

KINGDOM OF CAMBODIA
— NATION RELIGION KING —



Ministry of Social Affairs,
Veterans and Youth Rehabilitation

STUDY ON

ALTERNATIVE CARE COMMUNITY PRACTICES FOR CHILDREN

IN CAMBODIA



KINSHIP
CARE



FOSTER
CARE



INCLUDING
PAGODA-BASED CARE



GROUP
HOMES



BOARDING
SCHOOLS

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Commissioned by the Ministry of Social Affairs, Veterans
and Youth Rehabilitation of the Kingdom of Cambodia
and UNICEF Cambodia

FOREWORD

For the purpose of strengthening the alternative care for children in communities the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY), the United Nation for Children's Fund (UNICEF) and the United States Agency for International Development (USAID) in Cambodia has commissioned the Coram International to conduct an assessment on the different types of alternative care for children in communities in order to assess the alignment on the implementation of the 2008 Minimum Standard of Alternative Care for Children. The assessment has identified key positive and negative findings and provided with good recommendations for MoSVY and development partners on the monitoring and adjustment of kinship and foster care, pagoda based care, group home and boarding school. At the same time, it also proposed an increase in the number of professional social workers and para social workers within the Ministry and partner organisations to provide case management and support services to children and most vulnerable families in the community. On top of this, the study provides guidance on the implementation of MoSVY Action Plan for improving child care with the target of safely return 30 per cent children to their families 2016-2018, and the implementation of sub-decree 119 on the Management of Residential Care Institutions and sub-decree 34 on the Transferring of Functions for the management of state's child care centres to the Municipality and provincial administrations, the transferring of oversight of Non-Governmental Organisations' child care centers to the Municipality, City and District administrations, and the transferring of the management of child care services for child victims and vulnerable children in the community to the Municipality, City, and Commune administrations.

MoSVY will further study the recommendations, in collaboration with relevant ministries and partner organizations, will carry out subsequent implementations of the recommendations based on practicality in short and long terms to prevent separation of children from their families, and improve the service quality of the alternative care for children in the community.

I would like to thank the UNICEF and USAID in Cambodia for supporting child care in Cambodia, and to pay a compliment to relevant ministries, institutions, sub-national government administrations, and non-governmental organizations which have supported and provided inputs to ensure the successful completion of this study.

Phnom Penh, Thursday 7 June 2018

VONG SAUTH

Minister

Minister of Social Affairs,
Veterans, Youth and Rehabilitation

SUMMARY

INTRODUCTION

This report presents findings from a study on the use of alternative care in the community for children in Cambodia, including pagoda-based care. The study was commissioned by the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) and carried out by Coram International in 2016. Technical and financial support was provided by UNICEF Cambodia and USAID.

The study, the first on the use of alternative care in the community in Cambodia, assesses the use of different forms of alternative care for children in the community, the implementation of the Cambodian 2008 Minimum Standards on Alternative Care for Children and international standards, and identifies areas of required support.

The study's findings are based on qualitative and quantitative evidence collected in five target provinces: Phnom Penh, Siem Reap, Battambang, Kandal and Preah Sihanouk. Researchers visited kinship families, foster families, pagodas, group homes, boarding schools and a small number of RCIs in order to capture the diversity of alternative care arrangements in Cambodia. In total, researchers conducted 36 interviews with carers and managers of alternative care arrangements, 22 group discussions with children living in alternative care, 19 individual life-history interviews with children, and 28 in-depth interviews with key informants from government and civil society organisations. Its findings include a need to strengthen and regulate the child protection system and to raise the capacity of those working within it; a need for greater support of kinship carers and foster families, a closer collaboration between MoSVY and MoCR in relation to children in pagoda care and continued use of group homes as an alternative to residential care options (RCIs) for those who cannot be placed in kinship care or foster care. The study provides vital information for MoSVY as they move forward with the implementation of the National Action Plan for improving childcare, with the target of safely returning 30% of children in residential care to their families by 2018.

PUSH AND PULL FACTORS THAT IMPACT ALTERNATIVE CARE

Research findings suggest that although poverty is given as the main reason for children entering alternative care, there are often other factors which are critical to the decision. These include violence; abuse; family conflict; abandonment; migration; family death or illness and addictions. Alternative care services are also seen as a means of providing children with access to free and high quality education. This is a critical pull factor for families that live in rural areas, where quality education may not be available or affordable, as well as families that cannot afford to pay for supplementary 'extra-classes', or cover other educational costs.

THE CHILD PROTECTION SYSTEM AND ALTERNATIVE CARE

The Government, in its Policy Paper on Alternative Care of Children published in 2006, noted that there were a number of challenges to the policy which called for a greater use of alternative care for children who, for whatever reason, were unable to live with their birth parents. These challenges continue to have a negative impact on the prevention of family separation, the provision of family support and the use of alternative care in the community. They include

- The limited awareness of the rights of the child;
- The limited understanding of social issues at all levels;
- The lack of resources for all programmatic areas;
- The difficulty to prioritise issues and set achievable goals and objectives;
- The partially developed legal framework;
- The inadequate enforcement of national laws and ratified international legal instruments;
- The limited coordination among government institutions and Ministries, as well as with civil society organisations working with vulnerable children;
- The lack of integrated monitoring and follow-up systems at all levels and poor access to information;
- A number of consequences of modernisation such as individualism, the erosion of traditional values and of solidarity, etc.

The failure to resolve these challenges, means that 10 years later, too many children are still coming into the care system, and being accommodated in RCIs. There are also a number of additional challenges, which include: the lack of any State financial 'safety-net' for parents who do not have sufficient means to support a child; a lack of family support services in the community to prevent separation of families, and the costs associated with educating a child. Further issues include the lack of any particular dedicated 'body' to whom a child can make a complaint about the care they receive, and the low level of public awareness of child protection issues.

Overall, there is a need for MoSVY and its government partners to strengthen its case management capacity and the delivery of services in the districts. It is recommended that, in addition to its current National Action Plan for Improving Child Care, MoSVY should develop a strategic plan for development and delivery of child protection case management services in the districts over the next 5 years. The strategy should include the development of legislation and guidance regulating and formalising the different forms of alternative care, including the setting out of roles and responsibilities and standards of care; management, quality assurance and quality control of community-based care services. Consideration should be given not only to the development of government services, but also to the role that NGOs could play in cooperatively delivering such services in the districts and communes. An essential element of the strategy will need to be a thorough review of Chapter 7 of the Prakas on Procedures to Implement the Policy of Alternative Care to ensure effective permanency planning and new mechanisms for delivery of effective fostering and adoption services in the districts.

There is a pressing need for more social work staff in the districts and it is recommended that consideration be given to recruiting and training para-social workers to work alongside DoSVY and CWCC social workers in the districts, and to harnessing the considerable resources of the NGOs to deliver family support and alternative care services. The joint government / NGO case-management model developed in Myanmar may serve as a useful model for the government of Cambodia.



Kinship care refers to family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature. Kinship care is a prevalent and traditional practice in Cambodian communities when children are unable to be cared for by their biological parents. It has a number of advantages over other types of alternative care: children remain in their family of origin, retaining relationships and kinship networks, and are cared for by adults with whom they, for the most part, already have an established relationship.

While most kinship care arrangements in Cambodia are made informally, without involvement of NGOs or CCWC or DoSVY, in the cases where kinship care placements are facilitated by an NGO, there is often a lack of professional assessment of the ability of the kinship families to provide adequate care for the child, and regular visits by a social worker are rare, with some exceptions.

Kinship caregivers are frequently available but are often unable to provide care because they are unable to support a child financially. This appears to be a particular issue for older kinship carers, such as grandparents, and especially single grandmothers, who have no obvious source of income. In these cases, kinship care would be a viable option if an allowance was paid, and education costs covered.

RECOMMENDATIONS

- Where DoSVY, CCWC or an NGO intend to place a child with a kinship carer, that carer should be assessed.
- The placement of children in kinship care by DoSVY, CCWC or an NGO should be formally recorded by DoSVY.
- MoSVY and DoSVY should undertake a review how kinship care could be supported financially.
- DoSVY should review its current level of monitoring and support of kinship carers.



FOSTER CARE

Foster care refers to situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family selected, qualified, approved and supervised for providing such care. At present, foster carers are recruited, selected, trained, paid and supported by NGOs. There is no government foster care service. NGOs are placing up to six children with a foster carer, raising concerns about the level of individual attention it is possible to give a child.

Even though most placements into foster families involve NGO social workers, identification of suitable families and placement often happens on an ad-hoc basis, and with very limited government (CCWC and DoSVY) involvement. Foster families appear to be relatively well monitored in comparison to kinship families. However, foster children are rarely registered with the government, and whether they are, depends largely on the initiative of the foster families or NGOs involved in the placement. There was also evidence that some foster parents were informally 'adopting' a child, by changing the child's birth certificate. NGOs were found to typically support foster families with 30-40 USD per child per month, and some NGOs pay foster parents 'salaries' which can vary from 50 USD to 200 per month. There was no evidence of government financial support for foster families.

RECOMMENDATIONS

- A State foster care and domestic adoption service needs to be developed together with a legislative framework. This could be contracted out to NGOs in the districts that are recognized by MoSVY.
- No more than three foster children should be placed in a family, unless the children form a sibling group, in which case the foster carer should be allowed to take all the siblings.
- The assessment process should be strengthened, particularly in relation to the suitability of foster carers.
- There is a need to strengthen on-going monitoring and support (case work).



PAGODA-BASED CARE

In Cambodia, pagodas are viewed as havens of education, discipline and charity, and have a tradition of providing support to those in need. Pagoda-based care refers to care provided to children by Buddhist monks, nuns and lay clergy, often within a Pagoda setting. Pagoda-based care may include the provision of food, shelter, education, and other forms of care. Pagodas were found to provide care primarily to boys aged 10 and above.

Children come to live in pagodas for a variety of different reasons, including: to become monks; to access education not available in their home towns; because they are without parental care due to having been abandoned, because their parent(s) re-married; their family is unable to provide adequate care, or have difficulty managing the child's behaviour or because their guardians live and/or work in the pagodas. Admission of children into pagodas is often informal, with little or no involvement of NGOs or government representatives.

Children in pagoda-based care have access to education, usually outside of the pagoda, supplemented by Buddhist teachings within the Pagoda. In one case included in the study, secular education was provided within the pagoda by MoE teaching staff. The material conditions in the pagoda are relatively poor in comparison to other forms of alternative care and, in some instances, children reported that they had either insufficient or uncertain access to food. Research findings suggest that external monitoring of care provided in pagodas is extremely limited or non-existent.

RECOMMENDATIONS

- The MoSVY in collaboration with MoCR, , should review the Alternative Care Policy 2006 and Minimum Standards of Alternative Care for Children in order to strengthen the monitoring of provision of care for children to live in pagoda and other faith-based organization and inspecting them regularly.
- Pagodas should be required to inform DoSVY at municipality, province, khan and relevant authorities of the admission of any child where a child protection issue is the whole or part of the reason for admission, including a parent's migration, death, re-marriage and refusal to care for the child, or any form of abuse, neglect or violence.
- Where the pagoda and other faith-based cares for more than 10 children, the MoCR together with MoSVY should give consideration to employing a full time person on-site to be responsible their care.
- The MoCR should develop a model child protection policy for pagodas and revise the pagoda/monk code of conduct.
- The MoSVY and MoCR should develop a data collection system to cover all children resident in pagodas.
- The MoSVY and MoCR should develop a joint Memorandum of Understanding on responsibility for children in pagodas.



GROUP HOMES

Group home care is a form of alternative care in which a limited number of children (no more than 15, as set out in the Minimum Standards on Alternative Care) are housed in a family environment under the supervision of a small group of caregivers unrelated to the children. Group homes take a number of forms: in some, children were living in small groups with 'group home mothers' or 'fathers', while others functioned as 'semi-independent living arrangements' without resident care staff. Very few of the group homes visited by researchers conformed to the ideal of 'community-based' or 'family-like' care arrangements envisioned in the 2008 Minimum Standards.

Monitoring of group homes appears to function relatively well in practice, even though government involvement (by CCWC and DoSVY) is minimal. Contact with biological parents and re-integration attempts do not appear to be prioritised and were viewed sceptically by some group home caregivers.

The study found that material conditions and access to education for children living in group homes are often superior to their home environments; children participating in the study often described their experiences living in group homes in a positive light due to these improved living standards. However, the study also found that children in group homes rarely have access to a social worker on a regular basis.

Most caregivers in group homes appear to have received some form of training, even though this may be very rudimentary and/or informal. The limited evidence on group home costs suggests that, from the perspective of NGOs and the government, group homes are more expensive than family-based alternative care options.

RECOMMENDATIONS

- MoSVY should undertake a review of the current cost, financing and most economic model for provision of care in group homes.
- MoSVY should ensure that each district has sufficient group homes to cater for children in need of residential care who cannot live with kinship carers or foster carers.
- The definition of group home contained in the Minimum Standards of Alternative Care for Community-based Care should be reviewed and revised to conform to the UN Guidelines on Alternative Care.



BOARDING SCHOOLS

Boarding schools have a role to play within the education system, but the study indicated that the reason for the placement of some children in boarding schools was directly linked to child protection issues within the family. If children are to be placed in boarding schools as a form of alternative care, especially for older children, then once again, all the procedures currently contained in the legislation should be implemented.

RECOMMENDATIONS

- The MoEYS and MoSVY should develop minimum standards of care for children resident in boarding schools.
- Boarding schools should be required to provide information to DoSVY on the number of children resident in the school.
- The MoEYS should develop a model child protection policy for boarding schools, both in relation to child protection within the school and referral of cases where there are child protection concerns within the family.
- The MoEYS and MoSVY should develop a joint Memorandum of Understanding on responsibility for supporting children in boarding school.
- MoSVY should be responsible for monitoring and inspection of the care of children in boarding schools.

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LIST OF ACRONYMS AND ABBREVIATIONS

3PC	Partnership Programme for the Protection of Children
CBC	Community Based Care
CBO	Community Based Organisation
CCWC	Commune Committee for Women and Children
DoSVY	Department of Social Affairs, Veterans and Youth Rehabilitation (Provincial/Municipal level)
FCF	Family Care First
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation (Central level)
NGO	Non-Governmental Organisation
OSVY	Office of Social Affairs, Veterans and Youth Rehabilitation (City/District/ Khan level)
RCI	Residential Care Institution
UNCRC	United Nations Convention on the Rights of the Child
UN Guidelines	United Nations Guidelines for the Alternative Care of Children
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WCCC	Women and Children Consultative Committee

INTRODUCTION

1

This report presents findings from a study on the use of alternative care in the community for children in Cambodia, including pagoda-based care. The study, the first on the use of alternative care in the community, was commissioned by the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) and carried out by Coram International in 2016. Technical and financial support was provided by UNICEF Cambodia and USAID. The purpose of the study is to develop an evidence base on the different forms of, and approaches to, alternative care for children in communities in Cambodia, including kinship care, foster care, group homes and pagoda-based care, and to strengthen and inform reform of the childcare sector in Cambodia. In particular, the study aims to assess existing forms of care, determine whether these forms of care are in compliance with Cambodian Government's Policy on Alternative Care, the Minimum Standards of Alternative Care for Children and the UN Guidelines on Alternative Care (UN Guidelines), and identify the support that is required in order to ensure that existing forms of alternative care within the community provide appropriate care to children.¹

The study included the collection of in-depth qualitative and quantitative data on alternative care practices in Cambodia, and draws upon relevant secondary data (qualitative and quantitative). Primary data collection took place in five 'target' provinces; Phnom Penh, Kandal, Siem Reap, Preah Sihanouk and Battambang. Findings were submitted to an Advisory Group established by UNICEF and the UNICEF Research and Evaluation Group and feedback from the two groups incorporated into the report.

¹ Although costing of alternative care was included in the TOR, it was agreed that due to the limitations of time and data, the Study should not engage in costing except to the extent that monies were paid to alternative carers.

BACKGROUND AND CONTEXT

2

As in almost every society in the world, it appears that Cambodian families have traditionally used immediate and extended kinship networks as a means of caring for orphans and vulnerable children. It has been suggested that: “traditionally, the social norm in Cambodia prescribed that orphaned and abandoned children, who can no longer be cared for by their biological parents, are placed in the care of the extended family”, and that “pagoda-based care for boys is a traditional form of community-based care provided for orphaned and destitute boys”² where the family cannot care for them.

However, it appears that, in contrast to kinship care, pagodas have always served the ‘double-purpose’ of providing care as well as providing further educational services to children. Even before colonialization, Cambodian pagodas “provided primary schooling for boys, care for orphan boys and a refuge for the elderly.”³ Indeed, in the pre-colonial era, pagodas were the only available educational institutions in Cambodia, but historically pagoda-based schooling have not been open to women and girls.⁴

Existing evidence suggests that the ‘traditions’ of kinship care and pagoda-based care suffered from significant rupture during the Khmer Rouge era, with a devastating impact on immediate and extended kinship ties: “Parents no longer had authority over their children ... the Khmer Rouge regime accelerated the re-definition of values on family unity ... and started to break the ties that bind children, families and communities together.”⁵ During the Khmer Rouge regime, “all kinship networks were shattered, including women’s pivotal roles as mothers, with the family reconfigured into a collective entity, and egalitarianism sought in all aspects of life.”⁶

There is some evidence that Cambodian society has traditionally viewed the loss of one’s mother as more disruptive than the loss of one’s father. A popular Khmer proverb, states that it is “better to lose one’s father, than one’s mother; it is better to lose one’s goods when the boat sinks in the middle of river, than one’s goods when the house burns down.” However, according an anthropological study⁷, Khmer kinship terminology makes “no distinction between mother’s brother and father’s brother or between mother’s relatives and father’s relatives.” The study argues that the Khmer kinship system is bilateral - as opposed to patrilineal or matrilineal - with no consistent weighting of either the male or female lines. This implies that, in Khmer society, care by relatives of the mother is not necessarily preferred to care by relatives of the father. This was also confirmed by a key informant interviewed for this study, who suggested that preferences would ‘depend on the attitudes and characteristics of the relatives’ rather than on whether the kin are patrilineal or matrilineal.⁸

2 Westering, J. (2010). Changing Social Norms on Alternative Care for Children in Cambodia. UNICEF Final Paper.

3 Kent, A. (2003). Recovery of the collective spirit: The role of the revival of Buddhism in Cambodia. Working Paper.

4 Rany, S et al. (2012). Cambodia’s Higher Education Development in Historical Perspectives (1863-2012). International Journal of Learning & Development. Vol. 2, No. 2.

5 Westering, J. (2010). Changing Social Norms on Alternative Care for Children in Cambodia. UNICEF Final Paper.

6 Brickell, K. (2012). ‘The ‘Stubborn Stain’ on Development: Gendered Meanings of Housework (Non)-Participation in Cambodia’. Journal of Development Studies, Taylor & Francis (Routledge), 2011, pp.1

7 Ledgerwood, J. L. (January 01, 1995). Khmer kinship: The matriline/matriarchy myth. Journal of Anthropological Research, 247-261.

8 KII with UNICEF representative, Phnom Penh, 12.10.16.

The total number of children in Cambodia who are cared for by somebody other than a parent is not known. Further, there is little evidence on the number of children in kinship care or foster care, though there is evidence of various foster care services across the country, run mainly by NGOs, many of whom belong to the 3PC Partnership.

More evidence is available on the number of children in different forms of residential care, including group homes and pagoda based care. A recent Mapping Report on Residential Care by MoSVY, carried out in 2014 and 2015 (published in 2017), has put the number of children living in residential care at 26,187 (out of a population of around 5.5 million children), of whom 11,788 children (71 per cent of the total number of children in residential care) were in RCIs in the five priority provinces, which are also the provinces covered by this Study.⁹

The Mapping identified 639 institutions in the 25 provinces of Cambodia, of which 71 were categorised as group homes, (caring for 6 per cent of children in residential care); 72 as boarding schools (also caring for 23 per cent of children in residential care); and 65 as pagodas or other faith-based care facilities (caring for 5 per cent of children in residential care).

In the five priority provinces covered by this study, the mapping identified 400 residential care facilities housing a total of 18,007 children.¹⁰ 267 of the facilities met MoSVY's definition of a 'residential care institution';¹¹ 19 were categorised as transitional homes and temporary emergency accommodation; 57 were categorised as group homes; 46 as boarding schools and 11 as pagodas or other faith-based care facilities.

The Mapping Report confirms that care of children in RCIs remains at a high level in Cambodia. This has implications for the development of alternative care in the community, as it indicates the likely number of community-based placements that would be required to meet current need. Based on the child population for 2012, a very rough estimate would appear to show that around 0.48 per cent of children in Cambodia are in some form of residential care institution,¹² a figure more than six times greater than in England, (0.076 of children in residential care in England). While the development of the child protection system in a middle income country, such as Cambodia, cannot be compared to that of a high income country such as the UK, the figure is useful as giving an indication of the low usage of residential care in a developed child protection system, taking into account that the percentage of children in the care system in the UK overall is greater than that of Cambodia. The Mapping Report figures provides useful baseline data, which can inform efforts to regulate institutional care and develop family based care as the prevalent form of alternative care for children.

Existing data from government suggests that the number of RCIs and the number of children living in RCIs in Cambodia has decreased slightly since 2005. However, RCIs remain the main form of alternative care for children. As observed by UNICEF in a recent

9 Ministry of Social Affairs, Veterans and Youth Rehabilitation, "Mapping of Residential care facilities", 2017.

10 Ministry of Social Affairs, Veterans and Youth Rehabilitation, "Mapping of Residential care facilities", 2017.

11 A residential care institution is defined in the study as: 'A centre that provides services to all types of children who have been abandoned or cannot stay with their biological families or relatives in communities'.

12 It is interesting to compare this to England 60 children per 10,000 were cared for by the State, of whom 7% were unaccompanied asylum seeking children. Of the total: 70,440 children, 51,859 (74%) were in foster care. 11% or 7,600 children were in residential care. Data from the Columbia University study shows an even higher percentage of children in residential care.

child protection progress report, *'despite on-going awareness raising interventions, including policies to discourage institutionalisation, residential care institutions are still promoted, including by Commune Committee for Women and Children (CCWC) members, village chiefs and NGO workers'*.¹³

This conclusion is consistent with the results of a 2011 study on attitudes towards residential care, conducted by UNICEF in collaboration with the MoSVY. The study found strong support for residential care at the community level.¹⁴ It reported that the majority of village chiefs are supportive of residential care, and few have heard of alternative or community-based care options. The 2011 study also found families to be supportive of RCIs, particularly as a solution for children in extreme poverty whose parents cannot meet their basic needs, children whose parents cannot provide them with adequate care or children who are not in education. As the study points out, *'Cambodia lacks a social welfare network to support poor families in need, and residential care often fills this gap'*.¹⁵

POLICY

In 2006, the Government issued a Policy Paper on Alternative Care¹⁶ for Children in Need of Special Protection and Children at Risk. Within the policy paper, the Government set out a series of principles to apply to children in need of alternative care:

- Family care and community care are the best options for alternative care;
- Institutional care should be a last resort and a temporary solution;
- Specific strategies and measures shall be established to support parents to raise their own children and send them to school;
- These strategies and measures shall also be directed to families, relatives and communities caring for children where parental care is not possible, in order to avoid institutionalisation;
- Where institutional care cannot be avoided, minimum standards and guidelines for residential care are to be implemented, monitored and evaluated in accordance with the overriding principles of the Convention on the Rights of the Child;
- Residential care and /or community or family based care are requested to strive to meet minimum standards developed within the framework of this Policy. NGOs which provide alternative care service must request permission from, and sign an agreement with MoSVY.

The Government saw the main bottlenecks to implementing the policy being

- The limited awareness of the rights of the child;
- The limited understanding of social issues at all levels;
- The lack of resources for all programmatic areas;
- The difficulty to prioritise issues and set achievable goals and objectives;

¹³ UNICEF Cambodia, 'Strengthening Child Protection Systems in Cambodia', UNICEF Cambodia Quarterly Progress Report to the United States Agency for International Development (USAID), January to March 2016.

¹⁴ Ministry of Social Affairs, Veterans and Youth Rehabilitation and UNICEF, 'A Study of Attitudes towards Residential Care in Cambodia', 2011.

¹⁵ Ministry of Social Affairs, Veterans and Youth Rehabilitation and UNICEF, 'A Study of Attitudes towards Residential Care in Cambodia', 2011.

¹⁶ Alternative Care is defined in the policy paper at page 9 as care for orphaned and other vulnerable children who are not under the care of their biological parents.

- The partially developed legal framework;
- The inadequate enforcement of national laws and ratified international legal instruments;
- The limited coordination among government agencies as well as with civil society organisations working with vulnerable children;
- The lack of integrated monitoring and follow-up systems at all levels and poor access to information;
- A number of consequences of modernisation such as individualism, the erosion of traditional values and of solidarity, etc.

One of the specific objectives contained within the policy was the developing of a policy framework for regulating and formalising the different forms of alternative care, including the setting out of roles and responsibilities, standards of care and guidelines.

The Government has also acted to put in place ‘gate-keeping’ mechanisms to reduce the intake of children into residential institutions. The Sub-decree on the Management of Residential Care Institutions, which came into effect in September 2015, reiterates that *“permission for children to reside in the residential care centre is the last and temporary option and it may be made possible only after the search for parents or parent, relative or guardian or foster parent has been exhausted.”*¹⁷

Since the Sub-decree on residential care came into effect, the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MosVY) has defined the steps for its implementation and has developed a National Action Plan for Improving Child Care with the target of safely returning 30 per cent of children in residential care to their families and communities by 2018. The Action Plan was signed by the Minister in September 2016. Similarly, five provincial Operational Plans with the same purpose have been drafted for five focus provinces (Phnom Penh, Siem Reap, Battambang, Kandal, and Preah Sihanouk). The Cambodian Government has not authorised the development of any new residential care institutions (RCIs) since the issuance of the sub-decree.

Since the Government issued the Policy on Alternative Care in 2006, it has continued to emphasise its support and preference for family-based care options for children in need of alternative care over institutional, residential care, and has worked with aid organisations and NGOs to promote its policies. The Partnership Program for the Protection of Children (3PC) is a collaborative project involving NGOs working collaboration with UNICEF and MOSVY to strengthen the child protection system in Cambodia, including through improving social work services, emergency response, safe reintegration of children separated from their families and family-based care.¹⁸ In addition, further assistance has been provided by the ‘Family Care First Initiative’, a USAID-funded project aimed at promoting outcomes for children living outside of family care, preventing unnecessary family separation, and enabling children outside of family care to be placed in appropriate family care.

The approach taken by the Government has been constant over the last decade and is to be welcomed while at the same time, it has to be recognised that there are many challenges in implementing the policy. The policy is largely consistent with the CRC

¹⁷ Article 11, Sub-Decree on the Management of Residential Care Centres (2015)

¹⁸ There are 9 NGOs operating as implementing partners, 6 NGOs who are technical partners and 40 CBOs as network partners.

and with the UN Guidelines on Alternative Care,¹⁹ and current understandings of best practice. It is also consistent with traditional alternative care practices in Cambodia, which relied primarily on kinship networks and temples to provide care to children without parental care.

LEGAL PROVISIONS

As pointed out in the Policy Paper on Alternative Care, the legal framework covering child protection and alternative care is partial and fragmented.

KEY LEGAL PROVISIONS ON ALTERNATIVE CARE IN CAMBODIA

The Law on Marriage and the Family 1989:

Article 119: Revocation of Parental Power: Parental power shall be revoked and transferred to any organisation or relative by blood, from a parent who is at fault as follows:

- The parents fail to educate the child;
- The parents use improper power in violation of the child's rights or forcing him to commit crimes or acts against society;
- The parents treat their children badly;
- The parents behave against moral standards which have a bad influence over their children.

Article 120: the People's Court may withhold the power from parents who committed a fault if there is a complaint brought by the State organisation, a mass organisation, the authorities attached to the People's Court or any relatives of the parents

The Minimum Standards on Alternative Care, adopted in 2008, contain two separate legal instruments: The Prakas on Minimum Standards on Residential Care for Children and the Prakas on Minimum Standards on Alternative Care for Children in the Community.. The requirements in the Minimum Standards are largely consistent with the criteria set out in the UN Guidelines, with the exception that group homes are treated as a form of 'alternative care in the community' rather than residential care.

The Prakas²⁰ on Procedures to Implement the Policy on Alternative Care for Children, issued by MoSVY in 2011, to promote the practical implementation of the 2006 Policy on Alternative Care. The Prakas provides procedural guidance on the identification of vulnerable children and defines the roles and responsibilities of different departments and agencies.

The Sub-Decree on the Management of Residential Care Centre, issued in 2015, sets out strict requirements for the establishment and management of residential forms of alternative care, and provides useful context for understanding the changing management of forms of Alternative Care in Cambodia.

¹⁹ UN Doc. A/HRC/11/L.13, 15 June 2009.

²⁰ A Prakas has the same status as a Regulation (i.e. secondary legislation).

KEY DEFINITIONS

3

This section provides a definition of the terms used in this study. These definitions draw largely on the terminology set out in the Cambodian Government's Policy on Alternative Care for Children (2006), but where there is no definition of a term in the Policy, or the definition differs significantly from the UN Guidelines, reference is made to the UN Guidelines definition.

Child is defined as a person under the age of eighteen, in accordance with Article 17 of the Civil Code of Cambodia 2008.

Alternative care is defined as "care for orphaned and other vulnerable children, who are not under the care of their biological parents" (Cambodia's Policy on Alternative Care for Children, 2006).

Community and family based care is defined as "an approach designed to enable children either to remain within their own family or to be placed within a foster family, if possible within their community. Family in this context comprises the extended family offering kinship care, child-headed households and foster families unrelated to the child" (Policy on Alternative Care for Children, 2006). This study will not include child-headed households in its definition of family based care.

Informal care is defined in accordance with the UN Guidelines on Alternative Care, as "any private arrangement provided in a family environment, whereby the 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."²¹

Formal care is defined, in accordance with the UN Guidelines on Alternative Care, as "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 measures."²²

Kinship care is defined in the UN Guidelines as "family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature."²³ The Policy on Alternative Care (2006) does not explicitly define kinship care, but it falls within its definition of 'community and family based care' (see above).

²¹ United Nations General Assembly, Guidelines for the Alternative Care of Children, Resolution 64/142, 2010.

²² United Nations General Assembly, Guidelines for the Alternative Care of Children, Resolution 64/142, 2010.

²³ United Nations General Assembly, Guidelines for the Alternative Care of Children, Resolution 64/142, 2010.

Foster care is defined in the UN Guidelines as '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 that has been selected, qualified, approved and supervised for providing such care'.²⁴ Foster care is not explicitly defined in the Policy on Alternative Care (2006) but it falls within its definition of 'community and family based care' (see above).

Group-home based care is defined as "a form of alternative care whereby a limited number of children [no more than 15] are housed in a family environment under the supervision of a small group of caregivers unrelated to the children. A group home is integrated into a community setting, but is not run by the community" (Policy on Alternative Care 2006). It is important to note that 'group-home based care' would fall under the UN Guidelines' definition of residential care, but is treated as a separate category in Cambodia.

Pagoda-based care is defined as care provided to children by Buddhist monks (Preah Sang), nuns (Donjis) and lay clergy (Achars), often within a Pagoda setting (Policy on Alternative Care (2006)). Pagoda based care may include the provision of food, shelter, education, and other forms of care.²⁵ While some pagoda-based care may fall within the definition of residential care, all care provided within a pagoda setting is considered as 'pagoda-based care' for the purposes of the study.

Residential care is defined as 'care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short- and long-term residential care facilities'²⁶. This definition is taken from the UN Alternative Care Guidelines and is consistent with the Cambodian Policy on Alternative Care (2006). However, unlike the policy, the definition does not require that staff be remunerated.

24 United Nations General Assembly, Guidelines for the Alternative Care of Children, Resolution 64/142, 2010.

25 Government of the Kingdom of Cambodia, Policy on Alternative Care of Children, 2006, p.12.

26 United Nations General Assembly, Guidelines for the Alternative Care of Children, Resolution 64/142, 2010.

RESEARCH OBJECTIVES

4

The research study aims to fulfill four overarching objectives:

- 1 Assess the different forms of alternative care for children in the community,
- 2 Analyse how each of these forms of care are in compliance with the 2008 Minimum Standards of Alternative Care for Children and what the actual practices for each of these forms of care are;
- 3 Determine the costs of providing the different forms of care that are practiced in the community, and their funding sources; and
- 4 Identify areas of required support to ensure that existing alternative forms of care in the community are in line with national and international standards.

The study addresses each of these objectives by answering a specific set of research questions, which are set out below. The research questions can be sub-divided into three groups, depending on which objective(s) they seek to address:

Objectives 1 & 2 - Assess and analyse different forms of alternative care

- What are the characteristics of each of the forms of alternative care included in the study?
- What are their respective magnitudes (in terms of number of care services, number of children in care, number of care givers, etc.)?
- What is the profile of children in each form of alternative care?
- How are children identified and placed in different care settings? What are the decision-making processes? Who is involved and at what level?
- Does the child have a named social worker (or someone playing social workers role)? What gatekeeping (if any) can be identified? What is the role (if any) of the authorities? What are the roles of the parents and extended families?
- How long do placements in each form of alternative care tend to be? What (if any) are the mechanisms for review?
- Who decides about contact with the child's family (if in unrelated care) and biological parents (if in kinship care)? Is reintegration considered or promoted? Who facilitates reintegration?
- Are certain forms of alternative care in the community taking particular care of children with special needs (children with disability, children with HIV/AIDS, children survivors of violence and abuse)?
- What are the perspectives and experiences (positive and negative) of children and caregivers in each form of alternative care as opposed to residential care?
- Broadly, to what extent does each alternative care form comply with national and international standards?
- What are the protective and risk factors that build or undermine the fulfilment of children's rights?

Objective 3 - Provide information on the funding sources and financial models of alternative care

- How is each form of alternative care in the community financed?
- About how much does it cost to keep a child in each type of alternative care (costs per child/per day/per year)?
- How do costs compare between each form of alternative care?
- How do costs of community-based care forms compare with residential care?

Given the time constraints of this contract and the lack of data, it was decided that the study should only review costs on a superficial level, obtaining information on direct payments to carers and such other financial information on costs as was easily available.

Objective 4 - Identify areas of required support

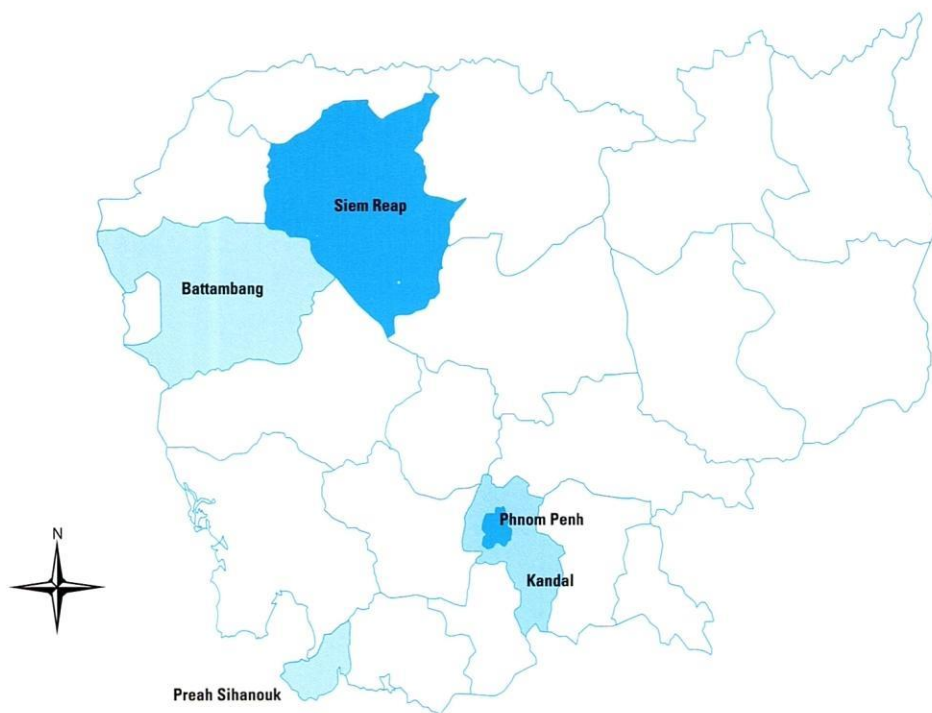
- What are the capacity-development needs of different types of alternative care in order to promote appropriate care for children (in line with national and international standards)?
- How can the Cambodian Government, donors and development partners support alternative forms of care to contribute to the government's overall commitment to reintegrate 30 per cent of children in residential care by 2018, particularly through providing care for children without parents?

METHODOLOGY

5

The research methodology for this study was developed with the aim of including a range of perspectives from all levels of government, care providers, NGOs and other key stakeholders, as well as children and families who have received (or provide) care services. This chapter sets out the geographical and thematic scope of this study; the data collection methods used; and the sampling approach taken to identify study respondents.

The study covered five pre-selected provinces²⁷ in Cambodia: Phnom Penh, Siem Reap, Battambang, Kandal and Preah Sihanouk. These are the five priority provinces mentioned in the National Action Plan for Improving Child Care and the UNICEF Cambodia Country Programme Action Plan for 2016-2018, in relation to which UNICEF and the Government of Cambodia have agreed an ambitious target of safe reintegration of 30% of the children in RCIs. The five provinces were prioritised in the Mapping of Residential Care Institutions recently conducted by the MoSVY and are the priority provinces for the Family Care First Initiative.



27 Phnom Penh is a municipality and not technically a Province. For the purpose of this study the term 'province' includes Phnom Penh municipality.

The study assesses and analyses four different types of community-based alternative care arrangements:

- Foster care
- Kinship care
- Pagodas and other faith-based institutions
- Group homes

In addition, researchers visited 4 residential care institutions and 3 boarding schools to enable valid comparisons between community-based and residential care arrangements.

RESEARCH METHODS

In order to answer each of the above-mentioned research questions and address the overarching objectives of the study, researchers employed a number of data collection methods, combining both qualitative and quantitative approaches. The study draws on the following six types of data sources:

- Individual interviews with key informants (semi standardised, qualitative)
- Individual interviews with care givers/managers (semi standardised, qualitative)
- Individual interviews with children in alternative care (semi standardised, qualitative)
- Focus group discussions with children in alternative care (semi standardised, qualitative)
- Observational checklist (standardised, quantitative)
- Survey with care givers/managers (standardised, quantitative)

The full set of data collection tools that were used for collecting both qualitative and quantitative data are attached as an Annex to the Report.

SAMPLING STRATEGY

The approach to sampling used for this study was purposive and aimed to capture the diversity of community-based alternative care arrangements in Cambodia as well as the differences in perspectives, experiences and processes that exist between carers and children in different forms of care arrangements.

Carers/managers (for individual interviews and the survey) as well as children in care (for FGDs and individual interviews) were sampled from a minimum of five cases of each of the four forms of community-based care (i.e. foster care, kinship care, pagoda-based care and group homes). In addition to these community-based care settings, the sample of cases also included four residential care institutions and three boarding schools. This

allowed researchers to make valid comparisons between residential and non-residential forms of care. In each of the five pre-selected provinces, researchers accessed at least one case (or 'site') of all five different forms of care arrangement included in the study. In addition to serving as a sampling frame for carers/managers and child respondents, the selected 'sites' also constituted the final sample of locations where researchers implemented the observational checklists. Complete tables, describing the profile of families and institutions visited for this study, are provided in the Annex 1 to this report.

SURVEY PROFILE

The quantitative survey was distributed to caregivers and managers in all institutions and families visited by the researchers. However, due to time constraints not all caregivers and managers interviewed for this study also completed the survey questionnaire.

In total, the survey was distributed to 41 caregivers and managers. In 26 cases, only one caregiver from the visited institution or family completed the survey questionnaire. In the remaining 25 cases, two caregivers filled in the survey questionnaire. 56% of caregivers included in the survey were female and 39% were male.²⁸ The average age of caregivers was 43 years, with the youngest caregiver aged 22 years and the oldest aged 75 years. 27% of surveyed caregivers indicated that they did not complete primary school, a key requirement in the Minimum Standards on Alternative Care (see Article 7 of the Prakas on Alternative Care in the Community).²⁹

Figure 1 displays the geographical distribution of respondents across the five provinces.

Figure 1: Number of respondents by province

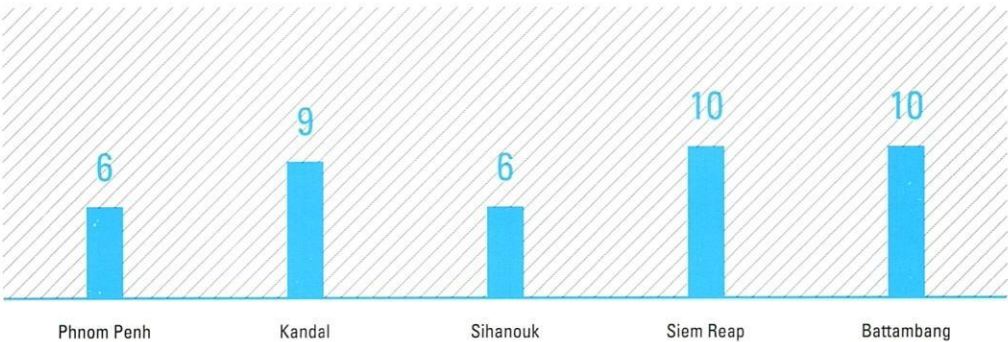
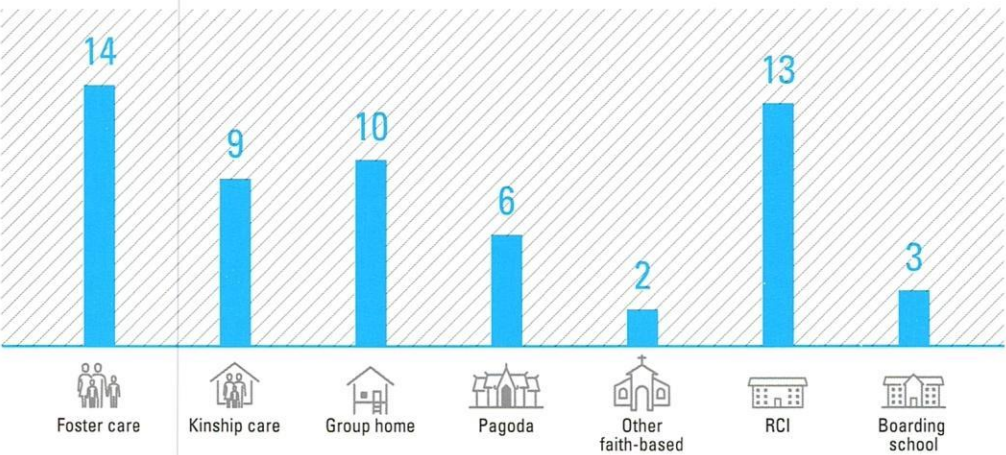


Figure 2 shows what types of care the survey respondents provided to the children living in their care. Foster care, residential care and group homes were the most common types of care provided by respondents in the sample. Some respondents provided (or managed) more than one type of care. For example, a Manager of community-based care in a large NGO could be responsible for foster care, kinship care as well as group homes.

28 The remaining 5% did not indicate a gender.

29 68% of respondents indicated that they completed at least primary school, and 5% declined to answer.

Figure 2: Types of care provided



LIMITATIONS

Representativeness: Given the primarily qualitative nature of the collected data as well as the purposive sampling approach used to identify respondents, it is important to emphasise that the findings are not representative of community-based alternative care practices in Cambodia in the strict sense. As mentioned above, the research sites were selected to capture the different types of alternative care in each province as well as some of the geographic and demographic diversity, with the aim of generating rich, complex, diverse and explanatory data, rather than representative and quantifiable data. While the limited amount of quantitative data collected for this study is comparable across the different alternative care settings included in the study sample, it is not intended to be representative of the different types of care settings in each province.

Generalisability: Given that the study was limited to only five ‘target’ provinces, it was not possible to draw conclusions about alternative care practices in the other 20 provinces or to generalise findings at the national level. In light of the study’s limited geographical scope, findings from the in-country data collection should be understood primarily as exploratory rather than comprehensive or conclusive.

Time and resource constraints: Given the short implementation timeline of the research study and the limited funds available for the in-country data collection, it was not possible to include a number of potentially interesting and relevant respondents/institutions in the study. Researchers spent on average five working days in each province and, even though efforts were made to visit respondents in remote/rural settings, the majority of respondents were accessed in provincial capitals and surrounding districts. In some cases, respondents from remote areas were invited to be interviewed in the provincial capital and then reimbursed for travel expenses. This allowed researchers to maximise the number of respondents as well as geographical scope of the study in light of the time and resource constraints.

Accessing respondents: International researchers relied on a small team of national researchers and the UNICEF Country Office in order to identify and access suitable respondents and institutions (in line with the pre-defined sampling approach). However, it is important to mention that respondents were primarily accessed through existing

networks (e.g. 3PC, Family Care First, etc.) and formalised providers of alternative care services. As a result, it is likely that the experiences and views of children and caregivers in informal care settings (i.e. care arrangements without government or NGO involvement) are somewhat underrepresented in this study. Further, as respondents were referred by established networks, it is possible that the sample was of a higher 'quality' (i.e. more likely to be supported and monitored) than the average. In addition, it should be highlighted that, despite official endorsement from MoSVY and UNICEF Cambodia, some residential care institutions and high-level government representatives were unable or unwilling to participate in the study.

Language barriers: Whilst international researchers used professional interpreters during the in-country data collection, it is likely that language barriers resulted in the loss of some potentially important contextual information and nuances in the respondents' answers.

Reporting: For evident practical and ethical reasons, evidence on child protection issues/concerns is based on reported as opposed to observed data. This leads to an inevitable limitation that the collected data may be based on either under or over reporting of actual experiences of abuse, neglect and other traumatic experiences. For example, whilst victims/survivors of child abuse may be reluctant to report their experiences for fear of being stigmatised or re-traumatised, perpetrators of may be reluctant to report their behaviour for fear of punishment.

Triangulation: Researchers always aimed to interview both the children as well as the caregivers in each care setting. However, it was not always possible to triangulate the life-histories of individual children using accounts from adults/caregivers/officials involved in their cases. Children's own accounts of how they came to live in alternative care may have been influenced by recall bias, reporting bias, and/or a limited understanding of the decision-making processes and the actors involved.

REVIEW PROCESS

An external Advisory Group was established by UNICEF Cambodia for the purpose of this study. The Advisory Group is composed of experts in the area of alternative care in general and the context of Cambodia in particular. Members of the Advisory Group provided guidance to the consultancy team in designing the research methodology and data collection tools, reviewed the study inception report, and provided feedback to the draft report of the study. A validation meeting was also held with key stakeholders and participants in the study to validate the findings and recommendations contained in the report.³⁰

³⁰ The stakeholders meeting took place on the 9th and 10th February 2017. In addition to the Advisory Group, UNICEF Cambodia has set up a Research and Evaluation Steering Committee as a peer-review mechanism that ensures that all studies, research and evaluations contracted by UNICEF Cambodia meet the requirements outlined in the UNICEF Procedures, including on ethical issues and any other relevant operational or technical issues.

THE CHILD PROTECTION SYSTEM AND ALTERNATIVE CARE

6

Whilst this study was not designed to entail a comprehensive assessment of the child protection system in Cambodia, it is important to establish an understanding of certain aspects of the system, which are highly relevant to alternative care. In particular, States require a strong identification, assessment and referral system to ensure that children are only placed in alternative care when family support is not sufficient to safeguard the child, and that if the child is placed in alternative care any such care is appropriate and meets the needs of the child.

Cambodian law and policy make it clear that it is the responsibility of the State to monitor alternative care providers, provide on-going oversight of children’s placement in care, and provide prevention and reintegration services. These responsibilities are set out in the Prakas on Procedures to Implement the Policy on Alternative Care for Children, which sets out operational guidelines to implement the Minimum Standards on Alternative Care for Children in the Community. The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) is the government agency with primary responsibility for child protection, social services and alternative care. Responsibilities for administration are also held by local government authorities, or ‘Councils’. A breakdown of relevant government agencies is presented below.

Government Agencies Responsible for Alternative Care		
National level	Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY): Its responsibilities are set out in Art. 12 of the Prakas on Procedures to Implement the Policy on Alternative Care for Children and include managing and monitoring implementation of policies, laws, regulations and legal procedures related to implementation of the Policy on Alternative Care for Children; maintaining a national database of children in need of care and placement of such children outside the family and awareness raising in relation to child protection.	Ministry of the Interior (no direct responsibility but oversight of councils).

Government Agencies Responsible for Alternative Care

Provincial / Municipal level

Department of Social Affairs, Veterans and Youth Rehabilitation (DoSVY): Its responsibilities are set out in Art. 10 of the Prakas on Procedures to Implement the Policy on Alternative Care for Children and include a duty to carry out permanency planning for all children in the province; support and guide the work of OSVY workers; expand resources to strengthen family based care; collect data and monitor the implementation of the Minimum Standards.

Women and Children Consultative Committee (WCCC) (Provincial Council): Its responsibilities are set out in Art. 11 of the Prakas on Procedures to Implement the Policy on Alternative Care for Children and include collaborating with DoSVY and City/District/Khan OSVY and WCCC for planning and advocating for needed services for children and families to enable DoSVY to carry out the tasks set out in Art. 10.

City / District / Khan level

Office of Social Affairs, Veterans and Youth Rehabilitation (OSVY). Its responsibilities are set out in Article 8 of the Prakas on Procedures to Implement the Policy on Alternative Care for Children, and include providing support, training and technical guidance to the CCWC in collaboration with the WCCC, and directly managing cases not covered by the Commune Council including but not limited to children in kinship or foster care, children placed in institutions and children in need of permanency planning.

Women and Children Consultative Committee (WCCC) (District Council). Arts 3, 6 and 9 of the Prakas on Procedure to Implement the Policy on Alternative Care for Children set out its role: which includes the identification and assessment of children and families who face situations of risk where the CCWC are not able to do so.

Commune / Sangkat level

n/a

Commune Council, Commune Children's Welfare Committee – responsible for implementing the tasks delegated by MoSVY under the Prakas on Procedure to Implement the Policy on Alternative Care for Children. They also have a duty to visit a child or family who are facing difficult circumstances that may cause the family to disintegrate and for opening a file on a family or child where necessary (Art. 6). Further duties are set out in Art. 7

The study included qualitative data collection from key child protection actors at commune, district, provincial and national level. These interviews were aimed at establishing an understanding of the child protection context in Cambodia, and the need for alternative care services, as well as the roles of relevant government authorities in relation to alternative care both in policy and practice. This section explores in particular: the process of identification of child protection cases and referral to appropriate services (including alternative care); reintegration and family reunification; and provision of preventative support for families. Monitoring of alternative care services and oversight of children's care arrangements are not addressed in this section, as these issues are covered in the 'care profiles' for each type of care.

IDENTIFICATION AND REFERRAL

As is demonstrated by the care profiles below, alternative care placements across all forms of care, and particularly pagoda-based care and kinship care, often happen informally, arranged by families and care providers, without the involvement of government bodies.

According to the *Prakas on Procedures to Implement the Policy on Alternative Care for Children in the Community*, (the *Prakas on Procedures*) the Commune/Sangkat councils have primary responsibility for identifying and assessing at-risk children and families; establishing a plan for access to necessary services; following up on the family's progress to preserve the child in the family; and making decisions on alternative care placement with kin in the same commune (though there is no specified period for which progress should be followed-up). This makes Commune authorities, and particularly the CCWC, the first point of contact when a family requires support or a child may require placement in alternative care. When the alternative care placement involves non-kin foster care, or involves placement in an institution or is a particularly difficult case, OSVY must be involved in this process. OSVY is also responsible for managing cases not covered by the Commune (CCWC) and collaborating with CCWCs to provide services to promote family preservation.

Both non-governmental care providers and OSVY representatives interviewed for this study reported receiving referrals from commune level authorities when they identified a child in need of care or protection. Furthermore, CCWC representatives and district level social workers interviewed for the study described responding to cases involving children in need of care and children who had experienced abuse, facilitating kinship arrangements, if necessary, and referring cases where kinship arrangements were not possible to relevant authorities in OSVY and DoSVY who would then conduct an assessment and arrange further placement.

Although there appears to be an increased involvement of CWCC, OSVY and DoSVY in responding to cases, part of this increase appears to be due to the need for NGOs to obtain a completed CWCC or OSVY assessment before they can admit the child to their care or place the child.³¹

31 See Article 15 *Prakas on Procedure to Implement the Policy on Alternative Care*.

We do inform the authorities if we take the children away from their family – first to the social worker in that location to get help and work with the local authority. We need to get everything signed and recognised by the village leader – if you do not do this you might get in trouble one day. We need to have everything to prove that it was agreed in a legal way. The social workers are from MoSVY but they work at the local level.... I always involve a social worker. They need to see what we are doing because our work falls under the Ministry.³²

The view of some respondents to the survey was that despite the requirements of the Prakas on Procedure, the CWCC and OSVY are still not responding adequately to child protection cases. As one NGO director bluntly explained, *"the Government is not delivering social work services. If we want them to visit the family we need to pay their transportation – their policy is not implemented."*³³ Indeed, several NGO representatives interviewed for the study reported that they were required to pay transportation, food and accommodation costs for DoSVY staff in order to guarantee their attendance at assessment visits. It is unclear to what extent, if any, this impacts the independence of the social worker and the content of their report.

While respondents described important limitations to government capacity to respond to child protection cases, research findings also revealed numerous capacity gaps related to staffing and financing, as well as knowledge and skill. For instance, in Battambang province, DoSVY representatives reported that commune level authorities are unfamiliar with legal requirements relating to care placements:

The commune staff's understanding of child protection is very limited. They should theoretically prevent placements into the RCIs, but in effect they facilitate this practice. For example, I often come across village chiefs who sign letters to send children to other provinces to live in RCIs even though there is no CP concern. This is a real problem. Before 2015 the commune didn't need DoSVY approval before a referral, but many are still not aware of the requirements... There is obviously a great need for further training to prevent 'unnecessary placement into RCIs'.³⁴

It is recommended that a simple guide setting out the duties and responsibilities of village chiefs and CWCC staff when a child is in need of protection should be developed and made available nation-wide, together with the development of training packs, training of trainers and available training courses in each district. Training courses should also be available on-line.

FAMILY SUPPORT SERVICES - PREVENTING SEPARATION

The Prakas on Procedures provides that CCWCs, OSVY social workers and the WCCC are responsible for collaborating with NGOs, pagodas and other religious centres, to provide family support services in order to prevent separation and promote reintegration. In addition to creating a 'service plan' and facilitating referrals between children and families and relevant services, this support should include follow up visits to assess

32 Group interview, director and donor, NGO providing day care and other family support services, Kandal Province, 12 October, 2016

33 Individual interview, Director of NGO providing alternative care and reintegration services, Kandal Province, 13 October, 2016

34 Individual interview, DoSVY representative, Battambang province, 18 October, 2016

the needs and progress of the family, as well as counselling and social work services where needed.

In practice, it appears that government authorities provide very little support to prevent separation of families or promote reintegration. Neither CCWC members nor OSVY social workers reportedly deliver counselling, case planning or material support themselves. Respondents consistently attributed this to time, budget and capacity constraints:

We need more social workers – at least 1 more is needed for follow-up visits. There is also a lot of work to do with the veterans, so I have to split my time between the veterans and the children.³⁵

There is no specialised or trained counsellor on our committee...³⁶

CCWC has never provided anything to a child during the reintegration process but we help with paper work to make sure the child is really going to the kin and relatives and there aren't any issues. But in terms of money and materials no, not at all. Our Committee has never had any funds on hand or in kind support.³⁷

Instead, OSVY and the CCWC tend to refer children to NGO services where these are available.

REUNIFICATION AND REINTEGRATION

Research findings suggest that a considerable number of the cases currently being addressed by government authorities, particularly by DoSVY and OSVY social workers, appear to be cases of children who are moving from an RCI, to new, family-based care arrangements. These efforts contribute to the governments' target of safely reintegrating 30% of children in institutional care into family-based care by 2018, and are consistent with responsibilities set out in the Prakas on Procedures to Implement the Policy on Alternative Care for Children. However, given the limited staffing resources, the focus on reintegrating children who are already in care may detract from the governments' ability to respond to new child protection cases when they arise in the general population.

In your experience, in the district where you work, what are the main child protection concerns?

Vulnerable children who were referred to an RCI and later would be reintegrated back into the community...We are working to trace their biological family or fostering family to help the child, for the child's best interest. If the family agrees to accept them we reintegrate them. For the kin, relatives, biological parents – we follow up every month to make sure that the child is doing okay, what would be needed in terms of support.³⁸

³⁵ Individual interview, district level social worker, Battambang Province, 18 October 2016.

³⁶ Individual interview, WCCC representative, Kandal Province, 14 October, 2016.

³⁷ Individual interview, CWCC representative, Preah Sihanouk Province, 21 October, 2016.

³⁸ Individual interview, district social worker, Kandal province, 14 October, 2016

REINTEGRATION IN PRACTICE

NGOs visited for this study adopted a range of different approaches to re-integrating children with their biological parents or kinship families. While some NGOs applied a meticulous pre-placement assessment procedure, and conducted long-term follow-up visits (up to three years), other NGOs place children into family-care arrangements with very little consideration of the family's capacity or child protection concerns.

The following quote from an interview with a RCI social worker illustrates well how some NGOs place the interests of the child before the aim of reintegrating children into family-based care alternatives:

There are three stages in the re-integration process: Pre-integration, re-integration, post-integration. First, pre-integration: we do a family assessment and develop a re-integration plan. At the re-integration stage, right after we placed the child back into the family, we do three visits. Then, post-integration, we do another few visits, but the number will depend on how the family is doing. Personally, I think that if there is a clear re-integration plan, then it is okay to prioritise re-integration. If there is no plan, then it is not a good idea. It is really important to look beyond the financial support for the families and to look also at the possibility of providing families with mental and attitudinal support. The parents need to be prepared before re-integration, otherwise it is a bad idea.³⁹

In contrast, the study also revealed that a number of NGOs re-integrate children 'at any costs', with little concern as to whether the biological or kinship family is prepared well enough for providing care, or whether the child will be at risk of abuse. For example, one kinship parent (the child's aunt) interviewed in Battambang indicated that no-one had come to inspect the property or talk to her family before the boy came to live with her. When researchers later asked the NGO social worker involved in the placement why no pre-placement visits were conducted in this case, it was suggested that the NGO simply did not have the necessary funds and capacity to conduct such visits.⁴⁰ It was not clear whether, in this case, the child has been consulted about reintegration before placement.

In another case, a young girl aged 16, who had been raped by her brother and given birth in an NGO-run shelter, was 're-integrated' into her family without any pre-placement assessments having been conducted by the NGO or government social workers. In this case, it appears that the police simply relied on the girl's mother to ensure the girl's and the infant's safety:

The police made me promise that this will never happen again. After that visit they came three times to inspect the property and check whether my son had actually left to live somewhere else.

Did they ever look for your son?

No they didn't visit him. I told them about what my son had done to my daughter. But I also said that I cannot complain against my own son. So the police agreed that it would be better not to bring a case against my son. You cannot bring a case against 'your own blood' they said.⁴¹

39 Interview with social worker, shelter for trafficking victims, Siem Reap, 14.10.16

40 Interview with kinship parents, Battambang, 20.10.16

41 Interview with re-integrated girl and mother, Siem Reap, 14.10.16

Several respondents expressed concern that government pressure to reintegrate children into families may in some cases result in reunifying children into families where their welfare is at risk, compromising children's best interests: as the director of an NGO providing reintegration support in Preah Sihanouk province explained:

To be honest we are struggling now. We allocate two staff – our reintegration team. They are ready to help MoSVY start the process. But we have always said – when we talk about reintegration we should not talk too much about numbers – we talk about quality. We are quite concerned if we have to push too much [that children will end up at risk].

Indeed, key stakeholders reported that it is often unsafe for children to return to their family environment, and this poses a challenge, particularly when institutions are closed:

One of the big challenges we are facing during our case management and reintegration is children who are experiencing abuse. The reintegration tends to fail due to alcohol abuse and domestic violence – that is why we spend much more time doing family assessment and family counselling. Sometimes we need to get the child back and send them back – sometimes we have a difficult situation with the child because the parents want to use the child for a different purpose.⁴²

It is essential that social workers and others involved in reintegration are able to identify cases in which placement in a particular family environment presents too great a risk of harm to the child. Departments responsible for child protection must also ensure that pressure to meet targets and quotas does not compromise children's well-being and that all reintegration is 'safe' reintegration.

42 Individual interview, UNICEF, Phnom Penh province, 12 October, 2016

PUSH AND PULL FACTORS THAT IMPACT ALTERNATIVE CARE

7

This section of the report explores the underlying drivers that influence the placement of Cambodian children in different types of alternative care. Whilst the study was not designed to collect robust or representative data on the reasons why children are placed in care, it did involve the collection of in-depth qualitative data on the push and pull factors that influence children's placement in alternative care.

The majority of children and their caregivers taking part in the study identified poverty as the main reason for the child coming into care. While poverty is clearly an issue for a substantial number of families in Cambodia, further investigation into specific cases tended to reveal that there are very often other factors which are critical in determining the decision to place a child in alternative care. Given the stigma surrounding children who come from a background of violence, abuse and family conflict in Cambodia, and a strong cultural preference for saving face, 'poverty' may be a comfortable and acceptable way to explain a child's placement, while avoiding disclosure of the real underlying reasons.⁴³ A number of the children included in the study had suffered abuse or severe neglect, and appeared to be at risk of physical, sexual or emotional violence. Others were abandoned or rejected, particularly when a parent re-married. Some were placed in alternative care because their parents migrated and chose not to take the child with them. Yet others had parents who were alcoholics or drug users who were unable to care for their children. Finally, others were placed because the material conditions and education that could be offered at home were very limited and a pagoda, boarding school or RCI was viewed as offering more opportunity to the child.

It can probably be said with some degree of accuracy that most children end up in alternative care for a number of interrelated reasons, with economic vulnerability, family dysfunction, separation, illness and death all playing their part. In addition, there is a tradition of grandparents and other relations looking after children in Khmer society while, at the same time, a reluctance of step-parents to take on their new spouse's children.

POVERTY

As noted above, income poverty is the main reason given by carers respondents across provinces and across different forms of care, although the use of the term 'poverty' is relative and used to cover a spectrum of financial circumstances from those who do not have the means to support their children to those who do not regard themselves as having sufficient financial means to provide the support they would like their children to have. For some Cambodian families, alternative care is a coping strategy when there is insufficient money in the household to feed, clothe and shelter the children. For others, it is a means of providing a standard of child care, education and potentially employment

⁴³ It is important to note that it was not clear in talking to children how much they really know about the reasons for their admission into alternative care, especially those who entered into alternative care at an early age. In addition, we were not able to gauge the degree to which children feel shame about their circumstances or fear the community's response if the real reasons, particularly those relating to physical and sexual abuse were known. Equally, we do not know the extent to which caretakers felt free to tell us the real reason why the child was in their care, especially if there was a chance that the child might overhear what was being said, or they wished to preserve the child's dignity and privacy.

opportunities for their children, which they could not otherwise afford and, on occasions, migration and employment opportunities for themselves.

Respondents described a strong perception held by many communities that placement in an RCI is the best option for a child from a poor family, regardless of whether that child has family willing to care for him in kinship care. As a DoSVY representative in Battambang province explained,

RCIs are the first option amongst the ordinary people I have met during my field visits. I think this is because of the material benefits that RCIs can provide. There is a general idea amongst ordinary people that 'our children can lead a good life in the RCIs'. It is very difficult to convince them that RCIs should be the last option.⁴⁴

EDUCATION

In addition to providing a child care solution for poor families and removing the economic burden of caring for a child, alternative care services – particularly pagoda based care, RCIs and boarding schools – are seen as a means of providing children with access to free and high quality education. Respondents described how this is in part a reaction to the poor quality of public education in Cambodia:

The second reason [that children end up in alternative care] is education. Families see residential care as a boarding school mainly, so they use them as boarding schools – they are convinced the type of education in the boarding school is much better than what they receive in the government school in the district.⁴⁵

The main reason the children come here is for education at upper secondary level. These education opportunities don't exist in their home villages.....⁴⁶

As the second excerpt suggests, for families living in rural areas where physical access to education is a challenge, alternative care services can facilitate children's access to schools. Even where alternative care services don't provide schooling themselves, they often provide additional tuition or 'extra classes' which children wouldn't be able to access or afford when living at home, and many respondents described as essential to educational success. As a director of a residential care institution in Kandal explained:

Without extra classes no one can do well. They have to learn everything twice! Education is free but if you want to pass you need extra classes. Even the parents say

44 Individual interview, DoSVY representative, Battambang Province, 18 October, 2016

45 Individual interview, key informant, Community Care First, remote skype call, 19 December, 2016

46 Individual interview, monk / caretaker, pagoda, Siem Reap Province, 11 October, 2016

*this. It is 30 dollars a month for extra lessons. If you send the kid home, they cannot buy extra classes... Many of our kids are top in school because of educational support. That is the biggest challenge. If they go back to the family, what will happen to the education they receive?*⁴⁷

The cost of educating a child places a significant burden on parents who are low wage earners, and the focus on the provision of education in alternative care placements (other than kinship care) is a major driver, particularly for pagodas and RCIs. Despite the fact that in law education at school is free, respondents maintained that in practice, the teachers demand payment from each child. Not only do alternative care institutions often pay the sums demanded by teachers at the state schools that the child attends, but also *“provide access to additional classes, tutors and school materials, as well as the opportunity to pursue further education at university and vocational training centres.”*⁴⁸

PARENTAL MIGRATION

Findings from the study demonstrate that children are often placed in alternative care when their parents migrate to find work. Respondents explained that (temporary) economic migration is on the rise in Cambodia, due to increasing demand for cheap labour in industrial zones within Cambodia and in neighbouring countries, particularly Thailand.

*Abandoned children are the most common cases needing alternative care in Siem Reap. They come from vulnerable backgrounds. For example, the parents migrate to Thailand and leave the children with the extended family. There, in the extended family, they lack warmth and care. They will either get support from the community or go to the Pagoda.*⁴⁹

Families tend to use kinship care arrangements as a response to parental migration, with care often provided by grandparents. However, it appears that parents migrate for long periods of time, often years, and grandparents grow old, cease to work, and are not able to care for and finance the children, especially in relation to payments for education. There was little evidence of parents sending money to support the grandparent or other relatives to care for the child. As a result, kinship care may breakdown with the child being placed in other forms of alternative care, particularly given that financial support from the State is not available.

FAMILY DEATH OR RELATIONSHIP BREAKDOWN

Respondents reported that children may enter alternative care when their parents separate, or due to other forms of family breakdown. This appears to be the case particularly in poor families, where a single parent cannot afford to support a child and is under economic pressures to work; *“The mother married and had two children. The husband left her and she became a widow – she couldn’t do anything to make her life better so she sent the children to the NGO.”*⁵⁰ In other cases, it was reported that

47 Individual interview, Director, Residential Institution, Kandal Province, 11 October 2016

48 Keeping Them Home: A Qualitative Assessment on Traditional and Community Responses to Children Requiring Alternative Care (author and publisher unknown) 2008.

49 Individual interview, WCCC Representative (provincial level), Siem Reap Province, 14 October, 2016

50 Individual interview, Commune Children and Women’s Committee Representative, Kandal Province, 14 October 2016

children were placed in alternative care because they were rejected by a step parent, or due to abuse, discrimination or mistreatment by a step parent; *"I was not happy living with my step mother – I was not in education and I had to work on the farm...I don't like to think about it."*⁵¹ Interestingly, respondents suggested that it was quite rare for a child to stay in the care of his or her biological parents after they had separated. While this may be partially due to the economic pressures faced by single parents, it may also reflect stigma, rejection and abuse experienced by step children, and broader social norms that are not accepting of family separation or the taking on of care and support of non-biological children.⁵²

CHILDREN WITH OFFENDING BEHAVIOUR

Alternative care, and particularly pagoda based care, is also reportedly used as a solution for children exhibiting difficult, or offending behaviour:

*Some boys are here not because of the family's poverty, but because the boys are not doing well – they are naughty or disobedient. So, to prevent that from getting worse, the parents send them here with the aim that they will soon become a monk here.*⁵³

And as a DoSVY social worker told researchers:

*There was a child placed with his grandparents, but the child was not an obedient one – it was hard for both the grandparents, and us as officers, to deal with the case. ... Later, the grandparents asked us at the district and provincial level: "please help us because our grandson is not obedient and steals things from people!" We removed him from the grandparents and placed him in an institution...*⁵⁴

CHILDREN IN NEED OF CARE AND PROTECTION

Finally, research findings indicate that children end up in alternative care because they have suffered or are at risk of suffering violence, abuse or neglect within their home environment. While this is often an underlying factor, caretakers interviewed for the study did not often give this as a reason for the child being accepted into alternative care. It appears that in some cases abuse may not be detected or reported or possibly that the carer is not informed, or informed fully of the abuse. Several children in care who were interviewed for the study, described having experienced different forms of abuse, including abuse that they had not reported to authorities or caretakers: *'nobody knew about my background – they thought I had come here for skills training...nobody asked me so I never told them.'*⁵⁵

51 Individual interview, 18 year old boy, Christian boarding school, Preah Sihanouk Province, 17 October, 2016

52 In "Keeping them Home, Traditional and Community Responses to Children Requiring Alternative Care in Cambodia, 2008 (publisher unknown) the report indicates that children who have lost their mother are more likely to be placed in alternative care than those who have lost their fathers: 70% of the children interviewed for this study were maternal orphans and 30% paternal orphans.

53 Individual interview, Vice Head Monk, Pagoda, Preah Sihanouk Province, 20 October 2016

54 Individual interview, DoSVY representative, Kandal Province, 19 October, 2016

55 Individual interview, boy in independent living, NGO supported, Preah Sihanouk Province, 19 October 2016

MULTIPLE VULNERABILITIES

As described above, the reasons for which children are placed in alternative care are interrelated and overlapping. Income poverty and lack of employment opportunities lead to parental migration and aggravate the vulnerability of separated families. Furthermore, in a context without a social safety net and where public services are extremely weak,⁵⁶ families who lack the resources to provide for their children rely on alternative care to ensure their children's basic needs are met. Economic deprivation also contributes to various forms of abuse and neglect, such as families using children as a labour source. In several cases, alcohol abuse and, to a lesser extent, drug use in the family, was found to lead to domestic violence and physical abuse, and ultimately, children's placement in alternative care.

CASE STUDY: KINSHIP FAMILY IN PREAH SIHANOUK

Who is living here with you? There are four of us living here... The girl is 11 – she is my granddaughter. Her mother was accidentally electrocuted. She was 9 when her mother passed away.

Does the granddaughter have any siblings? There are two girls and one boy – two are in an institution called 'Hope' and one girl is with the father. He is a construction worker in Phnom Penh.

Can you tell me about the decision to place the children in care – who made the decision and what did they decide? The boy lived with his paternal grandmother before the mother died – we did not know why he went to the institution where he is now – it was the decision of his father, the grandmother, or both. At that time the parents were still married but could not afford to raise children.

What was the mother's view? When the mother was alive the father never came to trouble me. After the mother's death the father came drunk and we couldn't work against him and so he took the girl. When she came back she looked so thin!

How long was she with the father? For ten days. Did he bring her back? She came back by herself. The great aunt called her back in. She did not dare to come directly because she was afraid her great aunt would beat her.

Did she say anything about the decision to come back? She said she did not have enough food and that her father was always drunk.

Have the authorities from your community been involved in the case at any stage? No local authority has been involved – I always managed to address the issues – the father is my son in law. I ask him – 'why are you coming here to take the girl back? You are a drunk and you cannot take care of her!' He just talks and talks and if nobody responds, then he goes!

Has he ever harmed you or the children physically? He threatened to burn the home. He is now a drug user. He said – 'if you do not return the girl to me I will burn your home.' ⁵⁷








⁵⁶ Public services also appear to be costly in practice - a number of respondents reported that even though public education is free in principle in practice it can be very costly in practice, both due to corruption within the education system, and additional costs associated with education, such as materials, tuition, etc.

⁵⁷ Group interview, family providing kinship care, Preah Sihanouk Province, 19 October, 2016

CARE PROFILES

8

This chapter provides a brief, descriptive overview of the characteristics of each type of alternative care included in the study: kinship care, foster care, group homes, pagoda-based care and residential care. Under each 'Care Profile', the following seven broad aspects of care are examined:

-
- a.  **Profile of children**
 - b.  **Identification and placement**
 - c.  **Monitoring**
 - d.  **Contact with biological parents (including a discussion of reintegration if applicable)**
 - e.  **Nature of care provided**
 - f.  **Training**
 - g.  **Costs and funding**
-

The exact structure of each 'Care Profile' was adjusted to ensure its relevance to each type of care. For example, the 'Care Profiles' for kinship and foster families it is not appropriate to use the term 'management'.





Key Findings: Kinship care

1. Kinship care is a prevalent practice in Cambodian communities when children cannot be cared for by their parents;
2. At present, most kinship care arrangements appear to be made informally. Where there is external involvement in placing a child in kinship care, this seems to be largely facilitated by an NGO;
3. In most cases where there is external involvement in placement of a child in kinship care there is a lack of professional assessment of the ability of the kinship carers to care for the child;
4. Even in families where an NGO is involved in placing a child in kinship care, regular visits by a social worker are reportedly rare, with some exceptions;
5. Kinship families included in the study received variable levels of material support, and do not receive regular payments to cover the costs of a child;
6. Only around 20% of kinship carers reported having received any training on caring for a kinship child;
7. All of these factors contribute to the possibility of placement break-down and school dropout.



PROFILE OF CHILDREN

There is no robust, nationally representative data on the number of children living in kinship care in Cambodia. However, anecdotal evidence from interviewees indicated that there is a long tradition of kinship care in Cambodia and that it is the major form of alternative care practiced in communities. Extended family networks are strong and important in Cambodian culture and it is very common for non-nuclear family relations to look after children at various points in their lives. For example, a DoSVY social worker from Koas Krala District in Battambang province suggested that kinship care was the most frequently used alternative care arrangement in his district:

Most of the alternative care in my district is kinship care. Children of parents who broke up, double and single orphans, children of migrants, HIV/AIDS orphans, war orphans; they all end up in kinship care! There is no residential care facility in my district. There are also no foster families that I know of.⁵⁸

It is common for parents in Cambodia to reach private, informal arrangements with members of their family for care of their children, especially for short periods of time. In most cases, there are no child protection issues and no reason for the State to intervene or become involved. Relatives also appear on occasions to take a child to live with them in order to remove the child from a situation where he or she is being abused, neglected or subjected to violence. If the relative is able to protect the child appropriately, then again, it is unlikely that the State will be called upon to intervene.



IDENTIFICATION AND PLACEMENT

In the eight kinship care cases included in this study, all involved external input, either by an NGO or the State, or both, either in the placement itself or in providing support following an informal placement. Some of the children were placed by their families, with support being provided by an NGO post-placement, while others were reintegrated into kinship care after being placed in a RCI.

How did you become involved in providing kinship care?

I have cared for this child since the time when his mother was still alive. She had TB and died five years ago. The boy lived in an orphanage for about three years before he came to live with us. He asked to come and live with us. I decided to take him in because he is my nephew and he has no-one else to turn to.⁵⁹

It was clear from the interviews that when a child is placed into kinship care by an NGO, DoSVY or CCWC, this does not necessarily mean that the kinship family in question undergoes a pre-placement assessment on the suitability of the placement, or that a detailed placement plan is developed, as required under Chapter 3 of the 2008 Prakas on Minimum Standards on Alternative Care in the Community. There was evidence of a professional assessment in only one of the eight cases. A kinship caregiver in rural Battambang noted that:

⁵⁸ Key informant interview, government social worker, Battambang, 18.10.16

⁵⁹ Interview with kinship caregiver, Battambang, 20.10.16

No, no-one came to check on the property or me before the boy came to live here. No-one talked to me before either. The boy's oldest brother, the one that is now in Thailand, arranged the placement with the NGO.⁶⁰

Another grandparent kinship carer said that a CWCC social worker had come to see them before the child was placed with them. Both of the grandparents are elderly and the grandmother disabled and immobile: neither of them had any income and relied upon their son for support. When asked whether she had told the social worker that they could not care for the 15 year old boy, the grandmother responded that she did not dare to tell the social worker that, but that she did say it would be difficult as they had no income. The social worker responded that *"there was nothing that they could do to support the child and the family would have to find a way themselves."*

Nearly all the children placed in kinship care had suffered significant loss in their lives and had dislocated childhoods, with a number of moves. Their need for emotional support to deal with anger, grief, and to adapt to their new life and circumstances is likely to require an understanding of the impact of these events on a child and a willingness to provide the required support. There was no evidence of counselling being made available for the child or social work with the family to help the child settle with his relatives.

Kinship carers and children interviewed for this study all regarded the placement as 'permanent' rather than a short-term, temporary measure, and most of the children were pleased to be placed in kinship care with their family, though some found the transition into kinship care difficult at first. It was evident from the 8 families, that although some of the children had living parents, for a variety of reasons it was not possible and/or in the child's best interests to reintegrate the children with them.



CHILDREN WITH SPECIAL NEEDS

Of the eight kinship caregivers included in the survey, one reported caring for a child with HIV/AIDS and one for a child with disabilities. Evidence from qualitative interactions suggests that kinship families may need particular support if they are to provide adequate care to children with special needs. This is because many kinship families have very limited financial resources and lack specialised training to care for children with special needs. The following case study of a kinship family in rural Siem Reap serves to illustrate this point.

⁶⁰ Interview with kinship caregiver, Battambang, 20.10.16

CASE STUDY: KINSHIP FAMILY IN RURAL SIEM REAP

Three orphaned children (two girls and one disabled boy) and their older sister live with their aunt near Siem Reap city. The aunt is unwell and is not able to help very much. The oldest sister (21 years old) is the main breadwinner for the family. The premises were in a very bad state.

The mentally and physically disabled boy has an improvised wheelchair made of wood. During the day there is no-one there to look after him. In the morning, before the older sister leaves for work, he is placed on a bed under one of the houses in the compound where they live. Here he has to wait until the evening, without access to a toilet. When the older sister returns from work in the evening, she washes him.

The following excerpts from the interview with his 21-year-old sister highlight the lack of capacity of this kinship family to adequately care for the disabled boy:

How do you support your siblings?

In total, I have about 160 USD to spend per month to take care of my siblings.

Do all the children go to school?

No, not the disabled boy... Also, the youngest (12 years old) has dropped out of school after repeating Grade 1 for four years in a row. The middle one is (17 years old) and is still in school. I dropped out of school in Grade 6 when our father passed away.

Why is it your responsibility to support your siblings?

I need to earn money to support my younger sibling because my older brothers do not support them. They have their own families... One of my older brothers is a migrant worker in Thailand. He doesn't care to send money to support us. Auntie has rheumatism, so she is not able to work.



MONITORING

3 of the 8 kinship carers included in the survey indicated that they were 'never' visited by an external official (from DoSVY, CCWC or an NGO) for the purpose of monitoring. From our very small sample, kinship placements that were arranged *without* NGO involvement were less likely to be monitored. Even where an NGO did monitor the placement, it appeared to be conducted largely on an ad-hoc basis, depending on the NGO's resources to conduct such visits. DoSVY and CCWC representatives, it appears, are rarely involved in monitoring of children living in kinship care arrangements. The peripheral role of the government in the follow-up period and the challenges were also highlighted by a key informant in Siem Reap:

How do you work with the government when you do reintegration? What is their involvement in pre-placement visits and post-placement assessments?

We mainly involve them in the pre-placement assessments. To engage them is pretty difficult – you have to cover all their expenses and it is tricky to justify those expenses to donors. Now with DoSVY social workers it is better – a few years ago no one knew how to fill out forms so we would fill them out and ask the government to sign them. With the CCWCs it hasn't improved – they don't understand what their role is supposed to be, they never conduct monitoring visits. Post-placement, their role is non-existent.⁶¹

If DoSVY or CCWC representatives are involved in conducting the follow-up assessments of kinship families, it appears to be primarily at the initiative of NGOs. However, if the NGO have undertaken the placement, DoSVY appears to leave them to undertake the monitoring and even when an NGO has run out of funding and cannot carry out the monitoring, there was no evidence that responsibility for monitoring was then taken on by DoSVY or the CWCC. The prevailing view appears to be that where an NGO has taken on responsibility for a case, the NGO retains responsibility for the child during childhood and not the State.

A DoSVY representative in Battambang noted:

We sometimes unofficially visit those re-unified families we know of, maybe twice a year. But only when we are invited by the NGO who did the placement. We do not want to disturb what the NGOs are doing.⁶²

In the few instances where follow-up monitoring takes place, this appears to focus largely on health and there is little evidence of the social worker building up a relationship with the child or engaging the child in discussion. The lack of post-placement support leaves children and their carers unsupported at what may be a difficult time, with a higher risk of placement breakdown.

When placements happen informally, it appears to be left entirely up to the kinship family to decide whether to register the new care arrangement with the local government.

How did you become involved in providing kinship care?

My niece's mother lives and works in Thailand. The girl was living with her grandmother, but she passed away. I then told the father to get the girl from the countryside – that idea came from me.

Did you inform the local authorities?

I do not know for sure what her father did there [in the countryside] – here, I registered the girl on the family residence card. In the book now there is myself, my wife and her.⁶³

61 Key informant interview, via Skype, London, 19.12.16

62 Key informant interview, DoSVY representative, Battambang, 18.10.16.

63 Kinship caregiver interview, Kandal, 15.10.16



CONTACT WITH BIOLOGICAL PARENTS

Children living in kinship care arrangements in many cases may still have one or both biological parents but they are likely to have migrated, re-married, and/or abandoned their children. There was little evidence of children in the 8 kinship families having contact with parents. There was no evidence that DoSVY, CWCC or a placing NGO saw it as their role to assist the child to keep in contact with the biological parents, or indeed to prevent contact where this posed a risk of significant harm to the child. The qualitative data suggests that the child is rarely involved in decisions and neither does he or she have any power to determine when or if contact takes place.



NATURE OF CARE PROVIDED

The quality and nature of care provided to children in kinship families varies widely. To a large extent, the quality and nature of care depend on the socio-economic standing of the kinship family and the amount of support that the family receives from NGOs.

Material conditions:

The quantitative data from the observational checklist indicates that kinship families often live in conditions of extreme poverty and material deprivation. For example, 7 of the 8 kinship families visited for this study did not have a functioning sewage system. In 4 children had neither mats nor mattresses to sleep on, and in 3, children did not have access to functioning toilets.

Access to education:

Children in kinship families were all attending either primary or secondary schooling. However, in one kinship family visited by researchers, the child had to work in order to pay for informal school fees, as the kinship carers were unable to fund the child's education.⁶⁴ The NGO who had reintegrated him did not provide the family with funding to enable the child to continue in education.

Given that researchers primarily accessed kinship families in urban areas, it is difficult to say whether children in kinship families in rural areas are able to access the same level of education as children in kinship families in urban areas. Evidence from key informant interviews suggests that children in kinship families in rural areas have difficulty accessing education due to the additional financial burdens (informal school fees, transport costs, etc.) that this entails, and the reduced opportunities for carers and children to earn money.

64 Kinship caregiver interview, Phnom Penh, 29.11.16

Access to healthcare:

As with access to education, children's access to healthcare depends largely on the socio-economic standing of the kinship family. While some kinship families visited by researchers could afford to send their children to a private doctor, others needed to rely on the public healthcare system. In some cases, kinship caregivers indicated that the NGOs who 'placed' children in their care would cover some of the costs associated with health care.⁶⁵

Access to social workers:

Evidence from the qualitative interactions suggests that children living in kinship families rarely have access to a social worker (whether from an NGO or the government) and the carer has little or no contact with a social worker, whether from the NGO or DoSVY. This pattern was also confirmed by the children living in kinship care arrangements, who rarely indicated that there was someone 'outside the family' that they could turn to if they had any problems.⁶⁶



TRAINING

Article 7 of the Prakas on Alternative Care in the Community states that all caregivers 'shall take a designated training course provided by DoSVY or other alternative care providers,' which should cover topics such as childcare, counselling and child abuse. Evidence from the quantitative survey suggests that only 2 of the kinship carers included in the survey received training. This covered the identification of child abuse and was offered by a NGOs. None of the kinship carers appeared to have received training on the likely impact of reintegration on a child, how to address behavioural issues or positive parenting.



COSTS AND FUNDING

Given the lack of robust, representative data, it is difficult to estimate the costs of providing kinship care. Furthermore, these costs are likely to differ widely depending on the age of the child, the specific care needs of the child and the family providing kinship care. In addition, costs of living are likely to vary substantially across the country. However, from the perspective of NGOs, donors and the government, kinship care can be considered the least expensive form of alternative care in Cambodia. This is because the costs of providing care are often be 'absorbed' by the families themselves, either entirely or partially.

When NGOs are involved in the kinship care placement they typically support one child with around 30 USD per month for a limited amount of time, with the exact amount being dependent on the specific needs of the child and the kinship family.

⁶⁵ Kinship caregiver interview, Kandal, 13.10.16

⁶⁶ Interview with children in kinship care, Siem Reap, 10.10.16

The amount of support we give to re-integrated children depends on the needs of the children. For example, we will support them more if they have disabilities or are HIV positive. For those that are HIV positive we provide additional food support and cover the transport to the hospital. Our budget limit per month per child is 30-35 USD. But this excludes the emergency budget we have for exceptional cases.⁶⁷

The NGO that placed the boy with us supports us with 20 USD per month, 50 kg rice every two weeks, shampoo, hygiene products and 3.5 USD pocket money for the boy.⁶⁸

For kinship families, the primary expenses are food and education.⁶⁹ For NGOs involved in kinship care placements, the primary expense is usually related to post-placement assessments and travel.⁷⁰

Most of the kinship carers surveyed were poor and struggled to find sufficient money for basic necessities and education of the child. It does not appear that DoSVY social workers have access to any funding that could be used to support the kinship care placement. A DoSVY district social worker from rural Battambang when asked whether DoSVY provided any support to kinship carers who were finding it hard to support another child, responded that:

The district office cannot provide financial support to kinship families. We have no budget for that but [a large INGO] has an office in my district and they can support kinship families with food, books and vegetable seeds.⁷¹

67 Key informant interview, via Skype, London, 19.12.16



68 Kinship caregiver interview, Battambang, 20.10.16

69 Kinship caregiver, Siem Reap, 10.10.16

70 Key informant interview, via Skype, London, 19.12.16

71 Interview with DoSVY district social worker, Battambang, 18.10.16





FOSTER CARE

Key Findings: Foster Care

1. The number of 'informal' foster families appears to be relatively small;
2. Foster parents overwhelmingly understood placements to be 'permanent', whereas NGOs supporting foster families primarily considered placements to be 'temporary'. In some cases, placements had clearly evolved from short-term to long-term placements;
3. Some foster families appear to take on a very large number of foster children (up to 6 foster children in the study sample) ;
4. Most placements into foster families involve NGO social workers, but identification of suitable families and placement often happens on an ad-hoc basis, and with limited government involvement;
5. Foster families appear to be relatively well monitored in comparison to kinship families
6. Foster children are rarely registered with the government, and whether they are depends largely on the initiative of the foster families or NGOs involved in the placement;
7. Foster families sometimes change the child's birth registration and give the child their name, in effect, adopting the child but without legal process;
8. Children in foster families typically have access to education and NGO social workers, even though this is rarely an 'assigned' social worker;
9. Relative to the cost of a RCI, foster care would appear to be a less expensive alternative care option. NGOs typically support foster families with 30-40 USD per child per month;
10. Some NGOs pay foster parents 'salaries' which can vary from 50 USD to 200 per month.



PROFILE OF CHILDREN

Foster care is generally defined as '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 that has been selected, qualified, approved and supervised for providing such care'.⁷²

Informal foster care refers to a situation where a family takes on responsibility and cares for a child who for some reason cannot be cared for by his or her parent without the involvement of a State body or NGO. Technically, informal placement does not fall within the definition of 'foster care,' but some families seek help from CWCC, DoSVY or a local NGO once they have the child. There is no quantitative evidence on the number of families who have informally 'fostered' a child, but according to anecdotal evidence, it is not a large number.⁷³

Although some foster care is arranged and supported by MoSVY through DoSVY or OSVY, the majority of formal foster care services are currently provided, managed and funded by a range of NGOs. As a result, the form, nature and geographical location of fostering varies according to the particular rules of the managing NGO.

Although each NGO has data on its own foster carers and the number of children it has placed with them at any one time, there is no national data on the number of children in foster care in Cambodia. Further, there is no comprehensive mapping of foster care services. Obtaining reliable data is made more difficult by the fact that it appears not all foster care providers are licensed.⁷⁴

Ten foster families were visited during the course of the study. While some of the foster care arrangements visited were understood by both the foster carers and the NGO involved in the placement as 'permanent', others were conceived as 'temporary' or short-term with reintegration into the birth family as the goal. Interestingly, foster carers and NGOs placing the children tended to take a different view on the nature of the placement. All but one foster parent included in the interviews indicated that the children were living with them on a 'permanent' basis, rather than on a short-term basis. The majority of NGO managers interviewed for this study indicated, however, that 'foster placements' were temporary, i.e. that children would be fostered until reintegrated into their biological families or able to move into alternative living arrangements.

Some foster care arrangements clearly evolved from short-term care placements into permanent care arrangements due to a change in circumstances: *"At first the children were only meant to stay with us on a temporary basis, but after their mother died [from HIV/AIDS] they wanted to stay permanently."*⁷⁵

It was not possible to look deeper and examine children's case files, but for most of the foster children in this survey, there appeared to be little realistic chance of reunification

⁷² United Nations General Assembly, *Guidelines for the Alternative Care of Children*, Resolution 64/142, 2010.

⁷³ Key informant interview, DoSVY representative, Siem Reap, 15.10.16

⁷⁴ See Capacity Development Plan for Family Support, Foster Care and Adoption in Cambodia 2017-2023, MoSVY, draft 15 December 2016.

⁷⁵ Foster parent interview, Siem Reap, 10.10.16

with their parents: either because the parents had died, or because the parent had remarried and the step-parent had rejected the child, or the family circumstances were such that return would place the child at risk of suffering significant harm.

There was little evidence of permanency planning for children in foster care, even in the case of small children. This left children very uncertain about their future. Children who were interviewed for the study were not clear whether they would be going back to live with their families – although many believed this would happen, even after some years away, with very little contact.

In some cases, the foster placements were more akin to an informal adoption, with the foster parents committed to the child long-term. There was evidence of some foster parents changing the child's birth certificate and substituting their names as the parents, and of the child being added to the parent's household register. In other cases, the foster parents were clearly 'professional' foster parents who derived their income from caring for children.

According to the survey data, the maximum number of children living in one foster care family was nine.⁷⁶ Qualitative data showed that some foster families take on a very large number of foster children.

Our foster parents take an average of 6 kids each. Of course they also have their own children. So, foster parents can end up with 10 or so kids.⁷⁷

The presence of so many foster children in one home raises questions about the ability to provide sufficient attention, emotional support and time to the child. This is likely to be a particular problem for children who have experienced loss of their family and possibly loss of other children and staff to whom they became attached in their previous placement. It was also clear that in some cases, the large number of children in the family placed stress on the foster carers.

Children living in the foster families who took part in the survey appeared to be primarily from younger age groups. A key informant working for a community care NGO in Phnom Penh noted that children aged 4-10 were the "biggest entry" category into foster families.⁷⁸

The study found few older teenage children in foster care. NGOs stated that older children were more difficult to place and had more difficulty adjusting to a new family. One NGO had a practice of removing children from foster care once they reach their mid-teens and placing them back in the RCI or in semi-independent living. This is a matter of concern, as it is yet another move for the child, is likely to be disruptive and is unlikely to be in the child's best interests. It was unclear why the NGO maintained such a policy, especially when a child has been with the foster carers for some years and has built up a relationship of attachment.

⁷⁶ The statistics on foster care arrangements exclude responses from managers/social workers/'teachers' in charge of monitoring several foster families at once.

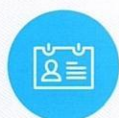
⁷⁷ Foster care NGO manager, Phnom Penh, 28.11.16

⁷⁸ Foster care NGO manager, Phnom Penh, 28.11.16

Some foster families have a clear preference as to the children they are willing to foster. Interestingly, a community care NGO manager in Siem Reap informed the survey that:

The foster parents typically prefer double orphans. They are scared that the biological parents will come back to take the child away again. Small children are also preferred to older children. And girls are preferred to boys, as they are perceived as being easier to educate.⁷⁹

This indicates that some of the foster parents, at least, appear to be looking for a long term placement similar to adoption.



IDENTIFICATION AND PLACEMENT

Even though placements into foster families typically involve NGO social workers or government representatives, the process of family identification and placement often occurs on an ad-hoc or 'opportunistic' basis. For example, one of the foster families visited by researchers in Siem Reap happened to have a biological daughter working at a local community care NGO. The daughter identified her own family as a potential foster family for three orphans, who were at that time receiving day schooling and food support from [the NGO].⁸⁰ In another case, the local authorities were only informed after an abandoned child was taken in by an 'informal' foster family.

She was abandoned next to a trash bin a few streets away. When my wife found the baby she brought her to the hospital. The child was only 1 month old when we found her. Everyone was simply walking past the trash bin, but my wife couldn't just walk away from the little one.

Were there any other actors involved? Yes, we informed the village chief and the commune representative. We didn't want anyone accusing us of stealing babies.⁸¹

In some cases, NGOs work together with local government officials in order to identify suitable foster families. For example, one community care NGO social worker suggested that he would "go to see a local CCWC, village leader, commune chief – to arrange for fostering. These people know families and the families can apply to foster."⁸² Other NGO social workers interviewed for this study conduct outreach programmes and trainings for potential foster parents.⁸³

NGOs use criteria for identifying suitable foster families that appear to focus more on eligibility than suitability, despite the fact that Article 6(1) of the Prakas on Alternative Care in the Community states that "in all cases, social workers of MoSVY or Alternative Care Providers [NGOs] shall conduct an assessment to ensure suitability of the potential foster family" (p.6). For example, one NGO social worker from Kandal stated that the criteria were that: "the potential foster parents must be at least 35 years old. The family itself should not have more than four or five children. They must not be former prisoners or have committed violence. They must be physically and mentally healthy – no hepatitis or tuberculosis"⁸⁴

79 Community care NGO manager, Battambang, 17.10.16

80 Foster parent interview, Siem Reap, 10.10.16

81 Foster parent interview, Battambang, 17.10.16

82 Community care NGO social worker, Kandal, 15.10.16

83 Community care NGO manager, Sihanouk, 16.10.16

84 Community care NGO social worker, Kandal, 15.10.16

The qualitative evidence suggests that pre-placement assessments of potential foster families are primarily conducted by NGO social workers rather than government social workers.⁸⁵ In some locations, however, the researchers were informed that local government undertake the pre-placement assessments. For example, one DoSVY representative from Siem Reap suggested that *“before placements [into foster families], we do one or two assessments of the family. Usually it will be a social worker from DoSVY, a CCWC representative, and village chiefs. Sometimes it is just the social worker from DoSVY.”*⁸⁶ Unfortunately, it was not possible to triangulate this statement and it may be that the practice varies depending upon the geographical location or that the local government respondent overstated his involvement in pre-placement assessments.



MONITORING

In contrast to kinship care, foster care arrangements appear to be relatively well monitored. All foster carers included in the survey indicated that they had been visited by an external official (from DoSVY, CCWC or an NGO) for the purpose of monitoring. Again, it is important to remember that the foster families included in the survey are not representative of all foster families in Cambodia. The quantitative data does not reveal whether NGOs or government actors are more frequently involved in the post-placement visits.

According to a high-level DoSVY representative from Siem Reap, DoSVY officials are (in theory) advised to use the MoSVY permanency planning guidelines for registering foster families.⁸⁷ However, in practice, permanency planning is virtually non-existent and foster care registration appears to happen on an ad-hoc basis: *“After I realised that the mother [of the abandoned child] would never show up, I went to the village leader and told him about this and he said – okay, you can take care of the child.”*⁸⁸

Whether or not a foster child is registered with the government appears to largely depend on the initiative of the foster parents and/or the NGO involved in the foster care placement. Consider, for example, the following quotes from interviews with foster parents in Battambang, Preah Sihanouk and Siem Reap:

*Now the child is using my name and she has been given a birth certificate. We also entered her name in the family book, so she has a right to inheritance.*⁸⁹

*Is the child’s name in your family book? No, I have never had a family book but he has a birth certificate and he is using my family name.*⁹⁰

*Is the child registered as a foster child? I didn’t do any of that myself. The NGO registered the child with the CCWC, the village chief and DoSVY. We never interacted with the government directly ourselves.*⁹¹

⁸⁵ This was confirmed by a CCWC representative from Kandal. Key informant interview, Provincial CCWC, Kandal, 14.10.16

⁸⁶ Key informant interview with DoSVY representatives, Siem Reap, 14.10.16

⁸⁷ Key informant interview, DoSVY representative, Siem Reap, 15.10.16

⁸⁸ Foster mother interview, Sihanouk, 18.10.16

⁸⁹ Foster parent interview, Battambang, 17.10.16

⁹⁰ Foster mother interview, Sihanouk, 18.10.16

⁹¹ Foster parent interview, Siem Reap, 13.10.16

Providing an indication of the ratio of registered to unregistered foster arrangements, one high-level informant from the provincial government in Siem Reap suggested that the “majority of foster arrangements happen under the table, without any registration.”⁹² Unfortunately, there is no representative, quantitative data to triangulate this claim.



CONTACT WITH BIOLOGICAL PARENTS

As with children living in kinship care arrangements, children living in foster families frequently still have one or two biological parents. The frequency of contact with the biological parents and re-integration attempts varies from case to case. In some cases the family circumstances are such that contact may place the child at risk. In other cases, logistics appears to be the main factor determining whether contact takes place and the level of that contact.

Is there any contact to the child's biological father?

Yes, the biological father sees the child maybe twice a year. But only when [the NGO social worker] drives him here. He lives 15 kilometres away. What do you think about these visits? We are a bit scared that the father [who is a drug addict] is going to be a bad influence on the child when she gets older. Have there been any attempts made to re-integrate the child with the biological parent who is still alive? [The NGO social worker] regularly assesses the situation of the biological father, but so far his situation has not improved.



NATURE OF CARE PROVIDED

The nature of care provided to children living in foster families depends to a large extent on the socio-economic standing of the foster family as well as the level of support provided by NGOs involved in the placements.

Material conditions:

The quantitative data from the observational checklist indicates that foster families live in better conditions than the kinship families involved in the study. This may be because it is primarily individuals from more financially secure backgrounds who volunteer to become foster parents and/or the financial support provided to foster parents enables them to have a better standard of living. 9 of the 10 foster families had a functioning sewage system, as opposed to only 1 out of the 8 kinship families. In all foster families visited by the researchers, children had access to functioning toilets. While these findings can only be indicative, given the purposive sampling approach, they do suggest that foster families are generally in a more secure economic position.

Access to education:

Children in the 10 foster families visited by researchers all had access to some form of education, the level of which was largely dependent upon the financial support from the NGO. However, in some of the foster families, foster carers had difficulties enrolling their foster children in public schools due to the lack of a birth certificate.

92 Key informant interview, high-level government representative, Siem Reap, 14.10.16

Access to social workers:

Qualitative evidence suggests that foster families usually have access to social workers through the NGOs involved in the foster placement, though there was evidence that rather than one designated social worker a number of different social workers visited. Such visits were largely to check that all was well in the foster placement. The following response from a boy living in a foster family in Siem Reap illustrates this point well.

Do you have a 'social worker' or anyone who is specifically assigned to help you?

Yes, there are four different social workers who come to visit us from time to time. I know all of them. But they don't talk to us; they only talk to auntie and uncle. Most of the time when they come to visit, we are at school.⁹³



TRAINING

A number of foster parents interviewed for this study indicated that they had received training on childcare and child protection from the respective NGOs involved in the foster care placement. Of the 10 foster caregivers included in the quantitative survey, 8 indicated that an NGO had provided them with training, and 1 indicated that a DoSVY representative had provided training.⁹⁴



COSTS AND FUNDING

It is difficult to assess the total costs of foster care, and it was not an aim of this study to do so. As with kinship care, the study did not look at the costs of monitoring but rather just direct costs to the foster carers. While foster care can be considered one of the less expensive forms of alternative care in Cambodia, and is certainly cheaper than keeping a child at an RCI, it is still costly, and support needs to be paid for as long as the child remains in foster care. Financial support for foster care placements comes primarily from local and international NGOs, with no evidence in the survey that there was any financial contribution from the Cambodian government. The typical monthly support varies from nothing to \$75 a child per month.

Usually there is no support for foster families. In a very few cases we have had to support the foster families with about 30-40 USD per month.⁹⁵

If you make a foster placement, what kind of support do you give to the foster families? It depends on the case. Sometimes, if the child has a disability we give 50 to 70 USD [per month], and hygiene products, diapers, shampoo, clothes, a mirror, rice, and some snacks.⁹⁶

93 Interview with child living in foster care, Siem Reap, 10.10.16

94 It is important to remember that the sample is not representative of foster families in Cambodia, and that survey respondents were sampled purposively.

95 Community care NGO manager, Battambang, 17.10.16

96 Interview with community care NGO manager, Sihanouk, 17.10.16

In contrast to kinship care arrangements, it appears that some NGOs pay foster parents a 'salary' for providing care to foster children, in addition to the support that goes directly to the child. For example, one key informant from the Family Care First Initiative suggested that some NGOs pay foster carers a salary, which can range from 50 USD per child to a flat rate of 200 USD per month.⁹⁷

There are sound reasons for paying a salary to foster parents: it recognises the worth of the work that the foster parents are undertaking when caring for non-biological children and it professionalises foster care. Further, well supported and paid foster parents are likely to continue to be available to the NGO long-term, making investment in further training of foster carers worthwhile, which in turn increases their skill and experience in fostering. Payments to foster carers also ensures that they can spend time with the children, and that one or both are not forced to work outside the home to provide sufficient financial resources for the family. There is always a fear that payment for fostering will encourage people with the wrong motives to apply to be foster parents. However, this is an issue that can be addressed in assessment of foster parents and in training.

97 Key informant interview, Family Care First representative, Phnom Penh, 28.11.16





PAGODA-BASED CARE

Key Findings: Pagoda-based care

1. Pagodas primarily provide care to boys, with only very few pagodas providing care to girls;
2. Pagodas primarily provide care to older children, usually above the age of 10
3. Children come to live in pagodas for a variety of different reasons, including to become monks; to access education not available or not affordable at home; because their parent(s) re-married or migrated; because their family was unable to provide adequate care, because their parents / family could not manage the child's behaviour or because their guardians live and/or work in the pagodas;
4. Identification and placement of children into pagodas is overwhelmingly 'informal' with little or no involvement of NGOs or government representatives;
5. Most children in pagoda-based care have access to education (mostly outside of the pagoda);
6. In some pagodas visited for the study children had either insufficient or uncertain access to food, having to eat the left-overs of the monks and/or nuns;
7. Material conditions in the pagodas are relatively poor in comparison to other types of care;
8. External monitoring of care provided in pagodas is limited and sometimes non-existent;
9. The level of supervision and individualised care that children receive in pagodas is often very minimal;
10. Children living in pagodas typically do not have access to social workers;
11. Pagoda based care is largely funded by donations from Buddhist followers, which means that funding fluctuates;
12. Qualitative evidence suggests that physical and sexual abuse of children in pagodas is an issue that needs to be addressed.
13. There does not appear to be a working relationship between pagodas who care for children and their DoSVY.

Visits were made to 7 pagodas across the 5 provinces in the survey. It is difficult to be certain of the number of children living in Pagodas, although some help comes from a recently completed mapping of residential care institutions in 25 provinces across Cambodia by MoSVY. The study identified 65 pagodas and other faith-based care institutions with 673 girls and 676 boys in residence.⁹⁸ It is likely that the estimate of the number of children in Pagoda based care is too low, given that much of pagoda based care appears to happen informally, without government oversight. For instance, in several provinces included in this study, figures on the numbers of children living in pagoda-based care provided by the Department of Cults and Religion at the province level were lower than those reported by monks at the pagodas themselves. Further, the almost equal number of girls and boys is surprising. The majority of children in pagoda-based care appear to be boys; only three out of the seven pagodas visited reported that they provided care to girls as well as boys, and all of these provided care to fewer girls than boys. One of the remaining 4 pagodas provided schooling to girls and explained that: *"traditionally in Buddhism we cannot touch girls, so we do not have a dormitory for girls yet. Everything for the girls is supported except accommodation – they go home to sleep."*⁹⁹ The fact that pagodas and other faith institutions were mapped as one group is likely to have made the data unrepresentative of pagodas, as the Christian organisations included do not have the same policy on admission.

The pagodas included in the study were diverse, varying in size, and providing care to anything from as few as 5 children to as many as 200 children. Although the researchers were told by one key informant that all the children living in pagodas were living with relative monks, this was clearly not the case. Pagodas provide care to a range of children but do not, as a general rule, take very young children. Only one of the pagodas included in the study reported that it provides care to children aged 3-6, and over half of the pagodas included in the study reported that they only provide care to children over the age of 10. This does not appear to be an official policy, however; according to one monk interviewed for the study, *"there is no limitation on the age of children we take."*¹⁰⁰

A number of respondents to the survey explained that, traditionally, pagodas are viewed as havens of education, discipline and charity, and have a tradition of providing support to those in need:

*Poor families send their children to the pagoda because they are Buddhists and they understand that Buddhism is a great umbrella or shelter for everyone – traditionally it is our community custom to provide support to those in need..... A number of our leaders, including the prime minister himself, have been pagoda boys. This is our Khmer culture and tradition.*¹⁰¹

Many of the pagodas visited in this survey appeared to be over capacity, and monks explained that while there is an intake process (explored in greater detail below), children are rarely turned away from the pagodas in practice: *"We never turn children away...I never say that we are too full because if I say that the children will become desperate and hopeless for the future. No matter how small the space is, they have to share."*

98 Ministry of Social Affairs, Veterans and Youth Rehabilitation, 'Mapping of Residential Care Institutions: Preliminary data compilation and findings', March 2016. This probably does not apply to grandchildren or other relative children cared for by nuns.

99 Individual interview, head monk, pagoda, Preah Sihanouk Province, 20 October 2016

100 Individual interview, head monk, pagoda, Phnom Penh Province, 30 November, 2016.

101 Interview, Department of Cults and Religion, Preah Sihanouk Province, 20 October, 2016



PROFILE OF CHILDREN

Findings from the study suggest that children come to live in the pagodas for a number of different reasons. In some cases, for instance, children wish to become novice monks and enter with that specific purpose. These children enter with the permission of their parents to undertake religious duties and religious education. They may stay 2 weeks, a few months, or permanently if they decide to remain as monks. Although they may not be in need of alternative care, nevertheless they are in the de facto care of the pagoda and fall within the definitions used in the Prakas on Minimum Standards on Alternative Care for Children in the Community.

A second group of children reportedly came to live at the pagoda in order to access education, mostly secondary education. Many, if not most, of these children came from rural areas, where a secondary school is not easily accessible, or is believed to be of poor quality. Most of these children were also described as being from 'poor' families.¹⁰² It is not clear in relation to these children whether the parents do not have the financial means to support the child and pay for secondary education, or whether the parent believes that the secondary education in the cities (where the pagodas surveyed were situated) would be more advantageous for the child, but they cannot afford to pay the costs of education, accommodation and maintenance for their child in the city.

Children who live in the pagoda do not pay for their education, nor do they pay for their board or lodging. In rare cases, if the child does really well and wants to attend university, some pagodas reportedly continue to provide free accommodation and food and even try to find support for the costs of university. Further, families believe that by staying with the monks in a pagoda, the children will learn to behave well and will not be exposed to bad influences in their teenage years. For this group of children, the pagoda seems to function as halfway between a boarding school (though children attend school outside the pagoda) and a supported hostel.

A third group of children come to live in the pagoda for more or less the same reasons as the second group, but these children are related to monks who live in the pagoda. Monks often take the view that it would be beneficial for their male child relatives to live in the pagoda in their teenage years because the education and atmosphere is more conducive to studying, and will help parents, who often have other children to educate.

A fourth group of children are very similar to those who are found in kinship care and foster care. These are children whose parents have migrated, remarried (and the child has been rejected), are too sick to care for the child, have died or the child is at risk of suffering significant harm if he (and sometimes she) remains in the family. They may be brought to the pagoda by relatives, frequently by grandmothers when the parents have migrated or by village chiefs. Many of the children interviewed for the study who were in other forms of care had either stayed in a pagoda themselves at one point in time, or reported to have a sibling who was staying in a pagoda.

¹⁰² As has been described above, the term 'poor' is used to describe a relatively wide range of financial circumstances.

A fifth group are children are those who live with nuns at the pagoda. Nuns were only present in two of the pagodas visited, and were only interviewed in one of the pagodas. In this pagoda, many of the nuns were elderly women and mostly widows. The pagoda allowed the nuns to have their grandchildren or close relatives (both boys and girls) living with them. The children attended public school outside the pagoda and had little connection with other aspects of pagoda life. In a few cases, the grandchildren were living in the pagoda to provide care¹⁰³ to the nun-grandmother, but in other cases, the nun-grandmother was the carer for the children. The latter group of children are clearly children in alternative care, though this is kinship care rather than pagoda care. However, these children are living on pagoda premises and it would appear from the Prakas on Minimum Standards of Care on Alternative Care for Children in the Community, fall within the definition of children in alternative care.

Thus, although the pagodas are home to different groups of children they are all covered by Article 2 of the Prakas on Minimum Standards on Alternative Care for Children in the Community, even if a child might be living in the pagoda primarily for the purpose of education, or living with a related nun.

Article 2: Pagoda and Other Faith Based Care is a care provided to children by monks (Preah Sang, nuns (Donjis), lay clergy (Achars) and religious bodies who provide the children their basic needs in the pagoda and other faith facilities.



IDENTIFICATION AND PLACEMENT

Research findings across the five provinces suggest that referral processes for care in pagodas operate informally. Families tend to learn about pagodas through word of mouth and children are typically referred by parents, or by relatives, neighbours or village authorities:

Most of these children are from the neighbouring provinces, rural provinces. The recruitment is not formal, it happens in an ad hoc manner. In most cases the parents or relatives would approach me and ask if we could take in their child.¹⁰³

There is no assessment or physical visit. Most of the children are brought by their grandmothers after their parents have migrated elsewhere to work. Sometimes I am away in other provinces, and new children are here when I return!¹⁰⁴

Monks at the pagodas explained that they only inform local authorities about a child's placement in cases where the child's parent or guardian is absent. This is inconsistent with the Prakas on Minimum Standards on Alternative Care of Children in the Community, which state that 'Commune authorities should be informed when a child is living in the care of a facility.'¹⁰⁵

¹⁰³ Individual interview, monk and caretaker, pagoda, Battambang Province, 18 October, 2016

¹⁰⁴ Individual interview, head monk, Pagoda providing care, Kandal Province, 11 October, 2016

¹⁰⁵ Minimum Standards on Alternative Care, Prakas on Minimum Standards on Alternative Care in the Community, Responsibilities of Alternative Care Providers, 2008, Article 6.2

In addition to receiving referrals, several monks at the pagodas reported that they occasionally recruit children to come and live in the pagodas themselves. One monk told researchers, *'Sometimes I also travel to the villages in the rural areas. When I am there I recruit children who are working on the rubber plantations.'*¹⁰⁶

Finally, while most children reported that the decision to place them in a pagoda was made by a parent or relative; in several cases, children reported choosing to stay in the pagoda independently:

How did you choose to come to this pagoda?

*There was an announcement about this pagoda wanting more monks. At the time there were monks from Thailand visiting and they wanted to preside over the ceremony for people to become monks. [When I asked my parents they] were happy and encouraged me to stay as a monk for as many years as I can. They want me to learn as much of the dharma as possible.*¹⁰⁷

Representatives from pagodas across all five provinces reported that there is no assessment of a child's situation at home (or otherwise) prior to his or her acceptance into pagoda based care. Respondents described the intake process at pagodas to be relatively simple:

What was the process to get approval to stay here?

My parents brought me here and spoke to the chief of the pagoda and I was accepted.

Were there any conditions?

*You must attend classes or you will be ousted.*¹⁰⁸

What criteria do you use to accept or reject children?

*The child has to be from a remote or rural area. The child's desire to learn is also very important.*¹⁰⁹

As is reflected in the quotations above, pagodas' acceptance criteria tend to relate to the material needs of the child, and to their commitment to education and good behaviour. Pagodas appear to take a very generous approach to intake and children are rarely refused or turned away.



MONITORING

Monitoring of care provided in pagodas in practice, appears to vary from limited to non-existent. None of the (pagoda based) carers surveyed for the study reported that their pagoda is visited by external officials for monitoring purposes. The provincial level Department of Cults and Religion is the government body with responsibility for overseeing pagodas. However, according to the DoCR representatives, regular visits aren't conducted to all pagodas, and monitoring mechanisms for child care provided by the pagodas are not in place:

¹⁰⁶ Individual interview, monk and caretaker, pagoda, Battambang Province, 19 October, 2016

¹⁰⁷ Individual interview, boy (novice monk), pagoda, Preah Sihanouk province, 19 October, 2016

¹⁰⁸ Individual interview, boy (laymen), pagoda, Preah Sihanouk province, 19 October, 2016

¹⁰⁹ Focus group discussion, monk/caregiver, Pagoda, Siem Reap Province, 11 October, 2016

I am the deputy of the provincial Department of Cults and Religion. We oversee pagodas and other faith-based organisations. Our department has nothing in particular to do with child care. But recently the Department has started to encourage the pagodas to provide shelter, food and education to vulnerable children.¹¹⁰

Findings from the study also confirm that the MoSVY does not provide oversight of, or support to, pagoda based care services in practice. The following excerpt, from a DoSVY representative in Battambang province, is consistent with findings from other provinces:

Do you ever place children in the Pagodas?

No – I am never involved in Pagoda placements. I also do not inspect Pagodas. Only the Cults Department knows how the children in the Pagodas are doing.¹¹¹

This lack of monitoring is inconsistent with the Prakas on Minimum Standards on Alternative Care of Children in the Community, which require that alternative care providers are 'responsible for regularly and continually following up child placements in the pagoda and other faith-based care and group homes, to ensure that these facilities comply with the Minimum Standards' (Article 6).



CONTACT WITH BIOLOGICAL PARENTS

Neither the monks nor DoSVY appear to be involved in maintaining or facilitating contact between a child and his family while he is residing in the pagoda. Further, neither the monks nor DoSVY reported that they were involved in the reunification of children with their families when they choose to leave the pagoda or finished school.

Some pagodas report to provide the Department of Cults and Religion with information about the numbers of children living at the pagodas, however this information appears to be of limited accuracy and to be provided on an ad hoc basis:

Interview with Department of Cults and Religion, Phnom Penh

Sometimes we can't inspect the pagoda because they don't tell us that they have children staying there. Sometimes the children are related to monks so we don't count them.

Interview with Department of Cults and Religion, Battambang

The head monk usually reports each child living in the Pagoda to the District Department of Cults and Religion. But we still don't know how many children are living in pagodas in Battambang...this is because reporting to the Cults and Religion Department is not mandatory. Some head monks report the number of children, some don't. Some just report partially. The problem is that children also move between the Pagodas especially those who want to become monks.¹¹²

110 Individual interview, representative of Department of Cults and Religion, Battambang Province, 18 October 2016

111 Individual interview, DoSVY representative, 18 October 2016

112 Individual interview, representative of Department of Cults and Religion, Battambang Province, 18 October 2016



NATURE OF CARE PROVIDED

Material conditions in the pagoda:

While conditions in the pagodas varied, they are relatively poor, in comparison to the conditions in foster care, group homes and RCIs. Many of the pagodas visited for the study appeared unclean, with piles of rubbish around the buildings and grounds. Several lacked functioning sewage systems, and in others bathrooms were not functional or in an acceptable condition.

Carers at the pagodas acknowledged that facilities were inadequate, and expressed a desire to achieve funding to improve and expand facilities. Children sleep in shared rooms, regardless of age, often with monks or with other children staying at the pagodas. The number of persons in a room at the pagodas visited for the study ranges from 2 - 15. Only 1 of the pagodas provides mattresses for children and these were in very poor condition; in the other pagodas, children sleep on mats or on the floor. In the pagoda where children were living with the nuns, the conditions in which the nuns lived were very poor indeed.

When asked about the conditions at the pagoda, many of the children described them as satisfactory or even an improvement on their situations at home, possibly due to the poor standard of living these children had experienced before coming to the pagoda, especially in rural areas.¹¹³

Education in the pagoda:

Education and study are an important part of life at the pagoda for children.¹¹⁴ All of the children in pagoda-based care included in the study reported being in education of some form, in line with education requirements set out in Article 5 of the Prakas on Minimum Standards on Alternative Care of Children in the Community. Monks caring for the children at all but one of the pagodas included in the study reported that children attended government schools. The exception, a pagoda in Kandal Province, appears to be unique in providing secular education within the pagoda, which is delivered by government teachers, and accessed both by children who live at the pagoda and children who attend as day pupils. The pagoda reported that, at the time of the visit, 697 children were attending the school each day, but only 200 were accommodated at the pagoda, the rest lived locally.

In addition to school classes, children at several of the pagodas included in the study reported receiving extra tuition and support from monks at the pagoda, which they found helpful.¹¹⁵

¹¹³ Individual interview, boy (laymen), pagoda, Preah Sihanouk province, 20 October, 2016

¹¹⁴ Individual interview, Department of Cults and Religions representative, 2 December, Phnom Penh Province, 2016

¹¹⁵ Focus group discussion, children living in pagoda, Kandal Province, 11 October, 2016

Food in the pagoda:

Pagodas provide food to the children who stay on their premises. However, the quality and consistency of the food was found to vary across pagodas included in the study; in some pagodas children eat the food left over from the monks, and if there is insufficient food have to provide their own. This applies particularly to those pagodas where the children enter to receive education:

*The pagoda provides free accommodation. We don't cover food expenses. Only when there are leftovers from the monks' meals, then the children can have free food from us.*¹¹⁶

—
How is the food here? How often do you eat?

*It depends – sometimes less than 3 times a day. We often have to skip breakfast. When the cook prepares food for the monks, what is left over will be for the children.*¹¹⁷

The Prakas on Minimum Standards on Alternative Care of Children in the Community requires that children have access to 'at least three meals a day' and 'balanced nutrition with protein.' It is not clear that the pagodas meet this requirement. This applies not only to the boys, but even more so to the girls living with nuns. In the Phnom Penh pagoda where nuns can have their children to live with them, it appeared that the nun was responsible for providing the child with food, rather than the pagoda.

At other pagodas, provision of food was found to be consistent with the Prakas; children reported that they are provided with three full meals a day, and enjoy the food.¹¹⁸

Health in the pagoda: Pagodas included in the study varied in terms of the support they are able to provide to children in accessing health services. While at one pagoda the monks reported that they funded children's access to health care services, spending around \$1,500.00 a year providing children with transportation to access health services, in others children reported to access health services on their own: '[if we get sick] we can go to the pharmacy nearby'.¹¹⁹

None of the pagodas included in the study had health facilities on their premises; however, monks at several pagodas explained that they provide some physical and psychological health treatments and therapies within the pagodas.¹²⁰

While pagodas try to provide some health care support to children, it appears that in most cases this support is inadequate to meet the criteria that: 'children receiving community alternative care shall be provided with access to: sufficient and appropriate health care and dental care; immunisation and treatment', set out in Article 4 of the 'Prakas on Alternative Care for Children in the Community'.

116 Individual interview, monk (caregiver), pagoda, Battambang Province, 20 October, 2016

117 Focus group discussion, children living in pagoda, Siem Reap Province, 19 October, 2016

118 Focus group discussion, boys living in Pagoda, Kandal Province, 11 October, 2016

119 Focus group discussion, children living in Pagoda, Siem Reap Province, 11 October, 2016

120 Individual interview, head monk, Pagoda providing care, Kandal Province, 11 October, 2016

Caregivers in the pagoda:

A critical issue to consider in relation to pagoda-based care is the lack of individualised care services provided within pagodas, particularly in comparison to other forms of care. While children staying in the pagoda develop relationships with the monks, and they are often reported to be assigned to a particular monk who acts as their 'teacher' (in several cases this person shared sleeping quarters with the child), the level of supervision and individualised care that each child receives appears to be minimal. As one respondent explained, 'the pagoda does not have the responsibility for providing much more for the kids. Each of the pagodas in a cell or house is responsible for the kids' education – once a monk accepts a child he is responsible and must care when the kid is sick and take him to the hospital, etc.'¹²¹

While the pagodas understand that *'The responsibility of care rests entirely with us, the monks,'*¹²² monks are not, and nor do they hold themselves out to be, the equivalent of foster carers. They all have their own religious duties. This is recognised, as noted by one head monk at a Pagoda:

"Frankly speaking, we are here as monks – we accept the boys to stay and eat, but we are not their parents. We cannot provide the attention to them that the parents would do. Boys of this age would have had better support and love from their biological parents."

How many of the adult monks are devoted to looking after the children?

*As of today's date I cannot tell how many adult monks have devoted to looking after the boys, but it is individual depending on the situation, the atmosphere... the management is very busy. They cannot devote individual attention to the boys.'*¹²³

However, bearing in mind that children staying at the pagodas reportedly only visit home once or twice a year, if at all, and none have a relationship with a social worker or counsellor from outside the pagoda, (at least at pagodas included in the study), the monks almost inevitably are the main attachment figures in the lives of the children living in the pagoda, some of whom are pre-teens.

The characteristics of pagoda-based care led several key informants to express scepticism about whether pagodas are an appropriate alternative care environment for children. When asked about which type of care is the most difficult or challenging, a key informant replied, *'it is the pagoda-based care, because the monks don't have the care of the children as their main priority: it is the religion.'*¹²⁴

A further issue relates to children living with nuns. In the case of the pagoda where nuns were interviewed for this study, the children and nuns lived in poor to extremely poor conditions with uncertain support. The nuns do not have any source of income other than payments made for the performance of religious duties and alms from those attending the pagoda to pray. Children living with the nuns at this pagoda said that they

¹²¹ Individual interview, Department of Cults and Religions representative, 2 December, Phnom Penh Province, 2016

¹²² Individual interview, monk at pagoda, Battambang Province, 19 October 2016

¹²³ Individual interview, vice head monk, pagoda, Preah Sihanouk Province, 20 October, 2016

¹²⁴ Individual interview, director at NGO providing alternative care services, 17 October, 2016

did not have other relatives with whom they could stay, and their future was clearly a matter of concern for them, especially if the grandmother died.¹²⁵ The conditions and the ability of the grandmother to care the children raise the question of which body should be responsible for providing support to the family where it is needed: the pagoda or DoSVY?

Key stakeholders expressed a diversity of views about the advantages and disadvantages of pagoda-based care when compared with other forms of alternative care. Some respondents emphasised the particular value of pagoda-based care, which allows children to maintain stronger bonds with their communities than other forms of residential care:

*If you look at the way it is functioning it is different than residential care – they go day to day to collect food or attend the state school but at night they stay at the pagoda in the monk clothes. When a child wears monk clothes even me – I have to respect them because in my mind they represent the Buddha... The children in residential care do not have that respect or connection with communities.*¹²⁶

By contrast, other respondents described the care provided at the pagodas as inadequate, due to insufficient food, poor living conditions, and a lack of individualised care provided by monks. Given this, according to one DoSVY representative, the pagodas should be a measure of last resort, for children without any relatives available to care for them; *'the children in pagodas are mainly in a worse situation than those who are in kinship care. They are from extremely poor households or households with widowed mothers.'*¹²⁷



TRAINING

There is a designated monk responsible for managing issues in relation to the children at all of the pagodas included in the study – often this was a deputy head monk, or, in rarer cases, the head monk at the pagoda. None of the pagodas pay staff to provide child care, although in most pagodas certain monks were designated as having responsibility for the children. Several respondents mentioned that in some pagodas, NGOs run professional child care programmes with paid staff: *"Pagodas can be divided into two groups. First are the pagodas that have professional care programmes with paid staff and carers. These programmes are usually run by NGOs within the premises of the Pagodas. Second, there are the pagodas that provide traditional pagoda-based care based on the charity of the Monks"*.¹²⁸

It is unclear how much training the monks responsible for children in the pagoda receive. All but one of the monks reported that they had received training on counselling and identification of child abuse from an NGO, but this appeared to be a short, one-off training. There is no standardised training programme on child protection for those responsible for children in the pagoda and no training on child protection, child development, positive discipline etc.

¹²⁵ It should be noted that the Head Monk of the pagoda was in the process of raising funds to erect a new building with modern facilities for the nuns and children living with them.

¹²⁶ Individual interview, UNICEF representative, Phnom Penh, 12 October 2016.

¹²⁷ Individual interview, DoSVY representative, Battambang, 15 October, 2016

¹²⁸ Individual interview, representative of Department of Cults and Religion, Battambang Province, 18 October 2016

Do the monks receive any special education or training in caring for children?

We will pay for trainings to get specialised training on caring for children. We get trained here in the pagoda with someone hired from outside and also send them to faculty of Buddhism in Phnom Penh.

For such cases I've attended seminars and workshops organised and funded by UNICEF.¹²⁹

All carers included in the survey reported to have completed primary school, which is consistent with requirements set out in the Prakas on Alternative Care of Children in the Community.



COSTS AND FUNDING

Pagoda based care is largely funded by donations which monks collect on a daily basis, as well as the donations they receive for conducting religious ceremonies:

The pagodas are totally reliant on the Buddhist followers – to construct a building we will need followers to pay. We don't rely on the state as the chance would be zero.¹³⁰

Where do you get funding to care for the children?

It is from the contributions of the Buddhist followers. We also perform ceremonies for fees. Then we get some money from the families who host ceremonies.¹³¹

Carers at four of the pagodas surveyed reported to receive some external funding: from an international NGO; a local NGO; a local religious body; and the Ministry of Cults and Religion. This funding appears to be quite minimal, however: when asked what his pagoda receives from the MoCR, one monk explained, “only learning materials for the Buddhist school, textbooks, and such.”¹³² Some children staying at the pagoda reported to receive small amounts of cash from their families on a monthly basis to supplement material support given by the pagoda, however, many children reported not to receive anything at all.

Spending at the pagodas appears to fluctuate according to what is available, and several pagoda representatives explained that they don't keep a regular budget. Furthermore, as mentioned above, many pagodas report that they do not turn children away, and therefore often operate with a budget below what is needed to provide a reasonable standard of care.

It is difficult to generalise based on costs per child reported by the pagodas in the study, because the material support and services provided to children differed across pagodas and within pagodas depending on available funds. When asked to approximate their costs per child (which were primarily made up of utility bills and food), pagodas reported spending between 30 and 50 USD per month on average. These costs should not be used as a standard, however, as all monks interviewed emphasised that

¹²⁹ Individual interview, head monk, Pagoda providing care, Kandal Province, 11 October, 2016

¹³⁰ Individual interview, head monk, pagoda, Phnom Penh Province, 30 November 2016

¹³¹ Individual interview, representative of Department of Cults and Religion, Battambang Province, 18 October 2016

¹³² Individual interview, monk/caregiver, pagoda, Battambang Province, 19 October, 2016

spending does not adequately cover children's needs. One of the pagodas included in the study reported specific monthly expenditures on health and education (extra classes) for children: *'Last September I spent 1,750.00 sending children to the clinic for health care... we spend 3,5000.00 on a teachers' salary per month on subjects such as Khmer language and computer class.'*¹³³

The lack of a continuous funding flow is a barrier to the pagodas providing reliable and sustainable care for children. Interestingly, key informants suggested that pagoda-based care has become less sustainable in contemporary Cambodia due to both the proliferation of pagodas and communities' loss of respect for the pagodas and reduced commitment to supporting them: *'the population has lost trust in the monks, they do not provide charitable contributions as they did in the past ... before we had one commune with one pagoda – now there are four or five pagodas so the funding is quite limited.'*¹³⁴



CHILD PROTECTION

While little robust or comprehensive data on issues of child protection within the pagodas exists, anecdotal evidence suggests that abuse of children is an issue in Cambodian pagodas, and in particular, sexual abuse of boys by monks. This issue was raised by several key informants in the study:

*The pagodas need to be formalised – they need to have a child protection policy to make sure the kids are not exploited or abused in the pagoda. There are parents who believe the pagoda is a good place for the children.*¹³⁵

*One issue we cannot ignore is the abuse by carers in the institutions. Sometimes this happens in pagodas.*¹³⁶

The qualitative research did indeed reveal incidents of sexual abuse occurring within the pagodas, as is revealed in the following interaction with a boy staying in a pagoda in Battambang.

133 Individual interview, head monk, pagoda, Kandal Province, 11 October, 2016

134 Individual interview, UNICEF Staff, Phnom Penh, 12 October, 2016

135 Individual interview, director at NGO providing alternative care services, 17 October, 2016

136 Individual interview, UNICEF Staff, Phnom Penh, 12 October, 2016

CASE STUDY: BOY LIVING IN A PAGODA, BATTAMBANG

Has anyone ever used sexual language with you?

Yes, there is this man from the neighbourhood who comes to the Pagoda to visit once a month or so.

Does he touch you?

No, there is no touching.

What does the man who uses sexual language do when he comes to visit the pagoda?

He plays with the children and talks to the boys.

Where does this happen? Outside or inside?

In the outside areas.

How old is he?

About 30 years... he lives close by.

Did he ever touch any of the boys in their private parts?

No, no touching... but the monk touches my penis

When does this happen?

When I am sleeping. Then I woke up and pulled up my trousers.

What happened then?

The monk stopped touching my penis.

How often does this happen?

Once a year maybe... it happened a while ago. Maybe a year. Since then he has stopped doing this.

Does the monk still live here?

Yes.

Did you tell your parents about this?

No, I didn't tell them.

Did you tell anyone else about this?

No – there is no one else to tell.¹³⁷

It is important to note that at the vast majority of pagodas included in the study, children maintained that they had never experienced sexual abuse in the pagoda, or heard of this happening to others. It is likely that some underreporting occurred, however, given the sensitivity and stigma that exist around sexual violence.

Research findings also suggest that physical punishment occurs quite regularly in the pagodas. In fact, some respondents described physical punishment as an integral part of the approach to discipline taken at the pagodas. Respondents described a range of physical punishment practices applied in pagodas, which can be quite severe:

¹³⁷ Individual interview, child in pagoda, Battambang Province, 18 October, 2016

Physical discipline is a bit of a problem in the pagodas. In one recent case a monk poured boiling water over a child as punishment.¹³⁸

—
What happens if you break the rules?

We get beaten by the monks.

With what?

With a stick.

Does this happen a lot?

It happens about once a month. Usually we get two whips. We are allowed to cry because it hurts a lot.

Are there any other punishments?

No, only beating.¹³⁹

The use of punishment and the related tale of abuse demonstrates that children and staff in the pagodas would benefit from having a child protection policy to which all are expected to adhere, and which sets out the steps to be taken when an allegations of abuse is made and the action to be taken to protect the child. The response of a provincial level DoCR representative when asked about child protection within the pagodas indicates that more also needs to be done to raise awareness of child abuse. *'Not one of us has ever encountered or identified a child protection issue within a Pagoda. We have an agreement amongst ourselves that serious cases will be reported to the chief monk and there is a potential reporting channel to DoSVY, but such a notification has never happened.'*¹⁴⁰

The pagodas present a paradox. On the one hand, the pagodas visited did not see their function as providers of long term care for children. They recognise that the only people available to care for children in pagodas are the monks (nuns do not take a role in caring for boys resident in pagodas, unless the boys is a relative of the nun and living with the nun). On the other hand, the pagodas see themselves as providing a safety net for children whose parents or family are unable to care for them (including the provision of education) or who are exploiting them (a role which should properly fall on the shoulders of DoSVY and CCWC).

The major purpose of taking children into pagodas, as explained to the researchers however, is to ensure that the children access education, both religious and secular. None of the pagodas referred to the Prakas on Minimum Standards on Alternative Care of Children in the Community, and there does not seem to be an understanding by either pagodas or the MoCR that the Prakas applies, and that this imposes certain obligations upon the MoCR and the Chief Monks.

¹³⁸ Individual interview, director at NGO providing alternative care services, 17 October, 2016

¹³⁹ Focus group discussion, children in pagoda, Battambang Province, 18 October, 2016

¹⁴⁰ Individual interview, representative of Department of Cults and Religion, Battambang Province, 18 October 2016





GROUP HOMES

Group Homes: Key Findings

1. Group homes cover a whole range of different care arrangements, with some being closer to 'traditional' foster families and some being closer to what would be considered 'independent living arrangements';
2. Most care providers understand group homes to be 'temporary' care arrangements for preparing families for re-unification or older children for independent living;
3. Some group homes are relatively isolated from their surrounding community and, in practice, resemble 'closed' residential care facilities, and do not conform to the ideal of a 'community-based,' 'family-like' care arrangement, as stipulated in the 2008 Prakas;
4. Placement of children into group homes sometimes takes place before other family-based care options have been exhausted;
5. Monitoring of group homes appears to function relatively well, even though government involvement is minimal;
6. Contact with biological parents and re-integration attempts are not prioritised and viewed sceptically by some group home caregivers interviewed for this study;
7. Material conditions and access to education are often significantly improved for children living in group homes;
8. Children in group homes rarely have access to a designated social worker on a regular basis;
9. Most carers in group homes have received some form of training, even though this may be very rudimentary and/or informal training;
10. Group homes are more expensive than family-based alternative care options;
11. Children often describe their experiences living in group homes in a positive light, due to improved living standards and access to education. However, older children expressed a desire for more privacy, which cannot the group homes are not generally able to provide at present.



PROFILE OF CHILDREN

The 2006 Policy on Alternative Care and the 2008 Prakas on Minimum Standards on Alternative Care of Children in the Community define group homes as a form of alternative care where a limited number of children (no more than 15, according to the Prakas) are housed in a family environment under the supervision of a small group of caregivers unrelated to the children.¹⁴¹ The mapping of residential care facilities, carried out in 2015 in all Cambodian provinces, identified 71 group homes. The total number of children under 18 years identified as living in these group homes was 1592, with slightly more girls (820) as boys (772). There are also a large number of 18-24 year olds living in the identified group homes (544). Research for the study showed that some of the over 18s are 'aged-out' children who were living in the group home or a RCI before the age of 18 and who have stayed on. Others appear to be students who are helping in the home for free or reduced board and lodging. The mapping did not provide a more detailed age breakdown and it did not necessarily capture all group homes in Cambodia, given that enumerators relied on key informants at the Commune level to identify relevant care arrangements.

Due to time and resource constraints, researchers were only able to visit 4 group homes, a small sample of group homes compared to those covered in the 2015 mapping exercise. Table 4 in the Annex provides an overview of the different group homes and independent living arrangement visited by researchers, including a description of the specific care arrangement. The number of children living in the group homes visited for this study varied from 3 to 13 children, aged between 4 and 22 years. The supervised independent living arrangement visited by researchers in Preah Sihanouk accommodated two children, aged 15 and 17 years.

A majority of the children in the group homes visited had previously spent some time living in RCIs or temporary shelters. The following case study of a girl living in a group home in Siem Reap illustrates well how children are passed from one care arrangement to another. Multiple moves are sometimes inevitable but should be avoided wherever possible as they are disturbing for the child, may prevent them from developing any form of meaningful attachment to their caregiver and may cause them to change schools, interrupting education.

¹⁴¹ See Articles 2 and 5.

CASE STUDY: 17-YEAR-OLD GIRL INTERVIEWED IN A GROUP HOME IN SIEM REAP

Where were you living before you came to live in [the group home]? I lived at [a shelter for abuse and trafficking victims on the outskirts of Siem Reap] before I came here. I stayed at [the shelter] for almost 4 years I think. What does [the shelter] do? What is its purpose? [The shelter] rescues children from violence. And also those children who have no shelter.

Why did you come to live in [the shelter]?

I suffered from violence. I got mistreated by my host family, where I lived before. Why did you live with a host family? I was sent to this family by my father so that I could get an education. Why were you sent to this family? My father made that decision. He had his network. My host father treated me badly and I was beaten and abused. How did you get out of this situation? The commune officials saw that I was often beaten by my host father. They often walked past the house I was living in at that time.

What happened then?

The commune officials then talked to my biological parents to see if they could take me back. But I didn't want to go back to them. There is no education in my village. So the commune officials and my parents decided that I should go to [the shelter].

And why did you leave [the shelter] and come to live here?

Because after 4 years, they decided that I should go to [the group home] so I could get a better education.

Evidence from the qualitative interviews suggests that NGOs and government representatives involved in placing children into group homes primarily conceive of this type of alternative care option as a 'temporary arrangement' rather than long-term or permanent care placements.

For children from violent families, we will place them in temporary group homes and then we train the parents on positive parenting until they are ready for reunification.¹⁴²

The respondents' understanding of 'group homes' as temporary care placements is in line with Article 21 of the Prakas on Procedures to Implement the Policy on Alternative Care for Children, which defines 'group care' as a 'temporary alternative', and which establishes a strict 'hierarchy of care', where group homes are not considered as appropriate as family-based options (i.e. kinship and foster care).

Interestingly, care providers interviewed for this study had very different understandings of what constitutes a 'group home', with some being closer to what would be considered 'temporary foster care' and some closer to what could be understood as 'independent living arrangements'. For example, one NGO manager interviewed for this study indicated that her NGO was supporting "eight group homes, with each group home having 4-5 children. These children will be placed with a family that already has a house, so we

¹⁴² Community care NGO manager, Battambang, 17.10.16

don't need to pay rent."¹⁴³ While the NGO would provide material support to the children and pay group home parents a monthly 'salary', the fact that children are placed into private homes makes this type of arrangement very similar to what would be normally considered a foster family.

Another NGO manager interviewed for this study said that the 'group home' arrangements supported by her Siem Reap-based NGO are typically *"4-6 month placements aimed at preparing children for independent living. We have a social worker who provides counselling and visits for eight hours a day but does not sleep [in the house] unless they are asked."*¹⁴⁴ In this case, it appears that the respondent's understanding of 'group homes' is much closer to what would normally be defined as supervised independent living arrangements, given that the carers are not resident.

Two of the group homes visited for this study resembled and were run more like a small RCI, rather than family-like care environments that are integrated into the community. For example, the group home surveyed in Siem Reap was completely closed off from the outside, with high walls and a guard. The only times children living in this group home are allowed to leave the premises is when they are driven to and from the nearby private school, or when the manager takes them to the movies in town.¹⁴⁵ Children living in a group home visited by researchers in Phnom Penh were also restricted in mixing in the community. *"Some friends come here, but we have never been to their house – we are not allowed to go out. We are not allowed to visit other people."*¹⁴⁶ While, clearly, children's safety is an issue that needs to be addressed, these types of group home arrangements do not conform to the vision of 'community-based alternative care' set out in the Prakas on Minimum Standard of Alternative Care of Children in the Community.



IDENTIFICATION AND PLACEMENT

It appears that placement of children into group homes typically involves external actors (NGOs or government representatives), which means that the number of 'informal' group homes is probably quite small. For example, in all of the surveyed group homes for this study, the placement process involved at least one external actor, either from an NGO or a government agency (DoSVY and CCWC).

The 'order of preference' in relation to placement established by Article 21 of the *Prakas on Procedures to Implement the Policy on Alternative Care for Children*, is first, placement with relatives, second foster care, third group homes and pagoda care and last, placement in a RCI. This approach seems to be adhered to by most of the NGOs visited for this study: children were placed into group homes only after re-integration into family-based care arrangements had been attempted unsuccessfully or were not possible. An NGO manager in Siem Reap, reiterated that a strict hierarchy of care is applied when placing children into alternative care arrangements.

143 Community care NGO manager, Battambang, 17.10.16

144 Key informant interview, NGO manager, London via Skype, 19.12.16

145 Caregiver interview, group home manager, Siem Reap, 11.10.16

146 FGD with children, group home, Phnom Penh, 28.11.16

How does your organisation go about reintegrating children previously in residential care?

"First, we contact DoSVY to see whether the children have parents or whether they can go to extended family members. Then, if there are no extended family members, the smaller children will go into foster families, and the older children will go into group homes."

Why do older children go to group homes?

Older children are more difficult to integrate into foster families.

Why do you think this is?

The few grown up children we have placed into foster families did not get along well with the biological children of the foster parents.¹⁴⁷

With respect to some children, though, it appears that family-based care alternatives were not attempted before placement into the group home. For example, a group home manager interviewed in Siem Reap described the identification and referral process for children coming to live in her group home.

How do children come to live here? What is the referral process? How are they identified?

Mostly it happens informally. For example, one of the girls was identified by our pizza delivery man. I also sometimes go to visit poor, rural villages and this is how I have identified some of the girls living here. I do random visits, around 3 times a year. I will go to talk to the village chiefs, the neighbours and community leaders. It's expensive to provide care for children here in this house, so we have to be very selective [sic].¹⁴⁸

The identification and placement process described above does not conform to the requirements in the 2011 *Prakas on Procedures to Implement the Policy on Alternative Care for Children*. The respondent made no indication that other family-based options were explored before children were 'recruited' into the group home, and the interview also revealed that family-reintegration was not considered a priority and rather considered a 'danger' for the children. However, these children were all regarded as being at significant risk of harm in their birth family.

How long do children tend to stay in your care?

As long as they need to. There is no upper age limit for the girls that stay here. The parents can decide when and whether they want to take the child back home. It's a big crack in the system! We have no power to prevent the parents from taking back their children.

Have you made any attempts at re-integrating the children in your care?

No, none of the families have improved enough for them to take back the children.¹⁴⁹

¹⁴⁷ Individual interview, NGO manager, Siem Reap, 14.10.16

¹⁴⁸ Caregiver interview, group home manager, Siem Reap, 11.10.16

¹⁴⁹ Caregiver interview, group home manager, Siem Reap, 11.10.16



MONITORING

Group home arrangements appear to be relatively well monitored in comparison to, for example, kinship families. All of the group home caregivers included in the survey indicated that they were monitored by external bodies. This practice appears to be in line with Article 12 of the Prakas on Minimum Standards on Alternative Care in the Community, which requires that alternative care providers supporting group homes are responsible for regularly and continually following up child placements to ensure compliance with the Minimum Standards.

Article 12 also places a duty on DoSVY to carry out monitoring visits of group homes at least once a year. However, evidence from the qualitative data suggests that the extent of government involvement in the monitoring of group homes, especially those that closely resemble 'foster families', is relatively limited. As one NGO noted:

*"Sometimes [DoSVY and CCWC] are too busy, so we go to the [group home families] alone and they [DoSVY and CCWC] just sign the form without having done the visits themselves."*¹⁵⁰

NGOs involved in placing children into group homes often face the same types of constraints as local government representatives. *"For children living close to our office, I would say [we conduct visits] 2-3 times a week. For those who live far away, we only visit them 1-2 times a month."*¹⁵¹

In contrast, for group homes that resemble small residential care institutions in their management structure and size, it appears that DoSVY is more involved in monitoring. A manager of a group home providing care to 13 children in Siem Reap City noted that:

*Representatives from the Provincial DoSVY [Siem Reap] make unannounced visits, around 3 times a year I think, but not in regular intervals. And then sometimes MoSVY from Phnom Penh send a team, usually once a year."*¹⁵²

While this case suggests that the official monitoring of larger group homes is largely in line with the 2008 Minimum Standards, it is important to remember that the small study sample may not be representative of all group homes in Cambodia.



CONTACT WITH BIOLOGICAL PARENTS

Children living in group homes may still have one or both biological parents. The frequency of contact with biological parents varied considerably between the different group homes visited for this study, with some children having weekly contact and other seeing their parents only once a year.

¹⁵⁰ Community care NGO manager, Battambang, 17.10.16

¹⁵¹ Community care NGO manager, Battambang, 17.10.16

¹⁵² Caregiver interview, group home manager, Siem Reap, 11.10.16

How often do you see your parents?

*They come to visit maybe 2-3 times every year. And we can call them on the phone, maybe 3 times a month.*¹⁵³

What about your parents? Do you ever see them?

*My mother comes and visits us maybe once or twice a year. Mostly she comes without telling us before. She is a beggar in Thailand.*¹⁵⁴

While parental contact is in principle a good thing for children, a number of care providers supporting group homes highlighted the negative influence that contact with biological parents can have on children.

What are the main challenges and difficulties that you face as a care provider?

*It is definitely the parents' negative inputs and their bad influence on the children. They say stuff like: 'school is not important', or 'we have a debt to pay off'. One of our girls [sic], she just turned 16, recently left to work as a cleaner because her mother was in debt and she felt like she had an obligation to support her mother. Culturally, the girls want to help their families.*¹⁵⁵

From the perspective of the children themselves, contact with their parents was generally seen in a positive light, even though few children said they would prefer to live with their biological parents. A group of girls in a Siem Reap group home were asked:

How do you feel about seeing your parents?

We like seeing our parents!

If you could decide where you wanted to live, your parents or here, where would it be?

*We prefer [the group home].*¹⁵⁶

In other cases, however, children did not view contact with their biological parents in a positive light. For example, one boy interviewed in a group home in Phnom Penh said that he was 'afraid of his mother' (she had apparently killed someone) and that he does not want to talk to her.¹⁵⁷ In cases such as this, contact (if it takes place at all) needs to be carefully handled.



NATURE OF CARE PROVIDED

Article 6(3) of the Prakas on Minimum Standards on Alternative Care of Children in the Community requires that 'each group home shall have two caregivers, as mother and father.' In practice, however, it appears that group homes rarely conform to the specific care structure required in the Prakas. For example, a group home visited by researchers in Battambang only had one 'female' caregiver.¹⁵⁸ In contrast, a group home visited in Siem Reap had more than three caregivers, none of whom were male.¹⁵⁹

¹⁵³ Interview with children, Group home, Siem Reap, 11.10.16

¹⁵⁴ Interview with children, Group home, Battambang, 17.10.16

¹⁵⁵ Caregiver interview, group home manager, Siem Reap, 11.10.16

¹⁵⁶ FGD with girls, Group home, Siem Reap, 11.10.16

¹⁵⁷ Interview with boy, group home, Phnom Penh, 28.11.16

¹⁵⁸ Caregiver interview, group home, Battambang, 17.10.16

¹⁵⁹ Caregiver interview, group home, Siem Reap, 11.10.16

The nature of care provided to children living in group homes is largely dependent on whether the care arrangement is closer to a 'foster family' (with a paid caregiver and/or rented home) or closer to a small residential care facility. In addition, the nature of care provided to children living in group homes depends on the level of support provided by NGOs. Even though it is difficult to make firm conclusions given the small number of cases visited for this study, it appears that larger, more 'institutionalised' group homes can typically provide children with services (access to private school, individual rooms, etc.) that children would rarely be able to access in family-based care arrangements such as kinship care or foster care.

Material conditions:

The quantitative data from the observational checklist indicates that children living in group homes enjoy a decent standard of living in light of the general living standards in Cambodia. For example, all group homes included in the observational checklist had a functioning sewage system and functioning toilets that were in an acceptable condition. Furthermore, the quantitative checklist revealed that all children living in group homes had access to safe drinking water.

Access to education:

Children living in group homes typically have good access to education. One NGO visited by researchers in Battambang even made proximity to a public school a condition for establishing a group home in a specific area.¹⁶⁰ In another group home visited by researchers in Siem Reap, all children were being driven to and from a private school with a small bus because the manager perceived public schooling to be of insufficient quality:

"I had a look at the public schools here, but they are not good. Some of the teachers would demand a bribe of 2500 Riel per subject, so I said to myself: I might as well send the children to a private school". ¹⁶¹

Access to social workers:

Article 6(3) of the Prakas on Minimum Standards on Alternative Care in the Community states that 'social workers [...] shall regularly conduct follow-up visits to the children and the caregivers in the group homes to ensure that the children are safe'. However, not all children living in group homes visited for this study had regular access to a social worker, let alone a designated social worker.

Does a social worker come to see you from time to time? [Girl of 13 years]

Yes, a social worker comes to see me sometimes. [The other children in the group were initially unsure about this but then agreed]

How often does this person come?

We think it is about once a year.

¹⁶⁰ Interview with community care NGO manager, Battambang, 24.10.16

¹⁶¹ Caregiver interview, group home manager, Siem Reap, 11.10.16

What do you talk about?

Whether we have problems, why we are living here, what our problems are at home...

Do you like talking to the social worker?

Yes, it is good thing. But we would like them to come and visit more often.

Is it not the same person each time?

No, it is not the same person who comes each time.

[Asking the girl who has been living in the group home for 1 month] Has a social worker come to see you as well?

No, I didn't meet any social worker.¹⁶²

The lack of access to a designated social worker was evident even in group homes that had an established management structure and were functioning more like small residential care institutions, such as the group home visited in Siem Reap.



TRAINING

Article 6(3) of the Prakas on Minimum Standards on Alternative Care of Children in the Community states that alternative care providers 'shall provide caregivers with the skills required to care for children, including children with special needs'. All caregivers of group homes included in the survey indicated that they had received some form of training. However, the qualitative data suggests that, in some cases, training may have been very limited and is delivered by a senior member of the staff."¹⁶³



COSTS AND FUNDING

From the perspective of NGOs, the government, and donors, group homes are *more* expensive than family-based alternative care arrangements such as kinship and foster care. This is because care providers in group homes typically need to pay rental for the premises of the group home. In addition, NGOs typically provide caregivers with a 'salary', or a payment per child. These sums varied from 25 USD per child per month¹⁶⁴ to 'more than 100 USD' or 140 USD per month, depending on the resources of the NGO.¹⁶⁵

For those NGOs that provide children in group homes with access to private education, costs per child can be even greater due to school fees and transport costs. For example, one group home visited in Siem Reap spends around 200 USD per child per month, which includes rent, food and private school fees. "*Our biggest expense is definitely education, then food.*"¹⁶⁶

¹⁶² FGD with children, group home, Siem Reap, 28.11.16

¹⁶³ Caregiver interview, group home manager, Siem Reap, 11.10.16

¹⁶⁴ Caregiver interview, group home mother, Battambang, 17.10.16

¹⁶⁵ Individual interview with NGO manager, Battambang, 17.10.16; Caregiver interview, group home manager, Siem Reap, 11.10.16

¹⁶⁶ Caregiver interview, group home manager, Siem Reap, 11.10.16

In the case of a group home visited in Phnom Penh, the manager estimated that it costs 1500 USD to provide care to seven children and two young adults (excluding salaries for staff), which amounts to around 170 USD per child per month. When salaries are taken into account, it was estimated that it costs around 3,150 USD per month to run the group home visited in Phnom Penh.¹⁶⁷

Given the small sample of group homes visited for this study it is difficult to draw general conclusions about the costs of providing group home care in Cambodia. However, the existing qualitative evidence suggests that group homes are more expensive to run than other community-based care alternatives such as foster or kinship care, raising issues of sustainability.



CHILDREN'S EXPERIENCES

When asked about their experiences living in group homes, many of the children interviewed for the study described their experiences in a positive light, especially in comparison to their experiences at home. A girl who had been abused by her step-father after her mother remarried commented. *"When I was living with my mother I was very sad. Then I came here and I am happy now."*¹⁶⁸

Most of the children living in group homes interviewed for the study reported that their material conditions and access to education had improved markedly as a result of living in group homes. For example, a group of girls interviewed in Siem Reap suggested that they preferred living in the group home (as opposed to with their biological parents), because 'there is always food here and there is also a good school we can go to.'¹⁶⁹ The improved living standards and access to education that children in group homes may experience can, though, pose a significant challenge when attempting to re-integrate the children with their families, who may only be able to afford a lower standard of living, and when they leave the group home and have to support themselves.

However, several children interviewed for this study also expressed negative views about living in group care arrangements, despite the material advantages. The main concern for children was the lack of privacy and personal space. Several children interviewed in group homes also indicated that they missed their parents and felt a lack of warmth living in group homes.

167 Caregiver interview, group home, Phnom Penh, 28.11.16

168 Individual interview with girl, group home, Phnom Penh, 28.10.16

169 FGD with children, group home, Siem Reap, 28.11.16

SEMI-INDEPENDENT LIVING ARRANGEMENTS

Semi-independent living arrangements are a type of community-based care alternative that is closely related to group homes; the main difference being that caregivers/social workers typically do not live on the premises or stay with the children over night. The Prakas on Minimum Standards of Alternative Care of Children in the Community does not address this type of alternative care arrangement.

However, the study revealed that a number of NGOs in Cambodia are using these care arrangements as community-based alternative care options. It appears that semi-independent living arrangements are mainly used by NGOs to prepare older children (usually aged 16 - 18) who have been living in RCIs or alternative care for unsupervised independent living.

We have a social worker who provides counselling and visits for 8 hours a day. The teenagers themselves choose who they will live with. We keep them in safe living environment and accompany them until they are ready for the independent living. We make sure they experience independent life, so they are able to move into independent living.¹⁷⁰

Independent living arrangements have many of the costs of group homes, though staffing costs are generally a little less. Many of the children living in semi-independent living arrangements are typically receiving vocational training or attending university. For example, the children that one Battambang-based NGO places into independent living arrangements receive vocational skills training from external trainers, which the NGO pays for: *"Many of our girls are training to work in beauty salons. We support them with 200 USD per person per month."¹⁷¹*

¹⁷⁰ Key informant interview, NGO manager, London via skype, 19.12.16

¹⁷¹ Individual interview with NGO manager, Battambang, 17.10.16





RESIDENTIAL CARE INSTITUTIONS AND BOARDING SCHOOLS

Key findings: RCIs and Boarding Schools

1. The evidence indicates that the distinction between RCIs and boarding schools is fluid in practice, with considerable overlap between the two categories of institution;
2. There has been a significant reintegration effort in relation to children in RCIs over the RCIs. In part this is due to the National Action Plan to safely reintegrate 30% of children in institutional care, partly to foreign donors withdrawing their support and partly to a change of focus by NGOs;
3. Whilst reintegration of children into family based care is a priority; in some cases, reintegration is being driven by funding concerns, rather than consideration of the best interests of each individual child;
4. Children's experiences within RCIs and boarding schools were diverse. A number of children reported feeling 'happy' and 'settled'. Others said they missed their families and communities.
5. Children appeared to have a low level of contact with their families in both RCIs and boarding schools: the majority of children reported that they rarely, or never, see their families.
6. Care staff in RCIs and boarding schools were more likely to have received MoSVY training, and tended to rate the quality of this training more highly, than caregivers from other types of alternative care arrangements.

Recent decades have given rise to a rapid proliferation of residential care institutions housing children in Cambodia.¹⁷² Overseas donor interests, investments and forms of 'voluntourism' have increasingly incentivised the placement and care of children within residential institutions as a default response or 'solution' to a range of child protection concerns and other needs.

This study included qualitative data collection from 4 residential care institution (RCIs) and 3 boarding schools providing alternative care to children, across the 5 provinces. The purpose of seeing these institutions was to provide a comparison to family based care and to give an insight into attempts being made to reintegrate children from RCIs into alternative care. 14 care staff in residential institutions were included in the survey. Only one of the 7 institutions defined itself solely as a 'boarding school', a further 2 defined themselves to be both boarding schools and RCIs, and the remaining 4 defined solely as RCIs.

The evidence indicates that the distinction between RCIs and boarding schools is fluid in practice. All institutions included in the study were found to be providing residential care to children. Some provided education to their children onsite (in the case of boarding schools), while the children went offsite in others, with some RCIs offering a combination of both on-site and off-site education. Improved access to education was found to be a significant pull factor for children to enter the RCI/boarding school across all institutions. However, although the underlying reason for placement appears to be 'access to education' this, like 'poverty' stands a cover for a range of reasons for placement. Certainly, in one boarding school, child protection played a major part in placement of girls as boarders at the school.

Staff interviewed at the boarding schools emphasised the educational function of their facility:

*This place is perceived as a boarding school – there are genuine kids in need and kids who are victims of abuse, but it is functioning like a boarding school for needy children (like scholarship children) rather than an orphanage.*¹⁷³

Others noted that they were classified as a boarding school by the DoSVY, despite the fact that they themselves considered their primary function to be related to providing a home for children in need of care:

*I think the Social Welfare cannot classify our unique situation. That is why we call it a home. For now they call us a boarding school. So I say that we stay here as a family – we work together, we live together, and we train them to reach out on their own and stand on their own feet.*¹⁷⁴

This boarding school appears to be an exception to the other RCIs/boarding schools seen. It contains a mix of children. The school contains 1200 pupils from kindergarten to grade 12 with 69 girl boarders (there is another school for boy boarders). Those who can afford it are asked to make a donation or pay a fee to support the school. None of the families of the boarders are able to afford a donation at the present time.

172 Ministry of Social Affairs, Veterans and Youth Rehabilitation, 'Mapping of Residential Care Institutions: Preliminary data compilation and findings', March 2016.

173 Individual interview with Direction, Residential Institution, Kandal Province, 11 October 2016

174 Individual interview, Christian Boarding School, Preah Sihanouk Province, 17 October 2016



PROFILE OF CHILDREN

Children who live in residential care institutions or boarding schools appear to have a diversity of profiles and backgrounds. Consistent with previous research, only a minority of children within residential institutions were reported to be 'double' orphaned (having no living parent) (approximately 1 in 5 according to the MoSVY mapping). The major reasons for children entering a RCI or boarding school were much the same as for any other form of care.

The MoSVY Mapping report indicates that children come into RCIs at a variety of ages, and often from infancy. But, the majority of children living in RCIs are adolescents: 67% being 11 years and above.¹⁷⁵ The survey data from MoSVY also shows, worryingly, that RCIs cater for more children in younger age groups, especially babies and toddlers aged 0-4 years than any other form of care, including foster care where it would be expected that such young would be cared for. Additionally, it appeared from the survey carried out for the study, that RCIs are housing more children with complex needs, such as children living with HIV or children with disabilities. More than half (61.5%) of RCIs are housing children with additional needs and almost half (47%) are supporting children with disabilities. These findings have important policy implications in terms of oversight and standards of care.

Consistent with the findings from the recent MoSVY mapping of residential institutions, there were slightly fewer girls staying in RCIs and boarding schools in our sample than boys (however, differences were not significant). The highest number of children in any one institution included for this study was 100, and the lowest, 45. Several institutions noted that the numbers of children in their care had fallen considerably over the last year due to reintegration efforts: one stakeholder described how three years ago they had 54 children in their RCI: *"that is when the deinstitutionalisation started – there are 14 left – scheduled to be out by the summer of 2017."*¹⁷⁶ There appeared to be some understanding amongst stakeholders that removing a child from their family is generally undesirable if it can be avoided, and that reintegration of children into communities should be a key priority.



IDENTIFICATION AND PLACEMENT

Referrals and placements of children into RCIs may be made through a variety of channels: including local authorities, law enforcement, (I)NGOs, UN (related) agencies (e.g. IOM) and religious organisations. As might be expected, placement of children into RCIs tends to be facilitated through more formal arrangements compared to other types of alternative care. Stakeholders reported that placement typically involves an initial assessment (albeit rudimentary) of a child's situation, and a 'formal' decision to place the child in an RCI, approved by a recognised 'authority': which may include the police, CCWCs, social workers from DoSVY, and commune chiefs.¹⁷⁷ The findings

¹⁷⁵ Ministry of Social Affairs, Veterans and Youth Rehabilitation, 'Mapping of Residential Care Institutions: Preliminary data compilation and findings', March 2016.

¹⁷⁶ Key informant interview, NGO Siem Reap, via skype, 19 December, 2016

¹⁷⁷ Article 11 of the Sub-decree on the Management of Residential Care Centre (8 December 2015), sets out the basis on which a child may be admitted to a RCI.

indicate that standardised procedures, and agreed criteria for assessing a child and making a placement determination are not being followed. In practice, decisions appear to be being made on a relatively 'ad hoc' and case by case basis.

The Procedures to Implement the Policy on Alternative Care for Children in the Community provide that a decision to place a child in residential care should be made by the relevant CCWC, OSVY and DoSVY jointly. Further Article 5 of the Prakas on Minimum Standards on Residential Care (2008) provides that written agreement with the child's previous caregiver (and the child if possible) must be obtained on admission. If the parents' consent is not provided then a court order must be obtained according to the civil code (2007) (chapter V), and the Law on Marriage and the Family (1989) (article 199).

Some participants emphasised that no child would be placed in their facility without formal authorisation from the MoSVY. In other cases, decisions were reportedly being made by NGOs, religious organisations and village chiefs. There were no cases encountered in which a child had been placed into an RCI by order of a court.

In practice, it seems, that struggling parents and caregivers are usually happy and willing to place their children in institutions, believing that it will be in the child's best interests in the face of poverty, illness and other challenges: *"we accepted one child who is three. The grandmother really begged me – she said, 'I cannot raise them because I am sick."*¹⁷⁸

In qualitative interactions, staff and managers at care institutions stressed that the threshold of need that a child should meet in order to be eligible for admission into their institution is high, and they were eager to note that the placement of a child into an RCI is a measure of last resort. Stakeholders explained:

*[Children] are admitted if they have been abused by their parents (those who suffer from domestic violence), poor families, and abandoned children, but before placing them in orphanage we have to make an effort to reunify children with their families. [The] RCI is only the last resort.*¹⁷⁹

*We don't jump to the RCI option immediately. We first look for extended family members who can take the child in and we communicate with commune councillors to identify kinship care arrangements.*¹⁸⁰

These findings reflect legal standards that permission for children to reside in a residential centre should be the last (and a temporary) option, and that every effort should be made to provide for family based care.¹⁸¹



MONITORING

In light of concerns about the proliferation of institutions housing children, and a lack of oversight and control, in recent years there has been a considerable policy and programme drive to establish and strengthen mechanisms for regulating and RCIs, to

178 Individual interview with Director, Christian Boarding School, Preah Sihanouk Province, 17 October 2016

179 Focal point - PNP-DoSVY, Focal person - Capital Level

180 KII with CCWC representatives, Siem Reap, 14.10.16

181 Sub-decree on the Management of Residential Care Centres, 2015

improve standards and ensure protection. However, it remains a concern that only those institutions that are officially registered, or who have a memorandum of understanding with MoSVY are inspected.¹⁸² The recent mapping of residential institutions carried out by the Ministry estimated that as many as 21% of all residential care institutions in Cambodia do not have a memorandum of understanding with the Government and that 12% are not registered with any government agency.

The only institution in the survey which defined itself solely as a 'boarding school' reported that it is 'never' monitored by an external agency. Although boarding schools' officially fall outside of the remit of the Policy on Alternative Care, it is important to note that there are a number of vulnerable children residing in the school year round, which raises the question of whether they ought to be subject to monitoring.



CONTACT WITH BIOLOGICAL PARENTS

According to official rules placement of children in RCIs should be on a temporary basis,¹⁸³ however, over a third of those interviewed for the study claimed that the majority of children residing in their institution were there on a 'permanent basis'. Contact with families for children at RCIs and boarding schools varies. The majority of children reported that they rarely, or never, see their families: visiting their homes, or receiving visitors only once or twice per year. The main explanation provided for lack of contact being that the institution was far from their family homes and that their relatives could not afford the costs of transport.

Before my family visited me, but they no longer do. The centre allows me to visit the family, [but] the province is very far and transport is expensive. That is why they no longer come to visit.¹⁸⁴

I do not see my mother and I haven't seen my father. My mother lives in Thailand and my father also went to Thailand for work. Sometimes we talk on the phone.¹⁸⁵

I don't know how my parents are doing – here I have no news of them. I don't see them very frequently because...they moved.¹⁸⁶

In the case of one boarding school, contact with the biological parents depended upon where they lived and the reason for boarding at the school. For those who had family close by, contact took place every month and when there were school holidays. For those who lived far away, contact took place three times a year, during school holidays, provided transport could be funded (and in some cases, adequately supervised). Only one child had no contact at all with her biological family, being unable to visit due to significant child protection concerns. There is little reason why the children boarding at this boarding school could not live with foster parents near the school and attend daily, but of course, such a foster placement would need to be funded. At present, the nuns

182 Ministry of Social Affairs, Veterans and Youth Rehabilitation, 'Mapping of Residential Care Institutions: Preliminary data compilation and findings', March 2016.

183 Sub-decree on the Management of Residential Care Centers (8 December 2015)

184 Individual interview with boy (16), Residential Institution, Kandal Province, 11 October 2016

185 Christian Boarding School, Preah Sihanouk Province, 17 October 2016

186 Meeting with children in boarding school, Phnom Penh, 1 December 2016.

in the school are not paid, either to teach or care for the children, and thus the primary cost is provision of food and clothing. It is not clear that the school has sufficient funding now or would have sustainable funding in the future to pay for foster care for the girls.



REINTEGRATION OF CHILDREN

Despite the low level of contact between children in RCIs with their parents and the birth family, the overwhelming majority of RCIs reported regular (at least every 3-6 months) evaluations of children in their care by an external body to consider the possibility of reintegration into their families. There is reason to suspect that this result may have been affected by considerable reporting bias, given that it is inconsistent with findings concerning the regularity of monitoring visits¹⁸⁷. However, these findings may be indicative of a growing concern amongst RCI managers that they ought to be prioritising and promoting reintegration of children into forms of family based care. Together with other findings, this result evidences the growing emergence of a cultural shift within the alternative care sector, away from institutionalisation of children.

As previously noted, the qualitative data indicates that there has been a considerable reintegration effort across RCIs over the last year: with reports of significant reductions in numbers of children in care, and closures of institutions. One key stakeholder described the process of reintegration:

[It was] not easy. Using the family reconnection programme, we are trying to strengthen family ties before placement. Children are sent home for pre-home visits, monitoring, counselling, surprise visits and monitoring during early placement to assess relationship and conditions.

When you decided to reintegrate was there a family assessment before a decision was made, in an individual case?

Yes, we had meetings with the family. Firstly we explained to the children and staff in the centre and informed the families about what we were planning to do, and the time frame.'

What was your time frame for reintegrating a child?

We have a time frame for assessing the family and then three years of monitoring. In the first year [we make] weekly or bi weekly monitoring visits, in the second year [we make] visits every month, [in the] third year, monthly, fourth year - follow up.¹⁸⁸

Whilst these efforts are to be encouraged, there is cause for concern that in some cases reintegration is being driven by funding concerns, rather than consideration of the best interests of a child in care. Whilst describing how reintegration takes place, the provider, quoted above, noted: *"we reintegrate children because we don't have any more funds in our programme."*¹⁸⁹ Another provider explained how they were finding it difficult to reintegrate the remaining 13 children in their institution after running out of funds:

187 It maybe that RCIs count visits from external bodies for other purposes as monitoring visits and thus the number of visits is inflated.

188 Key informant interview, providing family reintegration services, Siem Reap, 19 December, 2016

189 Key informant interview, family reintegration services, Siem Reap, 19 December, 2016

*We still have 13 more kids – the 16 year old girl cannot go back, as the area where the family live is dreadful - full of drugs and prostitution... [Another] girl – [her] mother lives nearby, she's a teacher, but she remarried and he [her husband] sexually abused the child... We took the child and now we haven't found a place for her yet. The girl refuses to go back home, but has agreed to go to another organisation.*¹⁹⁰



TRAINING

All those interviewed for this study in the RCIs and boarding schools indicated that they had received child protection training and counselling, and were significantly more likely to have received training from government authorities than caregivers in any other forms of care arrangements: almost half (43%) of RCI and boarding school staff said that they had received training from MoSVY.¹⁹¹ Care staff in RCIs and boarding schools included in the survey also tended to rate the quality of their training more highly than caregivers in other types of alternative care: 79% of care staff in RCIs/ boarding schools rated their training '5' out of '5', and carers overall gave the training a score of 3 or more. Some staff noted, however, that whilst training on the practical aspects of caring for children (e.g. hygiene and WASH) was sufficient, they would like more training in counselling and (child) communication skills. This is important given that many children in RCIs and boarding schools are likely to have complex psychological needs.



COSTS AND FUNDING

Funding RCIs and boarding schools is of course resource-intensive; and this type of care arrangement is generally more costly, and less sustainable than other types of alternative care. One stakeholder reported that their institution costs as much as 40,000 USD per quarter, which is largely spent on the salary of staff and food for the children. A qualified social worker, allegedly costs from 300-600 USD per month.

Almost all residential institutions are funded by foreign NGOs and religious organisations, with no RCI caregivers included in the survey reporting receiving government funding. Several stakeholders noted that accessing funding has become increasingly difficult in recent years, as international donors are starting to withdraw support. This is partially a reflection of the refugee crisis in Syria and surrounding countries and some is due to an increasing preference for family and community based care models.



CHILDREN'S EXPERIENCES

The data on children's experiences within the RCIs was diverse. A number of children reported feeling 'happy' and 'settled', and noted that life was 'more comfortable' or 'less tense' than at home. Children reported being glad to have the opportunity to access education, and said that they enjoyed being surrounded by friends. They also often appreciated the relative material comfort that they experienced in the care institution compared to their life at home.

¹⁹⁰ Caregiver interview, Phnom Penh, November 2016

¹⁹¹ Chi square, $p < 0.01$

At home, there is no modern stuff or garden like this. [Here] we are farmers- have a rice field and live as a family.¹⁹²

This place provides education, shelter, hospitality and knowledge to improve and change our behaviour. We get food, affection and love.¹⁹³

It was clear from visits that children in residential institutions live in relatively more comfortable material conditions than children in other types of alternative care arrangements. In all RCIs visited children had access to bathing materials, access to bathroom facilities, functioning toilets, a place to sleep, room to play, and space to exercise. Half the facilities had basic health and medical supplies. In fact, across every checklist criteria RCIs and boarding schools scored better than other types of care in terms of the quality of facilities available, their safety and their cleanliness.

Despite relatively comfortable facilities, not all children reported being happy in the RCIs and boarding schools. Children spoke of missing their parents; and even though they enjoyed spending time with friends, they sometimes reported finding the crowded conditions of the RCIs and boarding schools 'difficult' and 'tiring'. The mean number of children sleeping per room in the RCIs included the sample was 9 children. In one boarding school visited, 20 girls share a dormitory. One girl described her situation to researchers:

I would like to leave – it's tiring and I spend a lot of time studying and cleaning up. Education is important though and [this is] the only place where I would get education. It's fun to share rooms but sometimes it's disturbing as [the] study area and sleeping area are in the same room.¹⁹⁴

Being far from home was the main reason why children reported feeling unhappy in RCIs and boarding schools. Some children noted that even though they had more material benefits in the RCIs, life was 'happier' for them at home, where they could be with their families: *"it makes me feel very sad not to see my mother"; "Sometimes I miss my family. I want to help them because they are getting old."*

192 Meeting with children in boarding school, Phnom Penh, 1 December 2016.

193 Focus group discussion with children in RCI, Kandal Province, 11 October 2016

194 Meeting with children at the boarding school, Phnom Penh, 1 December 2016.

CONCLUSIONS AND RECOMMENDATIONS

9

In 2006, the Government set out a number of challenges that were likely to impact on the implementation of the Policy Paper on Alternative Care of Children (see p 13 above). Over the course of the ten years since the policy was published, there have been progress, with changes in legislation and programmatic and cultural shifts. However, many of the challenges remain and, as a result too great a number of children remain in the care system and too many continue to be accommodated in RCIs.

There are, in addition, a number of additional challenges, which impact on family separation, the provision of alternative care and the number of children entering the care system. The first of these relates to the lack of a State financial 'safety-net' for parents who do not have sufficient means to support a child. The State does not provide allowances or benefit payments for parents and kinship carers, even in the case of one-parent families, leaving children at risk of suffering family separation on the grounds of poverty. The second is the lack of family support services in the community to prevent separation of families, and third, the costs associated with educating a child. A further challenge, raised in the Policy Paper on Alternative Care for Children is the low level of implementation of existing laws and regulations, and this includes the Prakas¹⁹⁵ that have come into force since the Policy Paper was published, which were designed to ensure implementation of the Policy. It was notable that only one person interviewed for this study referred to the powers of the Court or the need to use legal provisions to protect a child and to ensure appropriate permanency plans are put in place.

There are also further issues worthy of mention. Although ChildSafe Hotlines provide advice and information on children's issues on the phone and can offer outreach services in some instances, there is at present, no formal child rights monitoring mechanism able to address or investigate a complaint about the care or lack of care that a child receives.¹⁹⁵ In addition, there is a low level of public awareness of child protection issues, and stigmatisation of children who have been abused, abandoned or removed from their families for child protection reasons. This, in turn, leads to explanations that children are in alternative care because their families are 'poor' and a tendency on the part of government bodies and NGOs to overlook the real reasons for the child coming into care and to take appropriate action to address them.

These underlying issues need to be addressed as a matter of urgency if the number of children in residential care and alternative care in the community are to be effectively and meaningfully reduced, and children enabled to stay with their families, where it is in their best interests to do so.

¹⁹⁵ ChildSafe is run by 3PC partners. In 2016, 2,271 calls were received. In quarter 1 of 2016, of the total of 677 calls received, 251 were from children aged 12-18.

RECOMMENDATIONS

Overall, there is a need for MoSVY and its government partners to strengthen its case management capacity and the delivery of services in the districts. It is recommended that, in addition to its current National Action Plan for Improving Child Care, MoSVY should develop a strategic plan for development and delivery of child protection case management services in the districts over the next 5 years. The strategy should include the development of legislation and guidance regulating and formalising the different forms of alternative care, including the setting out of roles and responsibilities and standards of care; management, quality assurance and quality control of community-based care services. Consideration should be given not only to the development of government services, but also to the role that NGOs could play in cooperatively delivering such services in the districts and communes. An essential element of the strategy will need to be a thorough review of Chapter 7 of the Prakas on Procedures to Implement the Policy of Alternative Care to ensure effective permanency planning and new mechanisms for delivery of effective fostering and adoption services in the districts.

There is a real and pressing need for more social work staff in the districts. At present the number of social workers delivering child protection services is very low. Developed European States have a ratio of 1 social worker to between 300 - 1500 inhabitants. Cambodia has a ratio of 1: 27,000 inhabitants.¹⁹⁶ It is by no means the highest ratio in the region: both Indonesia and Myanmar have higher ratios. However, two middle income countries: South Africa and Uganda, both have ratios of approximately 1:6000, a target that the Cambodian government could seek to match. MoSVY need to give consideration to how, in the short to medium term, human and financial capacity can be increased and improved. It will undoubtedly take some years to train new social workers and for them to develop the necessary skills and experience. It is not clear, however that the system can wait.

It is recommended that consideration be given to recruiting and training para-social workers in the short term, to work alongside DoSVY and CWCC social workers in the districts, and to harnessing the considerable resources of the NGOs to deliver family support and alternative care services. The joint government / NGO case-management model that has been developed in Myanmar may serve as a useful model for the government of Cambodia.

¹⁹⁶ The State of the Social Service Workforce, Global Social Service Workforce Alliance, 2015 available at www.cpcnnetwork.org. In Sweden there is a ratio of 1 SW in 300 inhabitants; in the United Kingdom: 1 SW to 600 inhabitants; in Italy: 1 SW to 1600 inhabitants; in Uganda: 1 SW in 6500 inhabitants and in S.Africa: 1:6096.



KINSHIP CARE

Kinship care is a traditional and prevalent practice in Cambodia where, for a variety of reasons, children are in need of alternative care. Kinship care has a number of advantages: children remain in their family of origin, retaining relationships and kinship networks and are cared for by adults with whom, for the most part, they already have an established relationship.

Kinship carers are frequently available but have not been used to their full extent, largely because of the inability of family members to support the child financially. This appears to be a particular issue in relation to grandparents, and especially lone grandmothers, who often have no obvious source of income and are themselves reliant on their children for support. In these cases, kinship care would be a viable option if an allowance was paid, and education costs were covered.

Several of the kinship care case studies included in the research appeared to be effective care arrangements with positive outcomes for children in care; in others, however, children reportedly experienced abuse, neglect and exploitation. Follow-up monitoring is, therefore, essential.

Those responsible for placing children in kinship care who were interviewed for this report, appeared to focus primarily on whether any member of the family was 'willing' to take the child. If somebody in the family was willing, that seemed for most to be the deciding factor, with little further assessment. Once the child was placed with them, kinship carers often struggled to meet the costs and care demands of the child.

RECOMMENDATIONS

- When a child is being placed with kinship carers by DoSVY, CCWC or an NGO, the carer should be assessed to establish whether the kinship carer is able to meet the needs of the individual child.
- The placement of a child in kinship care by DoSVY, CCWC or an NGO should be formally recorded by DoSVY.
- MoSVY and DoSVY should undertake a review of funding of kinship care to determine how kinship care could be supported financially.
- DoSVY should review its current level of monitoring and support of kinship carers.



FOSTER CARE

There is no government managed foster care programme and foster carers are currently recruited, supported and managed by the NGO sector. The different approaches taken by NGOs to selection, training, accrediting and monitoring of foster carers means that there is, at present, no uniform national fostering service in Cambodia. Further, all payments to foster carers are currently funded by NGOs. If an NGO provider suffers a fall in funding, and foster carers can no longer be paid, the children they care for are likely to be without a home. A foster care system dependent wholly or mainly on NGO funding is unsustainable in the long-term, and possibly even in the short term. A sustainable fostering service requires government buy-in and funding.

The nature and quality of foster care services included in the study varied considerably, depending on the commitment, resources, skills and experience of the foster carers.

It was noted that most foster carers were responsible for a large number of foster children at any one time in addition to their own children, with foster families sometimes caring for up to 9 foster and biological children at any one time. This inevitably impacts on their ability to give foster children sufficient time and attention and places and places an undue stress on some foster carers.

At present, there appears to be no distinction between short term and long term foster parents, and foster care providers are not engaging sufficiently in either permanency planning or planning for what is to happen when a child reaches the age of 18. Some children in the care of foster parents seen for this study clearly need long term foster parents: they are young, have been in care for several years and the family circumstances are such that the children are highly unlikely to return to the birth parents or the wider family. It is clear from the study that there are foster parents who would like to take a young child permanently and if such care is needed for an individual child, DoSVY should consider whether the best interests of the child are served by domestic adoption. Without careful assessment of the child and the foster carer, the child can end up being moved from one foster placement to another. One child seen for this report, was moved 7 times within her first 3 years.

RECOMMENDATIONS

- The Government should review the Prakas on Procedures to Implement the Policy of Alternative Care for Children on permanency planning with a view to delivering foster care and domestic adoption services in the districts as part of child protection services. MoSVY could work with NGOs to provide the service in the districts, but the State should retain responsibility for ensuring that fostering and domestic adoption services are available in each district and comply with the Minimum Standards.
- No more than three foster children should be placed in a family, unless the children involved form a sibling group, in which case the foster carer should be allowed to take all the siblings.
- The assessment process should be strengthened, particularly in relation to the suitability of foster carers.
- There is a need to strengthen on-going monitoring and support (case work).



Pagodas cater for different groups of children with different backgrounds and needs. While some enter purely to gain a religious education, others are in need of care and protection. At the present time, pagoda based care provides for children's basic needs of food and shelter and provides and supports children in education. Pagodas are, however, primarily religious establishments and not child care providers. Some monks are trained in child protection, but their religious duties do not permit them to be full time carers to children.

At the present time, conditions in the pagodas are fairly poor, and do not meet the Prakas on Minimum Standards on Alternative Care for Children in the Community. In addition, provision of food is highly dependable on charitable donations and there is not always sufficient food for all children.

There is a lack of oversight and planning for children. Pagodas do not appear to follow up on children who have left the pagoda and are unclear about what happens to their children when they leave the pagoda.

RECOMMENDATIONS

- The MoSVY in collaboration with MoCR, should review the Alternative Care Policy 2006 and Minimum Standards of Alternative Care for Children in order to strengthen the monitoring of provision of care for children to live in pagoda and other faith-based organization and inspecting them regularly.
- Pagodas should be required to inform DoSVY at municipality, province, khan and relevant authorities of the admission of any child where a child protection issue is the whole or part of the reason for admission, including a parent's migration, death, remarriage and refusal to care for the child or any form of abuse, neglect, violence or exploitation. Where the pagoda and other faith-based cares for more than 10 children, the MoCR together with MoSVY should give consideration to employing a full-time person on-site to be responsible their care.
- The MoCR should develop a model child protection policy for pagodas.
- The MoCR should develop a data collection system to cover all children resident in pagodas.
- The MoSVY and MoCR should develop a joint Memorandum of Understanding on responsibility for children in pagodas.



GROUP HOMES

Like other forms of alternative care, group homes vary in form and nature. Some of them are deeply embedded in the community and the children play an active part in neighbourhood life, while others are virtually closed institutions. Some group homes are similar in nature to a small RCI while others tend more to similarity with a foster home.

For the most part, the group homes visited were of a high standard, adequately staffed and well run. At the same time, a question lies over their sustainability as all are funded by NGOs who may face a downturn in funding at any time. They are, also, an expensive form of alternative care compared to foster care and kinship care, and are only intended to offer 'temporary care'.

There will always be a need for some form of residential, institutional care for older children who cannot settle in a foster family and for whom there are no kinship carers, and a small group home is to be preferred to a large RCI. However, there is a danger that some group homes will continue to operate as RCIs, with children having little contact with the community. This can be addressed by ensuring that children are only admitted to a group home following a full assessment and where admission is necessary to meet the needs of the child, and that children have a care plan when admitted which addresses their future care.

RECOMMENDATIONS

- MoSVY should undertake a review of the current cost, financing and most economic mode for provision of group homes.
- MoSVY should ensure that each district has sufficient group homes to cater for children in need of residential care who cannot live with kinship carers or foster carers.
- The definition of a group home contained in the Minimum Standards of Care for Children should be reviewed and revised to conform to the UN Guidelines on Alternative Care.



BOARDING SCHOOLS

In accordance with the National Action Plan for Improving Child Care with the Target of Safely Returning 30 per cent of Children into Residential Care to their Families by 2018¹⁹⁷ RCIs are starting to reintegrate children into their families. There is, however, a need to implement the Prakas on Implementing the Policy on Alternative Care for Children in the Community in relation to gatekeeping fully to ensure that further children are not being admitted to RCIs, except where absolutely necessary.

Boarding schools have a role to play within the education system, but the study indicated that the reason for the placement of some children in boarding schools was directly linked to child protection issues within the family. If children are to be placed in boarding schools as a form of alternative care, especially for older children, then once again, all the procedures currently contained in the legislation should be implemented.

RECOMMENDATIONS

- Boarding schools should be required to provide information to DoSVY on the number of children resident in the school.
- The MoEYS and MoSVY should develop minimum standards of care for children resident in boarding schools.
- The MoEYS should develop a model child protection policy for boarding schools, both in relation to child protection within the school and referral of cases where there are child protection concerns within the family.
- The MoEYS and MoSVY should develop a joint Memorandum of Understanding on responsibility for supporting children in boarding school.
- MoSVY should be responsible for monitoring and inspection of the care of children in boarding schools.

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ANNEX 1 – STUDY SAMPLE

TABLE 1: KINSHIP CARE

Case	Care arrangement	Reasons for living in alternative care	Placement process	Post-placement support	Child previously in residential care
Kinship care, Kandal	Care provided by grandparents	Parents migrated	Informal, decided within family	Yes, NGO built house and provides extra-classes, bicycle	No
Kinship care, Kandal	Uncle providing care to re-integrated child	Mother migrated, grandmother passed away	Informal, decided within the family	Yes, food support	Yes, but re-integrated to grandmother before child was placed with uncle
Kinship care, Preah Sihanouk	Grandparents providing care	Mother was electrocuted, father an alcoholic and drug addict, poverty, neglect	Informal, within the family	Yes, school shuttle and food support	Yes, two of the children were in residential care, but were re-integrated to other family members before being placed with grandparents
Kinship care, Siem Reap	Aunt and grandmother providing care	2 children were abandoned and picked up by NGO, 1 child was beaten and neglected by step-mother after the father re-married	2 children were referred by NGO, 1 child was placed informally after the aunt intervened	Yes, NGO provides 15 kg of rice per month through CCWC	Yes, 2 children were previously in residential care after mother left them in front of the NGO and ran away
Kinship care, Siem Reap	Aunt and 21-year old sister providing care	Parents died due to HIV/AIDS	Informal, within the family	No, only emergency food support from NGO if necessary. 21-year old supports her 3 younger siblings	No
Kinship care, Battambang	Aunt and uncle provide care	Mother died of TB, father re-married, grandmother beat the child	Formal, but no pre-placement assessment	Yes, 20 USD per month, 50 kg rice every two months, hygiene products	Yes, boy lived in residential care for three year before re-integration

Case	Care arrangement	Reasons for living in alternative care	Placement process	Post-placement support	Child previously in residential care
Kinship care, Battambang	Grandparents provide care to HIV-positive girl	Mother passed away because of HIV/AIDS, father re-married	Formal, NGO did two pre-placement assessments, together with CCWC and DoSVY	Yes, 35 USD per month, 50 kg of rice every two months, hygiene products, transport to hospital (HIV treatment is free)	Yes, girl lived in residential care for four years before re-integration
Kinship care, Phnom Penh	Grandparents provide care	Parents initially left the child with grandparents so that they could migrate and find employment: returned but settled near the Thai border and do not keep in contact/ visit/ support the child in any way (i.e. abandoned).	DoSVY social worker conducted a pre-placement visit but no assessment	No	Yes, boy lived in residential care but the centre ran out of funds, so the child was re-integrated

TABLE 2: FOSTER CARE

Case	Care arrangement	Reasons for living in alternative care	Placement process	Post-placement support	Child previously in residential care
Foster care, Kandal	Care provided by foster parents, the boys is the 15 th foster child	Abandoned, living as street child, grandmother refused to take care of the boy	Formal, NGO placed child into foster family	Yes, 2,5 USD per day per child in addition to toothpaste, a toothbrush, soap for washing clothes, a mosquito net, a blanket, a pillow, a towel. Health care expenses of the child are also covered	Yes, placed into foster care after residential care facility was closed down by DoSVY
Foster care, Kandal	Foster mother providing care to 9 foster children	4 foster children, abandoned by biological mother	Informal, foster mother found abandoned children on road-side, only later involved DoSVY	NGO provided 700 USD to build a bedroom	No

Case	Care arrangement	Reasons for living in alternative care	Placement process	Post-placement support	Child previously in residential care
Foster care, Sihanoukville	Foster parents providing care to 8-year old	Child was abandoned by mother	Semi-formal, NGO worker took over role as foster mother, CCWC was informed	After child turned 6, no further support was provided by NGO	No
Foster care, Sihanoukville	Foster mother providing care for 5-year old	Child abandoned by the mother	Informal, biological mother first asked the foster mother to temporarily take care of the child	50 USD per month, 20 kg of rice, 20-30 canned fish, NGO also covers health care costs	No
Foster care, Siem Reap	Foster parents providing care to 3 foster children (siblings)	Mother died of HIV/AIDS, father is also HIV-positive and cannot provide care to children	Semi-formal, biological daughter of foster family worked at NGO and arranged placement	30 kg of rice per month, 110 USD per month for three children (actual costs for three children is 300 USD per month according to foster father)	No, children only visited the day care centre run by the NGO
Foster care, Siem Reap	Foster parents providing care to stunted 4 year old	Biological parents were neglecting the child and alcoholics	Formal, village chief referred the case to NGO, which then placed the child into a number of foster families	Material support amounts to 150 USD per month (includes milk, soap, diapers)	No, the foster child briefly stayed in a hospital before being placed with a foster family
Foster care, Battambang	Foster parents providing care to five year old girl	Child was abandoned next to a trash bin in a street nearby	Informal, foster mother found the child and took it in. Authorities were later informed so as not to be accused of 'stealing babies'	No longer receive support. For 2 and a half years an NGO provided 50 USD per month	No
Foster care, Battambang	Foster parents providing care to 14 year old boy	Child was abandoned in front of NGO-run RCI	Formal, NGO did five pre-placement assessments, Commune chief signed re-integration form	No, NGO supported the family for half a year after placement with 50 kg of rice every two months and 20 USD per month	Yes, the child stayed in NGO-run RCI before placement

Case	Care arrangement	Reasons for living in alternative care	Placement process	Post-placement support	Child previously in residential care
Foster care, Battambang	Foster mother providing care to 3 boys (siblings). Arrangement called 'group home' by NGO involved in the placement	Children were trafficked (by biological mother) to Thailand to work as beggars. Children were deported to transit centre at the Thai border. Biological father is violent.	Formal, NGO and DoSVY conducted pre-placement visits	Yes, foster mother receives a 'salary' of 25 USD per month per child from NGO. The NGO also pays 45 USD per month per child and provides hygiene products and covers health care costs. The property was owned by the foster mother	Yes, children lived in NGO-run shelter before placement into foster care
Foster care, Phnom Penh	Foster parents providing care to 6 foster children	1 child has mother is HIV-positive and too ill to care for her; 2 siblings have parents who migrated and grandmother could not care for them; 2 children were rejected on mother's remarriage; 1 unknown, sexually abused in previous placement.	Formal, NGO placed children in foster family	Yes, foster parents get a 'salary' of 75 USD per child per month	Yes, children lived in RCI before placement in foster care (one boy was sexually abused while in residential care)

TABLE 3: PAGODA BASED-CARE

Case	Care arrangement	Reported reasons for living in Pagodas	Placement process	Support	Child previously in residential care
Pagoda, Siem Reap	15 boys aged 14-22 live in the pagoda. 10 boys come to study traditional music during the day. One monk has been assigned caregiver responsibilities. No girls	Access to upper secondary school not available at home; Parents unable to provide adequate care	Informal, mother or grandmother approaches head monk (some children come alone), pagoda applies selection criteria: from rural area and educational performance	Pagoda is funded by donations. Children receive accommodation and food, some parents report to support children with 5-25 USD per month	No
Pagoda, Battambang	6 boys aged 9-17 live in the pagoda. No girls. 7 adult monks provide care	Access to education (use pagoda as 'boarding house'); grandmothers unable to provide adequate care; orphans or abandoned children	Informal, neighbours or relatives refer orphans or abandoned children	Pagoda is funded by donations. Children receive accommodation and food. Estimated costs: 50 USD per child per month	No
Pagoda, Battambang	30 students (7 of them children). Care is provided by 2 senior students who were assigned this role by the Chief Monk	To be closer to school, reduce food expenses of family, access free accommodation; some children are orphans	Semi-formal, parents or relatives approach pagoda; pagoda conduct interview with guardians; requires signature from commune or village chief	Senior students providing care do not receive salary. Pagoda funded by donation. Children receive free accommodation and left over food from the monks; most cook for themselves. Some children receive financial or material support from their parents (average 7 USD per month)	No
Pagoda, Kandal	200 children live in the pagoda, over 56 are to become monks, 17 monks provide care. No girls. Pagoda provides education on the premises. Teachers are MoE employed. 700 children attend the school.	To access education, some children are single orphans or parents migrated	Informal, grandmothers or other relatives bring children to the pagoda	Pagoda funded by donations. School teachers paid by MoE; Children receive free education, accommodation, and food; food costs are 3,000 USD per month	No

Case	Care arrangement	Reported reasons for living in Pagodas	Placement process	Support	Child previously in residential care
Pagoda, Sihanoukville	172 monks (70 under the age of 18), no clear care arrangement	Access to free food and accommodation; children exhibit behavioural problems; orphans; parental abuse	Informal, parents or relatives bring child to the pagoda	Pagoda funded by donations. Children receive accommodation and food. Each monk is required to collect 77 USD per month	No
Pagoda, Phnom Penh	40 children living in the pagoda, aged 10-18, 141 monks live in 11 'cells', up to 8 boys per cell. No girls	Orphans; parents unable to provide care; access to free food and accommodation; parental migration	Informal, parents or relatives bring child to the pagodas	Children receive accommodation and left over food. No financial support from relatives. Monks expenses cover clothes, shoes, learning materials.	No
Pagoda, Phnom Penh	50 children, live primarily with their grandmothers (nuns). 10 live with monks.	Parents cannot provide adequate support; access to education; to become monks; orphans, parental migration	Semi-formal, some children are referred by NGOs, some were brought by relatives	Pagoda funded by donations. Children receive accommodation and food from nuns.	No

TABLE 4: GROUP HOMES AND INDEPENDENT LIVING ARRANGEMENTS

Case	Care arrangement	Reasons for living in alternative care	Placement process	Facility	Child previously in residential care
Group home, Siem Reap	12 girls (and one boy) aged 4-16, receive care from 3 house mothers (2 of them resident)	Parents who cannot take adequate care of children due to alcoholism, drugs, gambling. Some cases of exploitation for labour.	Semi-formal, manager visits rural villages to identify at-risk girls. CCWC and DoSVY sign off on placements	Rented by NGO, staff receive salary	Generally, not. One girl lived in a temporary shelter for abuse and trafficking victims before placement
Group home/ temporary foster family, Battambang	One group home 'mother' providing care to three boys, aged 8-14	Boys were trafficked to Thailand by mother to work as beggars	Formal, NGO and DoSVY conducted pre-placement assessments	Private house, 'mother' receives monthly salary	Yes, the children stayed in a shelter for trafficking victims before placement

Case	Care arrangement	Reasons for living in alternative care	Placement process	Facility	Child previously in residential care
Group home, Phnom Penh	One resident caregiver providing care to 7 children (aged 6-22)	Mother re-married and girl abused by step-father; Mother HIV-positive and unable to provide care; Mother alcoholic and abusive	Placement is formal, CCWC signs off on placements; Identification of children is sometimes ad-hoc	Rented house, staff receive salary	Once boy previously lived in residential care, but was 'expelled' because he was suspected of killing someone
Independent living arrangement, Sihanoukville	2 boys (15 and 17 years old) living in a supervised independent living arrangement, 2 social workers visit after work	Exploited for labour in Thailand, father abusive, lack of access to education	Semi-formal, NGO involved in the placement	Rented room paid for by NGO, boys receive 5-15 USD per week	Yes, boys stayed in residential care before placement into independent living arrangement

Case	Care arrangement	Reasons for living in Pagodas	Placement process	Support
Residential care institution (Christian organisation), Kandal	100 children aged 6-16 (50% female), 15 children in each room, 18 staff members,	Single parents or grandparents unable to provide adequate care; parents in jail; parents HIV-positive;	Formal, village chiefs, police and pastors refer cases, MoU with MoSVY	Food, accommodation, extra-classes. RCI receives 40,000.00 USD from foreign donors, which covers salary of staff and food
Boarding school, Sihanoukville	38 children live in the facility in 2 rooms (gender separate), 20 come for schooling in the afternoon, ages 5-18 years, 5 staff members	Parents migrated to Thailand; grandmother cannot provide care; abusive families; access to education	Informal, parents and relatives send children. RCIs applies criteria for acceptance. MoSVY conducts inspections.	No salaried staff, only volunteers; 65 USD per child per month (accommodation, food, education). Funding from Christian organisations in the US and Philippines
Residential care institution/vocational training centre, Siem Reap	46 children living in centre, aged 3-18 years (50% female), 9 house parents provide care, 2 internal social workers	Orphans, abandoned children, and trafficking victims	Formal; Referrals are mostly from DoSVY, CCWC and village chiefs	Funded by Australian donor; staff receive 125 USD per month; provide children with accommodation, food, vocational training, extra-classes; 4 USD pocket money per month;

Case	Care arrangement	Reasons for living in Pagodas	Placement process	Support
Residential care institution, Siem Reap	14 girls, 8 per house, 7 house mothers, 2 social workers, 2 counsellors	Sexual abuse victims, trafficking victims, labour exploitation	Formal, NGOs and DoSVY refer cases to the shelter	Food, accommodation, health check-ups, vaccinations, counselling, skills training, legal support, cover fees of private school
Residential care institution, Battambang	34 children living in the shelter (20 girls), 7 staff members, 2 social workers	Abandoned children, trafficking victims,	Formal, police refer children	Funded by UNICEF and international donors; provides shelter, food, counselling; operational budget for one year is 280,000 USD (includes re-integration programme)
Vocational training centre, Battambang	34 children (30% girls), aged 15-19, sleep in gender separated houses; 15 staff members, 1 social worker	Abandoned children, orphans, trafficking victims, abuse victims, labour exploitation	Formal, referrals by NGOs, police, DoSVY	Facility provides shelter, food and vocational training, cover tuition fees if necessary; funding from Japanese donors, cover rent for independent living (up to 3 months)
Boarding school, Phnom Penh	69 girls; 2 staff, 1 educator, 1 nurse 2 dormitories: good bathrooms and individual storage	Parents migrated to Thailand, abandoned children; neglected children; parents gambling or alcoholic	Informal, through the Catholic church (priests) and individuals	105 USD per month per child; some parents contribute up to 20 USD; provide education, accommodation, food

ANNEX 2 – DATA COLLECTION TOOLS

KEY INFORMANT INTERVIEW GUIDE – GOVERNMENT, NGOS AND CIVIL SOCIETY, ALTERNATIVE CARE EXPERTS, UNICEF STAFF

[Note to interviewer: This tool includes detailed follow up questions, which will not be relevant to all stakeholders. They have been included to guide the interview in case the stakeholder has a lot of knowledge about a particular aspect of alternative care. Because these interviews are intended to give a 'birds eye' view of alternative care practices in the community in Cambodia, it is fine to stick to broad questions].

INTRODUCE THE STUDY ACCORDING TO THE FOLLOWING SCRIPT:

We are in the process of conducting a study on care practices for children in Cambodia who are not in parental care. The study is being funded by UNICEF. The purpose of the study is to learn about the types of (alternative) care that are available, particularly within community settings, and determine how well they are working and how they could be improved. We have some questions for you regarding your knowledge of and experience with different forms of (alternative) care in Cambodia, your views about the different options that are being used in practice, and ideas about ways in which alternative care services could be improved in the future.

Explain that participation in the study is voluntary, and advise participants about confidentiality and anonymity.

ARE YOU HAPPY TO PARTICIPATE IN THE INTERVIEW?

(If the respondent agrees to participate) We appreciate your agreement to participate in this interview. The research is first and foremost a learning exercise for UNICEF so please do be as open and candid in your responses as you can. While we would like to draw upon your contributions in our report, we will always keep your comments anonymous. You may not have answers to all of our questions, so don't feel you need to answer them – we are interested to learn from your knowledge, views and experiences.

INTRODUCTORY QUESTIONS

1. Please give me a brief overview of your role and responsibilities. In particular, how does your work relate to alternative care?
2. Can you give a bit of background/context on alternative care in Cambodia (your province/district/commune)?

CONTEXT AND NEED

3. Who are the main groups of children in Cambodia (your province/ district/ commune) who are in need of care/ living without parental care?
4. For what reasons, why and how do these children typically end up in need of (alternative) care?
5. What typically happens to these children? Do they typically end up living with or without care? What type of care?

FORMS OF ALTERNATIVE CARE

6. What are the alternative care options that are available? (Define alternative care if necessary) (Probe if necessary) What about kinship care, foster care, group homes and pagoda based care?
7. How is each form of care being used in practice? What is the general profile of care of children in care?
8. What do you think are the best alternative care options for children in Cambodia (your province/district/commune)? Which are the worst options? Why?

For each form of care with which the informant is familiar, try to find out the following information:

IDENTIFICATION AND REFERRAL

9. How do children tend to end up in X form of care? How are they identified / who refers them? Is there a formal assessment/referral process? (If you are familiar with this process) how does it work/who is involved? Are any government (or other) authorities involved or informed? What is the role/involvement of the family parents and extended families?

CHARACTERISTICS OF ALTERNATIVE CARE

10. Who operates X service? How many children can X service accommodate? How many children are staying there in practice? Are you familiar with the facilities? Do you consider them to be a good environment for children? Why or why not?
11. How long do children tend to stay in X care? Are there efforts made to reunify them with their families? Are there mechanisms for reviewing a child's case? How does this work? When do children leave X form of care? Where do they go?

12. Are you familiar with the care services provided to children in the institution? What do they involve? Probe to find out whether children have access to:
- Social work services including counselling, care planning, etc.
 - Basic needs such as a food, health services, etc.
 - Education or vocational training services and other activities;
 - Legal advice and support;
 - Any other services provided at the care facility.

Probe to get as much specific detail as possible.

13. Are there any problems with the services provided to children in the institution? Is anything missing? How could alternative care services be improved?

MANAGEMENT, FUNDING AND ADMINISTRATION

14. Who manages X form of care? Is it formally registered with the government?
15. What are the staffing arrangements (how many, what is their background, etc)? Do staff receive any training or capacity building? Are there any capacity gaps? What are they?
16. How is X form of care financed? Are you familiar with the budget for operating X form of care? How is it spent?

MONITORING

17. Is anyone responsible for monitoring X form of care? What is the purpose of this monitoring exercise? What does it involve? How often does it occur? How are the results used?

RECOMMENDATIONS AND CONCLUSIONS

18. What do you think are the biggest gaps in alternative care for children in Cambodia? How could they be filled?
19. Do you have any recommendations for how existing alternative care services could be improved?

INDIVIDUAL INTERVIEW GUIDE FOR CAREGIVERS AND MANAGERS IN CARE

INTRODUCE THE STUDY ACCORDING TO THE FOLLOWING SCRIPT:

We are in the process of conducting a study on care practices for children in Cambodia who are not in parental care. The study is being funded by UNICEF. The purpose of the study is to learn about the types of (alternative) care that are available in Cambodia, how they are working, and how they could be improved. We have some questions for you regarding your knowledge of and experience providing care for children.

Explain that participation in the study is voluntary, and advise participants about confidentiality and anonymity.

ARE YOU HAPPY TO PARTICIPATE IN THE INTERVIEW?

(If the respondent agrees to participate) We appreciate your agreement to participate in this interview. The evaluation is first and foremost a learning exercise for UNICEF so please do be as open and candid in your responses as you can. While we would like to draw upon your contributions in our report, we will always keep your comments anonymous. You may not have answers to all of our questions, so don't feel you need to answer them – we are interested to learn from your knowledge, views and experiences.

INTRODUCTORY QUESTIONS

1. Please give me a brief overview of your role in providing / managing alternative care [if relevant specify foster care, kinship care, group home care, pagoda based care, residential care, etc.] for children?
2. (If the interviewee manages/is employed by an institution/organisation) Can you give a bit of background/context on your institution/organisation and the services it provides to children? What is the overall goal / mandate of the institution?
3. (If the interviewee is a kinship carer or a foster carer) How long have you been involved in providing foster care or kinship care? How did you become involved? Why did you decide to do this work?

GENERAL QUESTIONS

4. How many children are in your / your institution's care at the moment? How many children do you / your institution have the capacity to provide care for?
5. Tell me a bit about the children in your care – what are their ages/ genders? What is their social, religious, ethnic background? What are the reasons they need care? Do they have parents, or guardians?

(General questions for foster care / kinship care provider)

6. Who lives at your home? Do you have any biological children of your own?

7. Are you (or others in your family) employed? What is your household's main source of income?
8. Are children in your care assigned to a social worker? If so, where does the social worker come from?

(General questions for group home / Pagoda based care / residential care institution care provider)

9. How many carers do you have at your institution? Are there any other employees/ members of staff that are involved in providing children with care?
10. Are children in your care assigned a social worker either from within or from outside of your institution?

IDENTIFICATION AND REFERRAL

11. How do children tend to end up in your care? How are they identified / who refers them? Is there a formal assessment/referral process? (If you are familiar with this process) how does it work/who is involved? Are any government (or other) authorities involved or informed? What is the role/involvement of the family parents and extended families?

(Questions for foster care / kinship care provider)

12. How/ why did you end up providing foster care to this child/ these children? Who referred these children to you and what made you decide to care for them?

CHARACTERISTICS OF ALTERNATIVE CARE

[Note to interviewer: If you are interviewing a foster carer / kinship carer it may be more appropriate to ask questions about specific/particular cases].

13. How long do children tend to stay in your care? Are there efforts made to reunify them with their families? Are there mechanisms for reviewing a child's case? How does this work? When/under what circumstances will a child leave your care? Where do they go?
14. Tell me a bit about the basic needs services provided to children in your care? Are children able to access food, shelter, health services, etc? How? (Probe to understand what children have access to)
15. Are the children you look after in school, vocational training or any other types of educational activities? Who provides this education? Do you feel it is adequate / appropriate? Why or why not?
16. Do children have any particular activities/ tasks/ responsibilities that occupy them during the day? What are these? (Probe for details on the length of time spent doing any activities mentioned, and the nature of these activities.)
17. Do the children you look after access any social work services? Who provides these services? What do they involve? In your view are they effective / helpful to the child? Why or why not?

18. Do children in your care of access to legal advice and support? Is there someone outside or your family/organisation that they can contact if they have a problem? Who?
19. Are there any problems or gaps in the services you provide for children in your care? Is anything missing? How could the service you provide be improved?
20. Overall, what are the main challenges and difficulties that you face as a care provider? (Probe about how they feel about the children in their care).

FUNDING, ADMINISTRATION AND CAPACITY BUILDING

21. Who manages / oversees the care that you provide? Is your care service formally registered with the government? If so, with which government body?
22. Is the care you provide subject to any rules or regulations? If so, what are they? Were there any requirement you needed to fulfil in order to formally register / get approval as a care provider?
23. What are the staffing arrangements (how many, what is their background, etc)? (Probe about number of staff permanently present at any one time etc.)
24. Have you (/do your staff) receive any training or capacity building? Who provided it and what did it involve? Are there any capacity gaps/would you benefit from additional training? Please elaborate.
25. Do you receive external funding to provide your care service? How much and where does it come from?
26. How much does it cost to run your service? What are the particular expenses you incur in relation to providing care for children?
27. Are all of your costs covered by your budget? If you had additional funds to provide better care, how would you spend them?

MONITORING AND OVERSIGHT

28. Is anyone responsible for monitoring your care service? If so, who? What is the purpose of this monitoring exercise? What does it involve? How often does it occur? How are the results used?

RECOMMENDATIONS AND CONCLUSIONS

29. Do you have any recommendations for how your alternative care services could be improved?
30. What do you think are the biggest gaps in alternative care for children in Cambodia (your province, district, commune)? How could they be filled?

INDIVIDUAL INTERVIEW GUIDE – CHILDREN IN ALTERNATIVE CARE

Ideally, individual interviews should be held in a one to one setting (two to one, including the translator). If the child being interviewed is more comfortable, it is okay for him or her to bring a trusted companion into the interview. Interviews should be conducted in a secure, quiet place.

Introduce yourself and the purpose of the study: the study is about the care provided for children in Cambodia, particularly children who are not living at home or aren't cared for by their parents. We are looking to learn from your experiences so that we can find out what is happening in practice and what more could be done protect children in the future. Explain that it is voluntary, gain informed consent and advise participants about anonymity.

INTRODUCTORY QUESTIONS

1. To begin, can you tell me a bit about yourself: how old are you?
2. Where do you currently live and who do you live with? Who looks after you?
3. Where were living before? Was anyone looking after you then? Who?
4. (If this child is living in alternative care) How long have you been living here?
5. (If the child is living in alternative care) Where are your brothers and sisters staying at the moment?
6. Tell me a bit about your family – do your parents work? What is (was) your main source of income?
7. Do you go to school? Where do you go to school? Do you ever have to miss school for any reason? Why?
 - a. If the child DOES NOT attend school, then ask the child whether (s)he attends any training or whether s(he) works and if so what sort of work and for how many hours.
8. Do you like spending time here? Why or why not? What are the main reasons that you come to this place?
9. Where do you spend most of your time when you are not here? What do you do? Who do you spend time with?
10. Are there any problems you are dealing with at here, at school or in the community? Is there anything that makes you feel unsafe or at risk of harm?

CASE HISTORY

11. Probe to find out about the child's perspective on their placement in alternative care / referral to alternative care: What was the reason that you first came to live at this place? What was happening at that time? Were you having any problems at home, or at school, or elsewhere? Were you experiencing any type of abuse at home or elsewhere? Did you ever tell anyone about the problems you were having?

12. What happened? Who was involved in your case? Whose decision was it that you should come here? How did you feel about it at the time? How do you feel about it now? (Ask probing questions to find out as much detail as possible about the events that led up to the child's referral, how the case was identified and reported, and what the response and decision making process were).
13. Ask probing questions to learn how the case was handled / who handled it and what happened. Try to learn who was involved at each stage, whether the legal process was involved? What their role was, whether the child removed from his or her home at any point, did the child or his or her family received any services/ support? Also try to get a sense of the time frame within which all of this occurred.

EXPERIENCES IN CARE

14. How many other children are living here? What are their stories / why are they here? Do they come from nearby or from all over? Do you get along with them?
15. Tell me a bit about what things are like for you here – what is a typical day like? (Probe on the following points)
 - a. How is the food here? How often do you eat? What do your meals include?
 - b. Have you been sick since you have been here? Were you able to get the help you needed? (If the answer is no) What happens if you get sick? Who can you tell?
 - c. Where do you sleep? Do you have a mattress, a pillow, a blanket, etc?
 - d. Do you have a space of your own to keep your things?
 - e. What are the toilets and washrooms like? Are they clean/dirty?
 - f. How often can you wash/ shower? Do you have a private place to wash or do you have to wash in front of others? Who?
16. Do you have a 'social worker' or anyone who is specifically assigned to help you? Who is this person? Do you know where they come from? How often do you see them? What do you talk about? Do you find it helpful?
17. (If the child is in school) How do you find your school? Is it too hard/too easy? How are the teachers? What about the other students? Is there anything difficult for you at school?
18. (Other than going to school) are there any particular tasks or work that you are responsible for at this place? What tasks? How long do you spend doing this per day? How difficult is this work?
19. How do you feel about the staff/ caregivers in this place? How do they treat you? What are their attitudes towards you and the other children? Are there any differences in how they treat you compared to the other children in their care? What differences? Why?
20. What are the rules at this place? What happens if you break the rules? What are the punishments for breaking the rules? (Probe about physical punishment, frequency and severity).

21. Have you ever faced any problems with any of the other children or staff in this institution? What kind of problems? Has anyone ever caused you harm? Who? Did you tell anyone? Why/ why not? (If yes, try to gather as many details about the incident, context, severity, response and outcomes as possible.)
22. If you have a specific problem (for example if someone causes you harm), is there anyone that you can tell? Has this ever happened before?
23. Has anyone at this institution ever made sexual comments, used sexual words, or sexually touched you in a way that made you feel uncomfortable or unhappy? Who? Has anyone ever asked or forced you to have sex with them when they didn't want to? Did you tell anyone? Why/ why not? (If yes, try to gather as many details about the incident, context, response and outcomes as possible.)
24. How do you feel about this place overall? Are there particular things you like about it or particular things you don't? Are there any new problems you are dealing with now? Is there anything in your life that you would like to change?
25. Do you know how long you will stay here? How long do you want to stay?
26. Have things improved for you since you have been here? How?
27. What are your goals and hopes for the future?

RECOMMENDATIONS

28. Looking back are you happy that you came to stay here? Do you wish anything had been handled differently?
29. What do you think would make this place better for you and other children? If you could make recommendations to the government, the Pagodas, or any other organisations working for children, on how they could improve children's lives, what recommendations would you make?

Thank the participants for their time.

Explain again that the study will help understand what risks children face in the community, and what actions can be taken to improve the situation for children in the future.

FOCUS GROUP DISCUSSION GUIDE – CHILDREN IN ALTERNATIVE CARE

Ideally, focus group discussions should be held with 6-8 children and young people of the same gender, ages 12 years and above. They should be conducted in a private place, where respondents cannot be overheard by anyone.

Introduce yourself and the purpose of the study: the study is about the care provided for children in Cambodia, particularly children who are not living at home or aren't cared for by their parents. We are looking to learn from your experiences so that we can find out what is happening in practice and what more could be done protect children in the future. Explain that it is voluntary, gain informed consent and advise participants about anonymity. This FGD must only be done after the parents or guardians of all children under the age of 18 have given their consent for their child to participate.

BACKGROUND QUESTIONS

1. To begin, can you tell me a bit about yourselves: how old are you?
2. How long have you been living here?
3. Where do you come from originally? Do you come from a nearby area, or did you come from somewhere far away?

HOW DO CHILDREN COME TO BE IN ALTERNATIVE CARE?

4. Tell me about this place (refer specifically to the RCI, Pagoda, group home, etc). What is its purpose? How many children are staying here?
5. What types of children live here? How old are the children that come to stay? Are they from a particular area or from a particular background?
6. Can you give me some examples of reasons why children come to stay here? What are their stories? Can you give me examples of reasons why children may leave their homes and stay somewhere else? (If the children refer to their own experiences, or give examples of their peers' experiences probe to understand what events led or situations led to the children being at the institution).
7. How do children come to stay here? Who decides if a child will stay here? Do children ever come on their own? Are they sent by an adult or authority? If so, who sends them?
8. (Follow up if children refer to their own personal experiences organically). Who was involved in the decision to send you here? Were your parents involved / did they agree? What about you – did you get to participate in the decision?
9. Are there any children who aren't welcome in this place? Why?

WHAT ARE CHILDREN'S EXPERIENCES IN ALTERNATIVE CARE?

10. How long do children usually stay here? What are the reasons that children leave? Where do they go after they leave? Do you know how long you will stay here? How long do you want to stay?
11. Tell me a bit about what things are like for you here – what is a typical day like? (Probe on the following points)
 - a. How is the food here? How often do you eat? What do your meals include?
 - b. Have you been sick since you have been here? Were you able to get the help you needed? (If the answer is no) What happens if you get sick? Who can you tell?
 - c. Where do you sleep? Do you have a mattress, a pillow, a blanket, etc?
 - d. Do you have a space of your own to keep your things?
 - e. What are the toilets and washrooms like? Are they clean/dirty?
 - f. How often can you wash/ shower? Do you have a private place to wash or do you have to wash in front of others? Who?
12. Do the children here go to school? Are you going to school? (If participants answer yes) How do you find your school? Is it too hard/too easy? How are the teachers? What about the other students? Is there anything difficult for you at school?
13. (Other than going to school) are there any particular tasks or work that children are responsible for at this place? What tasks? How long do you spend doing this per day? How difficult is this work?
14. Is there a 'social worker' or anyone who is specifically assigned to help children? Who is this person? Do you know where they come from? How often do you see them? What do you talk about? Do you find it helpful?
15. How do you feel about the staff/ caregivers in this place? How do they treat you? What are their attitudes towards you and the other children? Are there any differences in how they treat you compared to the other children in their care? What differences? Why?
16. Can you give me examples of some of the rules at this place? What happens if a child breaks rules? What are the punishments for breaking the rules? (Probe about physical punishment, frequency and severity).
17. If a child has a specific problem (for example if someone causes you harm), is there anyone that he or she can tell? Do you know of a case where this has happened?
18. Does anyone at the institution ever make sexual comments, use sexual words or sexually touch the children here? Who? Is there anyone that you can tell about this? Why/ why not? (If yes, try to gather as many details about the incident, context, response and outcomes as possible as long as the children are comfortable.)
19. How do you feel about this place overall? Are there particular things you like about it or particular things you don't? Are there any new problems you are dealing with now? Is there anything in your life that you would like to change?

SCENARIOS

20. Discipline at the home/institution/pagoda: Chanda sometimes breaks the rules at the home and disturbs the staff/monks. When she is disruptive the caregiver makes her sit facing the wall in the corner. Sometimes the care giver shouts at Chanda and uses bad words. One day Chanda shouted back at the caregiver. The caregiver responded by taking Chanda outside and whipping her as punishment. Chanda was badly hurt and had to go to hospital.

Discussion questions: What do you think about this story? Do you think what the caregiver did was normal? Why/ why not? What should Chanda do? Would she tell anyone? Why or why not? Who could she tell? What would this person do about it? Does it make a difference how hard the teacher whipped Chanda, or whether it made a mark on not? Why?

Are the events described in the story things that sometimes happen? Can you tell me a case?

21. Sexual abuse: Vanaka, is a boy who stays here. One day, Vanaka came to you looking upset. He told you that the monk/caregiver was always teasing him. He asked Vanaka whether he liked women, and told Vanaka that he should not be having dreams about women. The monk/caregiver asked Vanaka to show him his penis – he started grabbing Vanaka's penis, tugging it and playing with it. The monk told Vanaka not to think about women anymore.

Discussion questions: What do you think about this story? Might this kind of thing ever happen here? What happened? If this happens, what would you do? Would he tell anyone? Why or why not? Who could he tell? What would this person do about it?

RECOMMENDATIONS

22. Looking back are you happy that you came to stay here? Do you wish anything had been handled differently?
23. What do you think would make this place better for you and other children? If you could make recommendations to the government, the Pagodas, or any other organisations working for children, on how they could improve children's lives, what recommendations would you make?

Thank the participants for their time.

Explain again that the study will help understand what risks children face in the community, and what actions can be taken to improve the situation for children in the future.

OBSERVATIONAL CHECKLIST

Please obtain the consent from the responsible person in charge of the alternative care institution/setting before implementing this observational checklist. Usually the responsible person will be the manager/supervisor in group homes and residential care institutions, a senior monk in pagoda-based care, and the head of foster care families or families responsible for kinship care.

Implementing the checklist should take about 5 – 10 minutes. Please be as respectful and un-intrusive as you can when accessing and observing the premises.

In addition to obtaining the consent of the responsible person, please also inform him/her that all of the information collected on this checklist will be kept strictly anonymous, and that you will not write down his/her name or that of the institution.

Background information	
Province (please tick)	<div><input type="checkbox"/> Phnom Penh</div> <div><input type="checkbox"/> Siem Reap</div> <div><input type="checkbox"/> Kandal</div> <div><input type="checkbox"/> Battambang</div> <div><input type="checkbox"/> Preah Sihanouk</div>
Commune (please write name of the commune)
Name (please write name of institution)
Date (please write the date of your visit)/...../...2016
Type of alternative care arrangement (you can tick more than one answer)	<div><input type="checkbox"/> Foster care</div> <div><input type="checkbox"/> Residential care</div> <div><input type="checkbox"/> Kinship care</div> <div><input type="checkbox"/> Boarding school</div> <div><input type="checkbox"/> Group home</div> <div><input type="checkbox"/> Other (please specify below)</div> <div><input type="checkbox"/> Pagoda</div> <div><input type="checkbox"/> Other faith-based institution</div> <div>.....</div>

Checklist		
Does the facility have a functioning sewage system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do children have access to safe drinking water?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are bathing materials (such as soap, towel, and toothbrush) available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is rubbish disposed of?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there unrestricted access to bathroom facilities (including for children with disabilities)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do all children have a mattress?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do all beds have mosquito nets?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there space for children to play?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For group homes only		
Are children over the age of 6 years separated by sex (for sleeping and bathrooms)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there livestock on or within close proximity of the premises?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any ponds or lakes on the premises are fenced off?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

For all institutions/homes					
What is your overall assessment of the physical conditions in which children live? (please tick the best answer) 1 = not very good; 5 = very good	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

CAREGIVER/MANAGER SURVEY TOOL

Our organisation, Coram International, with support from UNICEF Cambodia, is conducting a study on different forms of alternative care arrangements in communities in Cambodia – we are examining care in group homes, Pagodas and other faith-based institutions, kinship care and foster care. We would like to learn from you a bit about your work in providing alternative care to children, to help us understand how alternative care works in practice. We have prepared a couple of questions – it should only take 10 – 15 minutes. Please be as honest as you can in your answers: we want to learn from your knowledge and experience. All of the information you give us will be kept strictly anonymous, and we will not write down your name or that of your institution.

You do not have to fill out the survey form if you don't want to, and you can choose not to answer any or all of the questions. Would you like to take the survey? (Please circle a response).

Yes / No

We would like to use some of what you tell us in our report, but we will never use your name. Is that okay?

Yes / No

Background information	
Province (please tick)	<div><input type="checkbox"/> Phnom Penh</div> <div><input type="checkbox"/> Siem Reap</div> <div><input type="checkbox"/> Kandal</div> <div><input type="checkbox"/> Battambang</div> <div><input type="checkbox"/> Preah Sihanouk</div>
Commune (please write name of your commune)
Name of institution (please write name of your institution)	Name...../ Not an institution

Type of alternative care you provide (you can tick more than one answer)	<input type="checkbox"/> Foster care <input type="checkbox"/> Kinship care <input type="checkbox"/> Group home <input type="checkbox"/> Pagoda <input type="checkbox"/> Other faith-based institution	<input type="checkbox"/> Residential care <input type="checkbox"/> Boarding school <input type="checkbox"/> Other (please specify below)
What is your gender? (please tick)	<input type="checkbox"/> Male	<input type="checkbox"/> Female
What is your age (please specify) years	
Did you complete primary school? (please tick)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is your role in this institution/home? (tick the best answer)	<input type="checkbox"/> Manager/supervisor <input type="checkbox"/> Care provider <input type="checkbox"/> Teacher <input type="checkbox"/> Spiritual guide	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other
How long have you been in your role? (tick the best answer)	<input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years	<input type="checkbox"/> 3 years <input type="checkbox"/> 4 years or more
What is the number of caregivers in your institution/home? (please specify) caregivers	
What is the number of children living in your institution/home? (please specify) boys/ girls	
What is the age of children living in your institution/home? (please tick all the boxes that apply)	<input type="checkbox"/> Below 1 year old <input type="checkbox"/> 1-3 years old <input type="checkbox"/> 3-6 years old <input type="checkbox"/> 6-10 year olds	<input type="checkbox"/> 10-14 year olds <input type="checkbox"/> 14-18 year olds <input type="checkbox"/> Above 18 years

Are there any children with special needs living in your institution/home? (please tick all the boxes that apply)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, with HIV/AIDS <input type="checkbox"/> Yes, with disabilities
Typically, how long are children in your care? (tick the best answer)	<input type="checkbox"/> Less than 1 week <input type="checkbox"/> 1 week – 1 month	<input type="checkbox"/> 1 month – 1 year <input type="checkbox"/> Permanent
Education		
What type of education do children in your care receive? (you can tick more than one answer)	<input type="checkbox"/> Primary governmental schooling <input type="checkbox"/> Secondary governmental schooling <input type="checkbox"/> Pagoda or faith-based schooling	<input type="checkbox"/> NGO-based schooling <input type="checkbox"/> Vocational training <input type="checkbox"/> No education <input type="checkbox"/> Other (please specify)
Monitoring		
For how long has your institution/home provided alternative care for children? (tick the best answer)	<input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 - 2 years	<input type="checkbox"/> More than 2 years
How often is your institution/home visited by an external official for a monitoring visit/ to ensure that children are safe? (tick the best answer)	<input type="checkbox"/> At least once a month <input type="checkbox"/> At least every 3 months <input type="checkbox"/> At least every 4 months	<input type="checkbox"/> At least every 6 months <input type="checkbox"/> At least once every year <input type="checkbox"/> Less than once every year <input type="checkbox"/> Never
Who conducts these safety monitoring visits? (you can tick more than one answer)	<input type="checkbox"/> Department of Social Affairs, Veterans and Youth Rehabilitation <input type="checkbox"/> NGOs <input type="checkbox"/> Not applicable/ no visits	<input type="checkbox"/> Women and Children Consultative Committee <input type="checkbox"/> Other (please specify below)
How often are children in your care visited by an external official to evaluate the possibility of reintegration into adoptive/ biological families? (tick the best answer)	<input type="checkbox"/> At least every 4 months <input type="checkbox"/> At least every 6 months	<input type="checkbox"/> At least once every year <input type="checkbox"/> Less than once every year <input type="checkbox"/> Never

Who conducts these visits to evaluate the possibility of reintegration? (you can tick more than one answer)	<input type="checkbox"/> Department of Social Affairs, Veterans and Youth Rehabilitation <input type="checkbox"/> NGOs	<input type="checkbox"/> Women and Children Consultative Committee <input type="checkbox"/> Other (please specify below)
Do you keep written records about the children in your care? (please tick the best answer)	<input type="checkbox"/> Yes, for all <input type="checkbox"/> Yes, for some	<input type="checkbox"/> No
Training		
Have you received any training on counseling and how to identify child abuse? (please tick)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, who provided the training? (please tick)	<input type="checkbox"/> Department of Social Affairs, Veterans and Youth Rehabilitation <input type="checkbox"/> NGO <input type="checkbox"/> Other (please specify)	
How helpful did you find the training in preparing you for the actual care work you do? (please tick the best answer) 1 = not very helpful; 5 = very helpful	<input type="checkbox"/> 1	<input type="checkbox"/> 2
	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	<input type="checkbox"/> 5	
Funding (for managers and supervisors only)		
Do you receive external funding for providing alternative care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please indicate where you receive external funding from (you can tick more than one answer)	<input type="checkbox"/> Government <input type="checkbox"/> Child Welfare Fund <input type="checkbox"/> International religious body <input type="checkbox"/> Local religious body	<input type="checkbox"/> International NGO <input type="checkbox"/> Local NGO <input type="checkbox"/> Private Individual <input type="checkbox"/> Other (please specify)

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