THE GULF BETWEEN
RHETORIC
& REALITY

An examination of the gap between development theory and development practice in the care of Cambodian orphans.

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Craig Greenfield

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ABSTRACT

Like many other Developing World countries, Cambodia is in the midst of an orphan crisis. At least 77,000 children have lost their parents to AIDS and many thousands more have been orphaned by civil war, landmines and other tragedies. These orphans face an uncertain future. Traditionally in Cambodia, most of these children have been cared for within the community in which they lived with their parents. Current development theory strongly promotes such community-based care for orphans and argues that Non-Government Organisations (NGOs) should use their resources to support and strengthen communities in that task instead of placing children in institutions such as orphanages. However, for every community-based orphan care program set up by NGOs in Cambodia, six orphanages are established. The development rhetoric on care for orphans is not matched by the development practice reality in Cambodia. There is a gap between theory and practice in the care of Cambodian orphans, a disconnection between what development theorists promote and what development practitioners implement.

This research project examines the gap between development theory and practice in the care of Cambodian orphans. Results of the study will enhance understanding of the possible reasons for this disparity and suggest ways to close the gap and bring greater congruence between development theory and practice in this field.

The study initially looked at the literature on care for orphans and established general principles as advanced by the development texts. Secondly, the study provided an overview of current practice in Cambodia in the care of orphans. Finally, an examination was made of the gap between theory and practice in Cambodia; in order to understand this gap, primary research has been conducted with development practitioners to establish possible reasons for it.

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CHAPTER 1: INTRODUCTION

Research Question

Save the Children recently framed the need for research in this way: "In view of the lack of up-to-date research on institutional care, fostering and other forms of childcare in developing contexts, Save the Children calls for increased genuine enquiry into this complex theme…We need to achieve a more substantial empirical and knowledge base, including finding answers to such questions as: Why do some countries have many institutions while others have very few?" (2004: p4-6).

Cambodian orphans have traditionally been cared for within communities. Increasingly, however, Non-Government Organisations have been establishing residential care facilities to care for these children. To what extent is this development practice in line with development theory?

This thesis demonstrates that there is actually a significant gap between development theory and practice in the care of Cambodian orphans. Dozens of studies across multiple sectors have convincingly established that orphaned children are better cared for in a family and community environment than in an institutional or residential setting such as an orphanage (Foster, 2004; Save the Children, 2004; UNAIDS/UNICEF, 2004b; WHO, 2004). However, development practitioners in Cambodia continue to set up residential care facilities such as orphanages at a ratio of six for every one community-based care project. Thus, there is a gap, or disconnect between what researchers maintain is the best way to care for orphans and the actual interventions being undertaken.

I suggest that the difference between development theory and development practice in Cambodia exists for several reasons. Firstly, there is a general lack of preparatory research carried out by development practitioners, a lack of community development experience and understanding, coupled with isolation from other practitioners.

Secondly, the psychosocial needs of the children tend to be disregarded, resulting in an overemphasis on the physical and educational needs of the orphan. This leads to a greater emphasis being placed on physical comfort and wellbeing than on maintaining family and community ties.

This research contributes to a greater understanding of how the gap between rhetoric and reality, the disconnection between development theory and practice in the care of Cambodian orphans, can be narrowed.

The Context: Cambodia

Cambodia's demographic profile suggests that the country is at particular risk for orphans. Located between Laos, Thailand and Vietnam, Cambodia is in the middle of high volume cross-border traffic for business, tourism, drugs and sexual trafficking. The majority of Cambodians are Buddhist and more than 75% live in rural areas, surviving by subsistence farming. With a population of 12 million and a per capita gross national product of just $280, Cambodia is one of the poorest nations in the world today. Life expectancy is 51 years of age and infant mortality is one of the highest in the region with 115 deaths per 1000 live births (UNDP, 1999). Now, after more than 20 years of continuous conflict and violence including the murderous Khmer Rouge regime in the 1970s, more than half of Cambodia's population is under 18 years old, many of whom are living away from their families and communities to find work. This combination of poverty, war, social incohesion and lack of infrastructure has exposed Cambodia to a growing AIDS epidemic and as a result, numerous orphans.

Orphans in Cambodia

Cambodia's civil war and subsequent Khmer Rouge regime resulted in the deaths of around two million Cambodians and the orphaning of millions of children. However, the country is now relatively stable politically and HIV/AIDS has become the greatest threat to child development. According to Children on the Brink 2004, the high HIV/AIDS prevalence in the country has already resulted in over 77,000 children orphaned by AIDS (UNAIDS/UNICEF, 2004a: p25). An important and unique

characteristic of HIV/AIDS in regard to orphaning is that AIDS is more likely than other causes of death to create double orphans, i.e. children who have lost both parents (UNAIDS/UNICEF, 2004a: p12).

Since AIDS is the leading cause of death worldwide amongst people of childbearing aged 15 to 49, it is not surprising that children orphaned by AIDS make up the majority of double orphans in Cambodia today (UNAIDS/UNICEF, 2004a: p3).

The impact of the epidemic on Cambodian children and their families is both immediate and long term. My own personal observation during five years of working closely with hundreds of children affected by AIDS has provided considerable insight into the lives of these orphans. The majority of Cambodian children infected with HIV/AIDS by their mothers will not survive beyond their third or fourth birthday. Most of these children die from commonplace infections, and the quality of their short life is usually low. More often than not, one or both parents will die before the infected child, creating an especially difficult and stressful situation for the caregiver.

The majority of children affected by AIDS however, are uninfected by the virus. They will usually receive decreasing levels of care, support and protection as their parents become sicker. The parent's sickness invariably leads to a loss of income and the sale of assets as cash is redirected towards medical treatment. This undermines children's rights to education, health, survival and development, and protection from violence, exploitation, abuse and neglect. Girls especially, are often taken out of school to care for sick parents and younger siblings and may also be at increased risk of sexual exploitation.

Residential Care

Many of these Cambodian orphans end up residential care. Residential care, or institutional care, simply refers to any group living situation for children in which care is provided by staff, rather than traditional carers (Tolfree 1995: p6). The most common form of residential care is an orphanage[1] or children's home. In the literature review

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[1] The terms "orphanage" and "children's home" are interchangeable. However, the term "orphanage" is avoided by many practitioners because of its Dickensian connotations.

section I will demonstrate that residential care is not favoured by development theorists and researchers.

Save the Children estimates that there may be as many as 8 million children living in residential care worldwide (2004: p1). The Cambodian Government and a significant number of non-Government organizations establish more institutions such as orphanages every year aimed at providing residential care for orphans in Cambodia. Orphanages have been widely seen by adults as the preferred option to care for orphans in Cambodia (Dybdal and Daigle, 2002a: p15). However, admission to government institutions is restricted and their capacity is limited in terms of the number of children they can absorb (FHI, 2002a). Currently, there are at least 25 institutions providing residential care for orphans in Phnom Penh alone with dozens more around the country, including 21 government orphanages (Dybdal and Daigle, 2002a: p15).

Residential care facilities in Cambodia do not cater solely for children who have lost one or both parents. The largest number of children living in residential care are there for reasons of poverty (Dybdal and Daigle, 2002a: p16). This suggests that despite popular belief, the most common reason for placement in an orphanage is not that a child has been orphaned, but rather that the parents or other relatives are too poor to care for the child.

There may be more complex reasons for the willingness of parents to place their children in residential care facilities such as orphanages. HOSEA Project[2] (2002: chart 3.1) and Dybdal and Daigle (2002a: p16) both identified an over-representation of boys in these institutions and suggested that this was because girls are perceived in Cambodian society as more useful in performing housework and therefore more likely to be accepted and cared for by parents or extended family. They also suggested that because residential care is perceived as beneficial, families might choose to send school aged boys into residential care in order to take advantage of the opportunities for education, medical services and accommodation. In support of this hypothesis, others in the Dybdal and Daigle study observed that once a new residential care centre opened in an area they would invariably experience great demand from poor local families who

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[2] HOSEA Project is a research and training organisation established to provide support to orphanages and other NGOs working with orphans.

viewed the institution as a good opportunity for their children to receive basic accommodation, medical care and education (2002a: p16).

In this thesis I review numerous studies that show that children in residential care demonstrate a significantly increased level of social maladjustment, aggression, attention demanding behaviour, sleep disturbance, extremes of over-affection or repelling affection, social immaturity and tendency to depression. Attachment theory suggests that many of these difficulties result from the lack of availability of appropriate, nurturing, stable "mother substitutes" in residential care.

Other studies have also documented medical and psychological abnormalities arising from institutionalization such as physical and brain growth deficiencies, cognitive problems, speech and language delays, sensory integration difficulties, social and behavioural abnormalities, difficulties with inattention/hyperactivity, disturbances of attachment, and a syndrome that mimics autism.

From a more purely developmental perspective, residential care also lacks sustainability due to its relatively high costs compared to community-based care and is constrained by building size and staff numbers. Residential care takes away the responsibility for orphan care from the community thereby reducing the amount of community participation and ownership and sending a message that poor communities are not capable of caring for orphans. Children are separated from their families and communities and raised in situations that do not prepare them for life as an adult. Finally, children are more likely to lose any inheritance of land or property if they are not present to protect these assets from unscrupulous neighbours or relatives.

The alternative promoted by the development literature is community-based care that covers kinship care by related persons, teenager-headed households and foster care.

Community-based Care

Apart from residential care, going to live in an orphanage or children's home, the options for an orphaned child in Cambodia are limited. There is no ideal solution to the problem of orphanhood, only better or worse alternatives. Community-based care, in contrast to residential care, refers to any type of care for orphans by those who are not

the biological parents but are able to provide individual care and nurture in the context of a family and community. Community-based care interventions include foster care and kinship care (care by relatives). In the next chapter, I will show that according to development theorists and researchers, community-based care interventions are preferable to residential care for orphans for a wide range of psychosocial, medical and developmental reasons.

In Cambodia, communities have been devastated by decades of war and societal breakdown and to date have absorbed thousands of orphans into the extended family and informal community systems. Yet there is much evidence that families are struggling under the burden, reducing their capacity to provide and care for orphaned children. A study conducted by the Cambodian government and Family Health International (FHI) found that around 5 percent of families nationwide have taken in children who are not their own. In one district of Koh Kong province, as many as 22 percent of local families were found to be caring for children who were not their own, with only six percent of these receiving any outside support from NGOs (FHI, 2002a).

A common criticism of this traditional solution is that these children may be treated differently than the biological children of the foster parents and may be forced to work to earn income for the family (FHI, 2002a). What is clear is that when poor families take in orphans, all children in the household suffer to some extent since household spending is redistributed among a larger number of children.

In particular, households headed by elderly people (HelpAge, 2003: p1) and women struggle. Already living at the edge of poverty, they must stretch their insufficient resources even further to care for orphaned relatives. Child-headed and teen-headed households also battle to survive, dependent on each other and particularly on older siblings.

Study Design

The design and methodology of this research was informed by the literature review of relevant academic writing and research from Cambodia, neighbouring countries and the rest of the world. This literature review follows in Chapter 2. The qualitative methodology adopted reflects a greater concern with the relationships between

meanings than correlating variables (Stiles 1993: p593-618). This qualitative approach was chosen in order to identify key themes that may not have been elicited by a rigid quantitative methodology.

Field Work

Additionally, I drew on five years of experience working with nearly 1000 Cambodian orphans and an in depth knowledge of Cambodian language and culture in framing the study. A number of other expatriate and Cambodian stakeholders with knowledge of the context were consulted in the initial stages of design.

After reviewing the theory, an in depth analysis of the current situation in the care of Cambodian orphans was carried out by document review and site visits. This phase included visits to a number of institutions in order to familiarize myself further with current practice in the care of Cambodian orphans. The study was conducted in the urban and peri-urban areas of Phnom Penh, the capital city of Cambodia where the majority of NGOs in Cambodia are based.

Finally, I personally conducted ten in depth, semi-structured interviews with expatriate and Cambodian development practitioners involved in providing institutional and community-based care for Cambodian orphans. The semi-structured interviews were usually in the form of guided conversations where broad questions were asked relating to the topic of interest and the conversation was allowed to flow naturally. The interviews had all the typical attributes of semi-structured interviews in that they were informal, relaxed discussions around the topic being studied. The interviewer took detailed notes. Questions were prepared in advance but supplementary questions were asked as necessary. On a small number of occasions, the interviews were conducted via email due to some of the interviewees being out of the city or out of the country. These exchanges usually required several emails back and forth in order to query and follow up on threads.

The aim of these interviews was primarily to establish reasons for the gap between the development theory and their own approach to care for orphans and secondly to explore possible ways to close this gap in future.

Sample size

Only eight community-based projects are currently being implemented in Cambodia. Four of these projects were surveyed, providing the comparison group. The case group was made up of six residential care projects. Thus, ten in depth semi structured interviews with development practitioners were conducted. Most were with founder-directors of the projects concerned. This smaller number of participants was necessary to do justice to the intensive and richly descriptive nature of the research (McLeod 1994: p78).

Ethics and Confidentiality Issues

Great difficulty was encountered in gaining ethical approval from Massey University to interview the orphans themselves. Ethical approval was finally granted by Massey University to interview only the directors and founders of NGOs and the original plan to interview the orphans themselves had to be abandoned.

Limitations

The study has several limitations and/or biases that require noting:

- My location in Cambodia limited access to key literature and face to face advice from supervisors.
- Lack of funding meant that the four Cambodian interviewers hired as research assistants were inexperienced and previously untrained. However, I made every effort to provide training to them in neutral interview techniques and supervise their interviews.
- I founded and act as an advisor to a community-based program for orphans in Cambodia. However, every attempt was made to be objective and weigh up all the evidence on both sides.

Thesis Structure

Having given a broad overview of the context and research question, in the next part of this thesis I will provide an in-depth review of the relevant literature. This will establish the case against residential care for orphans by examining several decades of

multidisciplinary research comparing children raised in residential care to children raised in families and communities.

The alternative, community-based care will also be critically examined and finally I will demonstrate that development theorists clearly promote community-based care as the best approach to caring for orphans.

Chapter 3 will examine a variety of secondary sources to outline the current situation facing orphaned children and describe the diversity of development interventions targeted at them, both community-based and residential care in Cambodia. A case study in community-based care will demonstrate that the development theory described in the literature review is realistic and able to be effectively applied in the Cambodian context. A description of the residential care approaches commonly used by NGOs in Cambodia will establish that there is a broad disparity between theory and practice since residential care is still the option preferred by most practitioners.

Chapter 4 will describe the results of the primary research component of this thesis, which is an attempt to examine the attitudes and practices of development practitioners working in this field with a view to establishing some of the reasons for the gap between development theory and practice in Cambodia.

Chapter 5 will draw on the primary and secondary sources in chapters 2 to 4 to offer conclusions about why there is a disparity between development theory and practice in this field. Finally, recommendations will be made as to some steps that could be taken to close the gap.

CHAPTER 2: LITERATURE REVIEW

In order to establish the position of development theorists on the care of orphans I will review the relevant literature. The literature can be divided into two general categories – literature on the effects of residential care and literature relating to community-based care. Firstly, I will explore the literature on the psychosocial and developmental issues associated with residential care for orphans and this will establish the unsuitability of this approach to orphan care. Secondly, I will examine the literature on community-based care for orphans and establish that this approach is indeed the preferred method of orphan care in the development literature.

RESIDENTIAL CARE

Defining Residential Care

The term 'residential care' is interchangeable with 'institutional care', although the former is preferred in this thesis as it is considered a more neutral term (Tolfree, 1995: p6; Williamson, 2004: p12)[3]. David Tolfree of Save the Children defines residential care as "a group living arrangement for children in which care is provided by remunerated adults who would not be regarded as traditional carers within the wider society" (1995: p6). However, this definition excludes those institutions that may also be regarded as traditional carers, such as the Buddhist pagodas in Cambodia. Miles and Stephenson offer a simpler alternative definition: "group care by generally unrelated persons" (2001: p9). Ward proposes a third definition, "being looked after away from home by people who are not parents" (cited in Miles and Stephenson, 2001: p9); but this definition would also include foster care, which is generally not considered to be residential care. I propose for the purposes of this study that residential care be defined as "group care for children away from home by unrelated persons" since this definition retains the important concepts of group and separation from home and family. The overwhelming majority of residential care facilities are orphanages (also known as children's homes) and so this thesis will primarily focus on these facilities.

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[3] The term 'orphanage' also holds negative connotations for some and will therefore only be used in reference to specific cases that already use the term to describe themselves.

The complexity of issues that face orphans call for multidisciplinary and interdisciplinary approaches. Thus, the literature on residential care for orphans is vast and ranges through the fields of psychology, sociology and medicine to education and community development (Foster 2004, Lie 1999, Miles and Stephenson 2001, Ames, 1997; Johnson, 2000; Muhamedrahimov, 2000). Some of the most important research conducted, has examined the psychosocial impact on children of growing up in residential care facilities. Nils Lie (1999) has provided an excellent summary of almost every major study conducted in this area, however in most cases I was able to obtain the primary source documents and examine the original studies.

Psychosocial Impact

The dangers of institutionalization have been well documented over the past decades, although some early studies are now unavailable and secondary sources must be relied upon. An attempt to examine the results of the most important studies in chronological order will be made in this section of the literature review. The amount of research comparing children in residential care with children in the community decreased as residential care lost favour in the West, thus many of the studies are several years old and may be less rigorous in their methodology. However, the fact that the authors are almost unanimous in their findings cannot be ignored. The handful of later studies available confirm the earlier findings.

In one of the earliest studies of its type, Theis conducted research in 1924 that compared 95 adults who had spent a significant period of their childhood in institutions with 84 adults who had been in deprived homes as children. All had ended up in similar foster homes at a later stage. Theis found that 34% of the institutionalised children were socially maladjusted compared to 17% of the similar group who had spent their first five years in their own homes (cited in Bowlby, 1951).

In 1937, Gindl, Hetzer and Sturm used a developmental age test to score 20 infants under two years of age who had been in residential care for at least six months (cited in Casler, 1961: p19-27). They found that the mean developmental quotient for these children was significantly lower (ten points lower) than for a similar group of children who were brought up in inadequate homes.

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Lowrey studied 28 children who had lived in orphanages for significant periods of their childhood (1940: p576-585). He found that all the children displayed symptoms of inadequate personality development such as aggression, attention demanding behaviour, sleep disturbance, over-affection and repelling affection. In particular, Lowrey noticed a low level of speech development in all the children.

A larger study by Bender and Yarnell looked at 250 children from extremely deprived backgrounds (1941: p1158-1174). Many of these children had been in orphanages from infancy, given good physical care but little social interaction and discouraged from making any affectional ties. The researchers found that when the children were later placed in foster families they were unable to accept love or play with other children. They also noticed that these children tried hard to get contact with adults but were never gratified by these interactions. Bender and Yarnell later followed up ten of these children and found that all ten still had problems adjusting and relating to others. Bender also made general observations based on her interactions over a ten year period with more than 5000 children at Bellevue Hospital. She comments that the younger the child when exposed to deprivation, the greater the negative effect on the child's personality particularly in the first few years of an infants life. The major problem is that these children cannot form normal relationships with others because they have not experienced continuous identification during their infancy. It should be noted however that Bender's comments were based on observation only and do not represent a systematic scientific study with a control group.

Goldfarb carried out an interesting comparison of 40 institutionalised children around six years of age with 40 similar children who had grown up in foster homes (1943: p106-129). Goldfarb used a checklist of symptoms of behavioural problems to examine which group was most at risk and found that those children who had been in residential care all exhibited a variety of these symptoms while only a third of the other children who had been in foster homes exhibited symptoms. The most common behavioural problem he noticed was hyperactivity. Of greatest concern, however, was mental retardation found in 38% of the institutionalised children compared to only 8% of the other group.

Goldfarb went on to conduct a number of studies testing the theory that growing up in an orphanage has an adverse effect on personality development. For example, he looked at 15 adolescents who had lived all their lives in an orphanage, noted for its hygienic conditions but lacking any opportunity for the children to have a proper relationship with an adult. As infants, the only contact occurred during feeding, changing and dressing time. One nurse supervised between 15 and 20 children at a time and had little time for individual attention. Goldfarb matched these children up by age, sex and parental background with 15 children who had grown up in foster homes. He claimed that differences between the two groups were stunning. The institutionalised children were markedly lower in intelligence, social maturity, concentration and school achievement.

An obvious critique of these early studies and their applicability to today's context is that child-rearing practices have developed far beyond what was provided early last century. Thanks in part to these studies and other trends, there is a much greater understanding of children's need for interaction and stimulation.

However, in 1944 a rather unusual program for care of orphans was carried out in America, which seems to have been ahead of its time. Two famous child psychologists, Freud and Burlingham, assisted at a home for children displaced by the war and wrote up their experiences as a qualitative study in their book, *Infants without Families* (1944). The psychologists were already aware of the importance of mother substitute figures and tried to divide the children into very small groups of just three to five children for each caregiver. A very high standard of hygiene and nutrition was provided thanks to a US government grant. Unfortunately, children in the small groups reacted with possessiveness towards the nurses providing care and when nurses had to leave for various reasons, the resulting separation seemed to be just as distressing as the initial separation from the mother.

This case highlights a common difficulty with those institutions that attempt to replicate the family environment by employing staff as mother substitutes. Staff will invariably move on, causing further separation distress to the children in their care. Higher turnover means greater distress. Tizard and Rees found children in good orphanages in London had had up to 50 or more caregivers in a five year period (1975; cited in Lie,

1999: p148) and Tizard and Hodges found 8 year olds in residential care who had been cared for by 80 different people (1978; cited in Lie, 1999: p148).

Edmistone and Baird looked at the social abilities of a number of institutionalised children and compared them to ordinary children (1949: p482-488). They found that the children from orphanages were less well adjusted emotionally but that their social skills were similar to the community-based children.

Bodman et al. compared 51 institutionalised teenagers, the majority of whom had entered the orphanage after infancy, with 52 school children of the same age (1950: p173-176). The school children had also lost parents and some had been displaced by war, but were living with their families. The researchers found that the institutionalised teenagers had less contact with the community, less contact with relatives and were less successful in their careers. However, many of this group had parents or siblings with mental problems (47%) whereas none of the control group came from such a background, so the results may have been severely affected by this sampling bias.

In 1950 two researchers named Roudinesco and Appell initiated an interesting experiment (cited in Lie, 1999: p59). Initially they tested 40 institutionalised children aged under four years old and compared them with 104 children of a similar age and social class. The institutionalised children routinely came out lower on the development quotient (using the Gesell Test[4]). However, the researchers then arranged for eleven of the institutionalised children to receive special individual attention from a member of staff four times a week for 45 minutes. In a number of cases the development quotient improved significantly.

The previous study showed the importance of individual attention, something that most residential care facilities fail to provide. However, Fischer studied 189 institutionalised children in a Catholic home in the early 50's where the children were given plenty of individual attention and adult interaction (1952: p522-533). Nevertheless, she found that a third of the children suffered emotional problems, particularly in the two extremes

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[4] The Gesell Test was developed by the American developmental psychologist and physician Dr Arnold Gesell (1880-1961) in his Clinic of Child Development at Yale University, Connecticut, United States. Gesell studied hundreds of children to chart the normal stages of child development. His work was the basis of the routine testing of children by healthcare workers and it was also used to match up children with adoptive parents.

of passivity and hyperactivity. This study indicates that the reasons for the negative effects of residential care on children are complex and not easily solved by such measures as hiring more staff to provide individual attention to the child.

One of the few studies to conclude that institutional care for children has no negative effect was conducted by Du Pan and Roth in Switzerland where 14 children were given the Gesell Test to measure development quotient (1955: p124-129). Their results showed only slight retardation. However, the validity of this study is highly questionable given the lack of control group, the use of only one measure, the small sample size and the unrepresentative nature of the case group (which was made up of children from elite backgrounds sent to the facility for short time periods for educational purposes) (Lie, 1999: p65). Also, it is unclear why the researchers would conclude that slight retardation should be considered an acceptable outcome for these children.

In 1956 Klackenburg looked at a number of high quality Swedish orphanages where there was on average a nurse for every three children (cited in Lie, 1999: p71). However, she still found a statistically significant difference in emotional stability between the children in residential care and similar children in foster care.

Dennis studied formerly institutionalised children in Lebanon (1976; cited in Lie, 1999: p75). Up to 1956 the children were kept in the orphanage until age six. After 1956 they began adopting out the children at younger ages. Dennis was able to compare the mean IQ scores of children discharged before 1956 and after, and he found that the greater the age at adoption, the lower the eventual IQ. He concludes that institutionalised children should be adopted out as early as possible.

Researchers Provence and Lipton from the Yale University Child Study Centre conducted a five year study comparing 75 infants in an orphanage with 75 infants brought up in foster families in the late 50's and early 60's (1962; cited in Lie, 1999: p83). The orphanage was a three storey building, clean and in good condition. The children were provided with nutritious meals and excellent medical care. However, human contact and interaction was limited. The researchers note that most of the children had never seen a male adult or heard a man's voice in their lives. Anecdotal evidence would suggest that this is not uncommon in many institutions around the

world[5]. The researchers noticed that the institutionalised children did not spontaneously play with toys and were slow to develop speech. Other areas of development were delayed, especially social maturity. After being placed with foster families, these same children made dramatic gains, though there were some residual effects on their ability to form appropriate emotional relationships, particularly with men.

According to Yule and Reynes, the negative impact of institutionalisation on orphans is not limited to children in large institutions (1972: p249-258). The researchers studied 776 children in English "group homes", set up to mimic a family atmosphere with between eight and twenty children in each home and a "mother". The study found that emotional and behavioural disorders were significantly more common in these children than in the general population. According to Lie, the selection of controls in this study is suspect, though the results support the general weight of the evidence from other research (1999: p104).

Later studies show changing social attitudes to the importance of interaction and individual attention. However, in general the results still show a negative impact on children's development.

For example, over a twenty year period, Rutter and Quinton tracked 94 women who had been in residential care as children in group homes with up to 20 children under the care of three house-mothers (1984: p191-204). The quality of care was very high and child-adult interactions were strongly encouraged. However, there was a high level of staff turnover. The researchers compared them to 41 similar women who had never been in residential care. According to the researchers the worst adult outcomes came from women who had spent most of their childhoods in the institution. However, key differences between the case and control groups suggest that other factors may have played a part in these outcomes. Rutter and Quinton also looked at the differences between the case and the control groups and concluded that personality disorders were likely to stem from a combination of genetic and environmental factors, whereas poor social adjustment was more likely to stem from just environmental factors (1984: p204).

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[5] A contemporary study, The HOSEA Project Survey, found that many residential care institutions in Cambodia did not employ any male care givers (2002).

In 1991, Save the Children commissioned a three year study into residential care of separated children and alternatives in more than 20 developing countries. The results of this extensive research, described in the book *Roofs and Roots* by David Tolfree (1995), paints a depressing picture of institutional responses. Now recognized as the definitive book on alternative care for orphans, Tolfree emphasizes the importance of preventing separation, documents the typical shortcomings of residential care and discusses alternatives to it, de-institutionalization, and ways to improve residential care. He summarises the effects of residential care on children in this way:

○ Children in residential care lack opportunities for close relationships with trusted adults and this may impair children's capacity to make and sustain relationships with other people.

○ Children in residential care lack opportunities to learn traditional roles and skills – many young people emerge from childhood in an institution with no perception of different adult roles, and no understanding of the customs and traditions that underpin daily life.

○ Residential care creates a deep-rooted sense of dependency, with children being denied opportunities to learn to become self-reliant and self-directing.

○ Children in residential care often lose their sense of family, clanship or tribal identity; they lack the security and strength that comes from identifying with family and ancestors. Instead, they may assume a negative identity (for example, 'the orphanage child' and face the stigma and prejudice that results.

○ Where children have lost contact with their families they will have to enter adult life without the support, which the extended family and community traditionally offers in most cultures (Tolfree, 1995: p142).

In 1994, Kaler and Freeman studied 25 randomly selected children from an orphanage in Romania and compared them to 11 similar children in the community (1994: p769-781). A number of developmental tests were used such as the Bayley's Scales of Infant Development[6], the Vineland Adaptive Behaviour Scales[7] and the Wechsler Preschool and Primary Scale of Intelligence[8]. Results showed that the children in the orphanage

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[6] The Bayley's Scales of Infant Development identifies deficits in very young children across five major developmental domains: cognitive, language, motor, adaptive behavior, and social-emotional
[7] The Vineland Adaptive Behaviour Scales assesses a child's competence in daily living skills, socialisation, motor skills and maladaptive behaviour
[8] The Wechsler Preschool and Primary Scale of Intelligence measures cognitive ability in preschoolers

all showed significantly lower levels of cognitive and social development. They found no connection between low scores and birth weight, age at entry to the orphanage or length of time in the institution. In contrast, the community-based children were functioning at normal level for social interaction, communication and play.

In 1995, Chisholm, Carter, Ames and Morton also looked at children in Romanian orphanages and compared them to children of a similar background who had been adopted from the orphanage before the age of four months and a control group of Canadian children who had never been in residential care. It is not clear why the researchers felt this would be a comparable control group. However, they concluded that the children who had spent more time at the orphanage displayed significantly lower attachment security scores (1995: p283-294).

An interesting longitudinal study was carried out by Cheung and Buchanan who studied data from the UK National Child Developmental Study (1997: p575-580). Children born in 1958 were followed up at ages 7, 11, 16, 23 and 33. At age 23, the subjects were asked if they had ever spent time in any type of residential care institution. A Malaise Inventory test was used to measure tendency towards depression at the ages of 23 and 33. Results showed that those who had spent time in institutions had a greater tendency to depression than those who had not. The researcher then attempted to remove other factors that might have impacted on this result, such as early experience of poverty. They found that having been in residential care still significantly impacted on the tendency to depression. This study has a number of methodological shortcomings. For example, since subjects were asked retrospectively about being in care, their answers may have been unreliable if they were in residential care during early childhood and infancy. The researchers also made no attempt to distinguish between those who had spent long periods of time in care and those whose experience was brief.

In 1998, Vorria, Wolkind, Rutter, Pickles, and Hobsbaum compared 41 Greek children living in three residential care facilities with their classmates matched by gender and age who had mostly been brought up in two parent families (1998: p225-236). They found that compared to their classmates, the children in residential care were less attentive, participated in classroom activities less often and had less harmonious relationships with peers. Vorria et al. concluded that the strongest indicator of outcome

was the reason for admission to the orphanage, implying that the outcome was best for those children who had experienced stable loving family relationships before admission (1998: p236). However, Lie points out that this study has serious methodological inadequacies. For example, the analysis that that led to the conclusion is based on very small sample sizes of just 2, 3 and 4 subjects. Also, the researchers do not mention how and why these 41 children were selected from more than 600 children living at the same facilities, which implies that selection bias may be an issue (Lie, 1999: p119.

Wolff and Fehesa studied institutionalised orphans in Eritrea and published their research results in 1999. The results showed, over a five-year period, that the orphans improved as conditions in the residential care facility were changed to become more like a community, family-based environment. Observation documented an improvement in stranger attachment and social interactions also normalized significantly. The article does not propose institutional care over community-based care, but in situations in which institutions do exist, it demonstrates how conditions for children can be improved by identified changes in the structure (cited in Williamson, 2004: p50).

Chernet's 2001 study of orphans in Ethiopia found that the children in orphanages surveyed:

- O   felt lonely and hopeless
- O   developed a dependency on the adults at the orphanage for all their needs (some children had never even counted money on their own). Children were often not given even minor responsibilities while in the orphanage.
- O   felt inferior to local children and had low self-esteem.
- O   had little adult guidance and little individual attention from caregivers (2001: cited in Williamson, 2004: p51).

Additionally, because the orphanages were in urban areas; when the opportunity arose for children to be reintegrated into their home villages, the children were unwilling to be reunited with family members in rural environments, as they had become accustomed to urban settings. The children were given no skills training and were unprepared for adult life outside the orphanage (cited in Williamson, 2004: p51).

In defence of residential care, Jack and Barbara Tizard argued in the 1970's that blanket condemnation of all institutions is unfair since the classic studies have been conducted in residential care facilities which were obviously unsatisfactory (overcrowded, understaffed, under-resourced) thus conveying an unbalanced view of residential care. They claim that, "in the best residential nurseries the children we studied were not only healthy but intellectually normal, linguistically advanced, and exposed to a near normal range of general experiences" (1971; cited in Tolfree, 1999: p60).

It is true that many of the earlier studies were conducted in inadequate residential care facilities, but not all. For example Freud and Burlingham (1944), Fischer (1952), Du Pan and Roth (1955), Klackenburg (1956), Yule and Reynes (1972) all studied residential care facilities which were noted for their good conditions and still found negative impacts. Furthermore, inadequate conditions, particularly understaffing, still persist in a majority of residential care facilities in the developing world. So the results of these studies should still provide some insight into the impact on children living in these conditions.

There are some generalised critiques that can be made of the research summarised above. McCall points out that most of this research centers on a single issue - How do orphanage children compare with other children psychologically? He explains that while this is a legitimate outcome question, it does not deal directly with orphanage experience, or the root causes of psychological development within the institution. Almost never are direct, systematic observations made of the quality of orphanage care or the kinds of social experience provided. We learn nothing about the sleeping, eating, and moral habits of orphanage children. Are these habits different, better, or worse because of the regular schedules and predictable rules that characterize many institutions? (1998: ch8).

McCall claims that in most comparison studies insufficient attention has been paid to background differences other than orphanage experience. Since, childen cannot be placed in an orphanage solely for the purposes of the research, the original reason for placement may have had an impact on the results. Most researchers claimed to use similar groups for comparison. There is always the possibility that some unidentified cause explains score differences. For example, if more orphanage children come from

lower socioeconomic backgrounds where education and thus intelligence scores might be lower, one could expect lower IQ scores for them (1998: ch8).

McCall complains that there is too much reliance on extremely small samples, "This is especially risky in correlational designs, where numeric results are sensitive to uncontrolled or hidden factors. Since most psychometric instruments are subject to errors of measurement, large samples are needed to insure more valid comparisons". (1998: ch8). McCall's criticism has some validity. Kaler and Freeman (1994); Du Pan and Roth (1955); and Vorria et al. (1998) all used very small sample sizes. However, despite this criticism, a number of studies used relatively large sample sizes such as Yule and Reynes who looked at 776 children (1972).

McCall points out that the chosen samples were usually selected for reasons of convenience rather than because they were shown to be representative of some given orphanage group or orphans in general. He laments that very broad generalizations were made by the researchers about orphanage care (1998: ch8).

Most researchers (eg. Freud and Burlingham, 1944); Fischer, 1952; Du Pan and Roth, 1955; Klackenburg, 1956; Yule and Reynes, 1972) conclude that orphanage care was the cause of reported psychological defects. Yet, mere membership in the orphanage population was the only way that orphanage care was indicated. Actual treatment conditions were often assumed but seldom observed. The majority of such studies used no control for length of stay or other descriptions to show the quality or amount of care received.

A biased selection factor may be found in the tendency for editors in most fields to reject studies that show no difference for the comparison groups. For example, it is hard to be sure why a sample of orphans have the same average intelligence as a sample of home care children. There might be no true difference, chance errors might have made it appear so, or mistakes by the investigator might have obscured true differences. McCall claims that since most editors expect orphanage samples to show less intelligence, they would be skeptical of exceptions (1998: ch8).

McCall is almost a lone voice in critiquing this data and I do not believe the weaknesses he points out are sufficient to explain the fact that almost every study reviewed confirmed the hypothesis that orphanage care has a detrimental effect on a child's psychosocial wellbeing.

In summary, despite some methodological shortcomings, especially in earlier, less rigorous studies, the majority of the academic literature on this subject takes the stance that residential care, the care of orphans in orphanages or children's homes, has a negative effect on the psychosocial development of children experiencing orphanhood, and arguments are repeatedly made that wherever possible, the placement of children in residential facilities should be avoided (Gannon, 1994; MacLeod, 2001; Tolfree, 1995).

Medical Impact

From a medical perspective, Zeanah et al. (2003: p886) provide a sweeping history of literally dozens of contemporary studies that have documented medical and psychological abnormalities arising from institutionalization in residential care facilities such as orphanages and children's homes. These include physical and brain growth deficiencies, cognitive problems, speech and language delays, sensory integration difficulties, social and behavioural abnormalities, difficulties with inattention/hyperactivity, disturbances of attachment, and a syndrome that mimics autism.

Some of these problems may be associated with the very risk factors that initiated placement in residential care, but Zeanah et al. point out that quality of care is often inadequate and many problems seem related to institutional life itself (Ames, 1997; Johnson, 2000; Muhamedrahimov, 2000). One of the distinguishing features of the quasi-autistic syndrome reported in these children, for example, is that the symptoms improve dramatically following adoption (Rutter et al., 1999).

The psychosocial and medical research on the effects of residential care paints a clear picture. However, there are more concerns about residential care raised from the perspective of other disciplines such as economics and community development.

Lack of Sustainability

From an economic perspective, according to Save the Children, the cost of supporting a child in residential care is about twelve times the cost of support in a community based care program (2004: p13). Numerous studies support the observation that community-based solutions are a much more cost-effective approach. The high costs involved in building and running residential facilities are cited by many as unsustainable (Desmond and Gow, 2001; Desmond and Quinlan, 2002; Foster, 1999; Johnson, Modiba, Monnakgotla, Muirhead, and Schneider, 2001; Loening-Voysey and Wilson, 2001; Wright, 2001)

The high costs associated with residential care, coupled with the fact that most residential care facilities are now located in the developing world, mean that resources must be sourced from outside the country. This heavy dependency on major external funding is a cause for concern. HOSEA Project noted that local Cambodian NGOs with residential care facilities struggle for lack of funds and are often forced to close down (2002: p6). It is not known what happened to the children in these facilities after the service was discontinued.

Residential care facilities are further limited by the constraints of buildings and staff numbers. Since orphan numbers continue to grow rapidly and outstrip available resources, residential care is not considered a viable option for caring for the majority of orphans in the developing world (Foster, 1999; Johnson, Modiba, Monnakgotla, Muirhead, and Schneider, 2001; Loening-Voysey and Wilson, 2001; Wright, 2001). The UN points out that, "orphanages for 14 million orphans simply cannot be built and sustained" (UNAIDS/UNICEF, 2004b: p37). For example, in Cambodia, Dybdal and Daigle found that although 90% of development interventions for orphan care were residential, they accounted for at most 56% of the orphans reached by all programs (2002a: p24). In other words, the 10% of community-based programs in Cambodia were reaching a hugely disproportional 44% of the orphans. This indicates that community-based care initiatives have a much greater capacity to reach larger number of children, than residential care facilities such as orphanages which are limited by buildings and staff numbers.

Lack of Community Participation

Another important shortcoming, which should be noted, is the lack of community ownership and participation in residential care projects. The first aspect of community participation that should be considered is the participation of the children themselves. Adults do not necessarily know what is important for children. Research into informal fostering (cited by Save the Children, 2004: p13) suggests that a child placement preference is based on where they feel they will be loved and best taken care of, whereas parents and other adults prioritise economic factors in decision making. Seldom do the adults consult the children.

Secondly, residential care is a western model of care that ignores the ability of communities to solve their own problems in traditional ways. Communities are not given the dignity of caring for their own orphans (Williamson, 2004: pxiii). This relates to what has been called the "iron rule" of community development, "Never do for someone what they can do for themselves.[9]"

Disconnectedness

In the community, children are able to stay together with their siblings (a tremendous source of solace and support) and maintain a sense of connectedness with their extended family, their neighbours, their childhood friends, their culture, their heritage and their land. Foster maintains that, "Enabling siblings to remain together in the care of family members they already know and are prepared to accept as new, permanent caregivers is the best option and maintaining orphans in families should be our highest priority" (2004: p83). Dybdal and Daigle found that 23.8% of residential care programs in Cambodia reported that would not admit brothers and sisters, which raises serious concerns regarding the ability of these children to maintain family ties (2002a: p88). In the same survey, 43.7% of children admitted into residential care in Cambodia were admitted by parents or relatives, indicating that these children still had family. Save the Children lament that, "too often admission to residential care is synonymous with children losing all contact with their family and sociocultural background" (2004: p9). For example, one residential care facility in Cambodia requires the children to speak

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[9] The origin of this dictum is unknown, however it can be found in a variety of forms online. For an example of its use in working with the poor see, http://larryjamesurbandaily.blogspot.com/2005/11/creativity-and-poverty.html

only English (HOSEA, 2002: p12). Linguists and anthropologists alike agree that language and culture are intricately linked, and to deny a child the right to speak their own language at home is to deny them an essential link with their cultural heritage.

Children taken out of their communities are raised in situations which do not prepare them for life as an adult. Save the Children state that, "residential care does not prepare [orphans] for adulthood in the community" (2004: p3). In other words, institutionalization stores up problems for society, which is ill-equipped to cope with an influx of young adults who have not been socialized in the community in which they will have to live (UNAIDS, 2000c). The difficulty arises because children in residential care are subject to the routines, procedures and administrative needs of the institution, serving the needs of the home for order, efficiency and conformity. There is an almost complete loss of independence. This is in stark contrast to the normal patterns within a family home and causes serious problems when reintegration into society becomes necessary. In short, children in residential care are deprived of the life skills that they would learn growing up in a family and may find it hard to cope with life outside the institution (Save the Children, 2004: p9).

Finally, in the developing world where legal protection for minors is largely unavailable, children taken from their communities may lose their rights to their parents' house, land and inheritance. Sent away from their village, orphans are in danger of losing their meagre inheritance: parents' land and other property as well as their sense of belonging to a family (UNAIDS/UNICEF, 2004b: p9).

Abuse

Clearly abuse can and does occur in any situation. Biological parents and extended family are all potential abusers. However, is there anything inherently worse or more dangerous about abuse that occurs in residential care facilities such as orphanages and children's homes? Save the Children believe so. They assert that few outsiders are aware or care what takes place in these facilities. As a result many situations of abuse in residential care go unreported: "Anecdotal evidence suggests that children abused in institutions may have greater difficulty in reporting the abuse, escaping from the situation, or getting support from outsiders. Due to the child's utter dependence on the institution, the abuse may continue for a long time. Children with disabilities are

especially vulnerable" (2004: p9). A survey carried out amongst residential care staff in Cambodia found that many facilities do not do background checks or even require references when employing new staff (HOSEA, 2002: p8).

Children in residential care may be subject to physical, sexual or emotional abuse by staff or older children, and in the majority of developing countries there are no established child protection services to ensure a child's safety or prevent future abuse to other children. These cases are increasingly coming to light in the West and there is no reason to believe that they may not be just as widespread in the developing world.

Lie notes that the research conducted to date identifying social and emotional problems in institutionalised children does not take into account the possibility that these abnormalities may be the direct consequence of physical, emotional or sexual abuse. He points out that, "since we know that ... abuse is far more common than anybody expected a few years ago... [even] in orphanages with a rather good reputation, abuse may have contributed to problems observed in residential care children" (Lie, 1999: p129).

For example, Glenn Miles and Paul Stephenson of Tearfund UK suggest that, "if residential care means being cared for by generally unrelated people, and we believe that the essence of family life is the nurture and unconditional acceptance of children by adults in an individual adult-child relationship, then we see that residential care may fail to provide this. In fact the larger and more institutional the residential care, the less likely such individual nurture and unconditional acceptance is" (2001: p9).

UNAIDS comes out strongly against residential care in numerous publications, citing a number of reasons including the negative impact on emotional wellbeing and institutionalization. They maintain that countries that have relied on institutions to care for their orphans have learned that orphanages are not the answer, going so far as to say that these institutions set up to care for children can have catastrophic consequences on children's emotional lives and development: "While building more orphanages, children's villages or other group residential facilities would seem a possible response to caring for the growing number of orphans, this strategy is not a viable solution" (UNAIDS/UNICEF, 2004: p37).

Save the Children also strongly oppose residential care in their report, *A Last Resort: The growing concern about children in residential care*, stating categorically that, "many features of residential care are an abuse of children's rights" (2004: p1).

In summary, the position of the development literature is clear. Residential care can have profoundly negative effects on a child's psychosocial wellbeing and health. Residential care is more costly, less sustainable, less participatory and exposes children to potentially abusive situations. Increasingly, the gap between theory and the practice of larger international NGOs is narrowing as they acknowledging these issues surrounding residential care.

COMMUNITY-BASED CARE

With such a strong and growing case against residential care laid out in the literature, it would be prudent to ask if there are any viable alternatives available to development practitioners. Increasingly, development researchers such as Foster (1999) and Williamson (2004) are promoting a range of interventions loosely called community-based care.

Defining Community-Based Care

Community-based care for orphans describes care for children by those who are not the biological parents but are able to provide individual care and nurture in the context of a family and community. Williamson points out that although most agree that community-based is the preferred method of care, the steps to carrying out community-based care are less clearly defined. He defines community-based care as the situation whereby, "children are cared for by responsible adults within their own communities and within a family or family-like setting" (2004: p12).

Community-based care programs may be described as having a strong 'prevention' component, in that they seek to strengthen community coping capacities in order to avoid the institutionalization of the child.

Psychosocial Impact

The studies described in detail in the residential care section have already established a clear pattern showing that children raised in families and communities adjust better on a psychosocial level. Foster argues that children need more than just good physical care. They need the nurture, love, individual attention, identity, and social connections that families and communities can provide (2004: p84). According to the World Health Organization, "a loving, stable parental relationship is as critical to the young child's survival and health as is food and health care" (2004: pvii). For orphans this means a nurturing, long-term 'mother substitute'. Particularly in the developing world, where extended family and the community are the principal social safety nets, not having such connections greatly increases long-term vulnerability.

The extended family remains the principal support unit for orphaned children and this approach, known as kinship care, is supported by the overwhelming majority of the literature on this topic. For example, Foster points out that, "the first line of support for vulnerable children is their family, including the extended family and distant relatives, while households that struggle to meet the needs of vulnerable children may be assisted by members of their community. These informal safety net mechanisms are responsible for the care and support of the majority of vulnerable children in Southern Africa" (2004: p65). UNAIDS concurs that the first line of approach in orphan care must be community-based programs and families provide the best environment for bringing up children. If adequately supported, families will be best able to provide the care that orphaned children require (UNAIDS, 2000b).

Advantages of the kinship care model as identified by Dybdal and Daigle (2002a: p10) are that:
○ The child is kept in the network of people who have ties to the biological parents
○ The child grows up in a family environment close to the original community
○ Relatives generally feel more duty and responsibility than unrelated people to provide good quality care and nurturing to the child
○ Relatives are likely to make a long term commitment to the wellbeing of the child
○ It relieves the burden on the rest of society

However, sometimes the extended family is nonexistent or unable to provide for orphans. Some children are overlooked and end up in a variety of vulnerable situations. These include living and working on the streets, working for other people in low-paid domestic or agricultural settings, or living by themselves with their brothers and sisters in child-headed households (Foster 2004: p70). These children require special attention and support from NGOs in order to enable them to develop and thrive. Foster parents, teenager headed households and other creative solutions may form the basis of a community-based solution for these children who for one reason or another are unable to stay with extended family. However, Foster does point out that these children make up only around 2% to 3% of the total number of orphans, even in very high HIV prevalence countries (2004: p70).

Mother Substitute – Attachment Theory

One closely related subject comes through in the literature so strongly that it will be treated separately in order to highlight its importance. This is the idea of a "mother substitute". In 1951, the World Health Organization (WHO) asked John Bowlby to review the impact of separation from parents and caregivers on children in the Second World War. The resulting study has been translated into 14 languages and has had an enormous influence on our understanding of care for orphans today. Bowlby was convinced that, "an ongoing warm relationship between an adult and a young child was as crucial to the child's survival and healthy development as the provision of food, child care, stimulation and discipline" (Bowlby 1951: p13). He came to recognize that the lack of nurture from a mother or mother substitute during childhood can have a devastating effect on the child's health, growth, personality adjustment and cognitive capacity (WHO 2004: p1). For orphans, these types of nurturing, one-on-one adult-child relationships are more likely to be found amongst the extended families or within foster families than in a residential care facility.

Some may contend that a mother substitute could also be found within a well-resourced residential care facility. However, as recently as last year, the World Health Organisation again affirmed that the needs of children in residential care, "for physical and psychological contact with attachment figures, even in the stable care provided by 'substitute mothers', are constantly frustrated. Their daily contacts with caregivers are short, and they are frequently separated from caregivers as institutional staff are called

to other activities or go off duty" (WHO, 2004: p39). This is demonstrated clearly in the behaviour of these children: by indiscriminate attachment and friendliness, and by clinging and attention seeking conduct.

Since Bowlby's watershed research was published in 1951, a number of other studies have supported his theory of attachment. Michael Rutter concluded that, "the key features of Bowlby's theory, particularly the importance of early relationships for later personal and social competence – were empirically supported, and that attachment was the best supported theory of socio-emotional development available" (cited in WHO 2004: p10).

In summary, attachment theory and the concept of the importance of a 'mother substitute' are crucial to an understanding of the needs of orphans. "Young children who do not have a relationship with at least one emotionally invested, predictably available caregiver – even in the presence of adequate physical care and cognitive stimulation – display an array of development deficits that endure over time" (Shonkoff and Phillips, 2000: p389).

Sustainability

Community-based care not only has major psychosocial advantages over residential care, but there are also certain economic and developmental reasons why this approach is preferred. For example, as previously mentioned, community-based care for orphans is a more cost-effective approach to orphan care because the emphasis is not on providing resources from outside, but rather identifying the existing resources in a community and building on those. Foster refers to World Bank research in Tanzania that, found that institutional care was six times more expensive than foster care, while comparisons elsewhere showed the ratio of operating costs for a residential care to be 14 times higher than those for community care. Other studies have found a ratio of 1:20 or even 1:100 (Foster 2004: p84).

Community-based care seeks to build the capacity of a community to face future difficulties and thus is inherently creating sustainability. For example, the simple process of talking with parents and extended families about the variety of options for the future care of their orphaned children can help them to identify resources and support

networks they were previously unaware of. A study in Zimbabwe concluded that programs to keep children with the community, surrounded by leaders and peers they know and love, are ultimately less costly, both in terms of finance and the emotional cost to the child. In many instances, admission to placement could be avoided by targeting vulnerable families and providing financial assistance, such as school fees, to parents or relatives (Powell et al, 1994).

These words below, written by Bowlby in his influential 1951 monograph, *Maternal Care and Mental Health*, still ring true decades later:

> There are today governments prepared to spend up to £10 a week on the residential care of infants, who would tremble to give half this sum to a widow, an unmarried mother, or a grandmother to help her care for the baby at home. Indeed nothing is more characteristic of both public and voluntary attitudes towards the problem than a willingness to spend large sums of money looking after children away from their homes, combined with a haggling stinginess in giving aid to the home itself (cited in Lie, 1999: p168).

Adding a word of caution, Save the Children acknowledge that cost-effectiveness must not be at the sacrifice of quality. "While some research has indicated that community-based care is less costly than institutionalized care, more rigorous empirical cost-effectiveness analysis must provide convincing evidence that community-based care represents the optimal use of resources without compromising the quality of childcare" (2004: p6).

The best community-based care programs rely more on the existing resources in a community than on what is available from outside the community, so there is less dependency on outside resources (Levine and Foster, 2000; cited in Williamson 2004: p51). In developing countries where the political situation can be fluid, international NGOs cannot guarantee their long term presence, thus sustainability must be built into any development initiative from the very beginning.

Since community-based programs are limited only by the capacity of the community rather than the availability of outside resources they are able to reach very large

numbers of orphaned children with limited resources. For example, Bethany Project in Zimbabwe works with 8000 children and Project HALO works with over 800 children in Cambodia.

Theoretically, community capacity to absorb orphans could be exhausted, such as in some parts of Africa where much of the extended family networks have been wiped out by AIDS. However, Foster points out that this has not yet come to pass: "the extended family safety net is still by far the most effective response to economic and social crises throughout sub-Saharan Africa" (2004: p66). In a low HIV prevalence country such as Cambodia, though devastated by three decades of civil war, the capacity of the community is still much greater than that of residential care facilities which are constrained by buildings and staff numbers.

Community Participation

Furthermore, the capacity of the community can be strengthened over time by their participation in solving their own problems. This is why Williamson emphasises the importance of a sense of community 'ownership' for care of children and community involvement in the decisions, awareness raising, and solutions for orphans in need of assistance (2004: p30).

As previously mentioned, the first aspect of community participation that must be seriously considered is that of the children themselves. A key finding of the KHANA research[10] was that in contrast to adults, who overwhelmingly supported the idea of institutional solutions for caring for orphans, children invariably preferred family and community-based approaches over orphanages (2001). Mann found a similar discrepancy between the views of adults and children in Malawi (cited by Williamson, 2004: p47). Article 12 of the UN Convention on the Rights of the Child states that children have a right to participate in decisions that affect them in accordance with their maturity and understanding (1989). This right to participate in decisions should be applied according to the age, experience and understanding of the child concerned.

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[10] described in more detail in chapter 3

A guide to orphan care written by World Vision International laments that, "currently, little attempt is made to listen to children and to understand their fears and concerns about the situations they are in. Often decisions are made without consulting the children affected by the decision" (2004: p91). One reason may be that it can be difficult to hear directly from the children because adults often wish to speak on their behalf. This is true of any situation involving children in Cambodia, but particularly so in the community where neighbours have free access to one another's homes and children are encouraged to stay silent in the presence of adults. This may be a greater issue where the nature of the discussion is confidential, such as abuse or finances. However, the challenge is not insurmountable and privacy will be given if requested, though care must be taken not to give offence.

There is an extremely high degree of community participation in community-based care programs because the onus is on communities to care for their own orphans. Extended families will frequently take sole responsibility for many orphans, using their own resources to provide accommodation, food, clothing, education and nurture. Neighbours and local organizations such as churches often make a tangible contribution by helping out struggling families with child minding, advice and other contributions. In Cambodia, a visit by community-based care program staff to a family will invariably see the neighbours crowding in the doorway to participate in the conversation and they often end up becoming part of the solution.

It is important to help communities recognize and mobilize their own resources, and the greatest resource of a community is its people. A number of successful community-based development interventions have mobilized community members to show practical compassion to orphans. For example, the FOCUS program in Zimbabwe has mobilised community volunteers to visit and encourage more than 4000 orphans (Williamson, 2004: p15).

Connectedness

Gebrua, Mulugeta and Atnafou noted that, "the longer children stay in orphanages, the more likely they are to be detached from community life" (cited in Williamson 2004, p28). Community-based care allows children to stay within the network of people that have loved and nurtured them throughout their lives. The concept of a 'nuclear family'

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made up of a mother, a father and some children is a Western concept and leads foreigners to believe that a child who has lost their parents has lost everything and everyone important. In the non-Western world there is a much greater importance placed on extended family and community. Neighbours know each other intimately and privacy is largely nonexistent. Children who are able to stay in their own communities benefit from access to these support networks throughout the rest of their lives.

Dybdal and Daigle point out that a knowledge of one's family origin is important in the development and preservation of personal identity (2002a: p96). Children in community-based care will be more likely to hear and learn stories about their family and ancestors. These stories and other pieces of information will be built up over time as the child interacts with neighbours and extended family and play an essential role in helping the child to feel that they are part of a network of people with a unique history. Foster observes that children raised in residential care, separated from their communities, grow into adulthood and have difficulty reintegrating into society (2004: p84).

Finally, orphaned children, already vulnerable to exploitation, who inherit property from their parents are much more likely to retain that property if they are present to occupy and protect it (UNAIDS/UNICEF, 2004b: p9,16). Thus, community-based care allows children a greater connection with their land and property.

Abuse

As in any context of relationships, abuse is a possibility in community-based care programs (UNAIDS/UNICEF, 2004b: p19). Some development practitioners make much of the potential for exploitation, unequal treatment, neglect or abuse of orphaned children taken in by extended family members or foster parents. The majority of documented abuse takes place in residential care facilities such as orphanages. Nevertheless, the issue should not be minimized or disregarded. It may be simply that abuse is more likely to be documented in a residential care facility, while more easily hidden in the community and thus harder to document. This is an area for further study.

Foster acknowledges that cases of abuse, mistreatment or exploitation of fostered children have been reported. Girls may be taken in by relatives because of their value in

carrying out domestic chores or obtaining bride price. He reports child rape centres have noted an increase in cases of sexual abuse of orphans (Foster, 2004: p68). However, although several studies have demonstrated that orphans are disadvantaged compared to non-orphans in other families, few have demonstrated significant differences in the ways relatives treat their own biological children compared to fostered children. Although such cases undoubtedly occur, for the most part, relatives go to considerable lengths to keep orphans in school, including borrowing money through informal networks and selling their own assets (Foster, 2004, 68).

My personal observation, after six years living in a Cambodian slum community, is that abuse or neglect that occurs in the community, particularly close-knit communities in the developing world, is probably more likely to be discovered or known about since people live closer together and are thus able to observe each other's lives more easily. Although discovery does not necessarily lead to action, it is nevertheless an essential first step in the process towards resolution. Monitoring and meticulous follow-up should be an integral part of any community-based orphan care program in order to ensure that unequal treatment, abuse, or exploitation does not go unresolved. Community members themselves can also participate in monitoring these households to ensure that children are not being abused or exploited (UNAIDS/UNICEF, 2004b: p20).

Stigmatization

Stigmatization may occur simply because a child is orphaned, but the reasons for orphaning may intensify the discrimination. For example, Carswell's qualitative research amongst community-based orphans highlighted stigmatization and discrimination directed against children orphaned by AIDS. He found that 22% of the orphans and vulnerable children surveyed reported being treated unfairly (2004: slide 20).

The experience of stigmatization is potentially stronger for a child in the community, since he or she is exposed to the views of a wider range of people. However, it is doubtful whether removing children from communities is the answer to stigmatization in general. In fact, it may be argued that removing the object of stigmatization will increase stigmatization overall because there is a greater sense of mystery and fear is

reinforced by the perception that these people are isolated for good reason, such as to prevent the spread of a contagious disease.

On the other hand, stigmatization can also occur solely because a child is in residential care. Save the Children observe that, "children who are or have been in residential care are frequently stigmatized and discriminated against at school, and by society" (2004: p11).

Keeping orphaned children in the community means they will may have to face stigmatization and discrimination, but the burden of this evil on society decreases over time as people are better educated and in the case of children orphaned by AIDS, begin to see that AIDS is not as highly contagious as once believed and merely being orphaned by the disease does not necessarily mean infection.

In summary, Tolfree argues for a greater commitment to and investment in varieties of community-based care, despite the difficulties that fostering poses in some cultures (1995: p225).

The foreword of Tolfree's book is written by M.J. Aaronson and sums up the position of most of the literature on the subject of community-based care: "Throughout the developing world, the vast majority of children unable to live with their own families are cared for within extended family or community networks. However, most of the agencies, which provide care for separated children, concentrate their energies and resources on developing institutional forms of care. Not only is [residential care] extremely expensive, but in most cases, it fails to provide children with the environment they need to grow up into healthy and well-adjusted adults." She goes on to point out that the book, "is not arguing that all residential care is bad in principle, but current practice is certainly deficient, and in most cases it fails to respond to the full range of children's needs. The book's overall message is that more emphasis needs to be placed on children's basic needs and rights—to be loved and cared about; to feel a sense of belonging, and to develop a strong personal identity" (1995: p.ix,x).

Summary

Thus, a strong argument has been made in the literature that residential care is responsible for a number of negative impacts on orphans, including significantly increased levels of social maladjustment, aggression, attention demanding behaviour, sleep disturbance, extremes of over-affection or repelling affection, social immaturity and tendency to depression. Attachment theory suggests that many of these difficulties result from the lack of availability of appropriate, nurturing, stable 'mother substitutes' in residential care. Residential care also lacks sustainability due to its relatively high costs compared to community-based care and is constrained by building size and staff numbers. Residential care takes away the responsibility for orphan care from the community thereby reducing the amount of community participation and ownership and sending a message that poor communities are not capable of caring for orphans. Children are separated from their families and communities and raised in situations that do not prepare them for life as an adult. Finally, children are more likely to lose any inheritance of land or property if they are not present to protect these assets from unscrupulous neighbours or relatives.

The alternative, community-based care, still carries some risk of abuse and stigmatization, and those who provide the care often lack support and resources. However, these shortcomings can be partially met and mitigated by NGOs through support and monitoring for abuse. Community-based care offers orphaned children the opportunity to maintain a sense of connectedness to their extended family and community, a vital source of solace and support. The approach allows greater levels of community and child participation and is more sustainable. Thus, development theorists suggest strongly that alternative solutions, known as community-based care, should be more widely promoted and implemented.

CHAPTER 3:   CONTEXT

Having clearly established the position of development theorists in regards to residential and community-based care, let us specifically examine the context of orphans in Cambodia, and the development interventions that are directed at them.

To begin with, I will look at the research specifically conducted on the situation of orphans and vulnerable children in Cambodia. Then, I will conclude the chapter with an outline of the development interventions, both community-based and residential, currently being carried out in Cambodia with orphaned children.

PART 1: IMPACT OF ORPHANHOOD ON CAMBODIAN CHILDREN

Very few researchers have specifically studied whether Cambodian orphans face the same difficulties as children in Sub-Saharan Africa and other parts of the world with larger numbers of orphans. The handful of studies conducted have all been carried out in the last five years and focus mainly on children orphaned by AIDS (Alkenbrack 2004; Carswell 2004; Dybdal and Daigle 2002).

In one of the earliest studies, the Khmer HIV/AIDS NGO Alliance (KHANA) carried out research into the lives of children orphaned in Cambodia (2001). The study found that the most vulnerable children were orphans from poor families and that after the death of a parent, children were often denied rights to their parents' land, housing, and other assets.

The KHANA study found that of children orphaned by AIDS:

o 21% had to begin working to support their family
o 30% had to provide care and assume major additional household tasks
o 40% had to leave school and forego necessities such as food and clothing
o 28% had left home or been sent away from home

The study also found that children of infected parents were likely to suffer high levels of stress and stigmatization. This study, one of the first of its type in Cambodia, used inexperienced Cambodian NGO staff as researchers as a capacity building exercise, which resulted in a less than rigorous research process. However, the study still manages to convincingly describe the impoverishment in Cambodian families affected by orphanhood.

More recently, U.S. researcher Alkenbrack undertook research on behalf of Policy Project in 2003 and 2004, looking at the psychosocial situation of Cambodian orphans and vulnerable children affected by AIDS. This study compared children in 500 households of children experiencing orphanhood in Phnom Penh, Battambang and Takeo communities with a comparison population of 500 neighbouring households unaffected by orphanhood. The study did not cover orphans in residential care (Alkenbrack, 2004).

Alkenbrack found that Cambodian orphans had a reduced socioeconomic status, relative to their neighbours, and were significantly more likely to report decreases in household income. She also found that children affected by orphanhood were significantly more likely to report having fewer meals per day and not enough to eat in a month (Alkenbrack, 2004: slide 17).

Figure 1: Food Intake: How often do you miss a meal?

Orphans — 6%, 35%, 59%
Neighbouring Children — 1%, 17%, 82%

Legend:
- Never - I always have enough
- A few times a month
- A few times a week
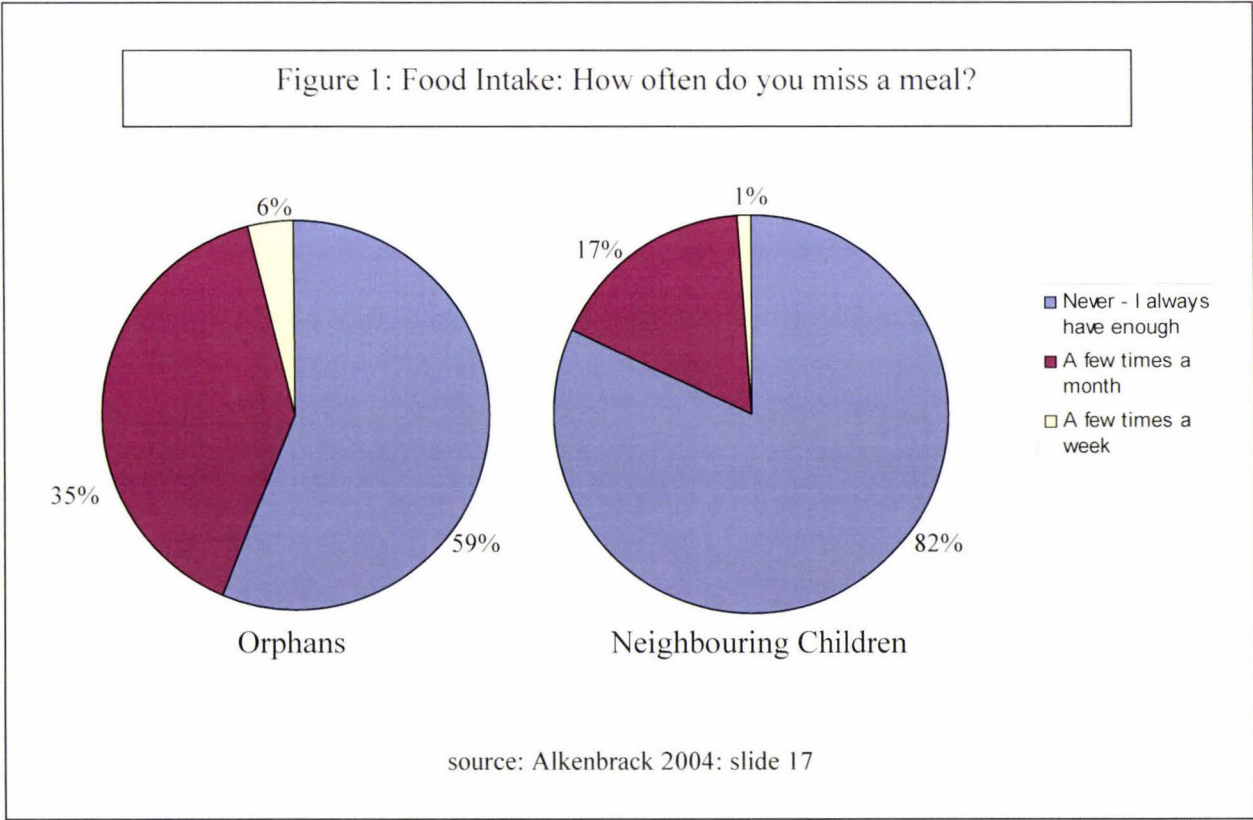
source: Alkenbrack 2004: slide 17

Figure 1 shows the difference in food intake between orphans and their neighbours. Children were asked how often they experienced missed a meal, giving an indication of hunger and poverty levels. Results showed that orphans were suffering hunger more often than their neighbours.

The Alkenbrack study used the KINDL[11] index to assess the quality of life in children and adolescents in the case and comparison populations. Children experiencing orphanhood were found to have significantly lower scores of overall quality of life than their neighbours. In the individual domains, orphans scored lower in five out of six individual domains: physical wellbeing, emotional wellbeing, self-esteem, family life and social/friends. Only in the area of education was there no significant difference between the case and the comparison populations (Alkenbrack, 2004).

The study, like many others conducted in Cambodia, was subject to translation inaccuracies and used an unadapted form of the KINDL index, which was developed in the West. Although the measure has been used in many countries, including some developing countries, it is not supposed to be adapted to take into account the local context, any further than translation. However, without any contextualisation to the unique situation in Cambodia the index fails to take into account such important local factors as community and extended family support. Thus, its measure of the wellbeing of these children is seriously undermined.

Alkenbrack concluded that HIV/AIDS is placing a significant burden on affected households and that orphans shoulder the burden in a number of ways including being taken out of school to care for sick relatives, lower food intake, stigma, discrimination and lower quality of life (2004: slide 24).

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[11] **Kind**er Lebensqualitätsfragebogen. The KINDL Index consists of 24 Likert-scaled items associated with six dimensions: physical well-being, emotional well-being, self-esteem, family, friends and school. The sub-scales of these six dimensions can be combined to produce a total score. The KINDL Index is available in customized versions for different age groups such as 4-7, 8-12 and teenagers and caregivers.

Another similar study was conducted at the same time. Ken Carswell was commissioned in 2004 by CARE, an international NGO providing support to several hundred community-based orphans, to undertake research into the psychosocial needs of orphans and vulnerable children in Cambodia[12]. This study looked at 190 orphans and vulnerable children in community-based care, primarily in households affected by AIDS (81% of the sample). The study did not cover orphans in residential care (Carswell, 2004).

Carswell found a number of changes following parental death as shown in the following graph (figure 2). Almost half the orphans had less food and money than before bereavement and more chores. A third became responsible for the care of siblings and about one in ten became homeless (Carswell, 2004: slide 10).

Figure 2: Life Changes Following Parental Death

source: Carswell 2004: slide 10

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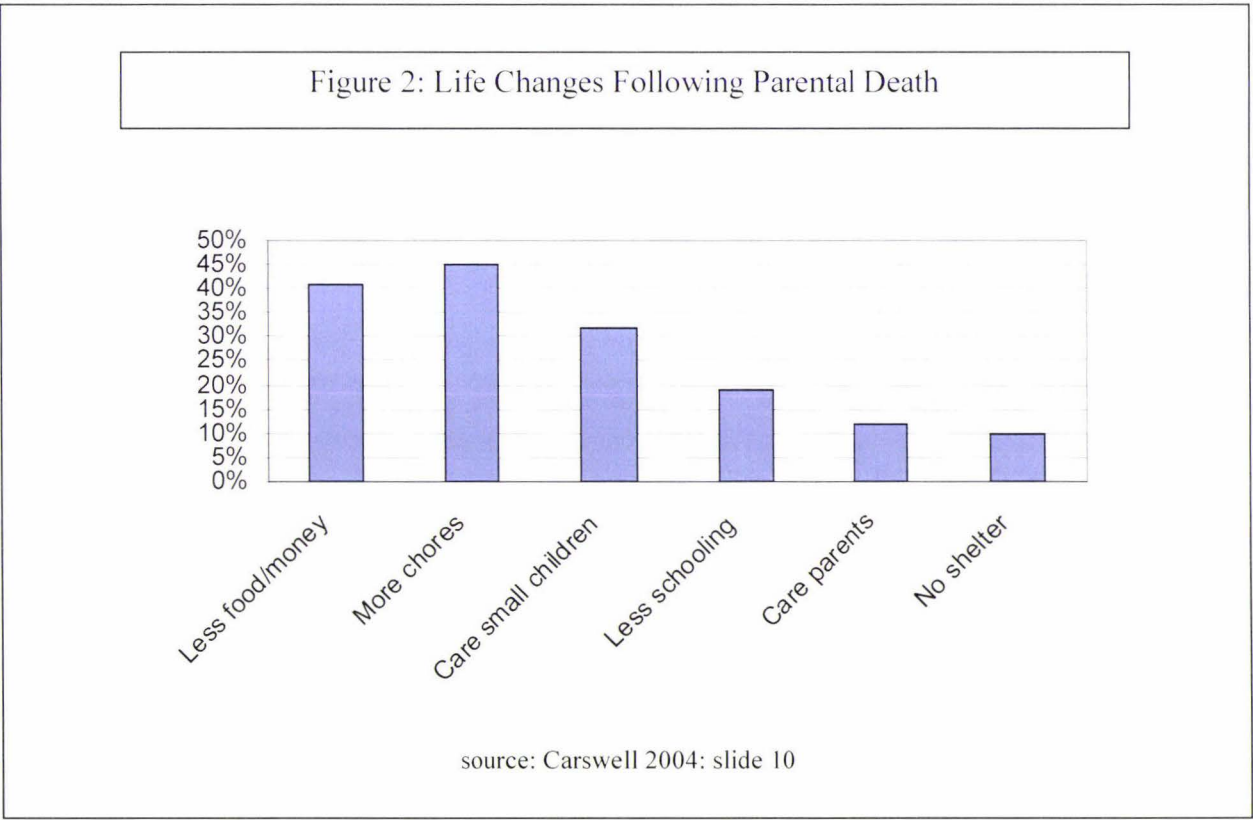
[12] Carswell included in his report a tool developed by the case study described later, Project HALO, to help children deal with bereavement called "My Memory Book".

However, despite the difficulties and changes outlined in figure 2, orphans and vulnerable children (OVC) in general reported feeling loved and cared for at home (Carswell 2004: slide 12). Only a slightly higher number than the comparison group of neighbouring children were unhappy living in their present environment as shown by the graph in figure 3 (Carswell 2004: slide 12):

Figure 3: Situation at Home

source: Carswell 2004: slide 12
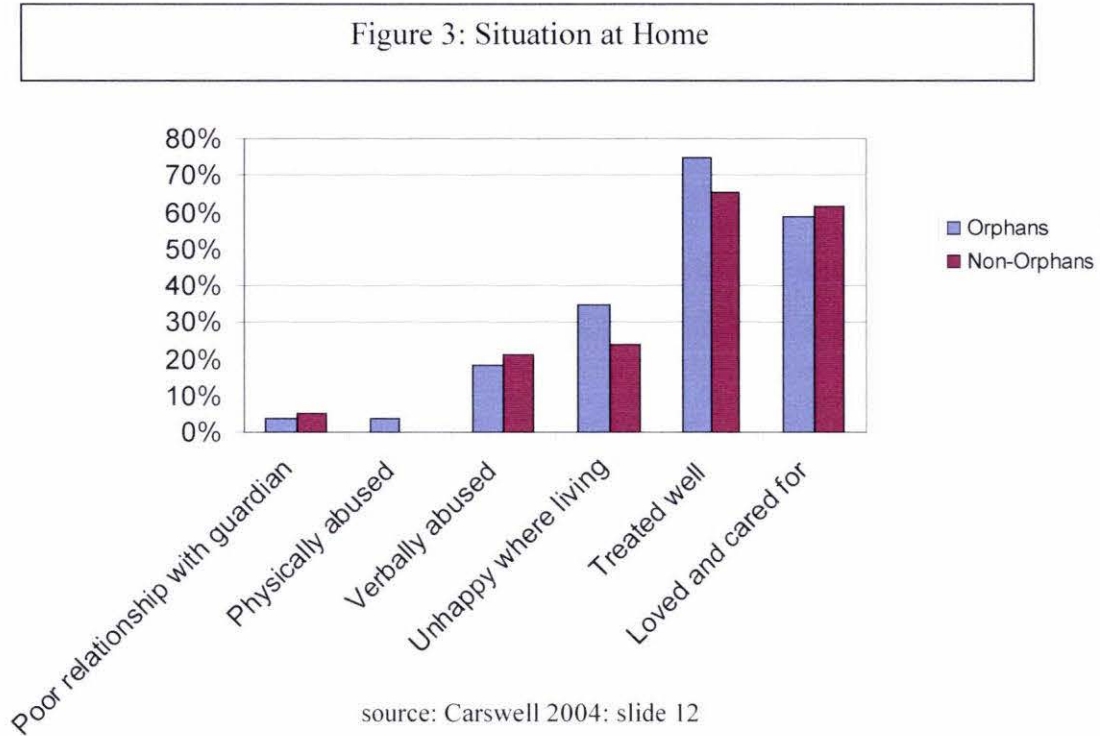
Figures 4 and 5 below show the results of Carswell's measurement of psychological distress in the orphans as compared to the control group. In figure 4, orphans and their neighbours in the comparison group reported similar levels of emotional distress and negative feelings. In figure 5, orphans reported slightly higher levels of unhappiness and anger than their neighbours.

Figure 4: Negative Feelings Reported
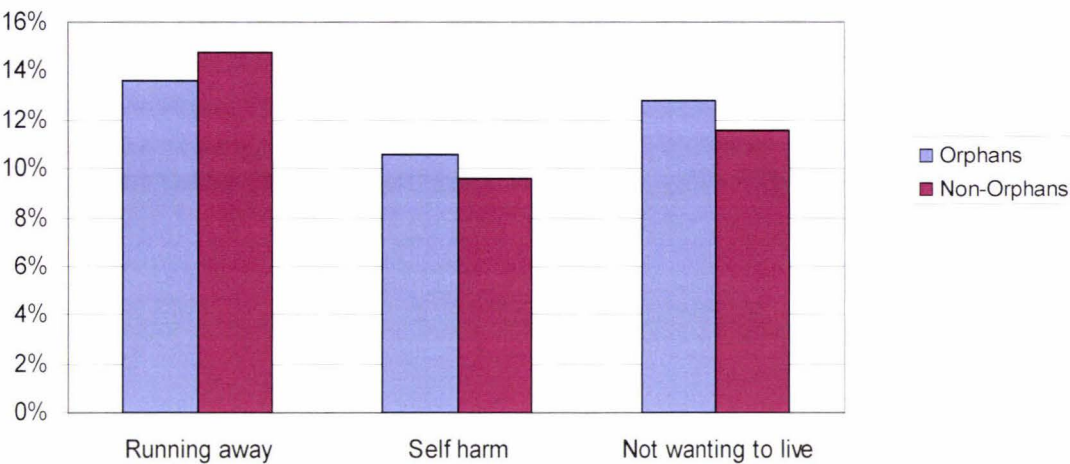
source: Carswell 2004: slide 13

Figure 5: Problems Experienced
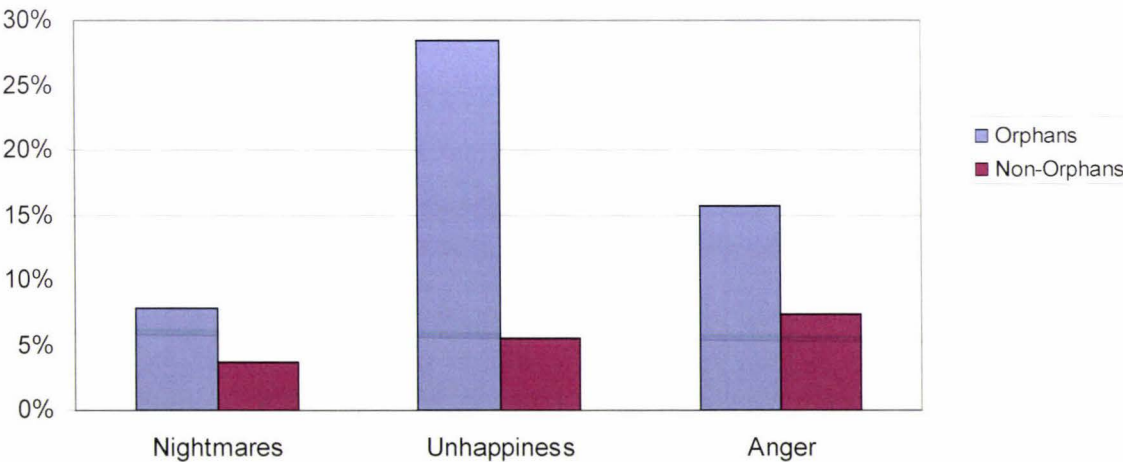
source: Carswell 2004: slide 13

Carswell identified a number of risk factors for the distress shown in figures 3, 4 and 5, including being physically or verbally abused, being unhappy where living or living with a care giver with a high level of distress. However, setting aside these risk factors, Carswell concluded that most Cambodian orphans are in general psychologically healthy (Carswell, 2004: slide 14).

In summary, these studies undertaken by KHANA, Alkenbrack and Carswell show that orphans in Cambodia experience significantly increased levels of poverty, homelessness and hunger. They typically take on a larger share of household chores and may take on more responsibility for the care of younger siblings or sick parents. Psychologically, they are more likely to experience negative feelings and distress if they are living in abusive situations or living with a distressed care giver.

PART 2: DEVELOPMENT INTERVENTIONS IN CAMBODIA

In 2001, I spent several days with UNICEF consultants Anne-Sophie Dybdal and Gary Daigle, along with a representative from the Cambodian Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation (MOSALVY), who were conducting a survey of providers of alternative care for orphans and vulnerable children. The survey results were published in 2002 and represented the first comprehensive survey of development interventions for orphans in Cambodia.

Dybdal and Daigle found that there were 21 government residential care facilities and 88 residential care facilities run by NGOs housing a total number of 11,500 children (2002a: p6). In contrast, there were only 12 non-residential programs run by NGOs (including in their definition, outreach programs and street children centres) catering for a total of 8,878 children (2002a: p9). UN figures for AIDS orphans alone show 77,000 children orphaned (UNAIDS/UNICEF, 2004a: p25), obviously not accounted for in these figures. This indicates that NGOs are not reaching at least 55,000 orphans in Cambodia, a significant shortfall.

Their survey data indicated that the overriding reason for children's entry into these programs was poverty rather than orphanhood, despite the stated aims of the projects.

They observed that the majority of children in care in Cambodia have at least one living parent[13]. Dybdal and Daigle found that although 81% of the programs stated that orphans were the main target group, only 2265 out of more than 20,000 children represented in these interventions were known to have lost both parents (2002a: p59).

Dybdal and Daigle's survey reviewed both community-based care interventions and residential care facilities in Cambodia. I will examine each type separately.

Community-Based Interventions

NGO support for community-based care of orphans is a relatively new phenomenon in Cambodia. However, this section will outline a number of ways, including a case study, that it is already taking place in accordance with development theory, thus proving that the gap between development theory and practice is clearly not due to the impracticality of applying the theory in the Cambodian context.

The first and one of the most extensive programs of this sort was established by Servants to Asia's Urban Poor in 2000. This was quickly followed by other similar programs implemented by a number of other international NGOs such as CARE, Maryknoll, Save the Children and World Vision. Only one local Cambodian NGO is known to be involved in this area in any significant way. Dybdal and Daigle, in their 2002 survey of alternative care programs in Cambodia, identified 12 community-based development interventions by NGOs (including a number of street children centres which are not considered community-based care for orphans for the purposes of this study) (2002a: p9). Their survey showed nearly 9,000 children in community-based care programs (2002a: p9).

There is a wide range of services provided by these NGOs within the community-based care model. Alkenbrack listed the most common services offered by NGOs to families caring for orphans in Cambodia: homecare (ie. visiting sick parents in their home), medical/education and food assistance, as well as counselling (2004: slide 24)

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[13] It should be noted that the Cambodian word for orphan is "kombria" which is used for anyone who has lost one or both parents, regardless of age. At times it can be used to describe children of divorced parents. Thus the term is much wider than the English word "orphan" which is normally restricted to children who have lost both parents.

In general, the two main models of community-based orphan care supported by development practitioners in Cambodia are kinship care and fostering. Kinship care includes care by grandparents and other relatives, as well as teenager-headed household:

1. Kinship Care

Kinship care describes the situation where relatives take in an orphaned child and provide care and support. There are a variety of sub-models within this category:

A. **Grandparents**. Specific mention should be made of the unique role and issues facing older care givers of Cambodian orphans. Older people have traditionally been involved in a variety of different ways in the care of children in Cambodia. However, the HIV/AIDS epidemic has unexpectedly increased the burden of care on Cambodian grandparents. There is no old age pension in Cambodia, nor any other kind of welfare assistance available from the government. In cases where vulnerable older people do not have family to take care of them, they are often seen homeless and wandering the streets. Issues facing these older care givers include sickness due to old age and lower levels of energy to work and provide an income to support the family. Older people's income earning capacity is further compromised by the necessity of caring for young children. The distress resulting from loss of family members and the stigma of being affected[14] by HIV/AIDS can result in feelings of isolation for these older care givers. Foster points out that, "it goes without saying that although this provides short-term respite, the ability of many elderly grandparents to protect and provide for children in the long term is limited" (2004: p70). Nevertheless, older people Cambodia-wide display remarkable resilience and play an extremely important role in the care of their orphaned grandchildren. It is an often overlooked fact that this is a reciprocal relationship whereby grandchildren grow up and provide their grandparents with economic security and emotional and psychosocial support and in return grandparents provide a loving home with care and emotional support when the orphaned children are younger (HelpAge, 2003: p8). Grandparents are the knowledge bearers of Cambodian society and are an important educational influence in the lives of thousands of Cambodian orphans.

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[14] People can be affected by HIV/AIDS without being infected, simply by having a family member who is infected and thus suffering a decrease in family income, as well as increased stress, stigma and difficulty.

B. **Aunts, uncles and other relatives**. The second major extended family category providing care to orphans in Cambodia is comprised of those other relatives who are closer in age to the orphan's parents. These people, mainly women, are often caring for their own biological children as well. A common criticism of this model is that the orphaned children are not treated equally in the household. Dybdal and Daigle noted that "some of the information available on kinship care describes children receiving love, care and nurturing from relatives, however, other anecdotal information describes exploitation and abuse by relatives" (2002a: p9). Clearly an unmonitored placement with extended family may turn out to be not in the best interests of the child and careful monitoring and follow-up should be carried out by the NGO or government agency. What is certain is that the addition of extra children in a household places strain on the resources of that family and will result in more economic and psychosocial pressure than might otherwise be expected.

C. **Teen-headed households.** Teenager headed households describe the practice in Cambodia where an older orphan will care for his or her younger siblings. The incidence of teenager-headed households or child-headed households in Cambodia is much lower than in Africa where the AIDS epidemic is on a larger scale and extended family are less available. However, there is still a significant number of these households in Cambodia and it should be noted that a household may be considered teenager-headed before the parents die, due to the leadership role a child may take when the parent becomes incapacitated due to AIDS. Often in the last stages of care for the AIDS patient a child, where there is no other suitable relative, will take on sole responsibility for patient care, finding food, cooking, cleaning and looking after younger siblings. In some cases this sole responsibility will continue after the death of both parents. Clearly these teenager-headed families are extremely vulnerable to exploitation, psychological trauma and stress, poverty, lack of opportunity to attend school and a range of other difficulties. However, Foster notes that, "not all child-headed households are equally vulnerable, and some child-headed households live in close proximity to nearby relatives who visit regularly and provide them with material support" (2004: p73). What is certain is that these families show an incredible resilience and resourcefulness in the face of extreme difficulty. A teenager-headed household may be the first choice of the

teenager themselves and the dying parents. This is partly because the teenager wishes to protect the inherited property which may include a house and land and which may be lost if the orphans are taken away to another location. A teenager-headed household may be the only option available because of a lack of able or willing relatives or broken relationships between family members. Sometimes, the oldest child is the only one the parents trust to care for the other siblings.

2. Fostering

Foster care has been defined as, "a less permanent form of substitute care which does not involve the transfer of parental rights and responsibilities" (Foster 2004: p83). Fostering and local adoptions are not officially recognised by the Cambodian government. However, the practice is widespread and a largely untapped resource in community-based care for Cambodian orphans. Due to the lack of medical services available for childless couples in Cambodia, many couples choose to adopt or foster children. These are not necessarily orphaned children but may come from deprived backgrounds where the parents feel they are unable to provide for their children's needs. Traditionally, some sort of financial compensation is provided to the biological parents or relatives in exchange for the child. This is known colloquially as "the price of the mother's milk". Children may change hands many times as brokers can become involved. Newspapers report that orphanages have also been involved in this type of exchange of children, especially babies[15].

In development practice, foster care may be short term or long term. If it is long term it can be labelled an "informal local adoption" and shares many characteristics with the traditional concept outlined above. Usually, these long term informal local adoptions are unremunerated. In fact, many couples are keen to deal with the NGO because they do not have to pay the "price of the mother's milk".

Short term foster care is more difficult and fewer Cambodian families are willing to assist an unknown child in this way without financial compensation. Often however in

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[15] Reports of orphanages involved in this sort of exchange abound. For example, http://www.oggham.com/cambodia/archives/000253.html and http://society.guardian.co.uk/adoption/story/0,8150,1356153,00.html both accessed 12/1/2006

the community, when children are orphaned, neighbours may provide some temporary care for them before seeking a longer term solution such as placement in a residential care facility. Again, this is an untapped opportunity to support community-based care for orphans, if instead of accepting the children into the orphanage, some kind of arrangement could be worked out so that these kindly neighbours could be trained, remunerated and monitored to care for the orphans already in their care and already in a relationship.

In summary, services provided by NGOs to Cambodian families caring for orphans have been listed and the various models of care described in general terms. At this point it is useful to turn to a concrete example of a community-based care intervention.

Case Study: Servants to Asia's Urban Poor

In addition to merely describing the characteristics of development interventions reaching orphaned children in Cambodia, a case study of a community-based development intervention will ground the theory in reality and provide some insight into the day to day activities of a community-based care project. The existence of this development intervention also helps establish the fact that community-based care is possible, if not preferred.

The community-based care for orphans program run by Servants to Asia's Urban Poor has been chosen as a case study firstly because it is the longest running and one of the most extensive. Secondly, a number of the tools and techniques used by the Servants program have been adopted by other NGOs in Cambodia such as the Memory Book and the Big Brothers and Sisters program described below. Thirdly, as mentioned, it has also been written up objectively as a case study by independent consultants (Dybdal and Daigle 2002b) who were able to interview many of the participants and provide some useful insights from an external point of view. Finally, as founder and advisor to this program, I am intimately familiar with the inner workings, strengths and weaknesses of the intervention[16].

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[16] Thus, the majority of information in this case study is taken from my own observation and understanding, rather than any particular source document.

Servants to Asia's Urban Poor (known as Servants) is a Christian Non-Governmental Organisation made up of volunteers living and working in Asia's city slums. Servants entered Cambodia in 1993, under an agreement with the Ministry of Health to provide health services in the poorest district of Phnom Penh. Servants' interventions target the very poor and underprivileged groups of society with the aim of developing and building on the existing resources within communities. In the course of their work with adults living with HIV and AIDS, many of whom are parents, the need to plan for the future of the children became evident.

In the year 2000, Servants established an initiative for children orphaned by AIDS called Project HALO (Hope, Assistance and Love for Orphans). The vision of Project HALO is to empower Cambodian communities to care for their own orphans. The program grew out of Servants' existing activities in HIV/AIDS home care and education. All of the children in Project HALO are affected by HIV/AIDS, in that their parents are either living with HIV/AIDS or have died of AIDS. A small percentage of the children are infected with the HIV virus. In total, Project HALO works with over 900 children whose parents are living with, or have died of AIDS, and facilitates support in a variety of ways.

The models of care in Project HALO are twofold and represent the main types of community-based care found in Cambodia as previously described. Firstly, Kinship care, where orphaned children are cared for by the extended family. Knowing the parents and listening to the parent's wishes regarding future care for their children is of crucial importance to the placement, and most parents indicate that they want children to stay with extended family members. A large proportion of the kinship care in this project is provided by grandmothers. Teenager headed households form another subset of the kinship care group, where the oldest sibling in a group of orphaned children provides care for the younger siblings in the family home. Normally, teenager headed households are located nearby or next to extended family who also offer support to the children. Care is taken by the staff to ensure that any property or land owned by the parents before their deaths is inherited and placed under the name of the teenage caregiver. Regular visits are made to monitor the situation and to provide encouragement.

Secondly, foster care, which is normally an informal in-country adoption in which a family agrees to take in an unrelated orphaned child to live with them and receive care and support in a family environment. In this context, fostering is seen as long-term accommodation and the child is integrated into the life, routines, and values of the family. Only a small number of foster families are currently being used by Project HALO as this is seen as a less attractive solution in comparison with the two options outlined above.

A key element of success is the relationship with the children's parents before they die from AIDS. Through this initial contact, program staff are able to discuss the parents' preferences regarding the future care of their children. They are also able to explore, with the parents, existing support networks such as older siblings and other relatives as potential care givers, and plan carefully for the support and encouragement that will be required after the children are bereaved.

A low level of financial and material support is provided for the children in Project HALO, such as school fees, uniforms, school supplies, hygiene supplies, emergency rice rations and medicine. Education costs in the form of school fees represent the largest program expenditure. Rice is provided only in emergency cases and medical care is available through the program clinic. Sometimes small business loans, designed to assist families to set up income generating activities, are provided to care givers. Support to the extended family and to the orphan is decided on a case by case basis. Support is also given in the form of visits which allow monitoring of the family's situation, encouragement, counselling and budgeting advice.

Project HALO uses about 100 "Big Brothers and Sisters" as volunteer helpers. These are young people drawn from local churches who visit, encourage, advise and serve as role models to one orphan each (i.e. 100 orphans) in the program. In the interests of sustainability, no financial assistance or per diem is provided to these volunteers. Instead, they are motivated by compassion. Storytelling, role modelling, positive peer influence, videos, preaching and music are some of the tools used to inspire and motivate the volunteers. T-shirts, certificates and other small items also give a sense of identity and achievement.

A memory book has been developed for the Cambodian context by Project HALO with input from a number of child psychologists and grief counsellors to help Cambodian orphans understand and deal with their loss. This interactive activity book is now being used by most of the other community-based care and many residential care providers in Cambodia.

Project HALO uses a holistic approach by taking into account the range of needs of families affected by HIV/AIDS and care givers. The program prioritizes community participation in the process of finding solutions to address the care and support needs of orphans. Project HALO emphasises the importance of having contact with neighbours, the community and relatives. Families' and communities' involvement strengthens their own capacities to deal with problems and ensures that the community is truly engaged with the issues facing these orphans.

Project HALO has also been independently evaluated by Dybdal and Daigle as part of their survey. Their assessment provides an objective view of the strengths and weaknesses of this program. Dybdal and Daigle observed that it was a distinct advantage that Project HALO has a wide range of interventions and a close-knit network of personal contacts. They noted that because of the small and informal style of the management, decisions can be taken quickly, and it is possible to adapt a solution to the specific situation of the family or individual in question (2002b: p11).

Dybdal and Daigle also identified cost-effectiveness as an important advantage of the program (2002b: p10). By using community volunteer networks and providing small amounts of support for special needs (education, rice in emergencies, medical care), Project HALO has been able to maximize its impact while maintaining relatively low costs. Dybdal and Daigle state that the average cost per child in the program is $32 per annum (2002b: p10). They quote Project HALO staff as saying that care provided by orphanages is expensive when compared to fostering and kinship care, and that older children in their program can receive vocational training and can then earn income for their families.

Clearly, in accordance with development theory, Project HALO's emphasis on family and community approaches to the care and support of orphans prioritizes non-

institutional responses. Dybdal and Daigle note that children in the program who have spent time in orphanages do not want to go back. When a foster child was asked "Which is better for children, staying in a foster family or staying in an orphanage?" The child replied, "For me, staying with my foster family is better because I can stay with my brother." (Dybdal and Daigle, 2002b: p10).

Dybdal and Daigle mention that for an NGO starting a similar program of community-based care, the building of community relationships and mobilising and training community volunteers would represent additional time and resource requirements (2002b: p11). They also comment that Project HALO's urban location where distances between communities are not excessive is also a facilitating factor for program activities (2002b: p11). In a rural setting, the distances between villages and between houses would also require additional resources.

Dybdal and Daigle note a possible difficulty in applying the Project HALO model to the care of children not orphaned by AIDS (2002b: p11). Project HALO works solely with children who will lose or have already lost parents to HIV/AIDS. This ties in neatly with another Servant's program providing HIV/AIDS home care by volunteers familiar with the community. Thus, Project HALO staff have ready access to information about the situations of families affected by AIDS, whether extended family members exist, and what the preferences of the children's parents are regarding the future care of their children after the children are bereaved. This access allows the program together with the family to explore various options of future care for the children. While this appears to be a very significant factor in Project HALO's success in supporting community-based care for children orphaned by AIDS, there are difficulties in the replicating this model in the situations of children who are without the care of their parents due to other reasons (e.g. death of parents due to accident, abandonment, trafficking, etc). In other contexts, access to information about the children, their parents, relatives, and communities is more difficult. Dybdal and Daigle conclude that it would be a challenge to find community-based care solutions that are best suited to the needs and rights of the child in other contexts. The authors observe that any expansion of this model to the circumstances of non-AIDS affected orphans would need to take this into account.

Two other challenges are discussed by Dybdal and Daigle. Firstly, there are no detailed legal provisions covering in-country adoptions in Cambodia (2002b: p11). Work is ongoing on a draft of civil code for this area. The law on marriage and family includes seven articles on adoptions, covering also in-country adoptions by Cambodians. There are no laws governing fostering relationships, and the current lack of this type of legitimacy for foster care is a constraint for all stakeholders. Secondly, they note that, as in many other areas of alternative care, a suitable placement may be difficult to find for children who are seriously ill or have behavioural difficulties (2002b: p11).

The Project HALO case study establishes that development interventions aligned more closely with the community-based described in the literature are indeed possible and effective. However, at this point I will turn to the residential care interventions currently being implemented in Cambodia. The description of these interventions and a representative case study will show that development reality is often far removed from development rhetoric.

Residential Care Interventions

The vast majority of development interventions for orphans in Cambodia are not community-based but residential. This section will examine the range and significance of residential care interventions being carried out in Cambodia which are not in keeping with the community-based approaches advocated by development theory. By comparing the practices described in this section with what is promoted in development theory we will be able to ascertain the gap between rhetoric and reality.

There are three main categories of residential care in Cambodia:

1. Pagoda-based care

A number of NGOs, such as Save the Children Australia, work closely with Buddhist monks to assist them in providing care to orphans and vulnerable children in the pagoda. There are now over 3000 Buddhist pagodas throughout Cambodia and monks have traditionally taken in orphaned boys (KHANA, 2001). The small number of children that are taken in are usually adequately cared for physically. Monks also sometimes provide food and shelter for other children in need but do not contribute to their education.

A major difficulty with this approach is that girls are usually not accepted in Buddhist pagodas, which results in siblings being split up and family ties weakened. Of 167 Cambodian orphan children living in pagodas surveyed by HOSEA Project, only 9 were girls (2004: p9). They highlighted the fact that "so few girls living in such a male dominated environment cannot be healthy for anyone involved" (2004: p9).

Additionally, pagodas are only able to take in a small number of children since they are totally reliant on the surrounding community for offerings of food, money etc. Sometimes this process may be disrupted through disputes and there are reported cases of tension between monks and children who are accused of taking food before it is offered to them (KHANA, 2001). HOSEA Project found that "due to the traditional system of collecting and distributing food, there is often not enough food for the children" (2004: p8).

Some researchers have expressed doubt about whether the psychological and emotional needs of orphans living in pagodas are adequately met. "While children regularly receive advice on morality and ethics, there is little or no acknowledgement of their inner needs, feelings or emotions. In most temples, monks...do not appear to interact with the children on a personal level, they do not seem to know or care what the children feel, and according to their own admission do not notice how the children respond to potentially difficult events such as the departure of caregivers. Furthermore, the children may be subject to further stigmatization because they live there. Children living in Cambodian pagodas are colloquially referred to as 'temple dogs'" (HOSEA, 2004: p8).

Many development practitioners take the stance that the Buddhist Pagodas, as an integral part of traditional Cambodia society, are actually community-based care. However, since they tend to have all the characteristics and problems of residential care facilities and fit the definition of residential care adopted earlier, "group care for children away from home by unrelated persons", I would suggest Pagoda-based care is in fact another form of residential care. In support of this assertion, the Supreme Patriarch of the Buddhist religion in Cambodia, Tep Vong, in addressing a networking meeting on the orphan issue, appealed to the government of Cambodia to establish "new

training and residential centres in pagodas to house the thousands of Cambodian children whose parents die of AIDS" (Collins, 2004).

Cambodian men traditionally only enter the monkhood for a one or two year period in order to make merit, a rapid turnover which could increase distress for orphaned children. It is doubtful whether monks can fulfil the 'mother substitute' role that good alternative care of orphans requires. They do not make a personal decision to become a care giver. Simply by entering the monkhood, they become caregivers by default, whether appropriate or not, or whether they want to or not. There is no way to conduct security checks, even if these were required by the temples. Therefore, it is highly likely that there are many monks who are not suitable for caring for children, or who simply do not want the responsibility (HOSEA, 2004: p9).

According to HOSEA Project, "The care of children living in temples is of poor quality generally... Children are, frankly stated, not adequately cared for within the temples. They are more or less just present, living separate lives from the monks most of the time (except when they are expected to serve the monks). Children do not get much positive attention and are not well regarded by the majority of the temple population. It is little wonder then that their behaviour is publicly perceived as unruly, and that their reputation as 'temple dogs' continues" (2004: p9).

Clearly, this is a sensitive issue for foreign development practitioners who wish to be seen as respectful of the host culture. However, because girls are not accepted, resulting in the separation of siblings (HOSEA, 2004: p9) and the monks do not generally interact with the orphans in loving and nurturing ways (HOSEA, 2004: p9), it is my contention that the Buddhist Pagodas do not reflect the best aspects of truly community-based care, such as keeping siblings together within their existing support network and providing a long term, loving 'mother substitute'. Therefore I have included this model under residential care where many development practitioners would classify it as community-based care.

2. Government Institutions

The government institutions that cater to orphans and abandoned children in Cambodia are notoriously substandard and lacking in resources. According to Dybdal and Daigle,

government institutions account for 16.7% of the orphan care in Cambodia (2002a: p8). It is beyond the scope of this thesis to examine in detail government perceptions and attitudes towards the care of orphans since the research question relates more closely to NGO development practitioners. However, suffice to say, the major emphasis of the Cambodian Government when it comes to care of orphans is on residential care.

3. Non-Government Residential Care Facilities

Thirdly and finally, residential care facilities are run by both local and international NGOs and account for 73.3% of orphan care in Cambodia (Dybdal and Daigle, 2002a: p8). Locally run orphanages are in the majority and tend to be underfunded (HOSEA, 2002: p6). Internationally run residential care facilities are in the minority and tend to be well funded and resourced (HOSEA, 2002: p6). According to Dybdal and Daigle (2002a: p16) almost all the orphanages in Cambodia provide basic accommodation, food, clothing and education. They offer further insights into the residential care scene in Cambodia:

"Education is the one common and greatest priority amongst providers. Most of the children in residential care have at least one living parent and often children have other relatives. Poverty is cited as the most common reason for children to enter residential care. Site visits and interviews reinforced the impression that Cambodian adults see residential care as a good opportunity for disadvantaged children to receive basic accommodation, medical care and education. One orphanage director explained that the program's policy is to accept only genuine orphans but they have found that some children apparently change their life stories many times, adjusting it, so that it becomes practically impossible to trace the family or make a true assessment. Other informants had observed that once a residential institution opens in an area, it would experience great pressure of demands for services for the children in disadvantaged families" (2002a: p16).

Dybdal and Daigle identified more than 100 residential care facilities in Cambodia (2002a: p23). Most of these institutions are situated around the major cities and town centres in Cambodia but the 21 government orphanages are scattered throughout many of the provinces of Cambodia. They state that the reality in Cambodia is that "the traditional orphanage has been and continues to be seen as the preferred alternative care

option for children in Cambodia" (2002a: p15). A disturbing trend found by Dybdal and Daigle is that the growth in the number of residential care programs has outpaced the growth in the number of community-based care programs. They provide the table in figure 6 as evidence:

Figure 6: Types of Orphan-care Projects Established Each Year

Year started	RESIDENTIAL CARE		COMMUNITY-BASED CARE (NGO)	TOTAL
	Govt.	NGO		
1979	4			4
1980	2			2
1983	1			1
1987	1			1
1989	1	2		3
1990		2		2
1991	1	1	1	3
1992	1	7		8
1993		6		6
1994	1	12	1	14
1995		4	1	5
1996		8	1	9
1997	4	8	3	15
1998	3	8	1	12
1999	1	10	2	13
2000		16	3	19
2001		3	1	4
TOTAL	20	87	14	121

source: Dybdal and Daigle 2002a: p23

Figure 6 shows that there are 121 development interventions aimed at orphans and vulnerable children in Cambodia. Of these, 88% (107) are residential care facilities such as orphanages and children's homes. Less than 12% are community-based care projects such as Project HALO described in the case study above.

From the table it may be noted that the Cambodian government only has one approach to the care of orphans: residential care. Since 1994[17], 78 residential care programs have been established, representing almost all the residential care facilities opened by NGOs in Cambodia (89.6%) in the past eleven years. In contrast, only 13 community-based programs were started during the same time period. In other words, for every community-based program started in Cambodia in the past eleven years, six residential facilities were established.

Another useful way to evaluate residential care is the staff to children ratio, which measures how many children are cared for by each staff member. Figure 7 was prepared by Dybdal and Daigle to show this data:

Figure 7: Average Staff to Children Ratios in Residential Care

Size of program by number of children	Average number of children / 1 staff ratio (only staff working directly with children)
Less than 21	13 children : 1 staff
From 21-50	44 children : 1 staff
From 51-100	29 children : 1 staff
From 101-200	16 children : 1 staff
More than 201	12 children : 1 staff

source: Dybdal and Daigle 2002a: p50

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[17] The Khmer Rouge were in power until 1979. Thus there were no institutions or other development interventions in operation during their four year reign of terror. The country became more stable in 1993, due to the presence of the UN, overseeing elections. At this point a number of NGO's entered and set up development programs for the first time in several decades.

Although the data is limited and nothing conclusive can be stated it appears that medium sized programs have higher staff to child ratios. This medium range may be skewed by the government facilities. Dybdal and Daigle also note that local NGOs had a 14% higher number of children per staff member than international NGOs (2002a: p50).

Nevertheless, figure 7 shows that on average most programs have at least 12 children per staff which would clearly be insufficient to provide the individual adult attention described as essential in the literature and by Bowlby's 'mother substitute' attachment theory (Bowlby 1951: p13). In community-based care, the staff to children ratio is unimportant since the children are not reliant on the NGO staff to provide all their adult input or to be the 'mother substitute'. However, in the residential care facility there are no other adults available to give the children individual attention. On this important factor, residential care facilities in Cambodia fail to adequately meet the needs of the children in their care.

Another key factor which contributes to the difficulty of a 'mother substitute' figure being established in an orphan's life in residential care is staff turnover. Dybdal and Daigle mentioned a number of reasons why these staff changed jobs. Moving to another job, often higher paid, was the most common reason given. Other reasons given indicated that the staff had been terminated by their employer for reasons such as poor performance, breaking the rules, abusing or hitting the children, stealing or corruption. The authors counted 97 staff members who had stopped work in the past 12 months and 226 who had started work in the same time period (2002a: p51). Clearly, staff in community-based care programs would also have a similar rate of turnover. In community-based care programs orphans are not reliant on the NGO staff for their adult relationships or 'mother substitute' figure therefore staff turnover is not an issue. However, in a residential care facility, the orphans are reliant on NGO staff to meet their emotional and social needs.

At this point it is helpful to examine a case study in residential care in order to gain a more concrete understanding of the development interventions undertaken by a typical NGO caring for orphans in a residential facility. As previously established, the majority of residential care facilities for orphans are orphanages and the majority of these

orphanages are run by NGOs (Dybdal and Daigle 2002a: p23). Thus I have chosen an NGO-run orphanage for the case study, Sunrise Children's Orphanage.

Sunrise and its Australian founder, Geraldine Cox, are well known in Australia and Cambodia and have been the subject of a number of documentaries and books. This allowed me to access a wider range of source documents in researching the case study. Ms Cox was out of the country when the research was being conducted and answered my enquiries by email. Additionally, Ms Cox has conducted numerous interviews with the press, written an autobiography and been the subject of at least three documentaries. Thus, her personal story and the story of the orphanage is well known and in the public domain. Further information was available from the official Sunrise Children's Orphanage website.

Case Study: Sunrise Children's Orphanage[18]

The orphanage cares for about 70 children and is located just outside Phnom Penh, the capital city of Cambodia.

Geraldine Cox initially travelled to Cambodia in 1993 with a female friend to work as volunteers. They assisted at a residential home for orphans near the Cambodian/Thai border. Later that year she co-founded the Australia Cambodia Foundation Orphanage Center. It is an Australian registered charity and in 1998, the Cambodian government recognized it as an NGO. Initially funded by individual donations, in 1994 the foundation was awarded a grant from The JP Morgan Chase Foundation, the charitable arm of the Chase Manhatten Bank, where she was an employee. They supported the orphanage with between US$15,000-20,000 every year for five years until 1999. Geraldine Cox moved to Cambodia full-time in 1996. She worked for the then First Prime Minister of Cambodia, HRH Prince Norodom Ranariddh who was deposed in a coup in 1997. She administered the orphanage in her spare time. After the July 1997 coup, she moved to working on the orphanage full-time.

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[18] The majority of information in this case study is taken from the official website of the Sunrise Children's Orphanage (www.sunrisechildrensvillage.com) and http://www.oggham.com/cambodia/archives/000400.html.

The first 24 orphans came from a home inside Site B Refugee Camp in Thailand. In 1993, the children were repatriated back to Cambodia, to a small village called Ampil in the province of Oddar Meancheay. The village is described as poor with no schools nearby. Due to the ongoing civil war, including the murder of one of the children by Khmer Rouge soldiers, the children moved to just outside Battambang township. In January 2001, the women moved again to the current location in Ta Khmao, a small town outside of Phnom Penh. They occupy a small rented villa with five bedrooms for more than 70 children and staff.

The Cambodian Government has donated to the orphanage a 10-hectare site about 17 kilometres outside Phnom Penh on a 50-year free lease to permit construction of a permanent orphanage. Ms Cox is now seeking about A$1 million for construction of a Children's Village including not only the orphanage but also a series of other buildings. The complex will provide accommodation for up to 100 children (with room for expansion) along with bathrooms, a medical clinic, classrooms and administrative areas.

Currently, the fulltime staff is made up of one general manager, one house father, one house mother, two music teachers, a dance teacher, a book keeper, three cooks, three farm hands. Two expatriate directors and various other expatriate volunteers assist on and off site for varying lengths of time[19]. Sunrise Orphanage reports on their website (www.sunrisechildrensvillage.com) that the staff provide the following services to the children:

- Love, food and Shelter
- Inoculation against Polio, TB, Typhoid, Hepatitis A and B
- Clothing (includes provision of 2 school uniforms)
- Medical and Dental Care
- Education at Government School
- Evening English language classes and English-Language Library
- Traditional Cambodian Music and Dance Lessons
- Sewing Classes
- Field Trips

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[19] www.sunrisechildrensvillage.com

- Personal Counselling when required
- Physical Exercise Program, Health and Hygiene Instruction, Family Planning and HIV Aids Awareness
- Computer School
- Carpentry School

Officially, children are admitted for a number of reasons: parents or other family members have been killed or maimed by land-mines, died of hunger or disease and often targeted for murder because of their political affiliations. Children are generally abandoned, orphaned or placed by their parents at the orphanage.

According to the official website, "the villagers sometimes make every effort to care for them, but more often than not, they are taken into homes and used as slave-labour in return for food and a place to sleep until their plight is brought to our attention."

These children are admitted to the orphanage according to the following admissions procedure. Initially, Sunrise receives a report of abuse, need or neglect in the community. Geraldine Cox and the Sunrise Cambodian staff members go to the village to assess each case to ensure that the need is real. Village leaders must produce background details on the children and give official notice that they wish the children to be cared for by Sunrise. These papers are then lodged with the Ministry of Social Action, and the children are taken from the village. Sunrise officially becomes their "guardians" until they are 18 years old. If the situation is not too traumatic for the children, photos are taken of the living conditions to compare later with life at Sunrise. Employment is secured for them when the children turn 18 and leave the centre whenever possible and according to the official website, "so far no child has left without a job and accommodation.[20]"

The Sunrise Orphanage case study is reasonably representative of the orphanages observed in and around Phnom Penh. As an internationally run institution it has more resources than locally established facilities. As with other orphanages, Sunrise places a strong emphasis on providing quality education and comfortable, high quality physical

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[20] www.sunrisechildrensvillage.com

surroundings. 70 children are cared for by one house mother and one house father, though other staff provide education, food, etc. The entire orphanage has been moved significant distances, several times, indicating that any sense of connection the children might have had with their home province or relatives would be extremely difficult to maintain.

The establishment of residential care programs such as Sunrise Children's Orphanage continues to outstrip community-based programs such as Project HALO at a rate of six to one. However, there is an increasing interest in community-based care for orphans in Cambodia by international NGOs. Unfortunately, local Cambodian NGOs are still lagging behind in establishing community-based projects.

In their report, Dybdal and Daigle concluded that ignoring community-based approaches to care sent the message that poor families cannot care for orphans and vulnerable children and that others (i.e. non-government or government institutions, wealthier families) can do a better job of caring for their needs. They noted that these messages run contrary to the entire concepts of empowerment of the poor and self-reliance (MOSALVY 2002). Confirming Dybdal and Daigle's criticism, the Sunrise Orphanage founder acknowledges that community-based models exist, "the villagers sometimes make every effort to care for them" but she dramatically writes off their efforts as abusive, "more often than not, they [orphans] are taken into homes and used as slave-labour in return for food and a place to sleep until their plight is brought to our attention[21]." Sadly in many cases, the efforts of Cambodian people to care for their own orphans are viewed with suspicion and the intervention of the NGO to remove the children from their support network is perceived as the only humane response to orphanhood. No doubt, Sunrise provides the children with comfortable, facilities, nourishing food and educational opportunities. However, the residential care model used by Sunrise and other orphanages in Cambodia has been shown by researchers to have serious shortcomings in meeting the psychosocial needs of orphans (Bowlby 1951: p13; Dybdal and Daigle, 2002a: p96; Foster 2004: p84; Williamson 2004, p28).

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[21] www.sunrisechildrensvillage.com

Evaluation and Summary of Development Interventions in Cambodia

The development interventions described in the first section demonstrate that community-based care is possible just as promoted by the development literature.

In summary:

1. Kinship care: institutional care or even fostering of children by non-relatives is not necessary in most cases because relatives are usually found who are willing to take in the children. With some support, relatives are almost always willing and capable of taking care of orphans. Supporting and strengthening the capacity of the extended family is the best option when possible.

2. Teenage headed households: another workable kinship care model, but sensitivity should be shown to the teenager's own needs as a young person with a right to recreation, education and security. No teenager should be left by themselves with the burden of responsibility and their own grief, without the practical and emotional support of adults.

3. Fostering: despite what many development practitioners in Cambodia claim, fostering is a viable option for community-based care as many people were found to be interested and suitable. Dybdal and Daigle, commenting on Project HALO, noted that more programs should examine this option, keeping in mind the needs for support, sustainability and the careful monitoring of the children (2002b: p12). However, many stakeholders are concerned about the possibility of abuse and this danger cannot be ruled out since any relationship between adults and children, including in institutional care or even with a child's biological parents, is potentially abusive. The key is not to reject a model because of the potential for abuse, but instead to conscientiously monitor and follow-up every situation to be certain that abuse is not present.

The process of exploring these options and planning within the family itself is a healthy and strengthening process where the stakeholders consciously are made aware of resources, vulnerabilities and capacities.

Dybdal and Daigle note the difficulty of community-based care for children who have a challenging behaviour or are ill or disabled (2002b: p11) and this issue emphasizes the need for more creative thinking in these cases, and possibly a necessity to use more resources .

The first case study, Project HALO, and other examples of community-based care in Cambodia show that development theory can and has been effectively applied in the care of Cambodian orphans, despite the difficulties. Their existence establishes the fact that development theory supporting community-based approaches need not be merely rhetoric.

The second case study and other examples of residential care in Cambodia show that the gap between development theory and practice is still wide. Despite the existence of vast amounts of literature and research showing that community-based care models are more effective, orphanages, such as Sunrise Orphanage, and other institutional approaches to orphan care are still the most popular development intervention at a rate of six to one. The reasons for that gap will be discussed in the next chapter in an examination of the primary research conducted amongst development project founders and directors.

CHAPTER 4: DATA ANALYSIS AND DISCUSSION

It has already been pointed out that despite the strong assertions in development literature that community-based approaches to orphan care are more effective, the rhetoric has not been matched in the reality of development interventions implemented today in Cambodia. This gap between development theory and practice has been well established in the previous chapter. Orphanages are still the most popular response to the problem of orphanhood.

In this section I will examine the reasons for this gap between rhetoric and reality. Using the raw data from my primary research, consisting predominantly of transcripts from a number of semi-structured interviews with key informants, I have identified emerging themes which help explain why institutional approaches are favoured. In some places I have also drawn on the development literature previously discussed in order to indicate where the interviewees are reporting practices that are encouraged in the development theory or otherwise.

The data was collected during ten in depth, semi-structured interviews with expatriate and Cambodian development practitioners involved in providing institutional and community-based care for Cambodian orphans. The semi-structured interviews took the form of guided conversations where broad questions were asked relating to the topic of interest and the conversation was allowed to flow naturally. The interviews had all the typical attributes of semi-structured interviews in that they were informal, relaxed discussions around the topic being studied. Appendices 1 and 2 outline the questions used, as well as the time, location and a brief description of each interviewee.

The rest of this chapter contains a summary of the four major themes that were identified. Firstly, the gap between development theory and practice arises because NGOs establishing residential care were generally less experienced in community development and less connected with the community and other NGOs. Secondly, the NGOs establishing residential care were less likely to have carried out significant preparatory research. Thirdly, the residential care practitioners placed little priority on

the psychosocial needs of the children in comparison to the physical and educational needs of the children. And finally, they demonstrated little commitment to or understanding of the importance of maintaining family and community ties.

Theme 1: Community Development Context

The first evidence of a significant divergence between the community-based care projects and the residential care projects surveyed is that the community-based care interventions were more likely to made in the context of existing development projects, relationships and networks.

Ability to draw on existing networks of community relationships

All the NGOs surveyed who implemented community-based care were already experienced and worked in other areas of community development, especially home based care for people living with HIV/AIDS. The community-based care for orphans' aspects was a natural progression from existing work in the community and built on extensive relationships and networks. For example, one project founder explains how the need for an orphan care intervention arose out of other projects already being implemented by the NGO:

"we were asked to develop a program for the growing number of HIV/AIDS orphans identified through [the NGO's] programs" (Community-Based Care Interview Transcript 1).

Another founder of a rural community-based care program which was already providing home-based care for people living with HIV/AIDS found that the orphan care developed very naturally out of their involvement with the extended family. The director commented that, *"it's just a natural transition, in that they are most likely already helping care and when the very sick [parent] dies, it can be a relief and ease on the family and they don't really think about orphans. This is why I am such a huge advocate for home-based care in provinces, before relationships are broken and people move to Phnom Penh to receive [orphan care] services..."* (CBCIT*2). This NGO was already in a relationship with those most likely to be able and willing to offer help for

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* CBCIT: Community Based Care Interview Transcript: see Appendices 1 & 2 for interview questions used and brief descriptions of the interview date, location and subject

the orphans when the parents died and those relationships provided the foundation for their response.

A third community-based project founder described how their orphan project was closely linked to another community health project, explaining that, "*it wasn't separate, it was linked with the health care coordinator program*" [CBCIT4]. Since this program worked through churches, once again community relationships and networks were already well established and these existing support structures could be called on to provide a network to the orphans. Dybdal and Daigle concur that NGOs with existing projects are in a better position to begin an intervention for orphans because, "relationships between the program and the community already exist thus facilitating the exchange of information and ideas and allowing the program to benefit from the…knowledge and understanding of the situations of families affected by HIV/AIDS and their communities" (2002b: p11).

In contrast, residential care programs were most often started by people with no previous experience in community development. For example, one founder of a residential care program described how he had been running a restaurant where he came into contact with street children, prompting him to establish an orphanage, "*in 1994 I was selling food at the market and kids would come up and ask for food scraps and I asked them why they were begging and they told me that they were very poor and orphaned. So I sold my restaurant for more than $2000 and built this orphanage in 1995*" (Residential Care Interview Transcript 1).

Another founder of a residential care program explained that he also had no community development experience before starting the orphanage, "*in the beginning I was a university student and a group of us were helping some street kids, giving them money and we thought that we should do it properly in the eyes of the government.*" [RCIT*2]. Neither of the residential care facilities run by the two interviewees quoted above had any previous formal community development experience.

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* RCIT: Residential Care Interview Transcript: see Appendices 1 & 2 for interview questions used and brief descriptions of the interview date, location and subject

Verhoef claims that development interventions for orphans have often been based on the assumption that informal care networks have been destroyed or are on the verge of collapse. In her opinion, NGOs do not spend time exploring the possibility that informal structures still exist (cited in Williamson, 2004: p40). This contention was supported by the finding that these residential care project founders did not appear to have significant relationships with people in the community networks that should be the first port of call in the care of orphans, such as the extended families of the orphans[22]. Thus it could be speculated that they were more likely to overlook these support mechanisms and seek to recreate their own. Williamson cites a program in Nairobi which found that when 200 single, HIV-positive mothers were asked who could care for their children if they became too ill to do so, half denied having extended family members who could provide care. However, after the social worker that interviewed the women developed a relationship with them, she discovered that most of the women had relatives from whom they had been estranged. The social worker was able to identify, in most cases, a grandmother, or other extended family members prepared to provide ongoing care for the children (Williamson, 2004: p9). In my experience the same situation occurs here in Cambodia and those without experience and community relationships will be more likely to overlook the existing support mechanisms.

Swift sums it up nicely in his comment that institutional responses are often "confused acts of power by individuals who wish to exercise benevolence" (cited in Tolfree, 1995: p226). Unfortunately, these 'benevolent acts' are too often undertaken in a vacuum of experience and relationships. As one orphanage founder puts it, ""*I do want to be needed. I think that's fairly normal in most women who don't have children. They've got all this maternal energy to give and nowhere to give it. I found a conduit for mine.*[23]"

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[22] However, when describing the admission procedure for orphans, it was common that extended family or even parents were involved. "*When our kids go to perform [traditional Khmer dancing] in the provinces, parents of other children see them and want to put their children in our orphanage. They come and meet the director.*" (RCIT1). This director indicated that most of the children he accepted into the orphanage had parents or at least extended family. It did not seem incongruent to him that he was taking on the role of parents to these children when their own biological parents were still living. Thus, although relationships could potentially have been established belatedly, it did not impact the approach taken.

[23] Residential Care Interview Transcript 5. This additional comment was taken from an independent interview reported on http://www.theage.com.au/articles/2003/11/08/1068243304513.html accessed April 2005.

Previous commitment to community-based approach

Three out of the six community-based care programs started in the same way, all commenting similarly that, *"the project came out of our AIDS homecare program."* (CBCIT3). It is worth noting that the AIDS homecare programs mentioned are also community-based responses. Therefore, a previous commitment to, and experience in community-based approaches had already been established well before the orphan intervention was initiated. Obviously, if an NGO is already taking a community-based approach, they are more going to be more likely to continue in the same course. Establishing this fact does not help in determining why a community-based approach was originally adopted, but merely suggests that once adopted, the ethos will carry over into new projects.

Possibly, the reverse scenario can also be assumed. If an NGO was previously committed to a residential approach, they would be more likely to continue to use the same approach in subsequent interventions. Thus, we see NGOs that have already built one residential care facility, expanding into different geographical areas by building a number of other residential facilities with the same model.

Holistic approach enhanced by NGO's other projects

The pre-existence of other community development projects run by the community-based NGOs means that key relationships and support networks are already in place to some extent. However, the benefits to orphan care are more extensive than just these networks and relationships. Since the NGO is more likely to be engaged in a range of development interventions, they are able to take a much more wide-ranging and holistic approach to assisting the community in their care for the orphans, *"I saw that the needs of orphans are interrelated with things like land issues for example"* (CBCIT4). The community-based NGOs already had a wide variety of development projects including micro-credit, nutrition, disability, women's health, birth spacing, income generation, etc. In support of this holistic approach Tolfree laments the, "compartmentalized approach to looking at care for children" taken by many development practitioners (cited in Williamson, 2004: p33).

The residential care project founders were generally unable to draw on a wider range of development interventions and experience in assisting the children. This would limit

the perceived options available to them in dealing with the children's poverty and other difficulties.

Greater likelihood of previous development learning

Also, while it was not mentioned specifically by any of the community-based care practitioners, it can be argued that a previous involvement in community development would increase the likelihood that some community development training had been undertaken. It would also increase the likelihood that the practitioner had previously come into contact with and possibly grappled intellectually with community development issues such as dependency, participation and empowerment. Having worked through these issues in the past would contribute to wiser, more informed development decisions in the future.

The evidence suggests that residential care projects such as orphanages are more likely to be started by groups that do not specialise in community development, such as churches and individuals. Since residential care interventions are more likely to be started by people inexperienced in community development, it can be surmised that these interventions do not benefit from the insights gained over years of working in community development, learning from successes and failures and undergoing training in key development principles (Save the Children, 2004: p5). Previous exposure to the development theory and literature specifically relating to the care of orphans is also much less likely. For example, one orphanage founder says, *"If I tried to do the work I'm doing now in Australia they would have said, 'Where is your teaching degree, your social welfare qualification, your nursing degree?' Cambodia let me work with its children and I love the country for that. It's given me a life that I couldn't have had in Australia.*[24]*"*

Contact with other NGOs

The community-based care projects were normally founded in the context of relationships with other NGOs whereas residential care projects were more often started in isolation from the learning that comes from seeing what others have made work.

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[24] Residential Care Interview Transcript 5. This additional comment was taken from an independent interview reported on http://www.theage.com.au/articles/2003/11/08/1068243304513.html

Community-based care project founders mentioned having at least heard of other NGOs doing community based care if not directly adopting and adapting these models for their own context. For example, one project founder related in our interview that she had, *"talked to many people, NGOs, missionaries, working with orphans in Cambodia..."* (CBCIT1)
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A rural community-based care project mentioned learning from other community-based projects that they had looked at. In particular she commented that they, *"went off things that we had heard from different folks like Halo and Bridge. Not modeling after those programs, but they helped point to areas to consider"* (CBCIT2). Another community-based program mentioned conducting informal interviews with a number of key informants saying they, *"went to see Project HALO, Glenn Miles at Tearfund, Sheila Reid..."* (CBCIT4).

Clearly, a great deal of learning can be gleaned from the experiences of others, and resources other than information may also be made available thus enhancing the quality of the intervention. For example, several community-based programs mentioned adopting the Memory Book developed by another program:

"we do HALO's emotion book with children whose parents die..." (CBCIT2)
"we have used the Memory Book a lot, our full time psychologist uses it a lot." (CBCIT3).

A second deduction can be made from the fact that the community-based NGOs are already more likely to be implementing community development projects. That is that they would be more likely to already be part of NGO networks such as Cambodian Cooperating Committee[25] and the Child Welfare Group[26]. These networks provide opportunities for cross-fertilisation of ideas and help disseminate important information such as new studies and reports. Access to these alternative ideas and extra information could be crucial in informing the process of deciding what intervention is likely to be most effective for the orphans.

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[25] an umbrella group for Cambodian NGOs which provides advice and information
[26] a network of NGOs working with children

One community-based care project founder mentioned that donors were able to provide some useful information with the added benefit of possible funding, saying she, *"also spoke to several donor agencies to see what their stance on the situation was. This opened doors to more examples as well as possible funding"* [CBCIT1]. However, donors vary in their ability and knowledge of good child welfare practices as well. Many donors, particularly religious institutions such as churches, private foundations and trusts, or wealthy individuals are not familiar with alternative care options (Williamson 2004: p16). Thus, donor education should be a component of advocacy on behalf of orphans.

In contrast with community-based care practitioners, residential care founders typically started their projects in isolation and with little or no reference to any other development practitioners. They generally did not mention consultation with other NGOs as part of their preparation process.

If other NGOs were visited, they were likely to be those NGOs that run orphanages, thus further reinforcing their chosen direction. For example, one residential care practitioner described how, *"at that [early] stage we went to see... Childhope Asia, who run orphanages, to see how they do it"* [RCIT3]. This shows that research into other NGOs' approaches to orphan care is not inherently useful but will be beneficial only if the models looked at are models of good or best practice. UNAIDS recommends identifying experienced NGOs and individuals (cited in Williamson, 2004: p18). Another residential care founder insisted that he had previously worked for a human rights NGO and therefore did not need to go and see what other NGOs were doing in the area of care for orphans. He asserted, *"we didn't go to look at any other NGOs because we already knew them from our previous jobs with other NGOs"* [RCIT5]. While this may have given him some general insights into community development and certainly made him more experienced than most other residential care founders, it would be unlikely to provide him with the insights needed to deal with this specific issue, particularly since he had long since left the human rights NGO and was working for an electricity company at the time. Again, the type of models looked at is the key, not the general fact that models are looked at.

Theme 2: Preparatory Research

Although Williamson raises the, "need for a comprehensive look at the literature on good child welfare practice to distil its key messages" (2004, px), the amount research carried out before starting the projects surveyed varied widely. Typically, seeing some of the needs of the orphans firsthand, a form of research, was the main stimulus for starting the project in both community-based and residential care projects. However, the community based care practitioners in general spent a much greater amount of time and effort in studying the context and various possible models of care.

One community-based care project founder seriously considered a number of approaches, including residential care, saying that they, "*saw a vast group of needs especially the needs of widows and orphans, and we thought how can we help. So we went around asking... We thought about group homes, building large orphanages. We saw that Cambodians already have a habit of taking orphans into their homes traditionally in Cambodian culture*" (CBCIT4).

Another community-based care project founder described a comprehensive survey her NGO conducted before embarking on their new project for orphans and vulnerable children:

"*Before starting this project, six of us did a three months survey, to know and understand more about what the community values and holds important, to understand more deeply about the culture. We interviewed lots of monks and went to talk to 15 other NGOs working with kids, we talked to poor people in the city and several provinces. We consulted with several ministries and took part in seminars.*" (CBCIT6).

One community-based care founder admitted that, "*I can't say we did any research*" (CBCIT3). However, knowledge of the NGO in question and their years of experience in community development would mitigate this statement. Even if no formal research was carried out, the intervention would have been well informed by the knowledge already gained by implementing other related community development interventions over a significant period of time.

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Some interviewees conducted research on the internet and found useful contacts and information in other parts of the world. For example, this community-based care founder described her thorough research conducted on the internet and by email:

"I searched the internet for those working with HIV/AIDS orphans, most of that information came from Africa, an excellent contact was someone from VIVA network who put me in email contact with people doing community-based orphan care. As I made contact with the program directors and asked them to send me information about their programs, I was greatly more optimistic about the possibility of community based care working in Cambodia even though others didn't do it or believe in it" (CBCIT1).

There is a wide variety of information about appropriate ways to care for orphans available on the internet that can now be accessed in numerous internet cafes for less than half a dollar an hour in Cambodia. The learning that can be gained from distant places such as Africa is readily available now in almost any place on earth thanks to the internet. However, it should be noted that many of the programs were started in the mid-1990's when internet access was not widely available in Cambodia.

Another community-based care project founder also used the internet to conduct research on different approaches. He did not mention seeing any of the more theoretical information available. Instead, he seemed to have paid more attention to actual examples of projects:

"We did lots of searching on the internet. We found a number of sponsorship programs on the internet but we didn't want to compete with these. We looked at ways that people were supporting orphans, on the internet" (CBCIT4).

Not only was the preparatory research conducted by community-based NGOs likely to be more wide-ranging, it was also likely to have lasted longer. The, *"three months survey"* (CBCIT6) described above was typical, through to the longer periods of time described by another practitioner who said they, *"spent around six months researching looking at a number of things"* (CBCIT4).

In contrast, residential care practitioners did not report carrying out a great deal of research. Too often, no research was conducted. Amongst those surveyed, none knew how to use the internet and thus access to information from outside Cambodia was severely limited. For example, one residential care practitioner admitted that, *"before opening the orphanage I didn't contact any other NGOs. I don't know how to use the internet"* [RCIT1]. Several others also reported not knowing how to use the internet. Empirical evidence of orphanages with high quality websites would suggest that this lack of technological proficiency is not representative of all residential care projects founders and may in fact suggest that those surveyed were less adept in research skills than the general population of residential care founders. This potential area of bias should be identified as a possible limitation.

The length of time spent researching was likely to be negligible. One residential care project founder stated that he, *"spent about a week researching"* [RCIT2]. This lack of research would have severely limited exposure to development theory on the care of orphans. It is unlikely that in a week he was able to come to an understanding of poverty and dependency issues, sustainability, community participation and empowerment or any of the other important development concepts for working in this area (Williamson, 2004: p44).

One of the most significant explanations that can be offered here for the differences is that residential care project founders are more likely to be Cambodian and community-based care founders are more likely to be foreigners. Of six residential care founders surveyed, five were Cambodian. This ratio is consistent with the ratios of local to Cambodian run orphanages in Phnom Penh and can thus be considered representative of the general population. The reverse ratio is true for community-based care projects. Of six project founders interviewed, five were foreigners. These projects represented the majority of community-based projects currently in existence in Cambodia.

Thus, a number of the differences noted could be cultural. The influence of this factor on the survey results should not be underestimated. For example, foreigners, generally coming from a higher socio-economic background, would have greater access to the internet than Cambodians and thus greater access to the development literature. Foreigners would be more comfortable with English language as a communication

medium, thus giving greater access to international NGOs and the various studies and literature which are invariably in English and rarely available in other languages (Lie 1999: p7).

Foreigners would be more likely to be familiar with the fact that residential care is no longer in favour in the developed world. Williamson alludes to this in his comment that, "Some organizations in western countries, with good intentions, still export the kinds of residential care that their countries no longer use, including traditional institutional care and children's villages" (2004: pix).

It appears incongruous that traditionally Cambodians have cared for their orphans within the community and extended family networks, yet Cambodians are often now more likely to opt for residential care, a foreign import. Although, some of these perceptions will be examined cursorily within this thesis, further research should be done to examine current Cambodian cultural perceptions of residential care versus community-based care.

Theme 3: Prioritising Needs

Both community-based and residential care practitioners tended to place a greater emphasis on the physical and educational needs of the children than on the psychosocial needs. However, the weighting of these priorities was different.

Physical Needs

Residential care practitioners frequently reported that poverty is the main reason for acceptance into the project. This tendency is identified in the development literature (Dybdal and Daigle 2002a: p16, Williamson, 2004: p13). Thus, a heavy emphasis was placed on meeting the physical needs of the orphans for food, shelter and clothing.

For example, one residential care project founder reported an almost passive approach to accepting children into his orphanage on the sole basis of their physical needs, admitting, *"they have parents but they don't have enough food so the parents saw our place and they sent their children to be with us"* [RCIT1]. The most commonly reported reason for admission into this orphanage and in several others surveyed was parental

poverty. Clearly, the parents were complicit in placing their own children in residential care, believing that their children's educational and physical needs would be better provided for. Sadly, research shows that while adults emphasize the material capacity of a family to care for an orphaned child, children are much more concerned about being cared for by adults who would love them (Williamson, 2004: p47).

The commitment of development practitioners to maintaining family ties will be discussed in more detail later but at this point suffice to say that decisions on admission of the children seem to have been made purely on the basis of physical and educational needs rather than the psychosocial need of a child to grow up in a loving family environment.

Tolfree concurs that what is, "depressingly widespread in the developing world is a model of institutional care which responds only to the children's physical needs" (1995: p64). The persistence of this attitude is understandable because the tangible and the concrete is more easily understood than the abstract and the intangible. The provision of food, clothing, shelter and education is tangible, measurable and easily shown to donors. Whereas, dealing with grief, psychological distress and behavioural difficulties are less tangible activities, difficult to measure and difficult to show to donors.

The intangible and complex nature of psychosocial needs may render them beyond the ability and professional experience of many development practitioners. This shortcoming is recognised by a joint UNAIDS and UNICEF publication, which says, "since psychosocial problems are sometimes poorly understood or difficult to assess, they are often not adequately addressed by programmes" (UNAIDS/UNICEF, 2004b: p16). However, this complexity just further highlights the need for mutual learning and a greater commitment to research into development theory and relevant literature and drawing on the resources of other NGOs as mentioned previously.

In contrast, the community based care practitioners were unlikely to recognize poverty as a good reason for removing children from the community and worked instead to alleviate the source of the poverty. This was achieved through the variety of development interventions mentioned previously such as microcredit, vocational training, income generation etc.

Several community-based care practitioners mentioned the increased cost-effectiveness of community-based solutions saying, *"it is more economical to keep children with their extended family"* [CBCIT3]. Although no-one made the link, these resources which are freed up by taking a community-based approach can then be invested back into the community in order to relieve the poverty of other families, thus reducing the demand for orphanages even further. Save the Children agree that, "in general, limited resources are often used to provide rescue centres, shelters or children's homes instead of providing assistance to support children to remain in family care" (2004: p14). Williamson concurs that "residential care is much more expensive per child than supervised fostering or local adoption, and any available resources can be used to provide family and community-based care for many more children than they can through building more institutions" (2004: pix).

Thus, all the community-based care projects surveyed were planning or had already implemented an income generation component for the adult care givers and/or parents. For example, one project made quilts, another made greeting cards, yet another made bamboo furniture. Others were actively planning an income generation component, such as this practitioner who foresaw that, *"in the future we hope to see this integrated with...income generation in each community"* [CBCIT4].

Residential care facilities also implemented income generation activities. For example, one orphanage trained the orphans to give traditional dancing performances and another made handicrafts for sale. The objective of these income generation activities was quite different however. Community-based income generation activities directly strengthened the capacity of the community to cope, whereas, residential care income generation activities met the needs of the orphanage to pay for overheads and other expenses. While the former met the needs of the community, the latter met the needs of the NGO. Etzioni points out that this is common amongst residential care NGOs, "once formed, organisations acquire their own needs, these sometimes becoming the masters of the organisation" (cited in Tolfree, 1995: p49). Tolfree goes even further in saying that the needs of children have become a secondary consideration in many of the institutions he visited (1995: p49). In one facility visited more than once over the course of a year for this research, it was very doubtful whether the funds raised were

invested back into the orphanage since the orphanage seemed to be kept in a constant state of disrepair despite large amounts of donor money flowing in.

Psychosocial Needs

The willingness to take children into a residential care facility solely on the basis of poverty with little or no regard for the psychosocial needs of the children is a major concern. Psychosocial needs were too often ignored or left unmet in many residential care projects. Tolfree concurs that, "a great deal of residential practice...suggested a lack of knowledge of child development and children's psychological needs. In many cases, this lack of knowledge was extreme, evidenced by the existence of models of care in which the meeting of physical needs (not always satisfactorily) and the maintenance of order were the primary or sole objectives being pursued" (1995: p63).

One orphanage was able to report some counselling and values guidance saying, *"we have other development programs apart from the orphanage such as... moral training... counselling"* [(RCIT2)]. Others provided dancing lessons and spiritual education, normally according to the religion of the project founder. However, these activities are grossly inadequate in dealing with the complex issues arising from bereavement and separation from family and community.

Community based practitioners were more likely to report initiatives taken to address the psychosocial needs of the children, though many also acknowledged a lack of confidence in addressing this area of need. For example, one community-based project founder lamented that, *"as a program I don't know how deep we can go into the psychosocial issues. We see it as integrated program with the church. It is difficult to get accurate info on the social circumstances of the children. The neighbours tell us one story, the family tell us another story and the pastor tells us a different story again"* [(CBCIT4)]. Although, he was unsure of how to meet the psychosocial needs directly through the program, this practitioner had obviously given the needs some thought and was relying on the local church pastor to provide emotional and spiritual support and counselling. Wider access to the entire support network of the community is one of the benefits of community-based care, whereas the onus is on residential care providers to provide for the full range of needs of children within the project. This observation matches the findings of Chernet (2001) who found that orphans in residential care in

Ethiopia developed a dependency on the adults at the orphanage to meet all their needs. In many cases, children were not given even minor responsibilities while in the orphanage (cited in Williamson, 2004: p51).

For this reason, there is markedly less pressure and responsibility on the community-based care practitioners to meet every need of the children. Nevertheless, when asked about psychosocial interventions one community-based project founder was able to describe a range of activities designed to assist the children with their cultural and spiritual needs as well as emotional wellbeing with some success:

"We have art classes and dancing classes for them. We try very, very hard to ensure that each child is receiving a religious education in the tradition that their parents choose for them. We take them to the pagoda or to the church. We have used the Memory Book a lot, our full time psychologist uses it a lot. She's finding it very helpful and the kids find it very helpful" [CBCIT3].

There are cultural issues at play here as Cambodian society is majority Buddhist and does not highly value emotion. There is a widespread belief that orphans (and others) should never be encouraged to express their sad feelings as this will simply intensify their sorrow. Suppression is the favoured means of dealing with feelings of grief in Cambodian society which can lead to increased mental health problems, alcoholism and domestic violence. As mentioned previously, most of the community-based care projects were using the Memory Book, a tool developed by child psychologists to help children discuss and deal with their feelings surrounding bereavement and contextualised for use in Cambodia At least two of these projects were also participating in a Big Brothers program which matches up young Cambodians aged 18-29 with orphans for encouragement, role modelling and mentoring. These two interventions have been shown to be very effective in relieving psychological distress and the higher rate of adoption amongst community-based care projects indicates a greater commitment to the psychosocial needs of the orphans.

In general, greater attention was paid to the psychosocial needs of the children in community-based projects. For example, a community-based project founder shared her own understanding of the needs facing these children saying, *"personally I believe*

the greatest need these kids have is someone to look up to and aspire to become. I see this being done through mentoring... emotional and spiritual support. I think our kids need to know that they are still truly loved and they have a great future ahead. Through the peer mentor, big brother and sister program within [the project] children are able to have an older person to look up to and rely on and be encouraged by them too. I think they deserve a break from worries of their life now and then" [(CBCIT1)].

Meeting the psychosocial needs of orphans is not something that can be easily measured. However, the community-based projects surveyed were inherently more effective in this regard since they were able to draw on the existing support networks within the community such as extended family. Furthermore, the community-based development practitioners themselves demonstrated greater understanding and commitment to meeting psychosocial needs by using mentors, the Memory Book and psychologists.

Educational Needs

A heavy emphasis was placed on education by both the residential care providers, and the community based care practitioners. This finding matches the observations of Dybdal and Daigle (2002a: p16).

Several researchers have attempted to investigate the impact of orphanhood on children's school attendance but results have been inconclusive. Some have found orphans to be systematically disadvantaged, while others have found little or no association between enrolment and orphan status. The World Bank concluded in 2002 that the impact of orphanhood on school enrolment is unclear. In contrast, an earlier UNAIDS report found that orphans who do not receive support are disproportionately likely to drop out of school (2000d).

In general, the residential care providers interviewed were very concerned that the children receive a good education and reported that many parents who chose to place their children in the residential care facility also viewed it as a good option for the schooling of their children. The residential care providers saw that education was one of the major components of their care for these children and thus put a lot of energy into arranging schooling and training options for their children. For example, a residential

care project founder explained that, *"after opening the orphanage we contacted UNICEF and Friends NGO to provide training for our children"* [RCIT1], and another said, *"we... send them to study or do vocational training"* [RCIT2].

A Save the Children report states that, "where residential care offers better standards of material care than can be provided in ordinary homes, children or parents may see it as the best option, or are persuaded that this is in the child's interests, in particular by the promise of education. In poor countries, this can attract inappropriate placements, and be a factor in sealing long-term institutionalisation and gradual loss of contact with the home environment" (2004: p12).

The community-based care project founders also placed a heavy emphasis on educational needs. Some explained that the project had been founded as a direct response to the educational needs of orphans. For example, one practitioner explained the centrality of education to the project in this way:

"our major focus is education but in the context of living, because they need food... I was responding from my own personal experience of meeting so many children who have never gone to school or who have gone to school and stopped, they were far from being literate or having basic numeracy. In our day and age children who have no education will be slaves of the worst kind the world has ever known. There will be so many looking for the most menial of jobs" [CBCIT3].

This response highlights the widespread perception that education is one of the keys to escape from the poverty cycle and thus one of the most important needs that must be met in order for orphans to do well in life. In Cambodia, education is officially free for all children. However, unofficially, most teachers require daily payments from students for everything from handouts to extra tuition (which is necessary in order to pass the exam). Many orphans and vulnerable children find these costs to be an obstacle to school attendance and drop out or never attend. As a result, Cambodia has very high rates of illiteracy and those few who are able to gain a good education benefit from greatly enhanced career prospects. For many parents trapped in poverty, gaining admittance for their children to an orphanage would be akin to parents in the West gaining acceptance for their children to an exclusive boarding school. Bulkenya

observed that a similar attitude was found in Uganda, "Ugandans accepted these institutions because they were believed to emulate the boarding schools that the British had introduced to educate the Ugandan elite" (cited in Williamson 2004; p25).

Thus, another community-based care project includes education as part of the vision statement, "*[we want to] assist these children in getting an education so that they will be able to have a better chance for a future,*" [(CBCIT2)], and described the interventions that meet this need, including a mention of advocacy on behalf of the orphans regarding the unofficial school fees collected by teachers: "*we are here to support the families that we serve. If they need help in caring for a child so far we have bought school books, uniforms, helped with registration and met with school leaders to not take fees daily*" [(CBCIT2)].

Another community-based practitioner mentioned the impediment of school fees, explaining that their, "*aim is to see all the children go to school wherever possible as well as help pave the way where obstacles stop children going to school [like having to pay] money to teachers for school fees*" [(CBCIT1)]. This project spends at least 25% of the budget on the educational needs of the children, mainly to cover the unofficial school fees demanded by teachers.

Because community-based care practitioners are usually reliant on the public school system they experienced greater difficulty in meeting the educational needs of the children. This was compounded by the fact that family members did not always place such a high value on education. One practitioner lamented that, "*sometimes the parents don't see the value of going to school. We simply say you are not in our program because this program is for children who go to school. We say we didn't throw you out, you threw us out. But if you ever do want to study again, then you can join our project again*" [(CBCIT3)].

As described above, greater creativity is often called for in a community-based setting where there are more stakeholders and the authority does not necessarily lie with the NGO. While some researchers have shown orphans to be at risk of delayed enrolment, poor performance and dropping out, there is no clear evidence to suggest that these rates are higher than in non-orphaned children living in poverty (Kinghorn, Coombe, McKay,

and Johson, 2002). Ainsworth and Filmer contend that though there are some special factors impacting school attendance among orphans such as hefty domestic or caregiving responsibilities, and grief, most of the reasons that poor orphans are not in school are the same as those that prevent other poor children from attending (2002). This explains the presence of so many non-orphans in residential care.

Theme 4: The Role of Family and Community

Orphanhood as criteria for acceptance

Neither the community-based care projects nor the residential care projects were unanimously strict about orphanhood as criteria for acceptance into the program.

From the perspective of some development theorists, limiting a community-based project to serve only orphans only increases stigmatisation (Save the Children, 2004: p5). A joint UNAIDS and UNICEF report concurs that, "targeting specific categories of children can lead to increased stigmatization, discrimination and harm to those children" (UNAIDS/UNICEF, 2004b: p28).

In general, the community-based projects tended to be more tightly focussed on a certain target group. In fact three of the five community-based interventions surveyed targeted only children affected by AIDS. Some reported tightening their acceptance criteria. For example, one practitioner stated categorically that, *"this project is for children whose parents are infected with AIDS. In the beginning we took a few desperately poor kids but we don't want to get to the point where we have to turn people away"* [(CBCIT3)].

Interestingly, this is the only major area in which a gap was identified between the practice of community-based care projects and the literature. Since these projects mainly target only children orphaned by AIDS, the literature would suggest that the projects are contributing to the stigmatization of these children because they will be more easily identified as affected by AIDS through the NGO's visits. When asked why there appeared to be a gap between development theory and practice in this area, a community-development practitioner reasserted that "*AIDS orphans*" are their target group, that they are not necessarily identified by the community as affected by AIDS,

but just as orphans and finally commented that *"there are far too many vulnerable children in Cambodia to deal with them all"* [(CBCIT3)]. From this response it seems that there are two major reasons for this gap. Firstly, it is likely that the specialisation is simply the result of an attempt at dealing with the reality of limited resources, as mentioned above also. Secondly, the practitioner disputes the position of the literature and claims that stigmatization is not increased because the community is not necessarily aware of why the child is being assisted.

However, others reported widening their acceptance criteria. For example, one practitioner explained that, *"actually the program started out as just for pure orphans but then we switched to look at children at risk. To avoid the jealousy. We were supporting an orphan family that was less in need than another family that had both parents but was more dysfunctional"* [(CBCIT4)].

Some targeted children from a wider range of backgrounds right from the beginning. Some children had lost both their parents, some just one and others had just experienced divorce. For example, in describing one community-based project, the founder explained that, *"there are not a lot of double orphans, but there are a lot of single orphans or children whose parents have separated. We treat them like all the other children in the community and let them know that they have people who love them"* [(CBCIT6)].

The residential care programs in general had a much wider acceptance criteria though. Tolfree, in his study of dozens of residential care facilities noticed, "the tendency for institutions to admit children whose circumstances and needs fall outside their formal (or assumed) admission criteria" (1995: p49). For example, in one orphanage the founder described the backgrounds of the children by saying that, *"the main problem is that the parents have split up, or secondly they make their children work to earn income for the family or thirdly they are victims of domestic violence."* [(RCIT5)],

Others identified parental poverty as a major issue, admitting that, *"they have parents but they don't have enough food so the parents saw our place and they sent their children to be with us. Others are naughty and their parents sent them to us"* [(RCIT1)].

As mentioned above, poverty was the most common reason for acceptance into residential care. The proportion of children in residential care who had lost both parents was startlingly low. In one residential facility, *"out of about 20 kids only three are double orphans"* [RCIT5], and in a larger orphanage, *"of 114 children about 20 are double orphans"* [RCIT1].

Miles and Stephenson observe that, "an 'orphanage' implies residential care only of children that have no parents. Yet it is rare to find children [in these facilities] with no parents or extended family" (2001: p12). In fact being orphaned is one of the least likely reasons for being placed in an orphanage in Cambodia. It is interesting to note the words of one orphanage director acknowledging that, *"most of the children in the orphanage have parents, about 80-90%. The main problem is that the parents have split up..."* [RCIT5]. And another residential care founder acknowledging that, *"when our kids go to perform [traditional Khmer dancing] in the provinces, parents of other children see them and want to put their children in our orphanage"* [RCIT1].

These proportions beg the question: why are the biological parents not caring for these children? Some of the answers are mentioned above: divorce, domestic violence, abuse, and many of these cases may be assumed to be genuine. However, the overwhelming majority placed their children in residential care solely because of poverty.

Since the development literature supports community-based projects as being useful interventions, their proliferation and growth to serve greater numbers of children should be viewed as positive. In fact, their potential to reach large numbers of children was apparent from the projects surveyed. One project was reaching over 800 children affected by AIDS and another was reaching over 400.

However, the development literature overwhelmingly views residential care as a harmful influence in the lives of children. In fact, a study by Save the Children states that children should be defined as "at risk" and "vulnerable" solely on the basis that they are in residential care, observing that "many features of residential care are an abuse of children's rights" (2004: p1). Thus, the proliferation or growth of residential care projects can only been seen as negative. This includes having acceptance criteria which allows children into the facility who have no appropriate reason or need to be

there. "All too often, residential care is seen as 'the solution', without an exploration of 'the problem', and children are admitted on an indeterminate basis" (Tolfree, 1995: p51). Luckily, by their institutional nature, residential care facilities lack the infrastructure to care for large numbers of children without huge financial resources. Thus, there is a natural constraint placed by the scarcity of resources on their liberal acceptance criteria. Of the residential facilities surveyed, only one catered for more than 100 children and most were less than 50.

Commitment to maintaining family and community connections

Williamson explains that, "the literature includes an abundance of research and expert opinion backing the belief that the family best provides for children's needs, and that the prevention of family breakdown will best assist children...throughout childhood" (2004, pxiii). Hence the observation that maintaining the family unit was not perceived to be high on the list of priorities of residential care providers caused some concern. As detailed above, all reported a general willingness to separate children from their biological parents and other relatives. The UN Convention on the Rights of the Child specifies the right for children to maintain "personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests" (Article 9).

Residential care practitioners were sometimes contradictory in their statements about the existence of extended family. For example, one orphanage director claimed that, *"the kids here don't have any extended family, their parents live far away"* [RCIT1]. However, later he admitted that extended family would have to be consulted if he were to release the children into foster care.

Whatever the case, it was obvious that the vast majority of children living in these residential care facilities did have extended family. During one visit to an orphanage during a Khmer religious festival, at least half the children were reported to be away visiting family. While this maintenance of the extended family contact is commendable, it raises the question of why these families, who can be trusted to look after their related children for several days at this time, could not be supported to care for them full time. Tolfree notes that, "institutional care detaches children from their families...This has extremely serious implications in societies in which the extended

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family, and possibly community systems, provide the principal sources of support throughout adult life" (1995: p74).

In contrast, all the community based care practitioners reported that it was extremely important to them that children stay with their families and communities. This attitude is in harmony with the conclusions of the development literature that that identity and social integration are based on a child's sense of belonging, not only to a family, but also to the larger community (Williamson, 2004: p4).

For many community-based care interviewees this objective was an integral part of a vision or mission statement. For example: *"To keep kids from having to be separated from their extended family or community."* (CBCIT2). Another put it more colloquially, but just as forcefully, saying, *"children staying with their family and community is the bottom line for us"* (CBCIT4).

When asked why she had chosen not to take a residential care approach, one community-based project founder said she, *"didn't need to. Most children, all so far actually, have been able to be absorbed into the extended family or community"* (CBCIT2). From this statement it is clear that residential care is perceived as only acceptable when there is no extended family available, in stark contrast with the practice of most residential care practitioners.

Community-based care project founders were strongly committed to the principle of keeping children in their communities. One practitioner rationalized that they, *"wanted children to be integrated into a community, we didn't want to make a separate community"* (CBCIT4). Others were able to articulate a number of reasons why this was preferable such as, *"it is better to keep the children with their own family then they know where they come from, as adults they have relations and their children have relatives"* (CBCIT3). This commitment is in harmony with the development literature on this subject (Bowlby 1951: p13; Dybdal and Daigle, 2002a: p96; Foster 2004: p84; Williamson 2004, p28).

However, the community-based care interviewees were not blind to the potential difficulties that could arise from keeping children in their families and communities.

For example, one practitioner stated emphatically that placement, *"has to be [with] an extended family that is nurturing. The other side is that if you put them with extended family they have more control than you do. For example, if the child is not going to school. Sometimes the parents don't see the value of going to school..."* (CBCIT3). The control issue was not mentioned by anyone else but presumably is a strong factor in the decision to embrace residential care as implied by this comment: *"If they are just staying with grandparents then its cheaper but we can't achieve good results. So we should put them all in one place"* (CBCIT6).

Hence, a key difference between residential care and community-based care is where the authority over the children lies. In residential care that authority is in the hands of the NGO. The NGO can wield all the power necessary to ensure quality control in the provision of education, nutrition, discipline, and other services. In contrast, community-based care by nature, is empowering of the community, and that means a loss of control. Access to education, nutrition, hygiene, discipline, everything, is in the hands of the care givers in the community. Only in cases of abuse or neglect does the NGO have a legal right to intervene. Thus, quality control is harder to achieve and in fact can only be obtained through a much more participatory approach. Clearly, that lack of control is an important factor for some in the decision to opt for residential care over community-based care.

The quest for a high quality service to orphans need not be compromised in community-based care and unlike residential care, the benefits accrue to the whole community, not just the children in the project. For example, one NGO runs a nutrition program alongside their community-based orphan project. Entire communities are reached by this approach since learning is passed on from neighbour to neighbour and the project works with family units, which can include up to twenty people. Likewise, toilets that are built for a family looking after orphans benefit not just the orphans but the surrounding community as well through reduced waste and increased latrine access for a number of people. So perhaps it may be noted that while the physical needs of orphans may be more difficult to meet in the community, when they are met creatively, the benefits can be much more widespread (Williamson, 2004: p33).

Contact with the community

There were only a few exceptions whereby children in residential care had outside interaction. For example, one residential care director described how his staff, *"get [the orphans] placements as apprentices in the market with motorbike repairmen and other jobs so they will learn how to do work"* [(RCIT5)]. However, many residential care project founders were fearful about the influence of the community on the orphans and were quite clear about their policy of separation. Save the Children explain this attitude by pointing out that, "the global use of residential care is often underpinned by a belief that if children are removed from undesirable influences in their homes or environment, given training, and subjected to strict discipline, they will somehow turn into 'model citizens'" (2004: p15). For example, one orphanage director was fearful because, *"kids around the outside of the orphanage use drugs like glue and amphetamines, so we keep our kids in the centre so that they are not in contact with those children outside"* [(RCIT1)]. This situation matches Tolfree's observation that, "a common characteristic of residential institutions is that they tend to be isolated from the community in which they are located" (1995: p75). Well resourced facilities with their own schools give even less opportunity for the children to interact with their communities. So Miles and Stephenson suggest that in order to avoid isolation it is better for children to, "attend local school and church rather than being in the institution for such activities" (2001: p24).

This situation reflects the common pitfall described in the development literature, whereby children in residential care are raised in an environment which does not prepare them for life as adults in the community and leads to an increase in the level of stigmatisation (Tolfree, 1995: p75; Save the Children, 2004: p3).

Belief in Community Capacity

Underlying a commitment to maintaining family and community ties is a positive attitude towards the community's capacity and ability to care for orphans. There was a divergence between residential care practitioners and community based care practitioners in their perception of the capacity of the community to provide for the orphans.

Studies by Goldfarb (1943), and Klackenberg (1956) confirmed that a good foster home is preferable to residential care, but that the child must stay long term with the same foster parents (cited in Lie, 1999: p169). However, the residential care practitioners reported feeling suspicious about the intentions of potential foster parents[27] and also the capacity of parents to care for their own children. For example, one residential care director warned that, *"if foster parents want to sponsor the children to stay here then good, but we can't trust them to take the children to live with them. They might sell the children."* [RCIT1]. In fact some residential care project founders seemed shocked or surprised at the suggestion that the children in their project might go to live with foster parents, asserting that, *"sometimes there is abuse and exploitation"* [RCIT5].

The reasons given by interviewees against foster care are twofold, distrust of the motives of the potential foster parents as described above and also the lack of agreement of the children. For example, one practitioner maintained that, *"the children don't really want to go because they don't know the foster families. They want to stay here because they know everyone here. Some foster parents even came here with gifts and jewellery and the children still refused to go. The foster parents were very angry with me, accusing me of being a liar... The children refuse to go to foster families. A lot of people have come to ask, rich Cambodians, but the children don't want to go"* [RCIT1].

Some residential care practitioners claimed that they would be open to adoption if the difficulties were surmounted, asserting that, *"if the children want to go then its no problem but we don't force them. We would have to get permission from the extended family who placed them here"* [RCIT5]. A couple mentioned that getting legal authority from the government to hand over the children would be an issue. For example, professing that they, *"would be open to sending the children to foster families only if it was all legally OK and if the children agreed"* [RCIT1]. Clearly, despite the rhetoric, none were being proactive in this area, indicating a generally negative perception of the ability of others in the community to care for the children in a family environment, and an unsupportive legal framework for adoption.

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[27] the word used for "foster parents" in Cambodian – "oubook m'dai jenjim" – is ambiguous and may refer to long term adoptive parents as well as short term care givers or even financial sponsors

Tolfree observed that, "in some cultures there is a danger that foster children are treated less well than other children in the household. On the other hand, negative attitudes to caring for unrelated children can and do change, and such cultural attitudes need not necessarily be an insurmountable barrier to the development of fostering" (1995: p196).

Certainly, the risk of placement with foster parents with bad motives is real but the idea cannot be written off as impossible to implement just because there are dangers. It has already been proven to be effective in several community-based projects. For example, one practitioner described his modest experimentation with using foster families saying that they, *"have a number of children in foster care and we give them a stipend. About five foster families"* [(CBCIT3)].[28]

In contrast, community based care practitioners reported much more positive feelings towards the capacity of the community to care for orphans. For example, it was common to hear sentiments such as this: *"we saw that Cambodians already have a habit of taking orphans into their homes traditionally in Cambodian culture"* [(CBCIT4)]. The same practitioner also stated that their, *"research showed that Cambodians already have a mechanism for caring for the orphans in their society"* [(CBCIT4)]. Again, this attitude is in agreement with the development literature on this subject (Bowlby 1951: p13; Dybdal and Daigle, 2002a: p96; Foster 2004: p84; Williamson 2004, p28).

The community-based care project founders did grapple with the difficulties inherent in trusting the community. For example, one community-based care founder told how they, *"thought about two issues, one was how can be sure that we can trust them and that they will use the money properly and secondly how can we avoid dependency"* (CBCIT4).

All four community-based development practitioners were positive about the ability and willingness of the community to care for orphans, pointing out that, *"in many cases, [the community and extended family] were helping before the parents died and actually after the parents have died..."* [(CBCIT2)].

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[28] Parry provides a set of useful guidelines for protecting against possible abuse, neglect, or maltreatment of children placed in a foster situation (cited in Williamson, 2004: p30).

However, many of these community-based practitioners acknowledged the fact that the coping capacity of the community is often severely limited by a lack of resources. For example, one recognised that in the poor communities in which he worked, *"they are day labourers. On one hand they don't have much capacity but if you can help them, they are more than willing to help their relatives. Many of them if we can help them minimally they are willing"* (CBCIT3). The general attitude of the community-based care project founders could be summarised by saying that the community is difficult to work with, poor and lacking in financial capacity, but that in the long run it is the best solution.

The well known adage about the glass being half-full or half-empty is applicable here. For residential care project founders, dubious about the ability of the community to care for orphans, the glass is half empty – the community does not have the capacity and there is no reason to invest or build up that capacity. For community-based care providers, positive about the ability of the community to care for orphans, the glass is half-full – the community may not have the capacity right now, but with a little assistance and investment, that capacity can be built up (Foster, 2004: p66).

Concluding Comments

This analysis of the primary data has yielded some interesting results. Many of the reasons identified for the gap between development theory and practice are mentioned in the literature, such as the overemphasis on physical and educational needs. Others are merely hinted at or not covered at all, such as the relative isolation and lack of experience of residential care NGOs. In the next chapter, I will move beyond data analysis in order to draw out some lessons and suggestions for narrowing the gap and informing future development practice.

CHAPTER 5: OUTLOOK

Thus far, I have reviewed decades of research critically evaluating and comparing residential care to community-based care. The bulk of the literature pointed to the inadequacies of the residential care approach, particularly in meeting the psychosocial needs of orphans. A community-based approach to orphan care was found to be more in keeping with development principles such as empowerment and participation, better at meeting the psychosocial needs of orphans and vastly more cost effective.

I then examined the Cambodian context in particular and described the development interventions that are being implemented to care for orphans. Both residential care and community-based models of care were found in Cambodia. I interviewed development practitioners, founders or directors of orphan care projects, in order to ascertain why they chose either a residential or community-based model of care. From their answers I was able to identify four key themes, which shed light on the process and motivation behind the establishment of these interventions.

Essentially, there were some key differences between those who had established residential care interventions and those who had established community-based care projects. Residential care facilities, such as orphanages, tended to be started by practitioners with less development experience, less contacts in the field of development and with less initial research. Residential care practitioners placed a high emphasis on education and meeting the physical needs of the orphans but were less likely to consider the psychosocial needs of the children. In contrast, community-based care practitioners affirmed the importance of education and the meeting of physical needs but placed an equally high emphasis on meeting the psychosocial needs of the orphans. Finally, community-based care workers maintained a belief in the capacity of the community to care for orphans and thus prioritised keeping the children within their own family support network. Whereas residential care workers were more likely to be suspicious of community and family efforts to care for orphans and were more ready to remove children from the community.

At this final juncture, I wish to pull together some of the lessons learned and point the way forward to better practice in the future. In this way, I hope that the gap between rhetoric and reality, the disconnection between development theory and practice in the care of orphans, will be eventually narrowed.

Each of the themes identified in the previous chapter will be examined individually and a number of related suggestions made under each theme on how to close the gap

Theme 1: Community Development Context

Relationships form the basis of a successful development intervention and over time yield important experience and insights. Clearly, community-based care practitioners have benefited from their previous community development experience and networks of relationships as would be expected, in a number of ways. Miles and Stephenson have argued that in development interventions targeting orphans, "priority [should be] given to building relationships – with the child, family, community, organisation or institution and between agencies" (2001: p19). Thus, my suggestions for improving the community development understanding of practitioners working with orphans begin with relationship-building.

1. Building Community Networks and Relationships

The first advantage of previous development experience identified is the establishment of networks of community relationships. These relationships form the basis of the proper response to orphanhood and should not be underestimated (Bowlby 1951: p13; Dybdal and Daigle, 2002a: p96; Foster 2004: p84; Williamson 2004, p28). Evidence suggests that residential care providers generally only begin these relationships when parents and extended family make contact with the residential care facility in order to place their children. An intentional effort must be made by residential care practitioners to work with those who form the support network around the children. Miles and Stephenson concur that, "initiatives to create bridges with the local community and wider society from an early stage [need to be] emphasised, to enable children to move successfully out of institutional care" (2001: p21). In most cases, the family members and communities themselves underestimate their own importance in the lives of their children. They are aware only that their own efforts to meet the physical and educational needs of these children seem inadequate. This is where the NGO can play a

crucial role in helping the family to see that they are indispensable (Foster, 2004: p66). Relationships take time and no development practitioner should expect to solve complex problems in one meeting. Yet, relationships are worth the time investment, since community development can only take place in the context of relationships. Clearly, even an NGO with no previous community networks can, with a strong commitment to building relationships, establish these over time (Miles and Stephenson, 2001: p19). However, it should be acknowledged that this relationship building will take greater time and resources than mere service delivery. Dybdal and Daigle acknowledge these difficulties in starting from scratch pointing out that, "for an organisation starting a similar program of alternative care, the establishment of linkages with communities …would represent additional time and resource requirements" (2002b: p11). Despite this cost, in time, energy and resources, every effort should be made to invest in these community relationships in order to identify and strengthen existing support networks, which contribute to orphan care.

2. Investment in Community Development Learning

The second benefit of previous development experience is the insight and learning gained over many years of community development practice. Related to this are the training opportunities that are often available to development practitioners. It is difficult to short cut this process, although some insights such as theories and general principles can be learned from books and short training courses (Williamson, 2004: p44). There is unfortunately a sense of misplaced confidence amongst many development practitioners who assume that interventions can be successfully established without the benefit of research. Clearly, building an orphanage is the first solution that enters many people's minds (Tolfree, 1995: p51). This is probably because the development theory and conclusions about orphanages in the literature have yet to enter the popular psyche. Over time this will change, but for the meantime every effort must be made to encourage those considering working with orphans to avail themselves of the vast literature on this subject.

3. Recognising the Importance of Networking

Thirdly, it was observed that community-based care projects were usually part of a larger development intervention context on offer from the NGO. For example, the case study, Project HALO, was part of the wider development program of Servants to Asia's

Urban Poor, including AIDS prevention and education, AIDS homecare, nutrition, microcredit and a number of other initiatives. The best care programs for orphans were those that were integrated with a much wider community development program, recognising that the needs of orphans cannot be separated from the needs of their family and community (Williamson, 2004: p33).

The advantage of this situation is that practitioners are able to take a more holistic approach to the care of the orphan, their family and community. The implication is not that every NGO wishing to work with orphans must tackle every social problem, but rather that NGOs should network and work in partnership together in order to face the innumerable challenges that developing world communities grapple with. Development practitioners should not neglect to make contact with other NGOs working with children before beginning an intervention. These contacts not only yield important information and new insights on alternative approaches, but forge relationships that can be beneficial in the future (for referrals, resources etc.)

The cross fertilisation that occurs when development practitioners meet together is invaluable and should be encouraged whenever possible. Clearly, exposure to alternative models plays a significant part in the approach taken. For example, all the community-based care interviewees mentioned being familiar with the community-based care case study, Project HALO, before starting; whereas none of the residential care interviewees were familiar with or mentioned community-based care projects. Thus, greater effort should be made to widely disseminate effective alternative models (Williamson, 2004: p18). Conferences and networks are the ideal forum for this sharing of alterative models.

Theme 2: Preparatory Research

As described in the second theme of the preceding Data Analysis chapter, extensive preparatory research is necessary to establish the context and the appropriate response. In general, the residential care practitioners interviewed had not conducted the same amount of preparatory research as the community-based care practitioners. Lie and Williamson both advise that those who fail to meticulously prepare and research may make interventions that are ill considered (Lie 1999: p7; Williamson, 2004, px). There

are a number of areas that need to be researched before embarking on an orphan care intervention.

1. Research amongst Local Key Stakeholders

Sufficient time should be taken to properly research and visit a wide range of key stakeholders, including children themselves. Research described in the Community Participation sections of the Literature Review showed that children's wishes for care often differed markedly from adult's perception of their wishes (World Vision, 2004: p91; Mann cited in Williamson, 2004: p47). Every effort should be made to listen to the orphans themselves and gain their perspective, in deciding which type of care is most appropriate in the context.

2. Accessing Relevant Literature

As pointed out by some interviewees and described in the Data Analysis section, the internet is a rich source of information and a number of websites are devoted entirely to disseminating the latest information and research on the care of orphans. Even projects that have already been established can benefit from this information as news of new techniques and resources comes out regularly.

3. Overcoming Cultural Barriers

As noted in Chapter 4, Theme 2, cultural barriers play an enormous role in maintaining the gap between development theory and practice. The vast majority of information is only available in English, and is aimed at those with the academic skills required to analyse it (Lie 1999: p7). A lack of resources hinders the widespread translation of materials into Cambodian language. Cambodians tend to prefer oral communication to written, so more creative methods and locations for disseminating the information must be found.

Theme 3: Prioritising Orphans' Needs

1. Balancing Physical Needs with Development Principles

Orphans have a range of needs and care must be taken to ensure that these needs are understood properly and met appropriately. Miles and Stephenson are very concerned that "all dimensions of children's development (physical, spiritual, mental, emotional and social) are taken into consideration, not simply one aspect such as disability, sexual

abuse or homelessness" (2001: p20). A great emphasis was placed on the physical needs of children by both residential care and community-based care practitioners (Dybdal and Daigle 2002a: p16, Williamson, 2004: p13). However, meeting physical needs is not the greatest challenge. The greatest challenge is meeting these physical needs in a way that does not undermine the attainment of other needs (Foster, 2004: p84; WHO, 2004: pvii). Clearly it is possible to meet physical needs in a variety of settings, both residential or community-based and in a variety of ways. Development principles such as empowerment, participation and the importance of avoiding dependency are essential in determining which approach is best. In residential care, the efficiency and quality of service delivery may be overemphasised at the expense of these development principles. A correct balance must be found, since the NGO should serve the needs of the people not the other way around (Tolfree, 1995: p49).

2. Control and Creativity

On the other hand, community-based care projects should strive to maintain the quality and efficiency of their response to the physical needs (Save the Children, 2004: p6). Since community-based projects allow the community and individual caregivers to maintain control and authority over the children, the quality of care is subject to the resources, educational level, priorities and biases of the individuals concerned rather than organisational policy. Much is made of this weakness, but it can also be viewed as an impetus towards creativity and a challenge to engage with the entire community. A wise development practitioner can play an important role in influencing the knowledge, attitudes and values of a community, as well as helping them to increase their resource base.

3. Poverty and Income Generation

The grounds for placement in a residential care facility may be re-examined. In reality as pointed out in the development literature (Dybdal and Daigle, 2002a: p16) and confirmed in the preceding Data Analysis chapter[29], most children are admitted for reasons of poverty and this undermines essential family and community connections (Bowlby 1951: p13; Shonkoff and Phillips, 2000: p389; Dybdal and Daigle, 2002a: p96; Foster 2004: p84; Williamson 2004, p28). The financial resources saved by taking a

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[29] Theme 4: Orphanhood as criteria for acceptance

community-based approach can be used to combat poverty in the community and in particular build capacity amongst families caring for orphans (Save the Children, 2004: p14; Williamson, 2004: pix). As mentioned above, this will take time.

Sustainable, empowering, income generation activities are needed to meet the felt needs of the parents who place their children in residential care. It was interesting to note that almost all the NGOs surveyed ran income generation activities. However, residential care NGOs ran the activities in order to increase the financial resources of the NGO, whereas community-based NGOs ran the income generation activities to increase the financial resources of the community. Although the distinction is subtle, in a microcosm, this reflects the general focus of the two types of approach. One approach feeds the needs and systems of the NGO and the other feeds the needs and systems of the community (Etzioni cited in Tolfree, 1995, p49).

4. Meeting Educational Needs in the Community

A second area which receives much attention from both residential care and community-based care advocates is education. This finding matches the observations of Dybdal and Daigle (2002a: p16). In general, a great deal of energy is expended in this area and meeting the educational needs of orphans was a great motivating factor for many in founding their projects. Therefore, it is not a question of whether enough emphasis is placed on the educational needs of the children but rather whether these needs are being met in a sustainable, empowering, and developmentally sound way. As pointed out in the literature (Williamson 2004; p25) and confirmed in the Data Analysis chapter[30], it is apparent that in Cambodia many parents view the orphanage as a kind of boarding school where children are sent to receive a good education and then reap the benefits when they reach an age where they are able to earn a good income (Save the Children, 2004: p12; Williamson 2004; p25). NGOs should be committed to investing in the public education system so that all children can benefit rather than just a few. Community-based non-formal education projects can bridge the gap in the short term.

A wider program of educational reform is needed in Cambodia, whereby education becomes truly free and standards are raised above the current level. Currently, the

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[30] Theme 3: Educational needs

pursuit of education for children places a heavy burden on many poor families who are forced to turn to free alternatives such as orphanages, which have the extra benefit of being perceived as providers of high quality education. In particular, orphanages run by foreigners may be perceived as excellent places to gain a top quality education in an environment with modern facilities and foreign teachers who have the added bonus of teaching foreign languages. Save the Children reports that, "in Zimbabwe, a family's inability to pay for school fees is often the critical factor [for admission]. It is an abuse of rights to place a child in a residential care facility simply to improve their quality of care. In such cases of need, a child's family should be supplied with the resources to improve material care" (Save the Children, 2004: p12).

A number of NGOs cover the informal daily school fees of orphans that must be paid in most public schools. This support meets the daily educational needs of the children and hopefully in the near future, teacher salaries will rise to the point where they can no longer justify taking these informal payments. This type of education sponsorship and the support of uniforms and stationery should be extended to cover the needs of more children who are shut out of the school system because of a lack of ability to pay the fees. Perhaps if these educational needs are met, even if in a temporary and less than ideal way, the pressure on parents to give up their children to residential care will be lessened (Save the Children, 2004: p12).

The public education system can be supplemented with extra educational and vocational training opportunities. A number of NGOs surveyed conducted art and dance classes, English and computer training for the orphans in their programs, as described in the case study on Sunrise Orphanage. In order to improve the connection between orphans and their surrounding community, these classes need not be done in the residential care facility but could also be run in the community with greater access and participation for community members, perhaps as volunteer teachers.

Quite rightly an emphasis has been placed by many on the importance of education for children in seeking to break the poverty cycle. However, a good education should never be placed ahead of the other psychosocial needs of a child.

5. Dealing with Grief

Clearly, a much greater understanding is needed of the emotional needs of orphans. Miles and Stephenson suggest that, "children in residential care may need particular care of their psychological needs linked with the reason for admission and/or the loss and separation they have experienced" (2001: p20). For example, bereaved children should be assisted to recognise and deal with their grief and learn to live with their loss rather than suppress and ignore it. Suppression is the favoured means of dealing with feelings of grief in Cambodian society and leads to severe emotional and social difficulties. The increasing use of tools such as The Memory Book amongst community-based projects and a few residential care facilities is encouraging but still inadequate. Greater resources should be dedicated to developing and implementing tools such as this. The employment of a full time psychologist in one of the community-based projects was ideal but beyond the reach of most projects. The fact that most practitioners expressed a sense of inadequacy in this area merely serves the highlight the importance of networking, sharing resources and conducting research into how these issues are dealt with in other parts of the world.

6. Meeting other Psychosocial Needs

Beyond the need to grieve and deal with the loss of their parents, orphans have psychosocial needs that were rarely commented on in the interviews. Tolfree affirms that, "particular emphasis needs to be placed on children's needs to be loved and cared about, to feel a sense of belonging, and to develop a strong personal identity" (1995: p225). Needs such as regular interaction with an interested and nurturing adult can be partially met through big brother / big sister programs but are only truly and adequately met with a 'mother substitute' in a loving and nurturing family environment, as described in the Literature Review, chapter 2 (Bowlby 1951: p13; Shonkoff and Phillips, 2000: p389; WHO 2004: p1). This need is unlikely to be adequately met in the setting of a residential care facility (WHO, 2004: p39). NGO staff rarely possess the emotional energy to invest properly in the individual lives of the numerous children under their care and the children become starved for adult attention. For example, interviews were conducted with several members of the care-giving staff working in an orphanage in another country in which they were asked about their relationships toward the children: "They all maintained that they actively avoided holding, cuddling, or trying to enter into a conversation with individual children because such actions caused

aggressive expressions of jealousy among the other children, who immediately clamored for special attention. The caregivers thought they would be overwhelmed (which they would be) if they opened up for close contact with children." (Williamson, 2004: p5).

Community-based project founders generally recognised these psychosocial issues and designed their program policies accordingly. Unfortunately, as described in the Psychosocial Needs section of the preceding Data Analysis chapter, residential care project founders usually failed to grasp the importance of a nurturing family and adult attention and described many incidences where they had unwittingly undermined this important source of nurture (Dybdal and Daigle, 2002a: p88).

Theme 4: Families and Communities

As mentioned above, a greater understanding is needed of the importance of family and community in children's lives, not just in order to meet the psychosocial needs of the orphans, but also in order to strengthen the coping capacity of the community itself. Too often, this connection with a child's kinfolk is severed unnecessarily (Save the Children, 2004: p9). Lie states that, "since virtually all research has shown the deleterious effects of institutional rearing, the primary aim should be to keep children in a family in which they are wanted" (Lie, 1999: p167)

In order to promote the care of children in families and communities it is necessary to scale up the responses of effective community-based projects and tighten the acceptance criteria of, or scale down, the development interventions using a residential care model.

1. Expanding the Acceptance Criteria in Community-Based Projects

In order to scale up the response of community-based care projects, it may well be appropriate to widen the target group of a development intervention to include other types of vulnerable children. Orphanhood does not necessarily mean that children or a family need outside intervention (Save the Children, 2004: p5). Cases were described whereby a family caring for orphans met the acceptance criteria for the project although they were not as vulnerable as a nearby family with both biological parents still living. This type of situation can create jealousy and increase stigmatisation according to

UNAIDS and UNICEF (2004b: p28). NGOs that work solely with people living with and affected by HIV/AIDS can cause the same problems with stigmatisation. In general, the reasons for limiting the project to a particular target group are sound: limited resources, greater focus on the unique needs of particular group, etc. However, perhaps creative ways can be found to ensure that those targeted are truly the most needy while still working within the limits of scarce resources. On this point alone, community-based care NGOs differed markedly in practice from the literature.

2. Gatekeeping: Tightening the Acceptance Criteria in Residential Care Projects

It has already been well established that residential care fails to meet the full range of needs of children at risk and therefore increases their vulnerability (Save the Children, 2004: p1). Thus, widening the acceptance criteria would be disastrous because accepting more children into residential care would expose greater numbers of children to the ill effects of residential care. Tolfree talks of the concept of 'gatekeeping', used to describe the process of assessment which should precede admission into residential care (1995: p50). When the vast majority of children in residential care are found to have one or both parents still living, serious questions need to be asked about the admissions procedure and policies of those institutions. Save the Children provides a useful list of questions that should be asked before admission which I have listed in Appendix 3 (2004: p8).

Children with living parents and extended family should not be accepted into residential care except in cases of abuse (UN Convention on the Rights of the Child Article 9). What is needed is for residential care facilities to radically alter their acceptance criteria to unprecedented and unrecognisable levels and begin to refocus on reintegrating as many children as possible. This process of de-institutionalisation is documented in the literature. For example, Williamson speaks of the importance of, "transitioning children from institutions into alternative care. For many such children, what is needed is reunification with family or relatives" (2004, p9). Family tracing and reunification are two major components of the de-institutionalisation process described by Tolfree (1995: p141). In Ethiopia, Rwanda and Uganda, evaluations of the effects of residential care led these governments to adopt policies of de-institutionalisation and support for family-based care (UNAIDS/UNICEF, 2004b: p37).

3. Strategy for Empowering Parents and Extended Family

Where parents are merely poor and quite admirably but mistakenly seeking a better life for their children in residential care, every effort should be made to work closely with these parents in order to help them raise their standard of living and reach a level where they are able to provide for their children's needs. Miles and Stephenson concur that, "parents need to know that financial provision is not as important as the emotional loving relationship they can offer the child, that cannot so readily be given in an institution" (2001: p10). Nevertheless, helping parents to understand this can go hand in hand with a soundly developmental strategy to help families improve their living standards.

Where children have lost both parents, there are almost always relatives who would be available to care for the orphans with encouragement and sometimes some material support. Every effort should be made to provide support to those extended family members who are deemed suitable caregivers for their orphaned relatives. As Foster points out, "the first line of support for vulnerable children is their family, including the extended family and distant relatives" (2004: p65).

4. The Use of Foster Families

Save the Children assert that, "children should not be in residential care just because they are disabled... Many children admitted to institutional care have a chronic illness such as HIV/AIDS, have experienced traumatic losses and/or serious abuse, and may also have physical or learning disabilities. These are children who need special help and attention regarding their development and wellbeing. However, very often the capacity and structure of institutions means that they are not able to meet the needs of these children or fulfil their rights to rehabilitation" (2004: p9) In cases of abuse, serious disease, disability or other situations where the biological family is unsuited or unable to care for a child, every effort should be made to find a suitable adoptive or foster family in a community context. This will ensure that the child has a long term "mother substitute" and the appropriate nurture and care (Bowlby 1951: p13; Shonkoff and Phillips, 2000: p389; WHO 2004: p1). The only case where a child should be admitted to residential care is where they require highly specialised care that cannot be provided in any other setting and this should be as temporary as possible, much like a hospital stay. It may be suggested that such may be the case with some children

infected with the HIV/AIDS virus who are receiving antiretroviral treatment. However, the need for nurturing adult relationships such as described by Bowlby's attachment theory is still an unresolved issue even in these rare cases if deemed justifiable (Bowlby 1951).

Fostering is an option that has not been meaningfully explored by any of the practitioners surveyed, although there are isolated cases of foster care arrangements in some of the community-based projects. This option is largely untapped and holds great potential, though extended family should be given priority where appropriate (Williamson, 2004: p5). Foster care may represent a way forward for residential care practitioners who wish to move towards community-based care but face the problem that many of the children in their care have lost touch with their families. Further research is recommended to assess whether this is a viable option to help facilitate with de-institutionalisation in Cambodia.

Narrowing the Gap: A Suggested Framework

In summary, I have modified[31] a framework from UNICEF (cited in Williamson, 2004: p5) which provides a useful schema for prioritising interventions and suggests the type of development activities that may be associated with each type of intervention. This list provides a rough framework and set of priorities from most preferred in the first place through to least ideal, though sometimes necessary, in last place. There are a number of options, which should be looked at before residential care is considered. NGOs should work hard to strengthen the capacity of those preferred options.

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[31] Particularly with a view to including a monitoring and child protection aspect

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1. Parental and Older Sibling Care
- Identify the most vulnerable families and children
- Provide urgent responses to prevent placement of children outside the family
- Provide material support to the family and attend to psychosocial needs
- Assist family to improve income if necessary
- Ensure HIV/AIDS-infected parents provide a will or appoint guardians for their children

2. Kinship Care
- Assist family to improve income if necessary
- Provide training, counselling and support if necessary
- Monitor situation to ensure no abuse or exploitation
- Identify resources, health services, schooling, vocational training, and grants

3. Foster Care
- Mobilize foster caregivers in communities if suitable extended family members are not available
- Train and support caregivers
- Monitor situation to identify and deal with any abuse or exploitation as soon as possible
- Help to obtain needed resources
- Assist family to improve income if necessary

4. Child-headed Households with Community Support and Protection
- Ensure education, training, and recreational needs are met
- Provide material support to the family and attend to psychosocial needs
- Facilitate guardianship arrangements
- Provide training for orphans outside the home

5. Community-based Day Support Programs
- Provide community schools
- Provide structured activities (games, sports, cultural activities)
- Serve meals and monitor nutrition

6. Residential Care including Outreach Support to OVC Families in Community
- Raise awareness and enlist community support and involvement
- Provide assistance in locating families and assessing their willingness and capacity to care for children
- Assist in finding support services for families that are willing to reunite with children

7. Modified Residential Care as Alternative to Street and other High-risk Environments
- Provide temporary residential care, education, and basic health care and other services
- Actively look for relatives; arrange foster care or other long-term solutions for children

8. Care by Shelters and Day Centers for Street Children
- Provide basic health and other services
- Serve meals
- Provide basic education
- Help children to find alternatives to living on the street
- Assist children in reuniting with family members

Concluding remarks

The gap between rhetoric and reality, or development theory and practice in the care of Cambodian orphans is wide. This thesis has shown that the lack of preparation and research by project founders, their lack of community development experience and insight, cultural barriers and many other factors have contributed to the implementation of development projects that do not always meet the needs of orphans in the most effective way possible. These projects may be unsustainable, inappropriate and at worst, harmful to the orphans involved. In contrast, development theorists describe another approach which is being implemented by a much smaller number of practitioners. The community-based approach to orphan care is more sustainable, empowering and participatory, as well as more cost effective and more effective in meeting the psychosocial needs of orphans. However, it has not been widely adopted. In fact, six residential care facilities have been established for every one community-based project in Cambodia.

Yet there is hope. The gap between the literature on orphan care and the practice can be narrowed. As practitioners increasingly commit to building relationships in the community and investing in community development learning and networking, their understanding of the range of interventions possible and their various merits will increase. Before undertaking an intervention, thorough preparatory research should be conducted amongst key stakeholders such as the orphans themselves, as well as relevant literature. This will ensure that the children's perspective as well as the latest ideas and theories are considered and if appropriate, adopted. Psychosocial needs must be taken into account and acceptance criteria for residential care facilities may be tightened. This will succeed best when practitioners work more closely with parents and extended family to ensure that their felt needs are met, and use foster families where other relatives are not available or appropriate.

When these steps are taken we will begin to see development practice in the care of orphans become more effective and truly benefit from all that development theorists and researchers have contributed over the years. Then, our reality will match the development rhetoric.

APPENDIX 1 INTERVIEW QUESTIONS

Questions used in Semi-Structured Interviews

1. How did this project start?

2. What research did you do before starting?

3. Did you look for information on caring for orphans on the internet?

4. Have you ever been to CCC or CDRI or any other NGO to get info about orphan care?

5. Did the Ministry or Government ever give you information?

6. Describe your admissions procedure.

7. How many of your children have one or both parents?

8. Why are these parents unable to care for their children?

9. How many of your children have extended family?

10. Why are these extended family members unable to care for the children?

11. Have you considered foster care?

APPENDIX 2 INTERVIEW SUBJECTS

RCIT1: Residential Care Interview Transcript 1

The interview took place at this orphanage in March 2005. The interviewee was an elderly Cambodian male, former Buddhist monk, founder and current director of the orphanage.

RCIT2: Residential Care Interview Transcript 2

The interview took place at the head office where coordination of the orphanage and other development activities takes place in March 2005. The interviewee was a middle aged Cambodian male, founder and director or the NGO.

RCIT3: Residential Care Interview Transcript 3

The interview took place at the head office where coordination of the orphanage and other development activities takes place in March 2005. The interviewee was a middle aged Cambodian female, current director and founding member of the NGO.

RCIT4: Residential Care Interview Transcript 4

The interview took place at the head office where coordination of the orphanage and other development activities takes place in March 2005. The interviewees were the young female director of the NGO, recently appointed; and a middle aged Cambodian male, founding member of the NGO.

RCIT5: Residential Care Interview Transcript 5

The interview took place over email in April 2005. The interviewee was the Australian founder of and current director the orphanage, a middle aged woman.

RCIT6: Residential Care Interview Transcript 6

The interview took place at the orphanage in March 2005. The interviewee is the Cambodian founder and director of the orphanage, a middle aged Cambodian woman.

CBCIT1: Community Based Care Interview Transcript 1

The interview took place at the NGO office where coordination and management of the project takes place in March 2005. The interviewee is the co-founder of the project, a Cambodian-born, foreign educated young woman.

CBCIT2: Community Based Care Interview Transcript 2

The interview took place by email in March 2005. The interviewee is the American founder and current director, female, of this community based care project.

CBCIT3: Community Based Care Interview Transcript 3

The interview took place in the office of the NGO concerned in March 2005. The interviewee is the American founder and current director of this project, an older male.

CBCIT4: Community Based Care Interview Transcript 4

The interview took place in a café. The interviewee was a British male, the co-founder and current director of the project.

APPENDIX 3 GATEKEEPING QUESTIONS

Adapted from Save the Children (2004: p8):

1. Why does the child need alternative care?

2. What is the opinion of the child?

3. How does the child feel?

4. Does the child have particular experiences(abuse, war experiences, etc) that need special follow-up, and how will they be dealt with?

5. Does the institution have competence in helping the child?

6. Does the child have siblings who are already in the institution or have been admitted at the same time?

7. What has the child been told about the admission and its causes? Does the child believe what she/he has been told?

8. How was the child prepared for admission?

9. What other alternatives have been tried or considered?

10. What is the benefit of the institution for the child? How does it benefit the family?

11. What will the care plan be and how long will the child need to stay?

12. How will the situation of the child and his/her family be reviewed?

13. Does the institution meet the needs of the child?

14. Why can't the child stay at home?

15. What support would be needed for the child to live at home, and who can provide this?

16. What is the plan for family and community contact? What are the child's expectations regarding this?

17. Are there any signed documents regarding the placement of the child?

18. Does the child have a guardian external to the institution?

REFERENCES

Ainsworth, M., and Filmer, D. (2002). **Poverty, AIDS and Children's Schooling: A Targeting Dilemma**. Washington, DC: World Bank Policy Research Working Paper 2885.

Ames, E. W. (1997). **The development of Romanian orphanage children adopted into Canada**. Final report to human resources development. Burnaby, Canada: Simon Fraser University.

Alkenbrack, S. (2004). **The Social and Economic Impact of HIV/AIDS on Families and Children in Cambodia**. POLICY Project. Powerpoint Presentation at Sunway Hotel, Phnom Penh. August 23rd 2004.

Aronson, R. (2001). **At-Risk Students Defy the Odds: Overcoming Barriers to Educational Success.** Blue Ridge Summit, PA: Scarecrow Press.

Barnett, T., and Whiteside, A. (2002). **AIDS in the Twenty First Century: Disease and Globalisation**. New York: Palgrave Macmillan.

Bender, L. and Yarnell, H. (1941). **An Observation Nursery**. *American Journal of Psychiatry, Vol 97,* p1158 – 1174.

Bodman, T.F., MacKinley, M., Sykes, K. (1950). **The Social Adaptation of Institution Children**. *Lancet, Vol 1,* p173-176.

Bowlby, J. (1951). **Maternal care and mental health.** London: Her Majesty's Stationery Office..

Casler, L (1961). **Maternal Deprivation: a critical review of the literature**. *Child Development, Vol 26,* p1-64

Carswell, K. (2004). **The psychosocial wellbeing of orphans and vulnerable children in the Thai/Cambodia border areas.** Powerpoint presentation. August 23, 2004 at Sunway Hotel, Phnom Penh, Cambodia.

Chapman PL., Mullis RL., Genet, J. (2000). **Racial differences in adolescent coping and self-esteem.** *Psychology, June 161,2,* p152-160.

Chernet, Tsegaye. 2001. **Overview of Services for Orphans and Vulnerable Children in Ethiopia**. Prepared for a workshop held March 27–29, 2001, in Kigali, hosted by the Ministry of Local Government and Social Affairs of the Republic of Rwanda

Chisholm, K., Carter, M., Ames, EW., Morison, S. (1995). **Attachment security and indiscriminately friendly behaviour in children adopted from Romanian orphanages.** *Development and Psychopathology, Vol 7,* p283-294.

Cheung, SY., and Buchanan, A. (1997). **Malaise scores in adulthood of children and young people who have been in care.** *Journal of Child Psychology and Psychiatry, Vol 38, No. 5,* p575-580.

Collins, J. (2004, June 24). **Dispute brewing over care for AIDS orphans**. *The Cambodia Daily,* p11.

Dennis, W. (1976). **Children of the Creche. Conclusions and implications**. London: Open Books.

Desmond, C., and Gow, J. (2001). **The cost effectiveness of six models of care for orphan and vulnerable children in South Africa.** University of Natal, Durban: UNICEF: Health Economics and AIDS Research Division.

Desmond, C., and Quinlan, T. (2002). 'Costs of Care and Support'. In K. Kelly, W. Parker and S. Gelb (Eds). **HIV/AIDS, Economics and Governance in South Africa: Key Issues in Understanding Response. A Literature Review.** Johannesburg: USAID/Cadre.

Devine S and UNICEF (2001). **A multi-sectoral approach to planning services for AIDS orphans**. Chiang Mai, Thailand: UNICEF

Dumont, M., Provost, M.A. (1999). **Resilience in Adolescents: Protective Role of Social Support, Coping Strategies, Self-Esteem, and Social Activities on Experience of Stress and Depression.** *Journal of Youth and Adolescence, 28, 3,* p343-363.

Du Pan, RM., and Roth, S. (1955). **Psychological Aspects of Pediatrics**. *Pediatrics, Vol 47,* p124-129.

Dybdal, A.S. and Daigle, G. (2002a). **The national survey of providers of alternative care for children in Cambodia: Survey Report.** Phnom Penh: MOSALVY/UNICEF.

Dybdal, A.S. and Daigle, G. (2002b). **The national survey of providers of alternative care for children in Cambodia: Fostering and kinship care: a case study.** Phnom Penh: MOSALVY/UNICEF.

Edmistone, RW. and Baird, F. (1949). **Adjustment of Orphanage Children.** *Journal of Educational Psychology, Vol 40,* p482-488.

Egger, Sukey Merry Suzanne. (1999). **Optimism as a factor that promotes resilience in inner-city middle-school students exposed to high levels of community violence.** *Dissertation Abstracts International: Section B: the Sciences and Engineering, Vol 59, 9B,* p5078.

Family Health International (2002a). **Cambodia CAA (Children Affected by AIDS) Review Report.** Cambodia: USAID.

Family Health International (2002b). **Voices from the communities. The impact of HIV/AIDS on the lives of orphaned children and their guardians.** Zambia: USAID.

Fischer, L. (1952). **Hospitalism in Six-Month-Old Infants.** *American Journal of Orthopsychiatry, Vol 22,* p522-533.

Foster, G. (1999). **Orphan care in Zimbabwe - a community response.** *AIDS Analysis Africa, 10, 2,* p14-15.

Foster, G., and Jiwli, L. (2001). **Psychosocial support of children affected by AIDS: An evaluation and review of Masiye Camp.** Bulawayo: The Salvation Army.

Foster, G. (2004). 'Safety nets for children affected by HIV/AIDS in Southern Africa'. In R. Pharoah (Ed). **A Generation at Risk? HIV/AIDS, Vulnerable Children and Security in Southern Africa.** South Africa: Monograph.

Freud, A., and Burlingham, D. (1944). **Infants without Families.** London: George Allen and Unwin Ltd.

Gannon, B. (Ed.). (1994). **Children and Youth at Risk: HIV/AIDS Issues, Residential Care and Community Perspectives.** Papers from the First All-Africa Conference and Ninth Biennial Conference of The National Association of Child Care Workers. Claremont: National Association of Child Care Workers.

Gershon TD; Tschann JM; Jemerin JM (1999). **Stigmatization, self-esteem, and coping among the adolescent children of lesbian mothers.** *Adolescent Health, 24, 6,* p437-445.

Gindl, I., Hetzer, H., and Sturm, M. (1937). **Unangemessenheit der Anstalt als Lebensraum fur das Kleinkind.** *Angew Psycholog, 52.* p310-358.

Goldfarb, W. (1943). **The Effects of Early Institutional Care on Adolescent Personality.** *Journal of Experimental Education, Vol B,* p106-129.

HelpAge International (2003). **Forgotten Families. Older people as carers of orphans and vulnerable children.** Brighton: HelpAge International/International HIV/AIDS Alliance.

HOSEA Project (2002). **The HOSEA Project survey of alternative care in Phnom Penh and Kandal Province, Cambodia.** Phnom Penh, Cambodia: Unpublished (acquired from the authors September 2005.)

HOSEA Project (2004). **The HOSEA Project survey of the level and quality of child-care in the temples of Kandal Province, Cambodia.** Phnom Penh, Cambodia: Unpublished (acquired from the authors September 2005.)

Jew, C.L., Green, K.E., Kroger, J. (1999). **Development and validation of a measure of resiliency.** *Measurement and Evaluation in Counseling and Development, Vol 32, 2,* p75-89.

Johnson, D. E. (2000). **Medical and developmental sequelae of early childhood institutionalization in Eastern European adoptees.** *Minnesota Symposia on Child Psychology, Vol 31,* p113–162.

Johnson, S., Modiba, P., Monnakgotla, D., Muirhead, D., and Schneider, H. (2001). **Home Based Care for People With HIV/AIDS in South Africa: What will it cost?** Johannesburg: Centre for Health Policy, University of Witwatersrand.

Kaler, S., and Freeman, B.J. (1994). **Analysis of environmental deprication: cognitive and social development in Romanian orphans.** *Journal of Child Psychology and Psychiatry, Vol 35, 4,* p769-781.

KHANA (2001). **Appraisal of Needs and Resources for Children Affected by HIV/AIDS in Cambodia.** UK: NAM Publications.

Kinghorn, A., Coombe, C., McKay, E., and Johson, S. (2002). **The Impact of HIV/AIDS on Education in Botswana.** Botswana: Ministry of Education Republic of Botswana and UNDP.

Klackenberg. G. (1956). **Studies in maternal deprivation in infant's homes**. *Paediatrics, Vol 45*, p1-12.

Levine, C., and Foster. G. (2000). **The White Oak Report: Building International Support for Children Affected by AIDS.** New York: The Orphan Project.

Lie. N. (1999). **Deprivation in Orphanages**. Bergen: Cantes Publishing House

Loening-Voysey. H., and Wilson. T. (2001). **Approaches to caring for children orphaned by AIDS and other vulnerable children: Essential elements for a quality service**: Unpublished report for UNICEF by the Institute for Urban Primary Health Care.

Lowrey. LG. (1940). **Personality Distortion and Early Institutional Care**. *American Journal of Orthopsychiatry. Vol 10*. p576-585.

McLeod. J. (1994). **Doing Counseling Research.** London: Sage.

MacLeod. H. (2001). **Residential Care**. Paper presented at the Orphans and Vulnerable Children: What Role for Social Protection. World Bank/World Vision Conference. Washington DC. 6-7 June 2001.

Marcus. T. (1999). **Wo! Zaphela Izingane: Living and Dying with AIDS**. Pietermaritzburg: CINDI.

McCall. J. (1998). 'Research on the Psychological effects of orphanage care'. A critical review. In R.B. McKensie (Ed). **Rethinking Orphanages for the 21st Century**. Sage Publications. Accessed online on 28/9/05: http://www.gsm.uci.edu/~mckenzie/rethink/mck97-ch8.htm

Miles. G. and Stephenson. P. (2001). **Children in Residential Care and Alternatives.** London: Tearfund UK

Muhamedrahimov. R. (2000). **New attitudes: Infant care facilities in Saint Petersburg, Russia**. In J. Osofsky and H. Fitzgerald (Eds). *WAIMH Handbook of infant mental health*. New York: Wiley.

Powell. G.M.. S. Morreira, C. Rudd. and P.P. Ngonyama. (1994). **Child Welfare Policy and Practice in Zimbabwe. Study of the Department of Pediatrics of the University of Zimbabwe and the Zimbabwe Department of Social Welfare**. Harare: UNICEF Zimbabwe.

Provence. S.. and Lipton. R. (1962). **Infants in institutions: a comparison of their development with family-reared infants during the first year of their life**. New York: International University Press.

Rutter. M.. Andersen–Wood. L.. Beckett. C.. Bredenkamp. D.. Castle. J.. and Groothues. C.. (1999). **Quasi-autistic patterns following severe early global privation**. *Journal of Child Psychology and Psychiatry and Allied Disciplines. 40*. p537–549.

Rutter. M.. and Quinton. D. (1984). **Long-term follow-up of women institutionalize in childhood: Factors promoting good functioning in adult life**. *British Journal of Developmental Psychology. Vol 2*, p191-204.

Safman. R. (2004). **Assessing the impact of orphanhood on Thai children affected by AIDS and their caregivers**. *AIDS Care, Vol 16, 1.* p11-19.

Save the Children (2004). **A Last Resort. The growing concern about children in residential care**. London: International Save the Children Alliance.

Sengendo. J.. and Nambi. J. (1997). **The psychological effect of orphanhood: A study of orphans in Rakai District**. *Health Transition Review, 7.* p105-124.

Shonkoff. J.. and Phillips. D. (2000). **From neurons to neighbourhoods: The science of early childhood development.** New York: National Academy Press.

Stiles. W.B. (1993). **Quality Control in Qualitative Research**. *Clinical Psychology Review, 13.* p593-618.

Swift. A.. and Allesbrook. A. (1989). **Broken Promise**. London: Hodder and Stoughton.

Tizard. B. and Hodges. J. (1978). **The effect of early institutional rearing on the development of eight year old children.** *Journal of Child Psychology and Psychiatry. Vol 19.* p99-118.

Tizard. B. and Rees. J.A. (1975). The effect of early institutional rearing on the behaviour problems and affectional relationships of four-year old children. *Journal of Child Psychology and Psychiatry, Vol 16*, p61-73.

Tizard, J. and Tizard, B. (1971). 'The social development of two-year-old children in residential nurseries'. In H.R. Schaffer (Ed). **The origins of human social relations**. London: Academic Press.

Tolfree, D. (1995). **Roofs and Roots. The care of separated children in the developing world.**. Aldershot, UK: Arena.

Ullman, C., Tatar, M. (2001). **Psychological adjustment among Israeli adolescent immigrants: a report on life satisfaction, self-concept, and self-esteem.** *Journal of Youth and Adolescence, 30, 4*, p449-463

UN Convention on the Rights of the Child (1989). Available online at http://www.unicef.org/crc/ (accessed January 2006).

UNDP (1999). **Cambodian Human Development Report.** New York: Oxford University Press.

UNAIDS/UNICEF (2004a). **Children on the Brink 2004: A Joint Report on Orphan Estimates and Program Strategies.** Washington, DC: USAID.

UNAIDS/UNICEF (2004b). **The framework for the protection, care and support of orphans and vulnerable children living in a world with HIV/AIDS.** Washington, DC: USAID.

UNAIDS (2000a). **Report to the Global HIV/AIDS Epidemic.** Geneva: UNAIDS.

UNAIDS (2000b). **Children Orphaned by Aids - Front-line Responses from Eastern and Southern Africa.** New York: UNICEF.

UNAIDS (2000c). **AIDS Epidemic Update: December 2000.** Geneva: UNAIDS.

UNAIDS (2000d). **National AIDS Programmes: A Guide to Monitoring and Evaluation.** Geneva: UNAIDS.

USAID, and FHI. (2001). **Care for Orphans, Children Affected by HIV/AIDS and Other Vulnerable Children: A Strategic Framework.** Washington DC: USAID.

Vorria, P., Wolkind, S., Rutter, M., Pickles, A. and Hobsbaum, A. (1998). **A comparative study of Greek children in long-term residential group care and in two-parent families: I social, emotional and behavioural differences.** *Journal of Child Psychology and Psychiatry, Vol 39, 2*, p225-236.

Walker, L. (2002). **"We will bury ourselves": A Study of Child-Headed Households on Commercial Farms in Zimbabwe.** Harare: Farm Orphan Support Trust of Zimbabwe.

Wang, M.C., Haertel, G.D., Walberg, H.J. (1998). **Educational Resilience.** Washington, DC: Office of Educational Research and Improvement.

Ward, A (1997). 'Working with Young People in Residential Settings'. In J. Roche, and S. Tucker (Eds). **Youth in Society.** London: Sage.

Wekesa, E. (2000). **The impact of HIV/AIDS on child survival and development in Kenya.** *AIDS Analysis Africa, 10, 4,* p12-13.

Wild, L. (2001). **The psychosocial adjustment of children orphaned by AIDS.** *Southern African Journal of Child and Adolescent Mental Health, 13, 1,* p3-22.

Williamson, J. (2004). **A family is for a lifetime.** Washington, DC: The Synergy Project, USAID.

Wolff, P., and Fesseha, G. (1999). **The Orphans of Eritrea: A Five-Year Follow-Up Study.** *Journal of Child Psychiatry, 40, 8,* p1231–1237.

World Bank (2002). **AIDS Orphans, Education and HIV/AIDS: A Window of Hope.** Washington DC: World Bank.

World Health Organization (2004). **The importance of caregiver-child interactions for the survival and healthy development of young children: a review.** China: Department of Child and Adolescent Health and Development.

World Vision (2004). **Guide to mobilising and strengthening community-led care for orphans and vulnerable children.** Monrovia, California: World Vision International.

Wright, J. (2001). **Working on the Front Line: An Assessment of the Policy Context and Responses of AIDS Housing and Related Service Providers in the Durban Metropolitan Area.** Durban: Built Environment Support Group.

Yule, W., and Raynes, NV. (1972). **Behavioural Characteristics of Children in Residential Care in Relation to Indices of Separation.** *Journal of Child Psychology and Psychiatry, Vol 13,* p249-258.

Zeanah, C.H., Nelson, C.A., Fox, N.A., Smyke, A.T., Marshall, P., Parker, S.W., and Koga, S. (2003). **Designing research to study the effects of institutionalization on brain and behavioral development: The Bucharest Early Intervention Project**. *Development and Psychopathology*, *15*, p885-907.