build a house here" (mother of a child in residential care, interview).

"If someone has land it is ok for them, when I have land I will take my child back" (father of a child in residential care, interview).

Land also plays a role in the issue of reintegration of children into their communities when they are adults.

"If you take a child without parents into residential care they will lose their claim to their land, and never get it back" (key informant, interview).

Migration is another factor that impacts residential care. In Battambang, Kampong Thom and, to a lesser degree, in Siem Reap many families spoke of migrating to Thailand because they were not able to make a living in Cambodia. A Village Chief in northern Battambang estimated that 50 per cent of the village had gone to Thailand, and in a focus group in this area most of the grandmothers were caring for children of parents who had left for Thailand. Migration separates children from their parents, and a few participants explained that people who have migrated sometimes disappear completely. Some elders described caring for grandchildren whose parents had left and had never been heard of again, whilst others reported receiving remittances. Parents described the high emotional cost of migration.

"It is very hard to leave, in one minute you miss your child, you work but your emotions are with your child, you work but your soul is with your child. When I think of this I want to cry. If we had enough we would never have gone. It is not that we don't love our children" (father of a child living in residential care, interview).

Migration was also described as the first step that can lead to placing a child in care. Several residential care directors said their centres housed children whose parents had migrated for work.

"We have no information about them [the children's' parents who had migrated to Thailand], and we raise our grandchildren, but my husband is 70 and I am 60. What will happen to the children when we have no money or are too old to support them?" (grandmother of children living in the community, interview).

"When parents go to Thailand to look for work, if they send back money it is ok, but if not there are problems…Their children live with relatives or grandparents or monks. In this case the best solution is an orphanage, because the orphanage manages them well" (Village Chief, interview).

However, other parents explained that migration was preferable to placing a child in residential care because parents can return from migration and reclaim their child, whereas residential care was seen as a permanent solution.

Availability of social welfare services

The lack of social welfare services is a further factor that contributes to families placing their children into residential care. Residential care was described by families, staff and local government members as playing a role akin to that of a social services network. Residential care centres take in children with a range of vulnerabilities, even those who have needs that might be more effectively and appropriately addressed through other interventions.

CASE STUDY: FACTORS INFLUENCING THE DECISION TO PLACE A CHILD IN RESIDENTIAL CARE

In most cases the decision to place a child in residential care was the result of a constellation of factors. In the following study a mother details how poverty, abandonment by her husband, a lack of property, a large family and the inability to provide an education for her child influenced her decision to place her child in care. At the end she explains that the recent economic downturn has caused her to consider sending another child into care.

One mother has six children and has sent one child into residential care. The child in care was described as *"around 8"* and had been in care for two years.

The mother had been married, but the husband had left to marry another woman and *"sometimes visits, sometimes not."* She lives in someone else's home and said it takes all her efforts to find enough money to buy rice.

She had seen a residential care staff member walking through the village and approached him to ask if he would take one of her children due to her poverty. He agreed and the process was completed without involving the Village Chief. She did not discuss the decision with the child, but says she chose this daughter because she had mentioned wanting to get an education. None of her other children go to school.

The mother has never visited the residential care centre because she says she lacks the money to pay for the trip, but her daughter returns twice a year on national holidays. She does not know the name of the centre where her daughter lives.

The mother explained that her daughter does not want to return to the village when she leaves the residential care centre because *"she realizes her parents are poor."* The mother thinks she will go to town and be an educated person and says if she returns to the village *"she would have to beg"*.

Recent floods have placed her in an increasingly difficult economic position and she would now like to place another child in residential care.

"We accept abandoned children, street children, trafficked children, children who use drugs, victims of domestic violence…children of convicted people" (residential care staff, interview).

"We accept children with mental illness, deaf and blind children and children with physical disabilities resulting from polio. Relatives do not like to raise those kinds of kids so they send them here[63]" (residential care director, interview).

Staff in residential centres usually lack the skills to care for children with specific needs (ICC/HOSEA, 2001). Few residential care centres or shelters have staff trained to work therapeutically with victims of trafficking or abuse, or to help drug addicts through a process of withdrawal (Boyle, 2010)[64]. Children with disabilities are also not being properly cared for and their needs are often not met.

Residential care was also presented as a solution for children in difficult situations at home.

"There was a mother who was mistreating her child, beating and pinching her, so I asked her to let me take the child to an orphanage" (Commune Council member, interview).

"Their father married a woman and the child was forced by the stepmother to look after the goats and not attend school, so an official saw this and took the child to the orphanage" (Commune Council member, interview).

"One boy came from a situation that was very bad. The small children in the house worked carrying big wood for charcoal; they never went to school but spent the whole day in the forest. I visited many times…until I could take him to the centre" (residential care director, interview).

However, the children were frequently placed in residential care without other options being explored. Cambodia lacks a comprehensive social protection system and therefore government officials will turn to the services they

[63] The director later explained that the centre staff were not trained to work with children with special needs, nor do they have special equipment.

[64] It must be stated again that there are a wide range of care alternatives within Cambodia, and during the course of the research one rehabilitation centre was visited that had highly trained therapeutic staff assisting traumatized children. This unfortunately was not the norm.

know to find solutions for children in need. Residential care centres have a high profile in their communities and are visible and available. However, when officials are exposed to alternative forms of care, attitudes can change towards promotion of family- and community-based forms of alternative care.

Awareness of options impacts decisions

Poverty was consistently given as a reason for sending a child to residential care. However, families with children at home were observed to be equally as poor and often mentioned that poverty was a crucial issue in their lives as well. Some of these families received support in the form of food or school support, while others did not. Most of those who received support explained that this helped them care for their children and said they did not want to send their children into residential care. Some of those who did not receive support had never heard of residential care or knew very little about it. But many of those families that had heard of residential care, and did not receive support, said they would like to send their children into residential care. These families spoke of the difficulty of providing for their children and said that the children would be better provided for in an institution. In other words, poverty affected all families interviewed regardless of whether they had children in care or not. It certainly contributed to the vulnerability of children. However, many interviews suggested that the deciding factors that pushed families to place a child in care were a) whether they knew someone at the institution or knew something about the institution, and b) whether they were offered a different form of support in the community that helped them keep their child at home. This suggests that building and publicizing residential care facilities will increase the number of children within them and that the increase in children in residential care is based on supply rather than need. It also suggests that support to vulnerable families helps to prevent them sending their children into residential care.

Role of the elderly

Grandparents in Cambodia play an important role in raising children whose parents have died, migrated or abandoned them. Grandparents interviewed for this study described themselves as having a special connection with their grandchildren. The elders interviewed confirmed this view, with many saying they felt compassion[65] for their grandchildren.

"Parents love once, but grandparents love double" (comment made by a few different parents, interviews and focus group discussions).

"Grandparents love grandchildren as much as parents, maybe my mother loves my son even more than me. This is the Khmer way" (father caring for his children at home, interview).

Many grandparents also described going to extraordinary lengths to support their grandchildren.

"My grandchildren are my blood. Even when I cannot sell enough to survive, I will borrow money at interest to support my children" (grandmother caring for her children at home, focus group discussion).

"Sometimes I don't feed myself but I keep the food for my grandchildren" (grandmother caring for her children at home, interview).

A key informant also described a conversation with an orphaned child in a village who explained that it was good she could live with her grandmother because it meant she could visit her mother's grave. Cambodian Buddhism places a great deal of importance on the relationship with deceased ancestors. *Pchum Benh* is a religious holiday in which most Cambodians visit the pagoda in which their ancestors were cremated to make offerings to their ghosts. Cambodian Buddhists believe that the ghosts will bring bad luck to their descendants if these offerings are not made. Children who live far from the site of their parents' cremation may believe that this could cause them problems in their daily life.

---

[65] The Cambodian word "anut" is imprecisely translated as compassion. The roughest approximation is love, pity and compassion.

CASE STUDY: A GRANDMOTHER RECEIVING ASSISTANCE TO CARE FOR HER CHILDREN AT HOME

One elderly woman interviewed lived in a house with a dirt floor. She wore dark glasses and when she took them off her eyes were streaming water, appearing to be infected. She was very thin, wore ragged clothes and was caring for two grandchildren, aged 10 and 15. She had never received an education, but was determined that this would not be the case for her grandchildren. She said they had always attended school and had never repeated a year.

The family was supported by a local NGO, who gave them a monthly donation of rice, vegetable oil, salt and an annual donation of school uniforms. The organization also encouraged her to keep her children in school, whilst another family member helped with school fees.

She had heard that residential care facilities offered children a good education, but said she was not willing to *"cut her feelings"* to separate from her grandchildren. Despite difficulties, she wanted to continue to care for her grandchildren.

Grandparents described both love and a sense of obligation towards their grandchildren, but they also revealed that caring for young children at an advanced age could be an incredible burden, as illustrated in the case study above. On the other hand, others explained that their grandchildren were a source of support. Some explained that grandchildren could help with household chores like gathering water, and one noted,

"When I am sick at night my grandchild, who is six, can help me and tell his aunt and uncle to bring food" (grandmother caring for her grandchild at home, interview).

Many elderly caregivers expressed concern for the future of their grandchildren, worrying about what would happen to their grandchildren after they died.

CASE STUDY: TWO GRANDPARENTS WHO ARE RAISING FIVE GRANDCHILDREN IN THEIR HOME

This study illustrates how migration increases the vulnerability of children. It shows how a combination of love, religious belief and support from NGOs has helped a family stay together.

The parents of the grandchildren migrated to Thailand about fifteen years ago. One daughter left because her husband was physically abusive. The grandfather does not hear from the parents nor does he know where they are.

Both grandparents are literate and he completed grade nine. They own their house, but the farming land they own has land mines and they are afraid to farm it. They grow food for themselves on someone else's land. He sells traditional medicine to women who have just given birth and his wife works as a midwife and as an occasional day labourer. He has received some support from an NGO that gave him two cows.

The grandmother said:

"It is hard to take responsibility for them. I have to get up in the morning to cook their rice, and work until ten at night. I worry for the children…I am willing to be employed to pick and shell peanuts and to take out cassava, I am the oldest one on the KohYoun[66] truck…I borrow rice and don't pay yet…sometimes I get money from being a midwife, sometimes not, we find money for food one meal at a time."

The grandfather then explained that he was caring for his grandchildren for merit in accordance with his Buddhist beliefs, adding:

"I don't care if they are grateful to me or not …because it is the act itself."

All the children go to school except for the eldest who is 17, who left school because the family was too poor to continue sending him and they needed an extra income. He works washing motorbikes. The second eldest is in grade 10, and the grandparents must pay money to his teachers and for extra lessons. The youngest three children are able to attend primary school for free because an organization pays the teachers' salary supplements to prevent the teachers asking for extra money from students. The grandchildren are also in a children's club run by an NGO that encourages and monitors school attendance.

There is a residential care centre in the village, but it has never approached this family. The grandparents approve of the assistance it gives to families, but do not want to send their own children. They explain that their grandchildren keep them busy and that they would not be able to "cut their feelings" to send them. They also feel the children would be miserable without their family.

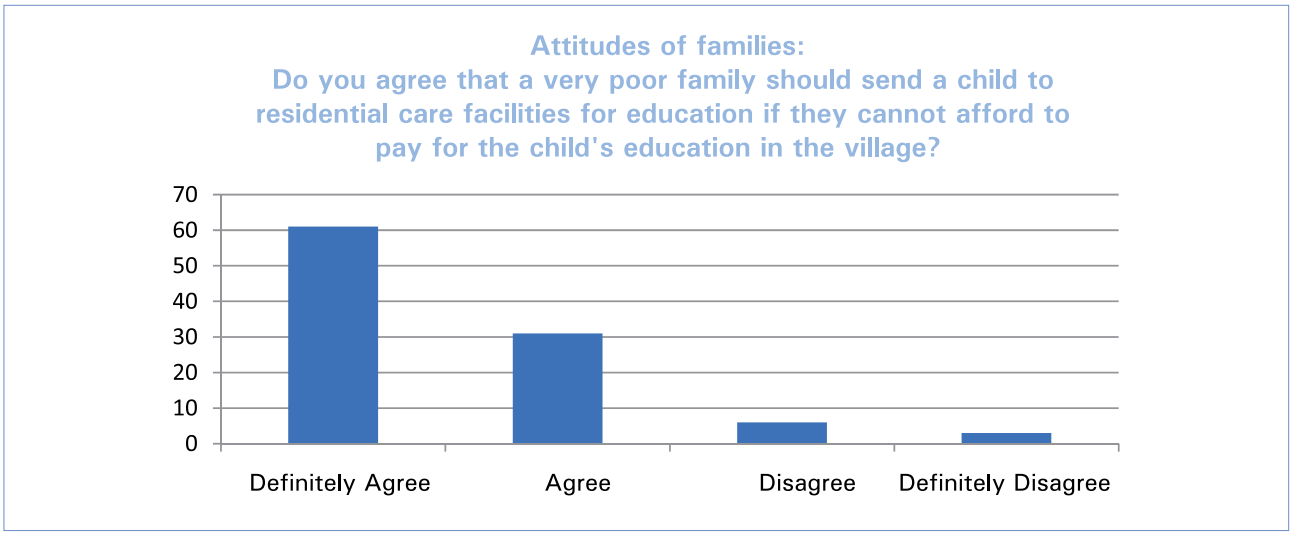
---

[66] Traditional Cambodian tractor/truck that delivers day hire labourers to the fields.

[67] In contrast, only 16.3 per cent chose "live with a relative" and 2.5 per cent chose "live with a different family in the community".

3.4.3. Attitudes that contribute to placing children in residential care

Families recognize the value of raising a child within a family unit as 61.1 per cent of families surveyed agreed/ definitely agreed that families are better at raising children than orphanages. At the same time families were found to support, overwhelmingly, residential care as an option for children without parents. When asked to select the best solution for a child without parents, 79.6 per cent chose an orphanage[67]. Families believed that residential care could offer advantages such as education and a better future that would not be available to poor children living in the village. These were believed to supersede the advantages of home life. However, as noted below, education and a good future are in no way guaranteed by residential care centres.



The belief that residential centres offer a good education

Education was cited as a major reason for placing children in residential care in almost every interview conducted for this research. It was mentioned by MoSVY staff, local government, residential care directors and families, both with and without children in care. A significant 89.4 per cent of families believed children in residential care received a better education than those living in the village, and 91.9 per cent of families surveyed agreed/definitely agreed with the statement *"A very poor family should send a child to an orphanage for education if they cannot afford to pay for the child's education in the village".*

Education was usually mentioned in connection with poverty: the poor cannot provide for their children's education and therefore putthem into residential care; the rich do not have to make this choice.

In principle, public education in Cambodia is free. In reality, however, teachers are paid very little and as a result take *"informal school fees"* from parents. In addition, parents must pay for school books and uniforms. Many also need to provide bicycles to help children get to school in the higher grades when schools are further away. A World Bank report in 2005 noted,

"The average schooling expenditure per primary school child accounted for 26.5 per cent of non-food spending among poorest households" (p.64).

Many families said they had sent their children to residential care because they could not afford to send them to school themselves. This is in line with MoSVY data, which show that children in the 6-12 age group form the

[68] MoSVY's database of registered residential care facilities shows a spike in the number of children admitted to care at primary school, grade 1.

largest number of new admissions to residential care centres annually. There is no disaggregated data, but the assumption is that this ties in with admission in time for grade 1.[68] Many families, both with and without children in residential care, mentioned the cost of informal school fees.

"My child complained that at exam time he needed extra money, and we didn't have it so he stopped studying" (mother caring for her child at home, focus group discussion).

Parents also said that it was hard to pay for uniforms and books. A few noted that their children suffered because they had to walk several kilometres to school and they could not afford bicycles or the bicycles they bought always broke down. They said children always arrived late as a result and were embarrassed to walk to school so they stopped attending. Although most villages are close to primary schools, this was not true of secondary schools, which were often described as being many kilometres away.

The value of education

Illiteracy

Most parents and grandparents that were interviewed described themselves as illiterate or said they only had one or two years of education. Many had lived through the Khmer Rouge period, which disrupted their education. Several expressed regret that they had not learned to read and hoped to save their children from a similar fate. Residential care was seen as a solution to this problem.

"It was the war, we had to run away, there was never any time to study" (grandmother caring for a child at home, interview).

"My family almost sent me to an orphanage, but my mother didn't want to cut ties. But I didn't go to school and now I cannot even write my name...when I see people reading a book I want to cry because I have no education" (aunt caring for a child at home, focus group discussion).

"I am illiterate, and I don't want my children to live like me" (mother caring for a child in her home, focus group discussion).

"Children are illiterate when they come to orphanages, and one year later they can read" (father of child living at home, interview).

The cost of illiteracy

Parents explained that there were few options for those who did not go to school. Children without an education were described as being poor and forced to *"live by physical labour"*, as opposed to the educated who *"worked with their minds".* Many families viewed education as the path to a better life and providing a good education was viewed as a way of showing love. A lack of education was described as creating a cycle of poverty and many parents viewed the education offered by residential centres as a way to break out of this trap.

"Those without education seem like boats without rudders, and those with education can get jobs" (mother of a child in residential care, interview).

"I do not want my children to have to work as hard as I do. I want them to have an education" (father of a child in residential care).

"When they do not go to school they live by physical labour. Even when they marry they remain poor. Uneducated people marry uneducated people and the ignorance goes on to their children" (grandfather, focus group discussion).

"If they had lived with me their future would have been bad. They might have picked up waste/scavenged for the whole of their lives" (mother of a child in residential care, interview).

Education and morality

Education was closely linked to being a *"good person"* by many participants in the study. Focus group members described those with education as having *"knowledge and respect".* This may be because of the close relationship between education and Buddhism in Cambodia, a country in which the main path to education has traditionally been through the pagoda. One key informant explained that before he left the village to pursue his education no one listened to what he said, but now when he returned people took him seriously. Those without education on the other hand were viewed as morally suspect. Many participants believed that education would prevent children from becoming rebellious youths.

"Those who have education can see good things, and copy and follow" (father of a child in residential care, interview).

"The uneducated cannot lead a good life and will do bad things" (Commune Council member, interview).

"In Khmer we call those who are uneducated 'gangsters'" (father, focus group discussion).

Education and understanding

The distinction between those with an education and those without was viewed as a defining feature of a person's identity. Education was seen to assign morality, and those without it were viewed with suspicion, as seen above. However, a few participants felt it went deeper than that.

"It is hard to talk to uneducated people, they have a hard time understanding" (mother, focus group discussion).

"I am illiterate. Life is hard when you are illiterate, when someone speaks to me I cannot understand what they say" (mother of a child in residential care, interview).

This woman implied that a lack of schooling had undermined her perceived ability to understand the spoken word.

Education and the future

Most families with children living at home did not articulate a clear vision for the future of their children. However, parents with children in residential care felt the future of their children depended on the institution. They repeatedly said that they believed the residential centre would give their child an education and that this would lead to a job in town. Whilst some parents believed their children would do vocational training and work as mechanics nearby, others had possibly unrealistic expectations.

"When they are knowledgeable they can do any work, without knowledge they can do nothing" (mother of a child in residential care, interview).

"If you have an education you can become a medical doctor and live and study abroad" (mother of a child in residential care, interview).

Education in residential centres[69]

Most parents say they send their children to residential care so they can get an education. The majority of residential care centres reported offering education to children[70]. However, the quality of education varied. Many institutions said they send the children in their care to the local primary schools. In some cases the residential centres pay the informal fees for the children, but some directors explained they asked the teachers to waive these fees. One director explained this made things difficult because the teachers resented the children from the centre because they did not pay.

---

[69] It is important to note here that this study is not an evaluation of residential centres. The views on education noted here are the views of participants, as described to the research team. They should not be assumed to offer an evaluation of education in residential centres across Cambodia.

[70] In Daigle and Dayble's (2001) survey of residential care in Cambodia almost all residential care facilities said they offered education to the children in their care. admitted to care at primary school, grade 1.

"The teachers make the children sit at the back because they don't have money. The teachers look down on children from the centre and the children are embarrassed because they study without paying money" (residential care director, interview).

It also appears that some centres are not sending the children to school everyday. As noted before, a few participants described children in residential centres being made to work in the rice fields instead of going to school. Others described children being taken out of class to give an apsara dance performance whenever a group of tourists arrived.

One key informant explained that parents also send their children to residential centres because they are often based in urban centres and there is a perception that urban schools are better. Teachers graduating from college with high scores are given first choice of where to work and they are less likely to choose poor rural villages. This may also relate to the parents stated desire to help their children move from a rural lifestyle to an urban one, from manual labour to *"mental"* labour.

Some key informants mentioned residential centres that ran their own schools for children within the centre. In some cases these were described as being of a very high standard. However, in this research, few parents mentioned children attending these kinds of schools and no residential care directors that were interviewed reporting running them. It was, however, common to hear of after-school programmes within residential centres. These after-school programmes were sometimes described as functioning as an additional school, offering many of the subjects covered in the National Curriculum. Parents explained that children in these schools would quickly advance.

"The child [I know] in the foreign orphanage is better off than mine, they are the same age but she is in grade nine, and mine is in Grade 6" (mother caring for her child at home, interview).

Many residential care directors reported offering specific after-school lessons, particularly English classes. In Siem Reap some also reported offering Japanese, Korean and French in order to prepare children for jobs in the tourism industry. Some directors also said they offered sports, arts and vocational training. Several participants cited extra lessons as one of the benefits of residential centres.

Some residential care directors said their organizations also paid for higher education for children who qualified. The highest levels of government have also offered government university scholarships for any child who qualifies from a residential care centre. However, most residential care directors did not think their centres could provide funds for higher education.

Time to study

Some residential care directors explained that children in their centres had more time to study and fewer distractions. They said that children in residential care did not have to worry about survival and were therefore more able to concentrate on their studies. They also said children in the community were more likely to skip school and go for a walk or play[71] after school, which would negatively impact their studies.

Residential care centres are viewed primarily as schools

Several key informants described residential centres as acting like *"boarding schools for children from the country".* Their main purpose was described as offering a good education in an urban environment. The confusion between residential centres and schools was reflected by a focus group of parents from the community, who said:

"We request an orphanage be built in our village so that we can send our children in the day time and bring them home at night."

---

[71] The Khmer word for this "daeur ling" literally means go for a walk, but is used to mean play or skip studies.

[72] The Cambodian word "ksai" literally means string and is used to describe a social connection.

In some cases middle-class parents described residential care as an attractive option due to the education offered.

"It seems hard to others when they want to go there and they have no strings[72]" (mother caring for her child at home, interview).

"If I was poorer they would accept my child. I would send her, to give her a bright future" (mother caring for her child at home, interview).

IS RESIDENTIAL CARE PERCEIVED AS BOARDING SCHOOL?

A director of a residential care centre in an urban area explained that residential care is often perceived as a form of boarding school. He explained that even relatively wealthy members of the community hope to send their children to residential care to advance their education. He told the following story, which he felt illustrated his point.

A child in the centre had died due to a fall whilst playing sports. The next day a man visited the centre and began accusing the staff of negligence for not taking better care of the child. The organization asked who he was and he replied that he was the child's father. The organization went back to their records, which noted the child was an orphan and the father was dead. These records had been confirmed and signed by the Village Chief. It became clear that this man was not only the father, but also the Village Chief and he had falsified documents to get his own child into the residential centre. In these cases the residential care centre is apparently viewed as an educational centre rather than a home for orphaned children.

Several participants explained that it was common for the children of the staff to live in the institution and this was observed during the research. One key informant described working in a residential centre in which *"some parents paid for their children to go there".*

Education and work or household duties

Several participants mentioned that children in the community had to support their families and this affected their education.

"Children at home have to work to support their daily life…they do not go to school and it harms their development" (DoSVY staff member, interview).

"If she stayed with me she would have to take care of this little one [gesturing to a toddler at her feet] when I go to work, but since she went to the orphanage I leave the little one with the neighbours" (mother of a child in residential care, interview).

"If I gave him to the relatives he would only herd cows, not go to school" (mother of a child in residential care, interview).

Residential care directors and local government members said that some parents refuse to let their children go into residential care because they rely on their children's income. One Village Chief said that in his village it was the children themselves who had refused to go because they pitied their parents and wanted to stay to contribute to the household income.

"All orphanages have the same problem; parents come to pick children up at 14 or 15 to get them to work on the farm" (director of residential care, focus group discussion).

However, no parents said that they had refused to send their children because they preferred them to work.

The International Labour Organization's (2001) Child Labour Survey in Cambodia found that 86.6 per cent of economically active children worked as unpaid family workers. The Labour Code of Cambodia says that children can be involved in light work[73]. Save the Children Norway's report on children's rights in Cambodia also

[73] As long as it is not hazardous and does not interfere with their schooling or development.

detailed the many chores a child does in a family that keep the child busy from dawn to dusk (Jordanwood 2008). These factors can all negatively impact on a child's access to education.

Education and community-based care

As stated earlier, certain donors do not want to fund community-based care projects because they do not trust that families will distribute the money for children. Meanwhile, residential care directors said that children in the community were more at risk of skipping school or going for walks instead of studying. However, several community interviews gave opposite views. Families who had children living with them at home and were receiving some kind of support from NGOs placed a high value on education. Almost every family receiving support in the community was sending their child to school. A grandmother in a house with a dirt floor, who received a bag of rice and cooking supplies once a month, was managing to educate all five of her grandchildren.

"The organization gives me food which helps me to save money so my child can go to school" (mother caring for her child at home, interview).

These families were living in very poor conditions, on a par, or more often below, those of their immediate neighbours. Nevertheless, their children were receiving an education. In one village an NGO had set up a project, which paid the salaries of the school teachers, so that parents were not required to pay *"informal school fees."* In this village the residential care director said he had to recruit children for his centre from a distance and took very few children from the town.

These families also said that their children did not skip school. They said the organization encouraged children to attend and that the children were good students.

Most families placed an almost blind faith in the ability of residential care facilities to provide an education for their children. Many parents had not visited the residential centres in which their children were placed and felt that the child was now the full responsibility of the facility. Some residential care facilities do offer a high standard of education, but this is by no means true for all. Key informants and families reported that some residential care facilities were unable to afford fees to send children to school and that children were working instead. During focus groups with children age 15-23 living in residential care centres, just over half said they were at the appropriate grade for their age. Most children enter residential care facilities at six or seven, so children age 15 or above would have already spent several years in residential care. The fact that so many children were not studying at their grade level calls into question the education that residential care facilities provide. Moreover, several child participants at the research workshops for children were illiterate. Families were placing their children into care for their education and yet some 15 year olds were still unable to read.

Most residential care directors and families said that children in residential care are sent to local primary schools. However, the cost of paying for the informal school fees and educational supplies for a child is minimal when compared with the cost of housing, feeding and paying for school. Vulnerable children could receive educational support and remain living with their families within their communities for a fraction of the cost of supporting a child in residential care. A child should not be forced to choose between an education and a family.

Other beliefs or attitudes that contribute to placing children in residential care

The residential care centre as a "better parent"

In surveys, most parents agreed/strongly agreed with the statement that families are better at raising children than orphanages. However, a significant number of families (38.9 per cent) disagreed/strongly disagreed with this statement. Previous research (Gourley, 2009) has also noted that families said they felt their ability to parent their children was insufficient. Children in residential care were described as more respectful because participants

believed institutions were more able to manage children. Some participants blamed parents, who were described as too busy or disinterested.

"Children in the orphanage are better children, they are respectful, they respect the elderly and do their work" (mother caring for her children at home, focus group discussion).

"Children behave better there because there is clear management and children are more afraid of teachers than parents" (Commune Council member, interview).

"Poor parents do not have time to monitor their children's studies, but in our orphanage we manage them well" (residential care director, focus group discussion).

"There is no support for children of poor families to be good...poor children don't get good advice from parents" (Commune Council member, interview).

Some participants felt that children were too free in the community and that residential care provided the necessary structure. Children were often described as *"going for walks"* in the community, which was frowned upon.

"A child's point of view is different than ours. They think only of the fun they can have in the present, not of their futures. When they are happy and playing they don't want to come back [to work] but here it is different, here they study. If they were to go to the village they would have freedom and become undisciplined" (residential care director, interview).

A COMMUNITY MEMBER DESCRIBES HOW RESIDENTIAL CARE IS USED AS A DISCIPLINARY SHELTER

"The family wants to send their child to an orphanage because he is hard to advise, the child is a gang member, he is bad/broken[74]. He does not do housework. He does not obey his grandmother; he does not go to school. He plays pool and games. He tries to run away from his grandmother.

He is the child of the first wife. When the father remarried the new family didn't like his behaviour so they sent him to the grandmother. He was sent to meet the uncle who is a policeman to get advice, but he did not take the advice. The uncle wanted to arrest him, but he is unable to. So now he wants to send him to the orphanage because he thinks they will make him obey. There is good discipline there".

Rebellion

Many felt children in the community might fall in with *"bad friends".* They were described as more at risk of joining gangs, and participants said the residential care centre would offer a form of protection.

"In the orphanage I don't have to worry about rebellious youths who could mistreat my children" (mother with a child in residential care, interview).

"There is no hope that the children who stay can be good people" (mother with a child in residential care,interview).

Residential care was also described as a remedial option for children already involved in gangs, as the example in the inset demonstrates.

The belief that residential care is an avenue to modern/urban life

Some participants explained that a residential centre was a good option for children because it was both modern and urban. Several participants believed that residential care centres served as a springboard to move from a rural to

[74] Koatch is a Khmer word that directly translated means broken, but it used to mean bad.

[75] In Khmer a karaoke girl is a euphemism for sex worker. However, not all girls who work in karaoke bars engage in sex with customers.

an urban existence. In surveys, 80.5 per cent of families said they agreed/strongly agreed with the statement *"Children in orphanages will have a better future than children in the village."*

"They [the children in the residential care centres] don't belong in the village anymore, these children have computer skills, they dress differently, they are modern kids now" (residential care director, focus group discussion).

"Most [graduates] go to town, not back to the village, because there is nothing for them there but farming" (residential care director, focus group discussion).

Discrimination/prejudice

In some cases prejudice amongst the community was described as increasing vulnerability of children. A great aunt explained that she cared for her grandchild because his father had married a *"karaoke woman"* [75] before his death and the child was therefore ostracized. Another woman explained that she was unable to rely on her relatives for help because they shunned her due to her poverty. She said this caused her to place her child in residential care. A key informant described being approached by a community that requested she start an orphanage for the children whose parents had died of HIV because the community felt that these children contained bad spirits.

Peer pressure

Both supporters and detractors of residential care used peer pressure. Some participants felt that families who refused to take in their relatives should feel shame. However, many more felt that it was the duty of poor families to send their children to residential care. Members of district and local government described persuading parents to send children to residential care for the good of the child. Families also reported being persuaded in this way. Some mothers spoke with pride in their voices, explaining they had made a sacrifice for the greater good.

"They said they were willing to live with hardship rather than send the child to the orphanage, but if they live with the grandparents they will have no development. They think it is good, but it is not good" (DoSVY staff member, interview).

"My relatives persuaded me to send [my child]. I was praised for sending him, for realizing I was unable to raise him myself" (mother with a child in residential care, interview).

PEER PRESSURE: AN EXAMPLE FROM A FOCUS GROUP DISCUSSION WITH MOTHERS FROM THE COMMUNITY

In one focus group discussion a woman commended her brothers' efforts to keep his family together. The group, however, disagreed with her viewpoint and felt that the children would be better off in residential care. The following brief excerpt illustrates the commonly held social values that pressure families into placing children into residential care.

One participant says: *"My younger brother has seven children; he cuts water lilies to support his family. Three meals a day cost a lot. Sometimes the children miss school to cut water lilies. And one of his children works for another family doing housework and sends money back to her family."*

Another participant interrupts: *"The poor should be sent to orphanages."*

The first woman replies:*"He tries his best, but he cannot cut his feelings."*

The second responds:*"It would be better for him to cut his feelings and send his children to an orphanage to get an education."*

Another group member adds: *"When they are sick they receive medicine."*

The second woman says: *"It is not good to keep them with their family but if the family is not willing to send them, they cannot cut feelings."*

The first woman closes the topic saying: *"Even though they are miserable he is willing to keep them, and it is better than sending them."*

Gender

MoSVY's database of registered residential care facilities shows that there are consistently more boys in residential care than girls. In 2008, there were 58 per cent boys and 42 per cent girls in residential care nationwide. Families did not explain why more boys were sent than girls, but some key informants felt this was due to the belief that girls were more at risk in residential care and more useful at home. Others said that in Cambodian families preference is sometimes given to a boy's education.

3.4.4. Attitudes that contribute to keeping children in the community

Love

Many parents and elders interviewed during this study had considered placing a child in residential care and had decided against it. The most common reason given for this was love for the child. They explained that they were unable to *"cut their feelings."* Parents explained that young children needed a mother's warmth. Several felt embarrassed that their love for their child made them unable to send them away.

During the research, parents were often observed showing great affection for their children, cuddling them, playfully tickling them, stroking their hair, twining and untwining fingers. This is worth noting because it is the experience of the research team that Cambodian culture is less expressive than many western cultures and as a result people are less likely to talk about their feelings. However, parents displayed their love for their children in other ways.

Many families who had sent children to residential care described a sense of loss for both caregivers and children. Some parents loved their children, but felt they had to let them go "to help the child".

"According to my living standard I should send them, but according to my feelings I cannot" (mother caring for her child at home, interview).

"They miss me so much, and the youngest one when he is sick he misses me. I take pity on them but I cannot solve the problem, the problem is the money to support them" (grandmother of a child in residential care, interview).

"I missed them. I fell asleep crying after they first left. They missed me too but I told them not to, I said when you grow up you can live with me" (mother with a child in residential care, interview).

A few children who had returned home after a period in residential care explained they returned because they missed their parents. One boy said he had cried every night until his aunt who worked at the centre brought him home to his mother. A residential care graduate spoke of feeling lonely for his first months in the institution, and residential care directors also noted that children missed their families. Several parents said they were unable to send all their children and decided to keep one child at home.

"If they have three they will send two…they need a child to live with for warmth" (residential care director, interview).

Parents also expressed fear that their children would blame them later in life for having abandoned them. A community member explained that later in life children might be angry with their parents and one mother began to cry as she described her fear that her children would resent her later in life for placing them in care.[76]

Parents repeatedly expressed the belief that they were sending children to residential care for their own good. The belief that parents can both love children and also send them away was illustrated when a three year old child walked in during an interview with a mother who had already sent an older child to an institution. *"Do you want to go?"* she asked the child, who firmly answered *"No". "But they will give you food, they will give you an education"* she replied whilst kissing and tickling the child.

[76] The researcher stopped asking questions as soon as the mother began to cry and the interview was gently terminated.

Khmer family

Participants also felt that the strong sense of family obligation in Cambodia helped families keep children at home. Many families receiving some kind of livelihood support said they would never send away their children because they were blood. Several grandparents were very clear about their sense of obligation towards family. One father explained that family would feel ashamed if they did not take in an orphan.

Merit

A small number of grandparents mentioned that they were raising their grandchildren in order to accrue merit. According to Buddhist belief those who do good in this life accrue merit, which helps them attain a higher status in their next reincarnation.

Mistrust of residential care

Some families who had chosen not to place their children in residential care explained they did this because they did not trust the centre to provide adequate care. One grandmother said she was afraid that children in residential centres would be mistreated or bullied. There was a repeated belief stated that children are at risk when they are *"far from our [the parents'] eyes".*

"We don't leave our children because they are blood, and in the orphanage we are afraid they won't get the same amount of care as with us" (grandmother, focus group discussion).

"If I gave my children they could be mistreated or trafficked...I don't trust anyone else" (father caring for his children at home, interview).

The expressions of love and familial responsibility were in sharp contrast to the stated opinions of some donors and residential care directors who thought families were untrustworthy, wanted their children at home for the free labour they offered, or were likely to abuse or sell their children. In making these arguments, donors and directors are calling into question the family unit itself. Their argument, taken to their conclusion, would imply that all poor children in Cambodia should be placed in residential care for their own good.

3.5. Attitudes of young people to residential care

Research was conducted with both young people aged 15-25 living in residential care and with control groups of children of a similar age living in the community. The research with young people in residential care focused on their present lives and their futures. It did not ask about their past since it was felt this might have been too invasive or emotionally upsetting.

3.5.1. Key findings

- Many children in residential care feel that the institutions fail to provide adequate physical care or education.
- They also feel that their emotional needs are not met and complain of a lack of personal freedom and love.
- Children in residential care fear for their futures, worrying that they will not be able to find jobs or will be forced into crime. They are afraid they will not be able to adapt to the outside world and will suffer from a lack of community support.
- Only 1.8 per cent of children or young people in residential care that were surveyed anticipate being independent at age 18. Meanwhile 76.3 per cent anticipate they will be independent when they have a job. However only 78.5 per cent of young people in residential care aged 15-22 that were surveyed actually have a job. This suggests that older children staying in residential care are inadequately prepared to enter society and live independently.

3.5.2. Present

Material concerns

Young people in residential care described the residential care facilities as lacking in physical necessities. Many children said that the facilities did not have enough beds. Others said there was not enough food and that they wished they had 'modern' clothes to wear. A few also said they wanted jewellery or make-up. A common theme was that young people did not have their own personal money.

Many young people also mentioned that they wanted more help with education. Some said they no longer studied and they were angry with themselves that they had stopped. Others said they lacked the money for extra lessons, transport or uniforms. Some mentioned they wanted to be able to take extra lessons in languages outside the centre.

Social/emotional concerns

Personal freedom

Many young people expressed frustration with the lack of personal freedom. They wanted to be able to go for walks or to go outside more often. They did not feel free to express themselves, saying that they were often prevented from speaking out, offering opinions or protesting. In one workshop when the research team asked the children for their opinions about their futures, the group burst out in applause noting they were happy to be asked.

"It always depends on the staff's opinions, not the children's opinions" (child in residential care, focus group discussion).

"The director does things without telling us the reason why" (child in residential care, focus group discussion).

Save the Children Norway's study of child participation in Cambodia found that children are not encouraged to express themselves or speak out within their homes (Jordanwood, 2008). It appears that this situation is exacerbated within residential care because the hierarchical patronage structure discussed in Gourley (2009) is also in play. Children are at the lower end of both of these structures and are not believed to be entitled to speak out. As one mother who had taken her child out of residential care noted, when her child was sick he did not dare to tell the staff.

Emotional concerns

Many children said they lacked warmth and love and that they lacked *"someone to depend on".* Some said that they wanted someone to encourage them and care for them.

"The staff get angry when we get homesick and want to run away from the centre" (child in residential care, focus group discussion).

Some said staff did not love them equally and were unfair and would take sides in disputes. Others said they felt that it was unfair that they didn't have sponsors, like the other children. A few said staff were abusive and threatened children.

"The staff cheat us to get things for themselves" (child in residential care, focus group discussion).

"The staff look down on the children" (child in residential care, focus group discussion).

Some young people mentioned the issue of rumours and gossip, noting that both other children and staff talked about each other behind their backs. They described this as very upsetting and wished others would discuss issues with them directly instead.

3.5.3. Future

Young people, both in residential care and in the community, were asked to discuss their feelings and attitudes towards the future. Both groups felt a mix of positive and negative feelings towards the future, many noting they were excited and happy about starting new lives and the freedom they would have outside the facility, but were afraid of what the future might bring.

Young people in the community and residential care were concerned about finding accommodation and jobs and being able to continue their studies in the future. They were also worried about crime. However, as will be seen, young people in residential care tended to be much more specific in their description of their fears and also more worried.

Both young people in residential care and those living in the community worried about where they would live in the future. However, those in the community focused on the need to find a place to stay, while those in residential care spoke also of the result of this i.e. being homeless.

"I will have to find somewhere to live by myself" (child in residential care, focus group discussion).

"I am afraid of being vulnerable again" (child in residential care, focus group discussion).

Both groups also worried about finding jobs. A few young people in residential care added that they would have no support networks to help them do this or would not have appropriate work clothes to wear. While young people in the community described this fear in general terms ("I worry that I won't be able to find a job"), young people in residential care were more specific and appeared more afraid. They mentioned a number of fears not mentioned by young people in the community, including fear that:

"...I will be like a beggar"
"...be a servant in a house"
"...will have to work in hard labour"
"...will end up scavenging rubbish"
"...to be scorned/looked down on by colleagues"
(Children in residential care, focus group discussions).

Young people in residential care may have had real reasons to worry about future jobs. The MoSVY database of registered residential care centres shows many young people stay on in residential care after the age of 18.In several provinces the rate of children leaving after 18 was as low as over 50 per cent. The lack of planning amongst residential care directors for reintegration of children was noted earlier.

Moreover, in Cambodian society great value is placed on the role and responsibility of the family (Gourley, 2009). Families are expected to help their relatives find jobs and, as one key informant noted, will often allow out-of-town relatives to stay with them while they start their careers. These connections would most likely be unavailable to young people leaving residential care. In this study, the general expectation of families was that children would find jobs in urban centres. Some young people in residential care centres wanted to learn rural farming skills. However, many families who had sent children to the centres said they did not own land. In Margaret Posnett's study for ICC/Project Sky (2010) on residential care, she found that families were wary of the suggestion that children might return to and require support from their parents.

Education

Both young people in the community and in residential care worried that they would be unable to complete their studies due to lack of money. This is a real concern for both groups since a small percentage of the population attend

higher education in Cambodia. Many young people in residential care said they had always expected to go to university. This goal seems unrealistic given the lack of funds of many residential care centres and the fact that many of the children were not at the appropriate grade level in school.

Many residential care centres offered some form of vocational training. In many cases this was divided along gender lines, with girls being offered classes in cosmetology and boys being offered courses in mechanics. Both boys and girls were offered training in computer and sewing skills. There appeared to be a lack of creativity in classes offered and there were few links to outside jobs, a fact also noted in Vijghen's report on residential care in 2004. Young people in residential care that were interviewed for this study were less likely to be interested in vocational training, having been raised to believe that they would be able to attend university. Many young people had expectations that were probably unrealistic given their circumstances. When asked which jobs they wanted to do in the future, most gave professional positions, such as doctors, lawyers or teachers. One young person said that "If you can read and write you can get a job", which seems optimistic given Cambodia's high level of unemployment. Interviews with former graduates of residential care found that they had difficulty finding work despite some of them having a high level of education.

Problems in society

When young people in the community talked about future problems in society, they focused on larger societal issues about which they were quite well informed. They mentioned corruption, the global economic crisis, insufficient government regulations, the supply of water and electricity and environmental concerns such as deforestation and the hole in the ozone layer. They also spoke of needing to live on good terms with their neighbours, but to a much lesser extent than those in residential care.

When young people in residential care talked about future problems they might face in society, they were much more interpersonal. They focused more on issues such as "doing what normal people in the community do". They talked about wanting to know how to solve problems or understand social situations.

"I don't know how to live in society" (child in residential care, focus group discussion).

Both groups mentioned the effect of crime on their futures, however for young people in the community crime was mentioned much less frequently and described in general terms of gangs, robbery and drugs. For young people in residential care, on the other hand, crime was a central concern. They too were afraid of gangs, being robbed and drugs, but they also voiced that *"being tricked by others"* or being trafficked were large concerns. One young person described his fears about leaving saying,

"I feel like a duck in a cage, afraid someone will cook it."

The greatest difference between the opinions of young people in the community and in residential care on the issue of crime is that those in care were also afraid of becoming criminals. They said they were afraid of,

"…being forced to traffic drugs."
"…being forced to rob."
"…afraid I'll have to be a gang member."
"…hitting my mother to get drugs."
"…afraid I will have to fight for land."
(Children in residential care, focus group discussion).

[77] According to the MoSVY database of registered residential care facilities in Cambodia.

Support networks

Very few young people in the community voiced concern about a lack of support networks in the future. This issue, however, was of great concern to young peoplein residential care. They spoke at length about their worries. They said they worried they would have no one to depend on, no one to encourage them, no one to care for them or help them with their problems. One young person said he wanted someone in the future to help encourage him if he had emotional problems. Many said they would miss love and support. These fears were specific to the young people in residential care and may have been well founded. Adults who had formerly lived in residential care shared these concerns:

"I never think about marriage. I do not have enough money to get married. If I had stayed in the village I might have been able to get married. I do not have a lot of friends; my only friend is someone who used to be a teacher at the orphanage. I feel lonely. I would like to be a normal person" (adult graduate of residential care, interview).

Discrimination

Many people in residential care said they currently suffered from discrimination because they lived in care and feared this would also be true in the future.

Family contact

Many young people in residential care said they lived with their siblings, which suggests that residential care facilities place a value on keeping children together. However, one noted she was afraid of leaving the centre because she was afraid that her siblings would fall under the influence of bad children after she had gone.

Most young people said they visited their families once or twice a year for the major Khmer holidays of PchumBenh and Khmer New Year. Families with children in government residential care facilities, which in 2008 comprised 11 per cent of facilities nationwide[77], said that their children visited approximately twice a month and noted that families could stay with the children when they were sick.

CASE STUDY: A GRADUATE OF RESIDENTIAL CARE

This case illustrates how residential care can leave children with no support network to help them re-enter society. Dara[78] has a high level of education, but he has no family, friends or home to support his first steps in the world of work. He hopes that his sponsor overseas will help him get a job and seems unaware that this is an unrealistic expectation.

Dara is 18 years old and still lives in the residential care centre in which he grew up. He has lived there for ten years and finished grade 12 the previous year. He still studies English in the mornings with the younger residents. He describes his daily schedule,:

"I feed the fish, I read books in the library and cook with my house-mother. I play basketball."

He is currently unemployed and has no concrete plans for his future. He says:

"Next year I hope that I can find a good job, I know how to cook and I can communicate with people from around the world. I hope my sponsor mother overseas will get me a job overseas but she says no, it is very expensive".

He explains that he has no mother or father and that his grandparents and brother live in the village. He says he visits his grandfather frequently, but hasn't seen his brother in years. He doesn't feel he can go back to live in the village and says:

"It's difficult for me because I don't have a home town. I used to have friends at the local school, but they have moved on and now I have none. Sometimes I worry that I will be alone; it's difficult for me to live because I have never been alone. It's hard to live alone and to buy food and to clean clothes…. I don't know where I will live".

[78] Names have been changed to protect individual identities.

[79] This study was not published.

3.6. The process of placing a child in residential care

3.6.1. Key findings

- Traditionally, Cambodian's have cared for separated children through kinship networks.
- The large increase in residential care facilities is creating a situation in which residential care centres are doing outreach through local government and communities to bring children to their centres.

3.6.2. Children in the care of relatives

Susan Andrews (2008), in her study for UNICEF *Keeping Them Home*[79], found that traditional Cambodian culture has a long established tradition of caring for vulnerable children within the community. This was also found in this research.

"Extended family here is very strong. Everyone is related somehow and there is a much stronger memory of how people are related. The idea of an orphan is different in Khmer or western cultures" (key informant, interview).

Village Chiefs interviewed for this study confirmed that it was much more common for children whose parents were unable to care for them to live with relatives.

"When relatives are poor to even offer rice we send them to someone we know a little bit, like a neighbour. We send them for a while, we only send them to survive" (grandmother, focus group discussion).

One father explained that this is always done with the understanding that the parents can reclaim the children when their financial circumstances have improved. Some participants spoke very positively about the experiences of children with relatives. No participants described poor treatment of children living with relatives in the course of this study, but it has been mentioned in another study by Posnett (2010).

"I treat her the same as my own child, she calls me "mother" (aunt raising a niece, focus group discussion).

3.6.3. Placing children into care

As noted earlier, when children are placed with relatives this is usually arranged within the family and without recourse to local authorities. However, when a child is placed in residential care, most participants said it required the signature of the parents, the residential centre, the Village Chief and the Commune Council. Many participants explained that residential centres were responsible for, in the words of a DoSVY staff member, *"finding children by themselves".*

"We ask for lists of the poor from the Commune Councils and the Village Chiefs and then approach families" (residential care director, interview).

"The organization came and selected children to be in the orphanage. My child was selected, but hasn't been taken yet. I don't know the name of the organization" (mother of a child about to enter residential care, focus group discussion).

In some cases the residential care directors were said to be using coercive tactics to recruit children. One mother said she and her husband were offered a job at the residential centre with the requirement that they enrol their children.

---

[80] As noted earlier, the Cambodian word "ksai" literally a string describes a connection to another person and is often used in terms of patronage. The word implies a guarantee of some form of assistance.

"The orphanage said if we did not bring our children to the orphanage, we couldn't work for them, so the whole family had to go" (mother with child in residential care, interview).

In another case a family working for the residential centre said they were not being paid a living wage so they were forced to send their children to the residential centre to survive. In one case a mother said that she used to 'squat' on pagoda land, but the residential care director had paid to build a house on his land and given her a job on the understanding that she would send her children to the residential centre. She explained that they were not allowed to sleep with her at night, but had to sleep in the institution. This situation was not an isolated incident. In another place, a residential centre had built a house for a family directly outside the gate of the centre, but again, only the parents were allowed to live in it. The children were required to live inside the institution. One director described parents as suspicious of his motives, saying:

"One time I gave clothes to a family and when I came back they hid from me, they thought that since I had given them clothes they would have to send their children to the orphanage" (residential care director, interview).

Some families said that other members of the community had connected them with residential care. Some mentioned neighbours, who were usually described as relatives of residential care staff members or as having children in care themselves. Others said village teachers had approached them to tell them about specific residential care centres. Many families described the people who had introduced them to the centre as their "string/connection".[80] One key informant said that parents felt reassured by the "string" and as a result did not evaluate the residential centre themselves:

"They just followed the string regardless of the quality."

Some residential care directors said that children already at the centre would recruit their younger siblings. The directors described this as a sign of their success:

"Families will bring one child and when they visit home and talk to the second child they will want to come too. It is a good thing for the orphanage to attract another child" (residential care director, interview).

Many parents and residential care directors explained that families were evaluated to make sure they were poor before their children were accepted.

Finally, in the few focus groups in which participants explained that they had no direct connections to a residential care centre, families said that all vulnerable children remained in the village. In these cases families said that they had never had a child[81] leave the village and that children whose parents were unable to care for them lived with relatives.

"There are twelve children whose parents have died in this village, they all live with relatives" (father caring for his child at home, focus group discussion).

This suggests that a personal connection to a residential centre is a determining factor in sending a child to live in the centre. Parents do not appear to knock on the doors of institutions, but are lead there by people they know in their own communities.

It is important to note however, that these families also said that they were poor, received no NGO support and many of their children dropped out of school. They were looking for help.

[81] To clarify, a child under the age of 16.

"I have never heard of an orphanage. What is it and how can it help us?" (mother caring for her child at home, interview).

In these circumstances, if a residential centre staff member approached the village, it would probably find families willing to give up their children.

3.7. Child protection issues

The purpose of this report was to examine attitudes towards residential care. It was not intended to be an evaluation of residential care in Cambodia. However, during the research, several participants made comments about conditions in residential care that were a cause for concern. These comments are not representative of residential care as a whole and more research is needed on conditions in institutions within Cambodia. They are included here due to an ethical obligation to report situations in which children are placed at risk.

Lack of background checks

Several participants and residential care promotional documents noted that neither staff working within institutions nor volunteers are subjected to background checks.

Sleeping arrangements

Several participants noted that children of all ages sleep together in the same room in some institutions. There were also reports of staff sharing beds with children. Although it is common for families to sleep together in Cambodia, when this situation is replicated in an institution, it places the children at risk of sexual abuse.

Bullying

Some participants explained that it was common for older children to bully younger children in residential care.

Neglect

Many young people living in residential care spoke of emotional neglect from staff. The very low staff-to-child ratio in many residential care facilities supports their claims.

"I've seen babies with bottles propped into mouths, children sitting in their own urine in bed, lead paint on beds, bloody diarrhoea, scabies on every head" (volunteer, interview).

[82] The interview was terminated at this point because of ethical concerns and a report was made to a local organization that investigated the situation and offered the baby help.

4 CONCLUSION

Global research has found that residential care has a negative impact on the development of children. It has been shown to result in delays in physical and mental development and to affect the long-term ability of children to find a place in society. Children in residential care are also more at risk of health problems and abuse. Community-based care allows children to grow up in a family environment and within their own culture, placing them in a better position to become fully functioning members of society later in life. Moreover, community-based care costs significantly less to implement than residential care.

The results of this research study were in line with several international findings. Children were described as showing several symptoms of institutionalization and were extremely anxious about their ability to adapt to the outside world. Moreover, several participants described situations in which children were at risk of harm or abuse. Most adults working in residential care did not appear to have undergone any background checks and children of all ages were described as sharing the same room and, in some cases, the same sleeping mats. Some residential care centres forced children to perform in dangerous situations, such as bars, in order to solicit funds. Children were described as being bullied, neglected, and physically and emotionally abused.

The rapid increase in residential care facilities in Cambodia is therefore cause for concern. Although it is part of a worldwide trend that cannot be explained by a single cause, this report has outlined attitudes toward residential care that have contributed towards the increase of residential care centres within Cambodia.

Foreigners play a significant role in founding and maintaining residential care centres in Cambodia. They do this, for the most part, with the best intentions and in the hope of having a new challenging experience. Since foreigners are known to give money, residential care centres have begun to solicit more funds through 'orphanage' tourism. This puts a burden on children and at its worst exposes them to risk. In some cases residential care facilities are being used to raise money in a way that begins to resemble a business. Tourism also generates funds that are often unmonitored and therefore more susceptible to corruption. Moreover, funds raised in this manner are unreliable, since individuals often change their minds, do not sign binding contracts and are often unable to make good on their promises. As a result, many residential care centres cannot engage in long-term planning. This funding insecurity places children in a dangerous situation in which basic needs are sometimes not met and children face an uncertain future.

The Government of Cambodia supports family- and community-based care and views residential care as a last resort. MoSVY promotes family-based care through the Policy on Alternative Care for Children and the Minimum Standards, however strong barriers still exist to the success of MoSVY's monitoring system, in particular with regard to enforcement of standards where they are deemed inadequate and in the case of unregistered residential care centres. A great deal of confusion still exists as to where a residential care centre should be registered and there are no specific qualifications required to start a facility. As the law now stands, theoretically anyone can open a residential care centre. This lack of clarity poses challenges for MoSVY to successfully enforce the Policy on Alternative Care and the Minimum Standards, promote reintegration of children in family- and community-based care where feasible, for monitoring as well as inspection in case of irregularities or allegations of abuse or neglect of children in care.

At the level of local government, most Village Chiefs favour residential care. Residential care directors reported locating poor families with children through Village Chiefs, and Village Chiefs said they had tried to persuade families

to place children into residential care. Village Chiefs play a pivotal role in the process of placing a child in care, since their signature is usually required before a facility will accept the child. Most Village Chiefs had not heard of community-based alternatives to residential care, but those who knew about other options were happy to use them.

Almost all families interviewed for this study described themselves as very poor, with many saying they had difficulty meeting basic daily needs. Indeed, 30.1 per cent of Cambodians live below the poverty line (World Bank, 2009). Many families explained that poverty had caused them to place their children in residential care. They mentioned the effect of rising food prices, in particular rice. Families also mentioned specific factors that had contributed to their decision. Some families said a physical or mental illness had caused them to go into debt. Others said that the death of a child had caused them to make the decision. Many participants said that women who were raising children alone or were married to alcoholic men were unable to adequately provide for their children. In some cases children were placed in care because one of the parents had remarried, and families who lacked land noted that they had a difficult time feeding their children.

Migration also increased the vulnerability of children. Parents were described as leaving Cambodia to look for work and leaving the children in the care of relatives or elderly grandparents. In some cases the parents never returned. The grandparents expressed concern about what would happen to the young children when the grandparents died or were too old to work.

Poverty alone was not the deciding factor in the decision to place children in residential care. Almost all families interviewed for the study were poor and not all of them decided to place their children in institutions. It seems instead that poor families sought support and residential care was most often the only support they could find. When families found community-based support instead, they expressed their happiness at being able to keep their children at home.

Residential care was also found to be acting as a social welfare service. Cambodia lacks a comprehensive social protection system. As a result, when families are in need due to poverty or other vulnerabilities, including abuse or disability in the household, local government will often direct them to the only form of care available: residential care.

Education was an important factor in families' decisions to place children in care. Parents describe themselves as trapped in a cycle of poverty and unable to afford informal school fees and associated costs. Most families interviewed who had children in care were illiterate and worked in the fields as farmers or labourers. They said they wanted an easier life for their children. Education was described by families as offering more than knowledge and those who had attended school were described as better people. Education was also assumed to assure a bright future and a professional or office job. Families said they did not have enough money to pay for school and saw residential care as the only option.

At the same time, most residential care facilities send children to local primary schools. Many children, aged 15-23, living in residential care said they were not studying at grade level. Some were even illiterate. In some cases the family's faith in the ability of the facility to provide education was misplaced.

While many families believed that placing children in residential care is in the best interests of the child, the children themselves did not uphold this view. Both residential care directors and children in care described the shortcomings of residential care, noting a lack of material and emotional provisions for children. Children and directors felt that residential care staff were not able to offer children enough love or attention and directors described behaviours in children consistent with institutionalization. Children spoke eloquently about their fears of the future. They were afraid they would be alone, unable to adapt to the outside world and, lacking a social support network, would be forced to break the law in order to survive.

5 RECOMMENDATIONS AND COMMITMENTS

5.1 Overseas donors

- Inform overseas donors of the negative impacts of residential care and the benefits of family-based and community-based care, which preserve existing family units. Organizations that represent or raise funds from individuals should be targeted, including:
  - UNICEF National Committees
  - Rotary Club International
  - Church councils, committees and groups
- Advocate for a change of policy amongst for-profit volunteer organizations to stop facilitating volunteer placements in residential care facilities.
- Advocate against orphanage tourism and for the promotion of family- and community-based care through online sources, including weblogs and sites frequented by tourists, volunteers and other key stakeholders. Examples include websites of development organizations, travel/hotel booking and review sites and the main travel blogs.

5.2 Donors in Cambodia

- Advocate with donors for family-based and community-based care. Provide a package of information to NGOs wishing to register residential care facilities and their donors on the negative impact of residential care and alternatives that promote family-and community-based support initiatives. This package might include the Minimum Standards, fact sheets and contact information for organizations already working in community-based care.
- Develop advocacy materials for various stakeholders. These could include leaflets and posters directed at tourists and donors. These leaflets should explain the adverse effects of residential care and promote family-and community-based support initiatives that help preserve families.
- Identify innovative advocacy models among key actors or facilitators of the residential tourism business, such as tuk-tuk drivers.
- Expansion of social protection measures, including social transfer programmes targeting vulnerable households, with the explicit objective of family preservation and reunification and de-institutionalization of children.
- UNICEF, multi-lateral donors and NGOs identify, support and expand community-based services that provide economic and welfare support and create opportunities for vulnerable households and children.
- Link local government with community-based care programmes and school-support programmes so that they can help make families aware of the available support options that enable them to keep their children at home.

- Further researchis needed into the conditions of residential care facilities in Cambodia. This is of upmost importance given the child protection abuses alleged by participants in this study. During the course of this study, the research team became aware of the large population of children who live in pagoda-based care. Only two small-scale studies have looked at this subject[83], which warrants further research.

5.3 Families

- Create radio spots that promote the value of raising vulnerable children at home, stressing the importance of not "cutting feelings" and the role of the Khmer family, thus addressing the peer pressure that families feel to send their children into care.

5.4 National Government

- Raise awareness among donors that, in adherenceto the UN Convention on the Rights of the Child, children have a right to be cared for in a family environment rather than an institution, and that residential care in Cambodia puts children at risk.
- Implement the National Social Protection Strategy and promote the development of child-sensitive social protection and preventative measures, including social transfers that support vulnerable households to continue to care for their children.

The Ministry of Social Affairs, Veterans and Youth Rehabilitation, in particular:

- Reinforce its mandate to:
  - Regulate, monitor and inspect unregistered residential care facilities.
  - Close residential facilities that repeatedly fail to meet the Minimum Standards on Alternative Care for Children and oversee the development of reintegration plans for children living within residential facilities.
  - Reject requests from organizations to start new residential care facilities, if those they already run repeatedly fail to meet the government's Minimum Standards on Alternative Care for Children.
  - Encourage organizations that attempt to establish residential care facilities to instead support programmes oriented towards community- and family-based care and support.
- Develop a procedure that requires the Ministry of Interior (MoI) and the Ministry of Foreign Affairs (MoFA) and other relevant ministries involved in the registration of organizations providing alternative care to inform MoSVY of all NGOs that are registered to provide any form of care for children.
- Advocate for the MoI and MoFA to require that all organizations wishing to provide care for children provide documentation within a specified timeframe to show that they have contacted MoSVY to initiate the procedure of evaluation for registration.
- Ensure that all ministries involved in the registration of organizations providing care for children liaise upon a new request for registration to ensure that requests to open new orphanages are re-considered and directed to community-based support assisting vulnerable families to care for their children at home.
- In collaboration with partners, put in place a quality and regularly updated data-management system on children living in alternative care settings that supports monitoring, oversight and enforcement of procedures.

- In collaboration with partners, develop procedures to enforce the application of the Minimum Standards on Alternative Care for Children and lay down the roles and responsibilities of government actors at all levels in oversight, management, inspection, placement, review and permanency planning and follow-up of children in alternative care. Procedures should address action taken against residential care facilities which repeatedly or seriously fail to comply with the Minimum Standards on Alternative Care for Children and support children in the event of such institutional centres closing down.
- Ensure that any closure of residential care facilities due to a shift in policy is gradual, measured and based on a thorough review of the needs of the children. Residential care facilities should only be closed if there is an articulated and funded plan for the placement of children with families, preferably by being reintegrated within their communities.
- Develop procedures for reintegration and permanency planning of children currently living in residential care, in close collaboration with residential care facilities and partners.

5.5 Local Government

- Offer training to sub-national officials of relevant ministries (including MoSVY, MoEYS, MoH, MoRD, MoI), as well as Commune Councils and Village Chiefs on roles and responsibilities relating to alternative care for children, including the benefits of raising vulnerable children within the family or with relatives, and the adverse effects of residential care.
- Village Chiefs and Commune Councils identify vulnerable children and their families and connect them with community-based social protection programmes, which support families to keep their children at home. The widely distributed National Directory of Services for Vulnerable People is a valuable resource (available at http://www.novctf.gov.kh).

5.6 Residential care

- All residential care facilities should conform to the government's legal and regulatory framework, including the Minimum Standards on Alternative Care for Children and the Policy on Alternative Care for Children, as well as the UN Convention on the Rights of the Child.
- Residential care providers must register with MoSVY and allow access to government inspectors.
- Residential care providers should strengthen gate-keeping procedures and regularly review the situation of children in their care, with the aim of reintegrating children into their families and communities wherever possible.
- Residential care providers have the responsibility to communicate the advantages of community and family-based care to their donors and to support these alternatives as the preferred option for vulnerable children. The measures taken by the institution to implement community- and family-based options should also be shared with the donors.

[83] They were mentioned in briefin: HOSEA (2004) The HOSEA Project Survey of the Level and Quality of Child-Care in the Temples of Kandal Province, Phnom Penh, Cambodia, and an unpublished study by Susan Andrews in 2009, Keeping Them Home, UNICEF: Phnom Penh, Cambodia.

REFERENCES

Ainsworth, S. Bell, L. and Stayton, D., 'Infant-mother attachment and social development: 'socialisation' as a product of reciprocal responsiveness to signals', in Richards, M (editor), *The Integration of a Child into a Social World,* London, 1974.

American Academy of Pediatrics, *Red Book,* Committee on Infectious Disease, 1994.

Andrews, *S., Keeping them home,* UNICEF, Phnom Penh, 2008.

Arensen, *L., Preventing trafficking of women: a study of origins and vulnerability factors for trafficking victims and direct sex workers in four Cambodian cities,* Pact Cambodia, Phnom Penh, 2004.

Bowlby, *J., Maternal care and mental health,* World Health Organization, Geneva, 1951.

Campbell, *P., Foster Care and the Community,* UNICEF, Phnom Penh, 2006.

Carter, *R., Family Matters: A study of institutional childcare in Central and Eastern Europe and the Former Soviet Union,* Every Child, London, 2005.

Chan Than, P., Article in Cambodia Daily, 4 November 2009.

Csaky, *C., Keeping children out of harmful institutions,* Save the Children, London, 2009.

Daigle, G. and Dybdal, A., The national survey of providers of alternative care for children in Cambodia, Ministry of Social Affairs, Veterans and Youth Rehabilitation, Phnom Penh, 2001.

Decanay, W. Balanon, L. del Castillo, L. and Manuel, *M., Alternative care for children without primary caregivers in tsunami-affected countries: Indonesia, Malaysia, Myanmar and Thailand,* UNICEF, Thailand, 2006.

Frank, D.Klass, P. Earls, F. and Eisenberg, L., 'Infants and Young Children in Orphanages: One View from Pediatrics and Child Psychiatry', *Pediatrics,* vol. 97, pp. 569-578, Illinoi, 1996.

Goldfarb W., 'Effects of psychological deprivation in infancy and subsequent stimulation', *American Journal of Psychiatry,* vol. 102: pp. 18-33, New York, 1945.

Gourley, *S., The Middle Way: Closing the Gap Between Children's Rights and Cambodian Culture*, NGO Committee on the Rights of the Child, Phnom Penh, 2009.

Greenfield, *C., The Gulf Between Rhetoric and Reality.* Research Dissertation for Massey University, Auckland, 2004.

Halliday, C., 'Mamma Khmer', in *The Age*, 9 November, 2003. Retrieved from http://www.theage.com.au/articles/2003/11/08/1068243304513.html, accessed November 2009.

Hostefter, M. Iverson, S. Dole, K. Johnson, D., 'Unsuspected infectious diseases and other medical diagnoses in the evaluation of internationally adopted children', *Pediatrics,*vol. 83, pp. 559-564, 1989.

Human Rights Watch, *Abandoned to the state: Cruelty and neglect in Russian orphanages,* Human Rights Watch, New York, 1998.

ICC-HOSEA Project, The Project Survey of Alternative Child Care in Phnom Penh and Kandal, HOSEA, Sarah Chhin, Phnom Penh, Cambodia, 2001.

ICC, The HOSEA Project Survey of the Level and Quality of Child-Care in the Temples of Kandal Province, Sarah Chhin, Phnom Penh, 2004.

Jordanwood, *M, Child Participation Research,* Save the Children, Phnom Penh, 2008.

Kacker, L. Varadan, S. and Kumar *P., Study on child abuse, Ministry of Women and Child Development,* India, 2007.

Kuhn, C. and Schanberg, S., 'Responses to maternal separation: mechanism and mediators', *International Journal of Developmental Neuroscience,* Volume 16, Issues 3-4, 7 June 1998, pp. 261-270.

Llorente, M. Charlebois, L. Ducci, V. and Farias, *A., Children in institutions: the beginning or the end? The cases of Italy, Spain, Argentina, Chile and Uruguay,* UNICEF, London, 2003.

Lowrey, K.G., 'Personality distortion and early institutional care', *American Journal of Orthopsychiatry,* vol. 15: pp. 247-255, 1940.

Loy, R., 'Abused girl makes progress', *Phnom Penh Post,* issued on 3 December 2009.

Moulson, M. Fox, N. Westerlund, A. and Zeanah, C., 'The effects of early experience on face recognition: an event related potential study of institutionalized children in Romania', *Child Development,* vol. 80:4: pp. 1039-1056, 2009.

National Institute of Statistics, Ministry of Planning and International Labour Organization, *Cambodia Child Labour Survey,* ILO, Phnom Penh, 2002.

Nelson, C. et al., 'Cognitive recovery in socially deprived young children: the Bucharest early intervention project', *Science,* vol. 318: pp. 1937-1940, 2007. Retrieved from http://www.sciencemag.org/cgi/content full/318/5858/1937

NGO Education Partnership, *The impact of informal school fees on family expenditures,* PAD, WDA and UNICEF, Phnom Penh, 2007.

NOVCTF, *Orphan children affected by HIV and other vulnerable children in Cambodia: a situation and response analysis,* MoSVY/National AIDS Authority, Cambodia, 2008, p. 15.

NOVCTF, *Making A Significant Difference: The National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia,* 2008–2010, MoSVY/National AIDS Authority, Cambodia, 2008.

O'Leary, M. and Nee, *M., Learning for transformation: a study of the relationship of culture, values, experience and development practice in Cambodia*, Krom Akphiwat Phum, Phnom Penh, 2001.

Parker, S. Nelson, C. and the Bucharest Early Intervention Project Core Group, 'The impact of institutional rearing on the ability to discriminate facial expressions of emotion: an event-related potential study', *Child Development,* Vol.76, No.1, pp.54-72, January 2005.

Posnett, M., ICC Project Sky, Phnom Penh, 2010.

Raftery, M. and O'Sullivan, E., Suffer the Little Children: The Inside Story of Ireland's Industrial Schools, 2nd Ed., New York, Continuum Publishers, 2001.

Rollinson, *R., Residential child care in England 1948-1975: a history and report,* The Irish Commission to Enquire into Child Abuse, Ireland, 2009.

Royal Government of Cambodia, Labour Code, Kram dated 13 March 1997 on the Labour Law.

Rutter, M. and Quinton, D., 'Long-term follow-up of women institutionalized in childhood: factors promoting good functioning in adult life', *British Journal of Development Psychology,* Vol.2, pp.191-204, 1984.

Rutter, *M., Maternal Deprivation Reassessed,* 2nd edition, Harmondsworth, Penguin Books, London, 1981.

Save the Children, A last resort: the growing concern about children in residential care, International Save the Children Alliance, London, 2003.

Scollay and Nara, *Article in Phnom Penh Post,* issued 4-17 January 2002.

Simasathien, S. Duangmani, C. and Echeverria, P., 'Haemophilusinfluenzae type B resistant to ampicillin and chloramphenicol in an orphanage in Thailand'. *The Lancet,* Vol.2, pp.1214-1217, 1980.

Smart, *R., Policies for orphans and vulnerable children: a framework for moving ahead,* Policy, USA, 2003.

Spitz, R., 'Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood', *Psychoanalytic Study of the Child,* Vol.1, pp.53-74, 1945.

Stativa, *E., Survey on Child Abuse in Residential Care Institutions in Romania,* ABSUR, Romania, 2000. Retrieved from: http://www.crin.org/docs/resources/treaties/crc.40/GDD _ 2005 _ stativa4%20eng.pdf (accessed on 25 April 2011).

Thurman, T. and Lavin, *B., Well-being of children living in transit homes in Chennai, India, World Vision and Rally, India,* 2009.

Tizard, B. and Hodges, J., 'The effect of institutional rearing on the development of 8-year-old children', *Journal of Child Psychology and Psychiatry,* Vol.19, pp.99-118, 1978.

Tizard, B. and Rees, J., 'The effect of early institutional rearing on the behavior problems and affectional relationships of four-year-old children', *Journal of Child Psychology, Psychiatry and Allied Disciplines,* Vol.27, pp.61-73, 1975.

Tolfree, *D., Community Based Care for Separated Children,* Save the Children, Stockholm, 2003.

Tolfree, *D., Roofs and Roots: care for separated children in the developing world,* Save the Children London, 1995.

UNAIDS, *The framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS,* UNAIDS, New York, 2004.

United Nations, UN inter-agency study on the impact of food prices on child labour and education in Cambodia, Phnom Penh, 2009.

United Nations, *Draft UN Guidelines for the Appropriate Use and Conditions of Alternative Care for Children,* 2007. Retrieved from the Better Care Network website: http://www.bettercarenetwork.org (accessed on December 2009).

Vijghen, *J., Child Recovery Centres: Intentions versus reality,* COSECAM, Phnom Penh, 2004.

Vuthy, D. and Sophanna, *M., Foster care programs in Cambodia: Is foster care a suitable option for children in need of alternative care?* The Asia Foundation, Hagar and International Organization for Migration, Phnom Penh, 2006.

World Bank, *Quality Basic Education for All,* Phnom Penh, 2005.

World Bank, *Cambodia Socio-economic Survey for 2007,* East Asia and Pacific Regional Office, Phnom Penh, 2009.

World Health Organization, *The ICD-10 classification of mental and behavioral disorders: Clinical descriptions and diagnostic guidelines,* Geneva, 1992.

World Health Organization, *Mapping the numbers and characteristics of children under three in institutions across Europe at risk of harm,* Geneva, 2005.

World Health Organization and the University of Birmingham, *EC DAPHNE Program Report,* WHO Regional Office for Europe, 2005.

World Vision International, *Analysis and programming suggestions for community-based care models,* USA, 2009.

Zeanah, C. Smyke, A. and Koga, S., 'Attachment in Institutionalized and Community Children in Romania', *Child Development,* September/October 2005, Vol. 76, pp. 1015-1028, 2005.

Alternative Report of Non-Governmental Organizations of Kazakhstan, 2002. Retrieved from: www.crin.org/docs/resources/treaties/crc.33/kazakhstan _ ngo _ report.pdf (accessed in November 2009).

Internet resources

Al-Jazeera Television, *Cambodia's fake orphans,* broadcast on 8 November 2008: http://www.youtube.com/watch?v=emYlQf-7piA (accessed in November 2009).

Central Intelligence Agency, *The World* Factbook: https://www.cia.gov/library/publications/the-world-factbook/geos/cb.html (accessed in December 2009).

Foursquare Cambodia: http://www.foursquareorphans.org/about _ fcop.htm (accessed on 30 November 2009).

KarenO'Toole: http://www.karenotoole.org/cambodian.php (accessed in November 2009).

Projects Abroad: http://www.projects-abroad.org/ (accessed in October 2009).

Advocacy materials

ACODO (Assisting Cambodian Orphans and the Disabled Organization), Promotional flyer: Siem Reap, 2009.

Pure! Volunteering and Supporting Children in Cambodia, promotional leaflet, 2009.

Designed by Graphic Roots: www.graphicroots.com.kh

unicef
unite for children