



**HOLISTIC REVIEW OF ALTERNATIVE CARE PROVISION
IN AN AREA OF THAILAND WITH A HIGH NUMBER OF MIGRANT CHILDREN :
THE BORDER DISTRICT OF SANGKHLABURI**

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June 2021

Key Findings



1. What are the alternative care options available in the area? Who are the beneficiaries?

Children in alternative care

- This research gathered data on 1,876 children in Alternative Care in Nong Lu subdistrict of Sangkhlaburi district, a border district with a significant migrant population. One thousand ninety children were in informal kinship care in 658 families, and 786 children were in 26 residential care facilities of various sizes (The normal population for these 26 facilities is 947, but 161 children were absent at the time of data collection, mostly because of covid restrictions). The number of children in Nong Lu was estimated at 10,588.
- At 10.32% of all children in the research area, the number of children in kinship care in Nong Lu is lower than the national average of 26% for rural areas. In contrast, the percentage of children in private residential care is nine times greater than the estimated national average.
- Nong Lu has an official population of 35,316 and is one of 7255 sub-districts or Tambons in Thailand, yet it has more private children's homes than many of the 76 provinces that make up the country. For comparison, the North East region of Thailand is recognised as the most impoverished. Twenty provinces make up the region and are home to over 22 million people. On average, 36% of children in the region live in kinship care (MICS 2019). Five provinces have no known private children's homes. The remaining 15 provinces have 55 private homes between them. (Alternative Care Thailand, 2021) This gives a ratio of 2.5 private children's homes per million people in the Northeastern region of Thailand.
- Children from the research area are also known to stay at government school dormitories and government boarding schools elsewhere in the province. Phone calls to just two of these schools identified a further 283 children from Sangkhlaburi district living in residential care.
- The prevalence of private children's homes in Nong Lu is likely a response to a high rate of support needs among children. This research found that most children need help because of poverty and access to education. By working together, all stakeholders should find solutions for these children that do not involve family separation.
- In all forms of residential care, most children are visited by family, go to visit family, and keep in contact with family by telephone and other means.
- It is estimated that at least 18.9% of 1,876 children in this research have lost one or both parents. The percentage is very high compared to the national average of 3.2%. More help is needed for single parents, especially non-Thai who cannot access government support.
- No double orphans (both mother and father have died) were found in kinship care. Thirty-four children (4.32%) in residential care were found to be double orphans. Twelve have visited family in the last 12 months.

- Fifteen single orphans (19%) (either mother or father has died but not both) were found among our interview sample of 80 children in kinship care suggesting we might expect 204 single orphans among all 1090 children identified in kinship care. 114 single orphans were identified in residential care. Among the 114 children, 82 have visited family in the last 12 months.
- 71% of single orphans in residential care had lost their father and 91% in kinship care. There are significantly more female single orphans in residential care than males, indicating that single mothers and remarried mothers might face challenges in keeping their daughters safe. In kinship care, there are more male single orphans than female.
- A large number of children do not know about their parents which could alter the number of orphans; a detailed explanation is in this report.
- Only 5.6% of the 786 children in residential care settings were aged under ten years compared to 60.6% in kinship care.
- Children of Karen ethnicity are consistently over-represented in all forms of Alternative Care in the study area.
- Thailand is a predominantly Buddhist country. Estimates vary between 1-3% of the population being Christian. In Nong Lu, 6% of children in kinship care identify as Christian, compared to 57% in private children's homes and 24% in school dormitories (two of which are Christian organisations).
- Other significant differences are in ethnicity, documentation and gender ratios.
- Many teenage boys are unaccounted for. They are seen in much smaller numbers than girls in the later stages of school education and are similarly underrepresented among the residential care facilities. The achievement gap between boys and girls is much more significant than that seen at the national level. Both government and local private agencies are failing to find ways to meet boys' specific needs effectively.

Children in family-based care

- No formal kinship care or foster care was found.
- One thousand ninety children were identified in informal kinship care within 658 families. In-depth interviews were conducted with 80 of these children and their 34 kinship carers. None of the 80 children interviewed had ever lived in residential care.
- Poverty and lack of access to support for non-Thai kinship carers mean they are more likely to relinquish children to residential care, even more so if one or both of the child's parents have died. 19% of children in residential care were previously in kinship care. This relinquishment has increased since the start of COVID-19. There has been a surge of children entering residential care in the last three months, and 25% have come from kinship care.
- The provincial public shelter and the Ministry of Social Development and Human Security office combined only have enough budget to support 45 kinship carers in the whole province. No one in the research area was receiving this government welfare.

Dependents in residential care

- Thirty-eight residential care facilities were identified. Some had reduced numbers as children were unable to return from home visits due to covid restrictions. Four did not have any children at the time of the research, and eight refused to participate in the research. 786 dependents of 26 participated residential care facilities were interviewed. This included 15 private orphanages with a total of 377 children, eight boarding schools/dormitories with a total of 357 children, and three religious places with 51 children. One hundred sixty-one children were absent from the 26 participated residential care facilities. Had all children been present and all facilities participated, it is estimated that 1,000 children would have been interviewed.
- Poverty and education are the primary reasons for children to enter residential care. 55% of children in residential care were girls (increasing to 61.5% if looking only at private children's homes).
- 105 of the 786 dependents interviewed in residential care were 18 years old or above.
- Carers identified six dependents out of 786 who entered residential care because of special needs.
- Eight dependents said they entered residential care because it was not safe at home. However, carers identified 15 dependents they said had entered residential care because of dangers at home. Seven of these children had visited family in the last 12 months.
- Carers identified 22 dependents they said needed to remain in residential care as the homes were not safe. Three of these children explained that they entered residential care because of danger at home, and 13 had visited family in the last 12 months.

2. What are their standards and practices of child care?

- Two private children's homes appear to have some awareness of the Necessity Principle. The rest seem unaware of the idea that poverty and access to education might be solved without separating children from their families.
- Legal guardianship is a grey area. Three private residential facilities referred to keeping relinquishment documents signed by parents and former guardians. This does make use of a legal loophole in Thailand where a parent can sign a simple letter relinquishing their child into another's care, in fact the child protection system largely depends on this approach rather than the more complex forced removal of children by the state. No other facilities made any reference to signed agreements with parents or guardians. This leaves many children in a situation where confirmation of their legal guardian is undefined. It also seems likely that many parents and guardians are unaware of their rights in regard to their interactions with those caring for their children and with regard to access to their children.
- 14 (53.8%) of residential care facilities give support to families, mainly food packages. None are offering long term education-focused support to families on any significant scale despite this clearly being the main reason children enter residential care.
- The average expense for private care institutions is 4,830 Baht (USD 155) per month per child. From this study, the average kinship family size was 5.3 people,

and the average household monthly income was 4,680 Baht (USD 146). This means an average monthly budget of 883 Baht (USD 28.30) per person. For non-Thai kinship families, this average drops to 4,261.90 Baht (USD 135) per month.

- Private residential care operators and government school dormitory operators may have incentives to increase numbers of children that can lead to decisions not based on children's best interest.
- No private care facilities have registered with the government despite a legal requirement that was brought to their attention by the director of the provincial office of the Ministry of Social Development and Human Security in a public meeting in April 2015. There has been minimal monitoring of these facilities by the provincial office of MSDHS.
- The director of a children's home in Nong Lu that is now closed was found guilty of physical abuse and fined. Researchers heard that she had previously partnered with a volunteering company and had trafficked children to gain financially from paying volunteers. After keeping a low profile for a few years, she has now established another private children's home in Nong Lu.
- Only about 40% of residential care facilities have child protection policies in place and some are not even aware of what they are. Only one residential care facility gave answers that indicated they used their policy in a meaningful and effective way. In most cases, the standard of behaviour expected of staff and volunteers towards children is undefined. Combined with an unqualified workforce, neither children or staff have any guidance to set and manage safe boundaries in their interactions and relationships. This is enhancing the power of unrelated adults over children in their care and leaves these children extremely vulnerable to abuse and exploitation.
- 324 volunteers have visited the residential care facilities in Nong Lu in the last 12 months. More than half of them were helping to teach English. 273 of the volunteers were foreigners. This number may have been higher if not for the covid situation and restrictions on international travel.
- 194 staff work in the 26 residential care facilities that took part in this research. Only one facility had a clear policy that all staff and volunteers must read and sign their child protection policy. This means that 493 adult staff and volunteers were given access to 692 vulnerable children in the absence of any effective child protection mechanism in the last 12 months.
- 69 children were interviewed in one government primary school dormitory however the director said that if not for covid 147 children would be present. There are three caregivers. Somewhat confusingly, the age range of children is from 4 to 17 years with an average of 12.83. It seems that this government primary school dormitory has in effect become a children's home. 87.5% of funding for private residential care facilities is from international sources and 93% are headed by foreigners.
- There is little record keeping about the children in residential care. Many children have been in care for many years; hence, knowledge of their parents and personal histories has become blurred. In a number of cases, there were conflicting responses between children and caretakers about whether parents are alive or dead, indicating the caretakers might not have accurate information or have withheld information from the children. There is a clear need for independent and impartial decision making about children's placements in alternative care based on professionally assessed evidence and factual information.

- Most children in residential care stay for the long term, usually until they finish high school. Younger girls and boys are present in fairly equal numbers but there are more female teenagers and youth than male. This warrants further investigation as it was beyond the scope of this research to ascertain whether boys are choosing to leave residential care more frequently than girls or if they are forced to leave.
- There is no evidence of individual care planning and regular reviews with parents and children. This implies that once a child enters residential care, their voice and that of their parents is rarely heard. In general, little importance is attached to parents once children enter residential care.

3. What would be the impact of a gatekeeping mechanism and family support services on the number of children entering formal alternative care?

- Small numbers of children are in residential care because of special needs or abuse and the risk of abuse. If issues of poverty and lack of access to education are addressed effectively, a minimal number of children would need to be assessed by an independent gatekeeper to determine the best alternative care placement for them if such a system was adopted.
- The number of children entering residential care under five years old has reduced to a very low number in recent years. It is a very achievable goal to reduce this to zero. With the district child protection committee as a gatekeeping mechanism, all children under-five and at risk of being without parental care could be reported to the committee. The committee then can manage each case and seek a return to family, kinship or foster care.
- There is a significant movement of children from kinship care into residential care, but this research found no evidence of children moving from residential care to kinship care, despite the majority of children having regular contact with their families. There was no evidence of any residential care facilities seeking family-based care options for the children in their care, confirming the need for an independent and impartial gatekeeper to oversee the case management of all children in residential care.
- There appears to be a lack of guidance for government schools operating dormitories with decision making about whether to accept children made at the local level without any apparent scrutiny from those overseeing the educational system.
- The government is covering the cost of 300 children in school dormitories in the study area (lower than previously because of covid) and not less than 284 children from the study district in schools elsewhere in the province. Yet, there is very little government support for the families of these children if the children remain at home.
- The only high school in the research area had 133 students staying at its dormitory. Most gave distance from home to school as the reason to stay there. However, a simple survey revealed that 50% of the students come from villages where other students travel from every day.
- Thirty-four children have left private residential care in the last 12 months, while 48 children have entered. Thirty-two of these children have arrived in the last three months. This raises concerns about the economic consequences of the COVID-19 pandemic for many families and suggests an urgent need to monitor this potential crisis.

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1. Background

1.1. Introduction

This report presents findings from the research to study different forms and standards of alternative care provision in an area with a high number of migrant children in Thailand. Different settings to care for children without parental care in the Thai context are examined to cover all alternative care environments, both residential and family-based. This includes institutional care homes, boarding houses, boarding schools, school dormitories, religious places, kinship (formal and informal) and foster care.

Thailand relies heavily on residential care, particularly private children’s homes. In 2021, there are at least 500 private child care institutions in the country. Only about 50% are legally licensed by the government. (Alternative Care Thailand, 2021) The average number of children in each facility is 58, making the projected number of children in private children’s homes across the country around 30,000. (CRC Coalition Thailand, 2016) However, this is only one type of residential care. There are other public and private facilities housing children without parental care overnight for an extended period due to parents’ incapacity to care for them. For example, another 1,082 children are in the government Protection and Development Centres for people with Disabilities, and 33,888 are in government charity schools (boarding schools) across the country. (Department of Children and Youth, 2020, pp. 30-31) However, the total number of children in other types of residential care such as school dormitories and temple care is yet to be known.

Apart from residential care, Thailand also has family-based alternative care. Though the number of formal foster and kinship care placements is minimal, informal family-based care arrangements are prevalent due to kinship care's well-established cultural practice. The 2019 Thailand Multiple Indicator Cluster Survey (MICS) found that 23.5% of children in Thailand live with neither biological parent. This increases to 26% in rural areas and is most prevalent in the impoverished North East region at 36%. Of these children, 95.5% live in households headed by their grandparents or other relatives. (National Statistical Office & Unicef, 2020, p. 47)

Concerning different types of alternative care, the Thai government has provided legal platforms primarily for residential care and formal family-based care. A few legal documents were issued to address the standards required and support provided for such care arrangements. However, there is no set of standards to govern all forms of alternative care, apart from the Child Protection Act. The child care sector, particularly the private residential care sector, is “largely accountable to itself”. (Unicef, 2015b) When comparing their child care practice against the *United Nations Guidelines for the Alternative Care of Children*, inconsistency and uninformed practices are found. Only care facilities with active and empowered professionals like social workers exhibit the prevention of unnecessary family separation. (CRC Coalition Thailand, 2018)

Given the existing literature, the followings are the main research questions to guide this study.

1. What are the alternative care options available in the area? Who are the beneficiaries?
2. What are their standards and practices of child care?
3. What would be the impact of a gatekeeping mechanism and family support services on the number of children entering formal alternative care?

The findings presented in this report provide a holistic picture of alternative care provision in an area with high migration in Thailand. The study sheds light on the impact of migration on the usage

of alternative care provision. This research does not only recommend alternative care policy suggestions for both the central government unit and local authorities responsible for child protection; it also calls for broader definitions of the alternative care environment and a clearer perception of the sector.

This study is mixed-method research, and applied quantitative and qualitative methods to fulfil the following research objectives.

1. To study all forms of alternative care in Sangkhlaburi
 - 1.1. To quantify and document all children and facilities of residential care and study their conditions
 - 1.2. To quantify formal and informal family-based care and study their conditions
2. To study the standards and systems of alternative care provided in Sangkhlaburi in comparison with the United Nations Guidelines for the Alternative Care of Children
3. To develop and apply a private institutional care quality assessment tool designed in line with *the United Nations Guidelines for the Alternative Care of Children*.

1.2. Methodology

1.2.1. Research area and period

Given the inclusion criterion of high migration and a previous study on institutional care, the Sangkhlaburi district of Kanchanaburi province was chosen for the study. Nong Lu Subdistrict, the central subdistrict where most of the private residential care in Kanchanaburi province is located, was identified as the research area. Data collection was conducted in all the forms of alternative care in the area; including institutional care, school dormitories, religious organisations, and family-based care. With the global pandemic situation, the data collection period was extended from February – December 2020.

1.2.2. Sample and data collection

This holistic review research collected data from both family-based and residential child care in the area.

1.2.2.1. Family-based care data collection

1. **Families in all villages:** families in all ten villages in Nong Lu Subdistrict, Sangkhlaburi District, Kanchanaburi province were surveyed to quantify family-based alternative child care in the area. The ten officials were already divided into household groups. Data was collected by local village heads, local government staff, or volunteers such as village health volunteers who had been working in each household group for more than one year. The criteria were to ensure that they possess a good understanding of the area and have established relationships with families in their respective area. The survey found 1,090 children in 658 kinship families. Preliminary data of each household was also collected.
2. **Kinship caretakers and children:** after the survey, family-based care arrangements, all of which were informal kinship care, were sampled. Due to the pandemic situation, only four from ten villages located on the Thai-Myanmar border were included in the sampling to avoid unnecessary health risks for the children, their

families, and the research team. A random sampling technique was applied to identify the surveyed families. 34 kinship carers were interviewed, and data of 80 children in their care was collected. 38.8% of the respondents were the children themselves who are above ten years old.

1.2.2.2. Residential care data collection

1. **All types of residential care:** this research recognises residential care every form of extended overnight care given to children without parental care due to their parents' incapacity. Four types of residential care were identified in this research; children's homes (orphanages), school dormitories, religious places, and boarding houses. All residential care operators were contacted to seek their participation. The provincial office of the MSDHS issued formal request letters to each of them to provide more information about this study. All residential care operators were invited to a meeting to learn more about the study and ask questions before participating.

The operators were visited twice at their convenience since the interview was arranged into two sessions. Each session lasted about 1.5 hours.

Thirty-eight residential child care facilities were identified. Four of them (3 religious places and one boarding house) did not have any children under their care at the time of the data collection. Out of 34 facilities, 76.47% (26 residential care operators) participated in this research. However, one private orphanage manager participated only in the first interview and was then instructed not to participate in the second.

As no children were present in the only boarding house at the time of research, the analysis sections of this report refer to only three types of residential care.

Table 1: Number of residential care operators who participated and who did not participate in the research

Types of residential care	Number of care facilities	Number of care facilities having children under their care	Number of operators participated	Number of operators not participated
1. Orphanages	17	17	15	2
2. School dormitories	9	9	8	1
3. Religious places	11	8	3	5
4. Boarding house	1	0	0	0
Total	38	34	26	8

2. **All dependents in residential care:** With the permission of the residential care operators, data of all children in each participating residential care was collected. Children were categorised into three age groups; under 10 years old, 10-12, and 13-17 years old. Another group was identified of those over 18 years old yet still living in residential care as dependents.

Interviews were necessary as no residential care provider was able to offer detailed records for the children in their care that could have been reviewed instead of interviewing children

The data of children under 10 years old was collected from the caretakers. There was no contact between the research team and children under 10 years old. The data of children 10-17 years old was collected through a guided interview with the children themselves, where possible. The interviews were often conducted in the evening when the children returned from school and had some spare time. One on one interviews were conducted privately but in an open space where they were visible to others. The interviews started by clarifying the research purpose, explaining the child's right to participate or not participate, and seeking formal documented consent from the caretakers and children, as per their level of understanding. The average interview time was 10.59 minutes.

At the end of each interview, children were asked to complete a short activity to help them recognise their resources. They were given a page with a drawing of a hand with a question on each finger. The questions were about their best skills, safe space, the one they love most, the one who loves them most, and their best life experience. The purpose of this activity was to end the interview on a positive note rather than to simply capture research data from the children.

786 children participated in this research. The total number of children for interview fluctuated for two main reasons; the school year and the pandemic. Some children were absent from residential care because of the COVID-19 situation, and some residential care facilities did not participate. Therefore, this research collected data of all children living in the residential care facilities at the appointment time, which was between February - September 2020. It is estimated that the number of all children in residential care in Sangkhlaburi is about 1,000.

1.2.3. Research tools

1. **Family-based care survey form:** the survey form was designed to accommodate the data collectors to collect data of each household that has children living without their biological parents. It comprises of nine questions; name and address of the household head for further data collection, name of children without parental care living in the family, age, gender, ethnicity, nationality, religion, relationship to the primary caretaker, and the main reason for not living with their biological parents.
2. **Family-based care questionnaires:** there are two questionnaires for family-based care respondents; one for the carers and another to collect children's data.
 - Questionnaire for kinship carers – there are three sections.
 - Section 1 carer basic information – this includes the name, gender, age, marital status, ethnicity, religion, education, and health
 - Section 2 household information – number of household members, average monthly income, comparison of income and expenses, types of household expenses, welfare or support received, challenges of caring for children
 - Section 3 facilities – building materials, utilities, and vehicles

- Questionnaire to collect data of kinship children – there are five sections. The first three sections are for either the child’s caretaker or the child who is above 10 years old to answer. The fourth section is only for the child who is above 10 years old to answer. The fifth section is only for the caretaker of each child to answer. The sections were designed so that the data of each section can be analysed comparatively.
 - Section 1 children’s basic information – name, gender, age, ethnicity, place of birth, religion, education, health, relationship to the primary caretaker, and the age they entered into care
 - Section 2 biological parents and the relationship between the parents and the child – if each parent is alive, their marital status, location, nationality, religion, the interaction between the biological parents and the child and its frequency
 - Section 3 other information – means to commute to schools, pocket money, and chores that the child does at home
 - Section 4 (only for the child who is above 10 years old to answer) listening to the child’s voice – favourite activities at leisure time, experience in the past month, the main reason for them to be with this caretaker, until what age the child intends to live with this caretaker, any messages for their parents and their caretakers
 - Section 5 (only for the caretaker of each child to answer) child-rearing – the main reason this child lives with the respondent, the main reason the respondent accepted the child under their care, the respondent intends to care for the child until when, any support given by the child’s parents, means of communication with the parents, and their perception on the probability of reintegration

- 3. **Residential care operator questionnaire:** the questionnaire for residential care operators was designed to collect data for this research and to also act as an assessment tool appropriate for private care institutions in the Thai context. This was in line with the research objective of developing and applying a quality assessment tool reflecting the principles in *the United Nations Guidelines for the Alternative Care of Children*. Assessment tools used with public child care institutions and questionnaires from the National Statistical Office were considered in the development process. Moreover, based on experiences of using it, the assessment tool has been further revised and developed to ensure its practicability. There are seven sections in the questionnaire. They were covered in two interviews, so each would not be too long. A few respondents answered both parts in one interview.
 - PART A
 - Section 1 care institution basic information – institution name and address, name, position, residential location and nationality of people of the highest authority, year first accepted a child into care, types of institutions, number and types of children, information on staff and volunteers, including professionals

- Section 2 institution management – umbrella organisation, institution registration with the government, government supervisory visits, financial management including funding and training (topics and which personnel have been trained)
- Section 3 facility – this section is designed per the criteria of orphanage registration. It collects data on the materials used for fencing and bedrooms, space and air capacity per child, water sources and other utilities

○ PART B

- Section 4 child protection policy – written policy and the personnel/visitors acknowledgement of it, policy revision, staff and volunteer background check, disciplining children, abuse or potential abuse cases, and means to promote the institution
- Section 5 accepting and caring for children – referring system used, decision making to accept a child, means to help the family before accepting a child, individual care plan, rules related to maintaining the relationship between the children and their families, and preparing families for reintegration
- Section 6 identity preservation and life skill enhancement – the faith or ideological-based components of the organisation, means to preserve children’s identities, child participation, and activities for children
- Section 7 ending care and following up – conditions or reasons to end care, care termination decision making, preparation before ending care, and follow up plan.

4. **Residential care children questionnaire:** To understand care standards and practice, children’s perspectives need to be considered. The questionnaire was developed in juxtaposition with the questionnaire for residential care operators, allowing for a comparative analysis to be made. This was the same model to develop the questionnaire to collect data of kinship children; themes and questions are similar. This residential care children questionnaire also has five sections. The first three sections are for either the child’s caretaker or the child who is above 10 years old to answer. The fourth section is only for the child who is above 10 years old to answer. The fifth section is only for the caretaker of each child to answer.

- Section 1 children’s basic information – name, gender, age, ethnicity, place of birth, religion, education, and health
- Section 2 ending care and information or previous primary caretaker – duration of stay, people who referred the child into care, previous primary caretaker (relationship with the child, status, location, nationality and religion), biological parents (if each parent is alive, their marital status, location, nationality, and religion)

- Section 3 relationship between the child and the family – the interactions between the family (or previous primary caretaker) and the child, frequency of such interactions, and rules related to maintaining the relationship between the children and their families
- Section 4 (only for the child who is above 10 years old to answer) listening to the child’s voice – favourite activities at leisure time, experience in the past month, the main reason for them to be with this caretaker, the age the child intends to live with this caretaker until, messages to the current caretakers at the institutions and messages to the parents or previous primary caregiver
- Section 5 (only for the caretaker of each child to answer) child-rearing – the main reason this child lives with the respondent, the main reason the respondent accepted the child under their care, the respondent intends to care for the child until what age, support given by the child’s parents, means of communication with the parents, and perception on the probability of reintegration. In the last section of the questionnaire, each child was asked to do a small activity – colouring and answering questions to help them recognise their resources. A page with a drawing of a hand with a question on each finger was given to each child. The questions were about their best skills, safe space, the one they love most, the one who loves them most, and their best life experience.

The key questionnaires were sent to three child protection experts for their review. After the revision, key questionnaires were pretested by the trained research assistants to increase their familiarisation with the tool and to revise the tools further. The pretesting was conducted in a district in Kanchanaburi province at 3 locations; a private children’s home, a Buddhist temple with novices, and a school dormitory.

1.2.4. Research team

Apart from the researchers, the data collection was also conducted by a team of 10 field researchers. The team were recruited in the local area. All are university graduates, have worked with children and young people, and understand the local context. The field research team collected data from children both in kinship and residential care. The team also conducted data entry.

1.2.5. Data management and analysis

Statistical software was employed for data management and analysis. The data was entered into the program by the research assistants, and the data cleaning was conducted by applying the frequencies command to check the values. In the analysis, two main principles of necessity and suitability, reflecting the *United Nations Guidelines for the Alternative Care of Children*, were used as a framework to answer all research questions.

1.2.6. Research ethical concerns and child protection policy

All the questionnaires, research information sheets, and consent forms for different age groups were sent together with the methodology to the Committee for Research Ethics (Social Sciences) (MUSSIRB), Mahidol University and were approved. (Certificate of approval number

2020/010.2801) Before each data collection, the respondent, regardless of their age, would be informed of the research objectives, research benefits, principle of confidentiality, the approximate time needed for their participation, and other essential information of the study.

A consent form was then presented. The respondents right to withdraw at any time or to decline to answer any of the questions without any consequences was ensured. The respondents and their caretakers, where applicable, signed on the information sheet and the consent form before the interviews began.

Concerning the child protection policy, every research team member and research assistant were given training on interacting with children and respecting their rights. Given their situation of living without parental care, questions about the biological parents could be sensitive. Therefore, the research assistants were trained and instructed to be very careful in posing such questions. Additionally, no photos of the child were taken and present to the public. If there was an observer, they were also required to sign and follow the guidance of the child protection form.

1.2.7. COVID-19 limitations

Thailand was among the first group of countries with confirmed cases of COVID-19. However, during the data collection, the country’s pandemic situation was still controllable, with no confirmed cases in the research area. Still, the data collection was significantly delayed in 2020. The postponement of the data collection gave the lead researcher more time to revise the research tools. When the lockdown restrictions were lifted, the research team collected data with precautions to reduce risks to the children and researchers.

The period with lighter restrictions allowed the research team to collect data from households providing family-based care, but not the qualitative focus group discussions with different groups of key informants as previously planned. However, the research team has developed tools ready to be used if there is an opportunity in the future.

1.3. Estimating the number of children in Nong Lu

To compare data in this research to the national average, we estimated the total number of children in the research area to be 10,588

It was difficult to find an accurate number for the population of children in the research target area of Nong Lu subdistrict. The local official data for the total population is as follows:

Table 2: Estimated number of children in Nong Lu

	Thai		Non Thai	
	male	female	male	female
Or Bor Tor Nong Lu (Sub district administrative office) (Nong Lu Subdistrict Administrative Office, 2021)		4,540	8,530	8,082
	9,447		16,612	
	26,059			
Thesaban Wang Ga (Wang Ga municipality) Registration Officer of Wang Ka Subdistrict Municipality (personal communication, April 2021)	3,498	3,305	1,207	1,247
	6,803		2,454	
	9,257			

The total population of the research target are $26,059 + 9,257 = 35,316$ people

Those classified as Thai are only Thai citizens (with a Thai ID card). Those with other government-issued documents such as colour cards are counted in the non-Thai group and those with no documentation. It is not certain how many people without any documentation are not counted, but most local people seem confident that the actual population is greater than the official 35,316.

The National Statistical Office Website provides population data from 2020. Unfortunately, they have measured the population of children within a category of those aged 19 years and under. (Rather than 17 or under). Their nationwide data shows that 22.22 % of the population are 19 and under. For Kanchanaburi province, 21.68% of the population are 19 and under. This data does not include non-Thai people. The website quotes 750,000 non-Thai people for the whole country, which seems relatively low.

Thailand Multiple Indicator Cluster Survey (MICS) 2019 identified that 20.9% of the Thai population was 17 or under. This was an average combining both urban and rural areas.

If Kanchanaburi's 21.68% is applied to the official Nong Lu population of 35,316, the estimated number of children would be 7,657.

We took another approach by obtaining the current numbers of children registered in grade one of primary school in all the 11 primary schools within Nong Lu. This data was collected from the zone three education office and individual schools in April 2021. The total number of children was 751. Although there is a high dropout rate at higher grades, local teachers and NGO staff are confident that a very high percentage of all children attend school at this stage, including non-Thai children with no documentation.

To assume that 751 represents all of the children born in one year, multiply it by 18; the result is the estimation of the total number of children $751 \times 18 = 13,518$. Some of the children in Nong Lu primary schools travel each day from neighbouring sub-districts and Myanmar, while many teenagers drop out of school and leave the area to find work elsewhere. Hence, the number of teenagers who were born within the same one-year period and are still in the Nong Lu area is likely to be less than 751.

The 7,657 and 13,518 figures set likely minimum and maximum numbers for the actual population of children in Nong Lu at the time of this research. We will therefore use the midpoint between these two values of 10,588 children for our calculations and comparisons.

Another challenge is determining the percentage of children in the research area who lives in different types of alternative care. There are certainly children from neighbouring subdistricts and Myanmar living in Residential care in Nong Lu as well. It is also clear that some private facilities and even government dormitories are caring for children who were previously living with their families in Myanmar.¹ Counterbalancing this intake of children from outside the area is the finding that a significant number of children from inside the area are living in High School dormitories in other parts of the province.

All of these factors must be considered when viewing the proportions of children in each type of Alternative Care and comparing those groups to the general child population of Nong Lu and the national average.

¹ This movement of children has been stopped due to the strict closing of the border during the covid situation, leaving some children unable to return from the families in Myanmar and others in Thailand unable to visit their families.



2. Children in alternative care

This research involved 1,876 children in alternative care. 58% of them were in informal kinship care, 20% in private orphanages, 19% in school dormitories, and another 3% in the care of religious organisations. 6.26% of all respondents are adults ranging from 18-34 years old. They were counted as “children” because they have lived there since they were not yet 18 years old and continue to depend upon the care received even after adulthood.

The highest percentage of dependent adults was found in private residential care. Adult dependents account for 13.23% of respondents in all types of residential care. No adult dependents were recorded in kinship care as researchers were instructed only to record those under 18 years old.

Figure 1: Percentage of children in each type of alternative care available in the research area

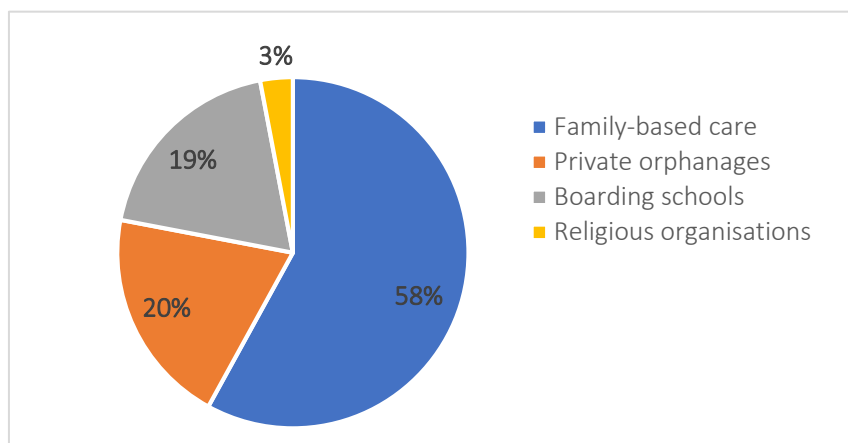
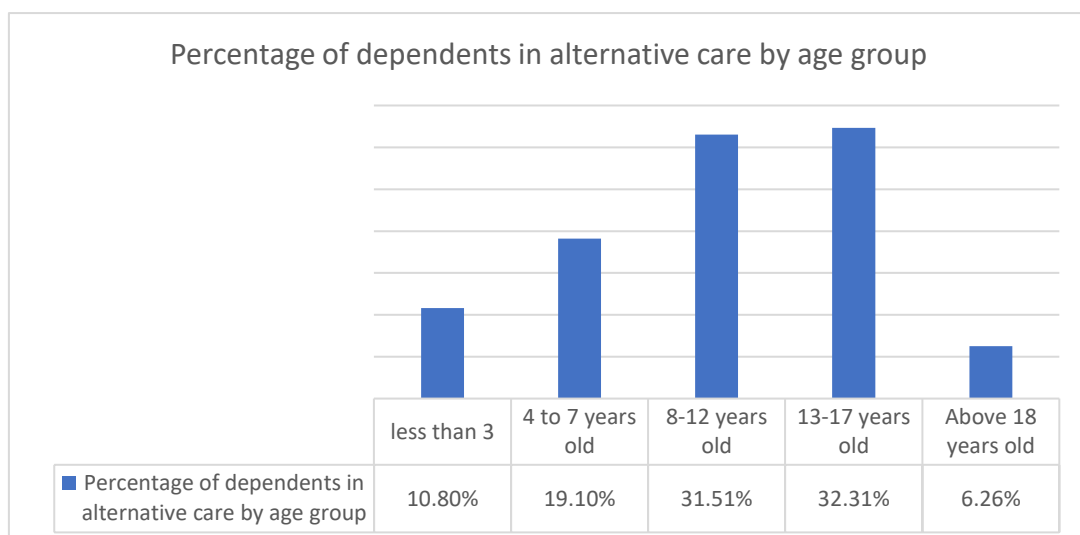


Figure 2: Percentage of dependents in alternative care by age group



63.82% of children in alternative care are older children age above 8 years old. The average age of children without parental care is 10.51 years old. However, the average age of children in kinship care is much lower than the average for residential care (detailed later in this report). The sex ratio is 96.85, as 49.2% are males and 50.8% are females. Regarding ethnicity, 30.2% of children are self-identified as Thai, 33.6% are Karen, and 27.5% are Mon.

Comparison to national averages

786 children living in residential care were interviewed for this research (or their carer was interviewed if they were aged under 10 years). Some children were absent, having not returned from visiting their family due to covid restrictions. Two private children's homes and five temples declined to take part in the research. We estimate the actual number of children in residential care to be about 1,000.

Using our estimation of 10,558 children in Nong Lu subdistrict, 9.47% of children are in residential care. However, while there are temples and school dormitories in the other subdistricts of Sangkhlaburi there are no private children's homes. Also, it has to be assumed that some of the children counted here are from those neighbouring subdistricts. This is counterbalanced by the finding that significant numbers of children from Nong Lu are in dormitory and boarding schools elsewhere in the province.

There is little national data available regarding children in residential care. Many private children's homes remain unregistered, and those that have registered with the government do not report the updated number of children currently under their care.

A coalition of NGO's called Alternative Care Thailand (ACT) has documented 545 private children's homes in Thailand (2021). The actual number is believed to be much higher. The average size of these private children's homes is 58 children (CRC Coalition Thailand, 2016), suggesting at least 31,610 children are living in private children's homes. ACT's documentation of private children's homes has been running for five years, and new care facilities are continued to be discovered. The final number could be more than 1,000 private homes. This enables us to set a maximum number of 58,000 children in private residential care in Thailand.

ACT's work has also shown that the distribution of private children's homes is very uneven. Some provinces are having more than 100 private children's homes, while some are having none. Nong Lu is one of 7,255 sub-districts or Tambons in Thailand. Yet, it has more private children's homes than many of the 76 provinces that make up Thailand.

With estimated 14,620,364 children in Thailand, 58,000 living in private residential care would represent only 0.4%. In this research, 377 children were found living in private residential care (children's homes), representing 3.56% of the children in Nong Lu – nine times greater than the national average. These numbers are rather crude; however, what is clear is that private children's homes in Thailand are a local or regional issue and not a ubiquitous one. In Nong Lu, the private children's homes and the children within them are vastly out of proportion with the national average. One of the impacts of that appears to be that the number of children living in kinship care is less than 50% of the national average.

Therefore, it is a reasonable question to ask whether the prevalence of private children's homes in Nong Lu is a response to a high rate of support needs among children. While that may be true in the hearts and minds of those who have opened private children's homes in the area, the findings of this research are that most children are in need of help because of poverty and access to education. By working together, all stakeholders should find solutions for these children that do not involve family separation.

It was beyond the scope of this research to establish a national average for the numbers of children in school dormitories and temples. Of the children interviewed in temple care, the numbers were relatively low, and many seem to stay for a short time. This is very different to some of the large

temples elsewhere in Thailand that often have hundreds of children; in effect, operating as huge children’s homes.

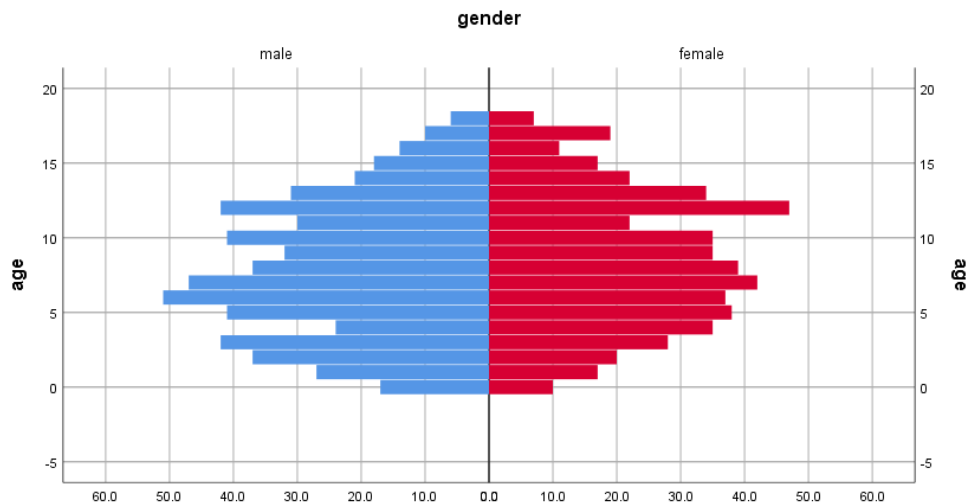
Among school dormitories, there was overcrowding and low staff ratios. High numbers of young children in one primary school dormitory were of concern. There was clear evidence that poverty was the reason many children stayed at the high school dormitory. The total student number at the High school was 1,622, so the 130 students staying in the dormitory represent 8%. It is unknown how this compares to other high schools in Thailand. It can be assumed that in rural areas like Nong Lu, the percentage will be higher than in urban areas.

2.1.Children in family-based care

The survey found that the largest number of children in alternative care are in family-based care. However, the prevalence of children in family-based care was less than 50% of the national average. In contrast, the number of children in residential care was much greater than the national average and was very close to family-based care.

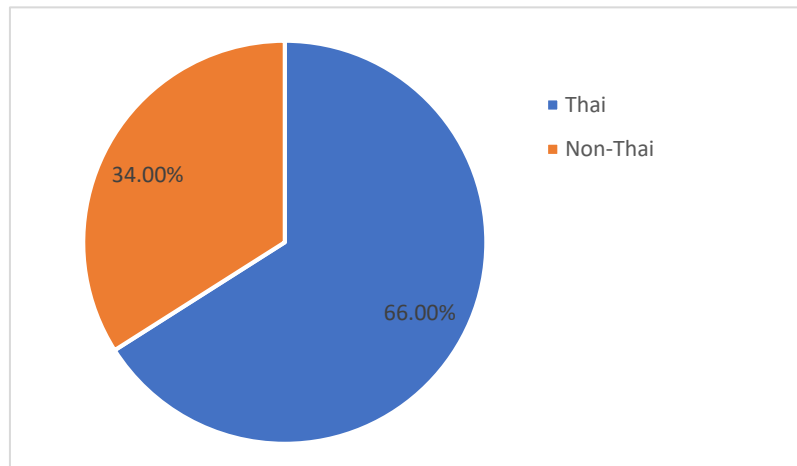
In the research area, no formal foster and kinship care were found. All 1,090 children in family-based arrangements are in informal kinship care. Almost 50% of the children in kinship care were found in two of the ten official villages that make up Nong Lu sub-district. The average age of children in kinship care is 8.18 years old. 60.6% of the children are under ten years old. Males are slightly more than female with a sex ratio of 110.01. 52.4% are boys, and 47.8% are girls.

Figure 3: Population pyramid of children in family-based care, age by gender



The ethnic make-up of this group was: Thai (38%), Mon (32%), Karen (24%), Laos (3.3%), Burmese (3%), and Karang (0.3%). 66% of all children in family-based care have Thai nationality, while 20.6% has other identification documents issued by the government. 13.4% do not have any identification document indicating the challenges of acquiring services and welfare available. Regarding faith and beliefs; 92% are Buddhist, 6% are Christian, 1.4% Muslim, 0.3% Ananda Marga, 0.2% Animist.

Figure 4: Percentage of Thai and non-Thai children in kinship care



The main reasons separating the kinship children from their biological parents are parental divorce (42.3%) and their parents' outmigration. (41.2%) Both reasons result in the lack of caretakers, hence having the children live with relatives.

When sampling further with 80 kinship children living in 34 households, 49 children (61%) were under ten years old. This is consistent with the ages recorded for the entire 1090 children in kinship care, where 60.6% were under ten years old.

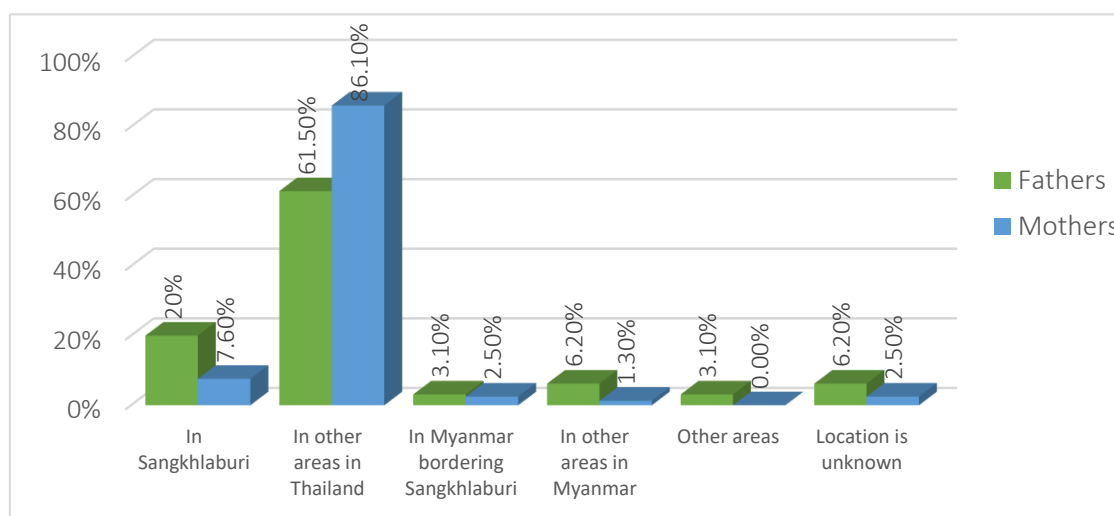
All but one of the children said they were born in Thailand; 62.5% has Thai ID card, 25% has other government-issued cards, and 12.5% had no ID document. The majority of them had been in kinship care since a very young age. 50% of these children have been in kinship care since they were aged one year or less. 76.3% were in kinship care before they were five years old. Regarding the duration of stay, 9% of these children have been in kinship care for one year or less. 25% of these children have been in kinship care for 10 years or more.

Of 80 kinship children, 15 children (19%) of kinship children are single orphans, 14 children have lost their father, and one child has lost their mother. This research found no double orphans in kinship care. Of the remaining 65 children, 35 children said their parents had divorced, 27 said their parents were still married and living together, one said parents are separated by work in different places. Two said parents separated for other reasons. This means that among the children in kinship care who have two living parents, 54% have divorced parents.

The majority of divorced or widowed parents have remarried. 49 mothers who had divorced or whose husband had died, 37 had remarried. 16 fathers had remarried. Eight did not know about their father's situation, and 3 did not know about their mother's situation.

Of the parents who are still alive, most live in another area, with mothers less likely than fathers to have stayed in the same area as their children. Of the 66 living fathers, 40 live elsewhere in Thailand. 13 are in the local area, six in Myanmar and seven unknowns. Of the 79 living mothers, 67 live elsewhere in Thailand, and six live locally, three in Myanmar and four unknowns.

Figure 5: Recent locations of parents of children in family-based care



Most children are in regular contact with their parents. Most said that they and/or their kinship carer receive financial support from their parents. In the previous 12 months, 63 children had been visited by their parents. Some children very frequently and others less often. Sixty-eight children are in contact with their parents by telephone, and 41 children have their own phone (with 34 having internet access).

70 out of 80 children said that their parents send some money to their kinship carer. Fifty-five children said that they receive some money themselves from their parents. Seventy-one kinship carers contact the children's parents and share information and updates about the children.

In the traditional Thai context, large extended families may have lived in the same village for many generations. The pressures of urbanisation have seen parents migrate to cities or even overseas to find work. Children remain at home, often with grandparents (Institute for Population and Social Research & Unicef, 2016, p. 24) and with other relatives in the same area. Thai parents face no legal barriers to moving around the country or finding employment.

It seems a reasonable assumption that kinship care in a large extended family rooted in an area for a long time would be more stable than migrant kinship family, who were uprooted and moved to another country, usually in small groups rather than as a larger extended family unit. Additional factors such as ethnicity, lack of Thai documentation and religion are explored more in the following sections. Although Sangkhlaburi is recognised as a major entry point for migrants from Myanmar, there are still many barriers for non-Thai people to travel further in Thailand and find employment.

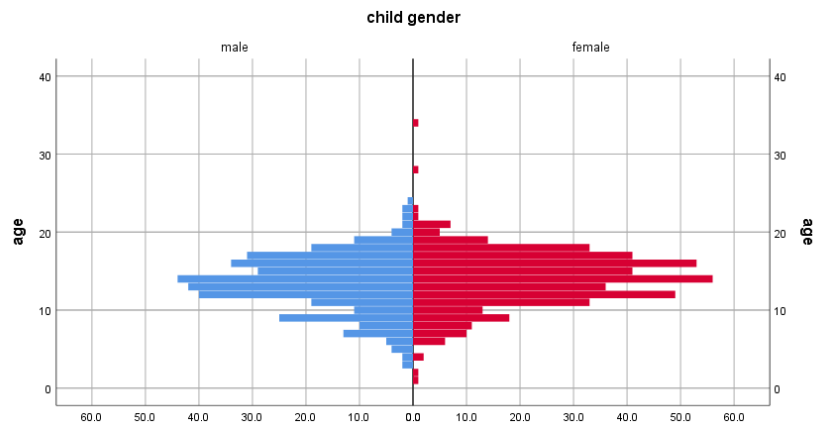
Although the percentage of children in the research target area in Alternative Care is very significant at 19%, it is lower than the national average of 23.5% of children not living with either biological parent found in the 2019 MICS. (National Statistical Office & Unicef, 2020) One explanation is that parents' level of economic migration from Sangkhlaburi into other parts of Thailand is actually lower than from other rural areas of Thailand, where the migrating parents are likely to be Thai citizens and therefore take fewer risks and face less barriers. It could also be that many migrant parents take their children with them as they do not have a stable kinship arrangement available to them.

Both the high death rate among fathers and the high divorce rate are concerning factors and clearly impact the number of children entering kinship care and residential care.

2.2. Dependents in residential care

Among the dependents of all three different types of residential care, 44.8% are males, and 55.2% are females. The age ranges from less than one year old to 34 years old. The average age of all dependents in residential care is 13.73 years old compared to 8.18 years for children in kinship care.

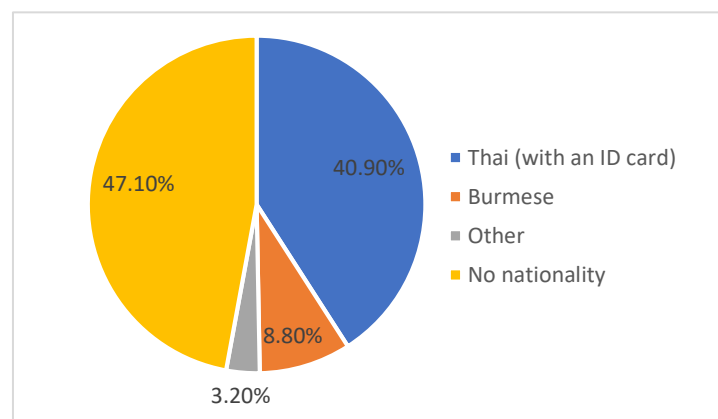
Figure 6: Population pyramid of residential care dependents, age by gender



Residential care dependents are not all children. 13.23% are adults (18-34 years old). Among this group, 74% of them are 18-19 years old. 72.5% were enrolled in formal education, resonating with the 73.1% of all children in residential care who indicated that the most important reason for them to live in residential care is to have an education. However, some adults live in residential care as dependents for other reasons, including having physical and mental disabilities.

The majority of residential care dependents are Karen (47.8%) and Mon (20.8%), respectively. Regarding citizenship, 47.1% possess none, while 40.90% are of Thai nationality even though 79.5% claim to have been born in Thailand. Despite the educational access granted to all children, there are at least three children in residential care whose primary reason for not enrolling for school is having no nationality.

Figure 7: Nationality of residential care dependents



When calculating the length of stay of all residential care dependents, the median and mode are 36 months or three years. 28.4% first entered residential care while they were between 10 to 13 years old. 51.9% were brought to the care facility by their parents. The other 29.7% were there by

the decisions of their primary caretakers or relatives. Furthermore, at least 14% lived in other child care facilities before, which could mean children changed schools.

Looking at private residential care facilities alone, the average duration of stay is significantly longer at about 68 months or 5.6 years. When first accepted into institutional care, the average age is 9.29 years old, but the majority entered care at 7 years old. 44.9% were sent to private residential care by their parents, and 36.2% by their main caretakers or relatives. At least 10.3% said they used to live in institutional care before entering this care.

The majority of residential care dependents are not orphans. Before entering residential care, 89.13% were living with either their parents or relatives. Around 70.73% indicates that both of their parents are alive. Only 4.32% are double orphans whose parents have both passed away, and another 14.50% are single orphans who still have one living parent. Many children do not know their parents' whereabouts, meaning they are potential single or double orphans. If we combine the potential double orphans with the confirmed double orphans, it gives us a maximum of 9.92% of the residential care dependents without both parents. The average age is 14.42 years old, and 87.2% are non-Thai or do not know.

Table 3: Percentage of types of residential care dependents on orphanhood

Types of children in residential care	Percentage
Children whose both parents are alive	70.73%
Potential single orphans*	4.83%
Single orphans	14.50%
Potential double orphans	5.59%
Double orphans	4.32%
Total	100%

*Not knowing about or cannot reach one or both parents

The main reasons children entered residential care were poverty and access to education. From the caretaker's perspective, 32.3% of all residential care dependents were accepted into care because their homes are far from schools, 6.9% because they could not afford education, and 26.5% because they are poor. However, because this research defines school dormitories in the local context as residential care, pupils residing in school facilities were also calculated. If we consider only private institutional care's dependents, the most common main reasons for entering care is poverty (31%).

Although Sangkhlaburi is a rural district, the distances to primary schools are not very far, and even the only high school is at most 25km. Many children travel daily from all of the villages within the high school catchment area. In most cases, it is reasonable to assume that when "home is far from school" is cited as the reason to enter residential care; poverty is the underlying reason. Transport costs and keeping teenager clothed and fed can be a challenge for many families in the area. The average monthly income among the kinship families interviewed in this research was 883 Baht per person per month. The monthly transport cost to the high school from one of the further away villages can cost this much.

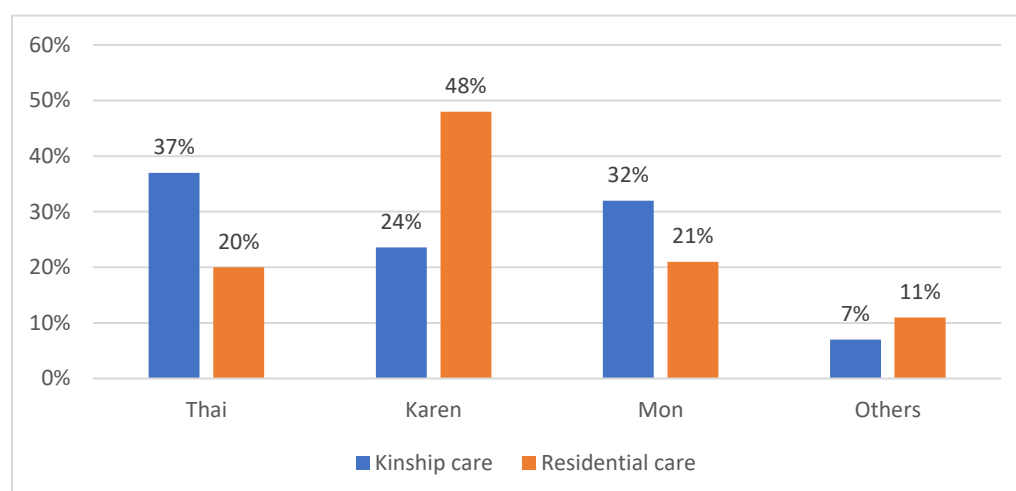
2.3. Comparison of children in Family-Based care to those in Residential Care

The profile of the group of children in family-based Alternative Care is very different to the profile of children residential care settings. Only 5.6% of the 786 children in residential care settings were aged under ten years compared to 60.6% in kinship care. More boys are in kinship care (52%/48%), yet more girls than boys in residential care (55%/45%). The percentage of girls grows to 61.5% in private residential care.

The average age of all dependents in residential care is 13.73 years old, older than the average age of children in family-based care at 8.18 years. This is partly because the age of all 786 residential care dependents, including 52 young adults, were calculated. But for the age of family-based care children, only data of those under 18 years old were collected.

The ethnic identity of the children is also very different. Thai ethnicity is the most common among children in kinship care (38%), followed by Mon (32%) and Karen (24%) and others (7%). This is very different to the children in residential care with Karen (48%), Mon (21%), Thai (20%), Burmese (8%), others (3%).

Figure 8: Percentage of residential and kinship care children's ethnicity



66% of children in kinship care are Thai nationals. 21% having a Thai government-issued document. 39% of children in residential care are Thai nationals, with 24% having a Thai government-issued document. 13% of children in kinship care have no documentation compared to 36% in residential care.

92% of children in kinship care said they were Buddhist, whereas 59% in residential care are Buddhist. 6% of children in Kinship are Christian compared to 38% in all types of residential care. However, most children who identify as Christian are in private care institutions rather than Thai government school dormitories:

Table 4: Percentage of children's religion, by types of residential care

	Private care institutions (Children's Homes) 377 children	Religious orgs (temples) 51 children	School dormitories 357 children
Buddhist	40%	100%	73%
Christian	57%		24%
Other	3%		3%

The movement of children from kinship care to residential care

The research identified 150 children (19%) among the 786 in residential care who had previously been living in kinship care. If we add children living with a non-related person, such as a neighbour known to the child closely for many years before entering residential care, this will increase the total to 187 children (24%).

Looking at this group, we can see clear indicators of what makes children in kinship care more vulnerable to being placed in residential care.

Table 5: Comparing key data of children in residential care, in kinship care, and in residential care who used to be in kinship care

	Children in residential care at the time of research	Children in residential care who used to be in kinship care	Children in kinship care at the time of research
No. of children	786	150	1090
Under 10 years old	5.6%	5.3%	60.6%
Religion			
• Buddhist	59%	58%	92%
• Christian	38%	39%	6%
Ethnicity			
• Thai ethnic	20%	18%	38%
• Karen ethnic	48%	48%	24%
• Mon ethnic	21%	23%	32%
Legal status			
• Thai National	39%	38%	66%
• Thai gov issued paperwork	24%	No data	21%
• No documentation	36%	53%	13%

Karen children and children with no Thai documents are at higher risk of moving from kinship care into residential care based on their over-representation in residential care than their presence in the population of children in kinship care.

Christians in Nong Lu are most commonly of Karen ethnicity. The number of Christians outside of the Karen community is small. However, not all Karen people are Christians. Among the 34 kinship carers interviewed, 15 gave their ethnicity as Karen, yet only one carer said they were Christian. Thirty-three said they are Buddhist. This leaves us with a question not answered by this research about how many children were Christian before entering residential care and how many became Christian after entering.

There is a significant difference in the numbers of single and double orphans in different Alternative Care settings:

Table 6: Number of double and single orphans in different groups of children

	Residential care at the time of research	Residential Care who used to be in Kinship Before	Kinship care at the time of research
No. of children	786	150	1090 (sample size 80 children in 35 households)
Double orphans	34 children (4.32%)	17 children (11%)	No children
Single orphans	114 children (14.5%)	27 children (18%)	15 children (19%)

50% of double orphans in residential care were in kinship care before (17 out of 34 children). There are no double orphans in kinship care, suggesting it is challenging for kinship carers to keep children with them if both parents have died and there is no one to offer financial support.

However, the percentage of single orphans is higher among children in kinship care than in residential care, suggesting that as long as one parent is still alive and offering financial help, kinship carers can keep children with them.

The percentage of single orphans in kinship care is almost identical to the percentage of single orphans in residential care who were previously in kinship care. We can summarise that there is little chance for children to remain with a kinship carer if both parents have died. Our data suggest that if one parent has died, then there is a 50% chance that a child will be able to remain with a kinship carer rather than move into residential care. The factors that will play a role in this outcome include the nationality of the parents and carers, whether they find support from the government or private organisations, their ethnicity and religion.

In addition, if we look at parents whom children cannot reach and do not know about, we can see the potential single and double orphans should these parents be confirmed as deceased:

Table 7: Potential single and double orphans, by different groups of children

	Residential care at the time of research	Residential Care who used to be in Kinship Before	Kinship care at the time of research
No. of children	786	150	1090 (sample size 80 children in 35 households)
Father alive and do not know about mother or Mother alive but do not know about father – potential single orphans.	38 children (4.8%)	5 children (3.3%)	4 children (5%)
Do not know about father or mother or one parent is dead and do not know about the other – potential double orphans	44 children (5.6%)	15 children (10%)	No children (0%)

More children in residential care do not know where their parents are or alive, compared to those in kinship care. This supports other evidence gathered during this reach that suggests residential care facilities could do much more to maintain and strengthen family connections and relationships.

Among single orphans in kinship care, 93% have lost their father compared to 71% in residential care. As there are no double orphans in kinship care, it appears that surviving parents of single orphans in kinship care have an important role in supporting the kinship carer. The role of these surviving parents seems less vital once a child enters residential care. Only 7% of single orphans in kinship care have a living father compared to 29% in residential care. We have also seen that the most common kinship carers are maternal grandparents. For single orphans in kinship care, it appears that they are less likely to enter residential care if their surviving parent is their mother and if the kinship carer is the maternal grandmother.

Most parents continue to be an essential part of children's lives when they are in kinship care, providing financial support and keeping in regular contact. If both parents die and this support is no longer available, it is challenging for kinship carers to look after children. This research did not find any double orphans living in kinship care at the time of research. Yet, the group of children in residential care who were previously in kinship care has the highest proportion of double orphans of any group of participated children.

29% of children in residential care who had previously been in kinship care had entered residential care in the last six months. This is a significant increase compared to the previous few years. It is likely the result of the economic impact of covid on some of the kinship families. Interviews with kinship carers showed that many of these families struggle financially and do not have access to the Thai government welfare programs.

2.4. Orphans

Research has consistently shown that around 90% of children living in orphanages worldwide have at least one living parent. This section will look at how many children in this research have lost one or both parents.

UNICEF and global partners define an orphan as a child under 18 years of age who has lost one or both parents to any cause of death. By this definition, there were nearly 140 million orphans globally in 2015, including 61 million in Asia. (Unicef, 2015a)

Thailand Multiple Indicator Cluster Survey (MICS) 2019 (National Statistical Office & Unicef, 2020) identified that 3.2% of children in Thailand had lost one or both parents. In urban areas, this drops to 2.8% and in rural areas increases to 3.5%.

Using the findings from the sample group of kinship care interviews of zero double orphans and 19% single orphans, we can estimate 207 single orphans among the 1,090 children in kinship care. When combined with the double and single orphans found in residential care, the total is $207+114+34 = 355$ children, who have lost one or both parents among the 1,876 children in all forms of Alternative Care. At 18.9%, this is much bigger than the national average. This percentage could be even higher if any of the parents whose whereabouts are unknown were confirmed dead.

It is worth noting that only 34 out of 355 children are double orphans. These numbers confirm the challenges faced by surviving parents and kinship carers after the death of one or both parents and the need for more support so that they can continue to care for their children without relinquishing them to residential care.

From this research, among the 786 dependents living in residential care, 556 Children (71%) have two living parents. Thirty-four children (4.32%) are double orphans (both mother and father have died). Nine of these double orphans were aged 18 or older at the time of the research. If we follow

the strict definition of an orphan as a child under 18 years old, then the number of double orphans identified in this research drops to 25 children (3.2%).

One hundred fourteen children (14.5%) are single orphans (either mother or father has died but not both). Twenty of these single orphans were aged 18 or older at the time of the research. If we follow the strict definition of an orphan as a child under 18 years old, then the number of single orphans identified in this research drops to 94 children (12%).

In addition, 44 children (5.6%) do not know where their father is and have no contact, and seven children (0.9%) do not know where their mother is and have no contact. A further 31 children (3.9%) do not know where their mother or father is and have no contact.

There is a significant difference in the numbers of single and double orphans in different Alternative Care settings:

Table 8: Numbers of single and double orphans in different alternative care settings

	Residential care at the time of research	Residential Care who used to be in kinship Before	Kinship care at the time of research
No. of children	786	150	1090 (sample size 80 children in 35 households)
Double orphans	34 children (4.32%)	17 children (11%)	No children
Single orphans	114 children (14.5%)	27 children (18%)	15 children (19%)

2.4.1. Confirmed double orphans in residential care

This research identified 34 double orphans in residential care, all entered residential care as children, but nine are now over 18 years old. Seventeen are male, and 17 are female. An assumption has been made that the children were double orphans when they entered residential care. However, the interview questions did not specify this, and some of these children may have become double orphans after entering care.

At the time of research, the youngest double orphan was four years old. The next youngest are two children aged eight. The fourth and fifth youngest are two children aged eleven. This suggests that for at least four years, no babies have entered (and remained in) residential care in Sangkhlaburi because they are double orphans.

Ten of the older double orphans entered residential care before they were five years old. It appears that there has been a reduction in the numbers of very young double orphans entering residential care in recent years. Interestingly, no double orphans were identified in our sample of 80 children among the 1,090 children in kinship care. However, 17 of the double orphans in residential care had previously been in kinship care.

One suggestion to explain this reduction in double orphans in Alternative Care is improved access to HIV treatment and access to medical insurance for migrant parents. However, it is beyond the scope of this research to confirm this.

With hindsight, some interview questions were narrow. This results in most double orphans stating the reason for entering residential care as “parents have passed away”. It is more helpful to look at whom they were living with before entering care and whether they still have contact with their family, indicating their previous caretakers. From 34 confirmed double orphans in residential care, it is found that 17 children (50%) lived with kinship carers, seven with their mother, five with both parents, two with their father, and three did not answer this question or did not know. Of the 17 children previously in kinship care, eight were with maternal grandparents, five with maternal aunt or uncle, three with siblings and one with paternal grandparents.

Regarding their contact with their family or previous caretakers in the last 12 months, nine children (26.5%) were visited by their family. Twelve children (35%) visited family, particularly during school holiday. Fifteen children (44%) had other types of contact with family, such as phone calls.

Among the double orphans, only five children (15%) said they had a Thai ID card. Sixteen children (47%) indicated they had no nationality. The rest specified that they are Burmese (3) or they do not know (or do not answer) (10). Karen is the most common ethnicity (13), then Mon (10), Burmese (5) and one each for Thai and Karang. Four did not know or did not answer.

2.4.2. Confirmed single orphans

Among the 114 confirmed single orphans in residential care, there were 48 males and 66 females. Thailand Multiple Indicator Cluster Survey (MICS) 2019 also identified more girls than boys to be single orphans throughout Thailand. (National Statistical Office & Unicef, 2020) Likely, a significant number of teenage boys are not counted in such surveys and research because they are no longer living in the family household or residential facility. Both MICS and our data show that the school dropout rate among boys is much higher than girls. Explanations include:

- Many of these boys have left home and are working.
- Boys appear much more likely to become involved in drug-taking. Kanchanaburi juvenile detention centre typically has 40 to 45 residents. They rarely have any girls. It is common to have around 25% of the boys in residence come from the Nong Lu subdistrict, a population of 35,316 within a province of almost 1 million. The offences are almost always drug-related. (personal communication, July 2020).
- By 18 years of age, the gap in numbers between men and women becomes apparent as teenage boys and young men die in greater numbers due to motorbike accidents and unsafe working environments.

This research found that 71% of single orphans in residential care have lost their father compared to 29% losing their mother. Migrant mothers, especially those with no documentation, can find themselves with little or no support if they divorce or become widowed. Many opt to remarry, often to older men. Anecdotal evidence suggests that sexual abuse of girls by stepfathers is common in the area. This could be one reason single mothers are more likely to put their daughters into residential care than their sons.

Among 15 single orphans in kinship care, 93% have lost their father compared to 71% in residential care (based on the sample group of 80 children). There were nine boys and six girls. This is based on a small sample group but does suggest some differences between where a widowed mother might place her son or her daughter if she feels unable to care for them or needs to move away to find work.

Among the single orphans in residential care, 32 children (28%) said they had a Thai ID card. Fifty-six children (49%) said they had no nationality. Of the rest, 11 children indicated Burmese nationality, 3 of other nationalities, and 12 did not know or did not answer. Karen is the most common ethnicity (58), Mon (26), Thai (13), Burmese (10), Karang (3) and four do not know or did not answer.

At the time of research, the youngest single orphans in residential care were two children aged six. There was a small number of children of each age from six up to age ten. This is a sharp contrast to the number of children aged 11 years old (8) and 12 years old (18), which are secondary school age. It is when a steep increase in education costs might be a challenge for single parents.

Historically, 20 children (17.5%) entered residential care when they were under five years old, with four of these children being under one year of age. As the youngest single orphan at the time of research was already six years old, it is assumed that no single orphan under five years of age has entered residential care for at least a year.

Before entering residential care, 72 children lived with parents; 11 with their father, 39 with their mother and 22 with both parents. There was no evidence to confirm whether the 22 children living with both parents became single orphans after they entered residential care or if they entered immediately after the death of one of their parents.

Thirty-two children (28%) were living in kinship care with siblings (5), paternal grandparents (1), paternal aunt or uncle (5), maternal grandparents (9), maternal aunt or uncle (5), a non-related person (7). Additional nine children (7.9%) were living with another organisation, and one child/carer did not know or did not answer.

In the past 12 months, 69 single orphans (60.5%) have been visited by family. Eighty-two children (72%) have visited their family, and 75 children (66%) have contacted the family in the last 12 months.

Fifty-six children (49%) said the reason they came to live in residential care was either poverty or lack of access to education. Thirty-seven children (32%) selected “other or did not know or did not answer”. The remaining children/carers mostly said parents were living elsewhere in Thailand or that there was no one to take care of them.

2.4.3. Children who do not know where their parents are and have no contact

Among 114 single orphans, 81 children (71%) have lost their father, and 33 children (29%) have lost their mother. Among the 81 children whose father has died, four children do not know where their mother is and have no contact. Among the 33 children whose mother has died, nine children do not know where their father is and have no contact. In addition, 31 children do not know where either their mother or father is and have no contact.

Some of these children are likely to be siblings and refer to the same mother and father. If non are siblings, we can consider 35 mothers and 40 fathers who cannot be contacted. If all of these parents have died, then the number of double orphans would increase by 44 children. It would increase the number of double orphans to 79 children, which would account for 10% of children in residential care. Therefore we can be confident that at least 90% of the children in residential care have at least one living parent.

The 31 children who do not know if their mother or father is alive are potentially double orphans.

Twenty-seven of them (87%) were aged ten or older at the research time, while another four were younger than ten years old. Among the 31 children, 11 of them were identified as an orphan by the caretakers. (although answers did not specify if this was one or both parents). The age range of these 11 dependents was from 11 to 19.

These children live in three children's homes and one temple. Seven of them live in the same children's home. This children's home was also where many other children said they did not know about one of their parents and whether they were alive or not. Some children may be reluctant to talk about the death of their parents. However, there is a possibility that some children's homes do not have accurate information about parents or that they are withholding information about the death of parents from children who are old enough to know about it.

Such a high number of children not knowing whether their parents are alive or not indicates a systemic failure, especially in the vital role that residential care facilities have in maintaining family bonds. If working in the spirit of the *United Nations Guidelines for the Alternative Care of Children*, residential care operators would be taking proactive steps to empower parents to reconnect and maintain their relationships with the children. Unfortunately, little evidence was found of any such approach in this research.

Similarly, while 150 children were identified as having moved from kinship care to residential care, no children were found who had moved from residential care to kinship care. We would expect to see this movement into kinship care if any residential care facilities were working in the spirit of the guidelines and seeking family-based care options for children in their care.

The main languages used in Sangkhlaburi residential care facilities are Thai and English. Not all parents in the area can speak Thai, and many can speak it only a little. Without proactive effort by residential care operators, children can lose their native language and, at the same time, their ability to maintain a meaningful relationship with their parents. Similarly, the facilities in residential care can be very different to the traditional lifestyle that parents continue. Over time children can lose the ability to feel at ease in their parent's homes and their communities of origin. That is why residential care facilities need to be proactive in maintaining relations with parents and/or extended family members—failing to do so results in the erosion of the children's cultural roots and identity. It also increases the chance that parents might disappear, feeling no longer valued or needed.

2.5. Children entering residential care when under five years old

Many countries have set a milestone in their journey to fully implement the UN Guidelines for the Alternative Care of Children. No child under five years old should enter institutional care. Although harmful to children of all ages, institutional type care is particularly damaging to young children. It denies them opportunities to form a solid attachment to a primary caregiver. Such attachment is recognised as one of the vital building blocks for healthy relationships later in life.

This research identified 12 children (1.6%) currently aged five years or younger among the 786 children and youth living in the participated residential care centres. These children were found in three private children's homes except one in a government primary school dormitory. One private children's home accounted for eight (66%) of these children.

Of these children, 9 (75%) were identified as non-Thai and three were identified as having a Thai ID card. While for ethnicity, two were identified as Thai, one each as Mon and Burmese and eight as Karen. One of these children was a double orphan. This child came to live in a private children's

home when they were four years old. Until then, they lived with their mother. This child's ethnicity is Burmese, and they have no Thai ID card.

Before entering residential care, one of these children stayed with only their father, six with only their mother, five with both their mother and father. Among these twelve children, eleven have a still-alive mother, and nine have a still-alive father.

Poverty and divorce are the main reasons given for these children to have entered residential care. Poverty and "no main caregiver" are why they need to remain in residential care.

2.5.1. All children who entered residential care before they were five years old

Among the 786 children and youth living in the residential care centres that took part in this research, 105 children (13.4%) were found to have entered residential care before they were five years old. 43.80% are boys, and 56.20% are girls. 53 Children (50.5%) are now aged 11 or older (evenly spread up to 19 years of age). 26% of these children have a Thai ID card. Almost 50% of these children are of Karen ethnicity. With Thai, Mon and Burmese making up most of the rest in equal proportions with around 14% each. (One child was Karang, one Laos and seven unknowns).

Thirty-nine children (37%) were living with their mother before they entered residential care. Twenty-nine children (28%) were living in different types of kinship care, with maternal grandmother being the most common (12 children, 11.4%). Twenty-four children (23%) were living with both parents, and seven (6.6%) were living with their father. (Six children did not know or could not answer).

Forty-five children (43%) have a living father. Twenty-five fathers are recorded as deceased, and 35 are unknown or not able to contact. Sixty-five children (62%) have a living mother. Twenty-one mothers are recorded as deceased, and 19 are unknown or not able to contact.

Ten children (9.5%) are in government school dormitories, and 95 children (90.5%) are in private children's homes. Forty-four children (42%) are in one private children's home. Eighty-six children (82%) are in only three of the private children's homes.

In the last 12 months, family of 56 children (54%) visited them. Of these children, 23 (40%) were visited by their family at least once a month. Eleven children (19%) were visited more than once a week.

Forty-five children (44%) had visited home in the last 12 months, 57 (56%) had not, and three did not answer. The COVID-19 situation may have impacted this as some residential care operators did not allow children to go home. Of the children who did visit home, 11 children (23%) had visited at least once a month. Fifteen children (32%) had stayed at home for more than 30 days in the last 12 months.

2.5.2. Children entering residential care aged one or younger

Among the 786 children and youth living in the residential care centres that took part in this research, 28 children were found to have entered residential care aged one or younger. 13 boys and 15 girls. Their age today ranges fairly evenly from 2 years old to 17 years old. Karen is the most common ethnicity, nine children. Mon seven children, Thai 6 children, and Burmese three children. Eight of these children have a Thai ID card, and 11 have some other Thai issued card.

These children entered private children’s homes with one private children’s home accounting for 14 children (50%). Before entering residential care, 16 of these children were with their mother. Five were in kinship care, 4 with both mother and father, one with their father, and two do not know who they were with.

None of these children was a double orphan when they entered residential care. Twelve children (43%) have a living father. Three fathers are recorded as deceased, and 13 are unknown or not able to contact. Seventeen children (61%) have a living mother. Six mothers are recorded as deceased, and five are unknown or not able to contact. Families have come to visit 17 children (61%) in the last 12 months. Six children have been visited more than once per week. And 13 children (46%) have visited family in the last 12 months)

For the five children living in kinship care before entering residential care, all primary kinship carers are alive.

2.5.3. Double orphans who entered residential care before they were five years old

Among the 105 children who entered residential care before five years old, ten were identified as double orphans. They account for 29.41% of double orphans found among all 786 residential care dependents.

Their ages at the time of this research were 4, 11,12,13 (2 children), 14 (2 children), 17 (2 children) and 19. Six were boys, and two were girls. Eight children were living in private children’s homes, and two children were living in government school dormitories. Karen is the most common ethnicity, four children. Also, one Mon, one Burmese and four do not know of their ethnicity. Only one of these children has a Thai ID card.

Before they entered residential care, six of these children were in kinship care, one was with their mother, one with both mother and father, and two do not know. Four of these children have been visited by family in the last 12 months. Only one child had visited home in the last 12 months.

Four children entered residential care aged three years, and six children entered aged four years. The two youngest of these, 4 and 11 years old, indicate that only one double orphan aged less than five years has entered residential care during the last seven years.

2.6. General Health and Children with Special Needs

Among all residential care dependents, 6.48% (51 children) had a chronic illness, and six children had a disability. The following health issues and disabilities were identified:

Table 9: Number of residential care dependents having chronic illness and disability

Description	No. of children
Allergies and Asthma	15
Blood disease	9
Stomach ache	8
Heart disease	7
Skin disease	2
Panic	2
Diabetes	1

Convulsions	1
Kidney disease	1
HIV/Aids	1
Tumor	1
Stress	1
Muscle pain	1
Groin pain	1
Other	4
Physical disability	5
Visual disability	1
Mental disability	1
Intellectual disability	1
Learning disability	1

Four children and two adult dependents, five female and one male, were identified as being in residential care because of their special needs. All are over ten years old and therefore interviewed directly. Two indicated that their special needs were the reason for them to stay in residential care. This, however, was not confirmed by their carer, who gave a different reason. For two children, both the child and the carer identified special needs as the reason, and for the remaining two children, only the carers gave this reason.

These six children and dependents range from 12 to 34 years old and live in four different private children's homes. For their health status, one replied normal, 3 said chronic illness, and two said disabled. Blood disease was the health problem for all three who answered chronic illness. No other health issues were recorded among these six children. (Thalassemia is unusually common in the Sangkhlaburi area, and sometimes expensive drugs are needed for children that most migrant families could not afford to buy). For disability, one replied visual disability and another physical disability. These children and dependents reported no other disabilities.

One of these children had only arrived two months ago, one had been at the children's home for 12 years, and four said they had been there for 14 years. There may be some error as one of the children's homes has not been running this long. Another possibility is that the dependents have been living with the caretakers long before living in the current residential care.

Between these four children and two adult dependents, five have a living father, and three have a living mother. Family had visited five in the last 12 months, and four had visited the family. All six had contact of some form with family. When asked why they needed to remain in residential care, five answered that it was because they wanted to graduate from school, only one answered that it was because of their disability or health.

There was no evidence that other children with special needs moved in and out of residential care in recent years. It seems that the number of children with special needs is very low. Only one child with special needs has entered residential care in Sangkhlaburi in recent years. For at least three children with chronic health issues, it may well be the cost and management of their treatment that has brought them into residential care or, put differently, the poverty and lack of understanding of their families.

In summary, special needs is not a significant factor in the movement of children into residential care in Sangkhlaburi. The special needs identified among the very small number of children in residential care seem less serious than those in the area who still live with their families.

2.7. Abuse and Neglect and the level of need for Child Protection Case Management

The overall number of abused and neglected children are small. However, there is some variation between what children said and what caretakers said.

Eight children and one adult dependent said that they had entered residential care because it was not safe at home. These seven females and two males ranged in age from 12 to 21. Six of them were either 14 or 15 years old. Two had arrived in residential care in the last 12 months. The others had been in residential care for 2- 14 years. One entered residential care when under one year old. The others were aged 5,8,11,12, or 13 years old when they entered residential care. Before entering residential care, four were living with parents, and five were in kinship care. Six have a living father, and seven have a living mother. Family had visited four children in the last 12 months, and six had visited their family.

Caretakers identified 15 children whom they said had entered residential care because of physical or sexual harassment at home. These children were all living in two of the private children's homes. Only two of these children are among the nine children described above who said themselves that they lived in residential care because they were unsafe at home. Their age ranged from nine to 21 years old, with two of them over 19 years old. There were ten females and five males. Ten of them had been in residential care for five years or more. Family visited nine in the last 12 months, and seven had been to visit family. Notably, five of these children did not give a reason why they had come into residential care. Two said because it was not safe at home, three said family is poor, one said home is far from school, three said parents are divorced, and one chose "other".

Caretakers identified 22 children whom they said could not go home because it was not safe. These children were in the same two private children's homes that identified 15 children who they said entered residential care because of abuse at home. Four were adult dependents, and 18 were children – nine to 21 years old. The group included four males and 18 females. Family had visited 13, and 13 had visited family in the last 12 months. Only three of these children said they entered residential care because they were not safe at home.

There are several factors to consider when looking at these responses:

The two private children's homes involved with these children are much more aware of the UN Guidelines than any of the other children's homes involved in the research. The familiarisation with the guidelines perhaps shaped their answers to show their child protection efforts.

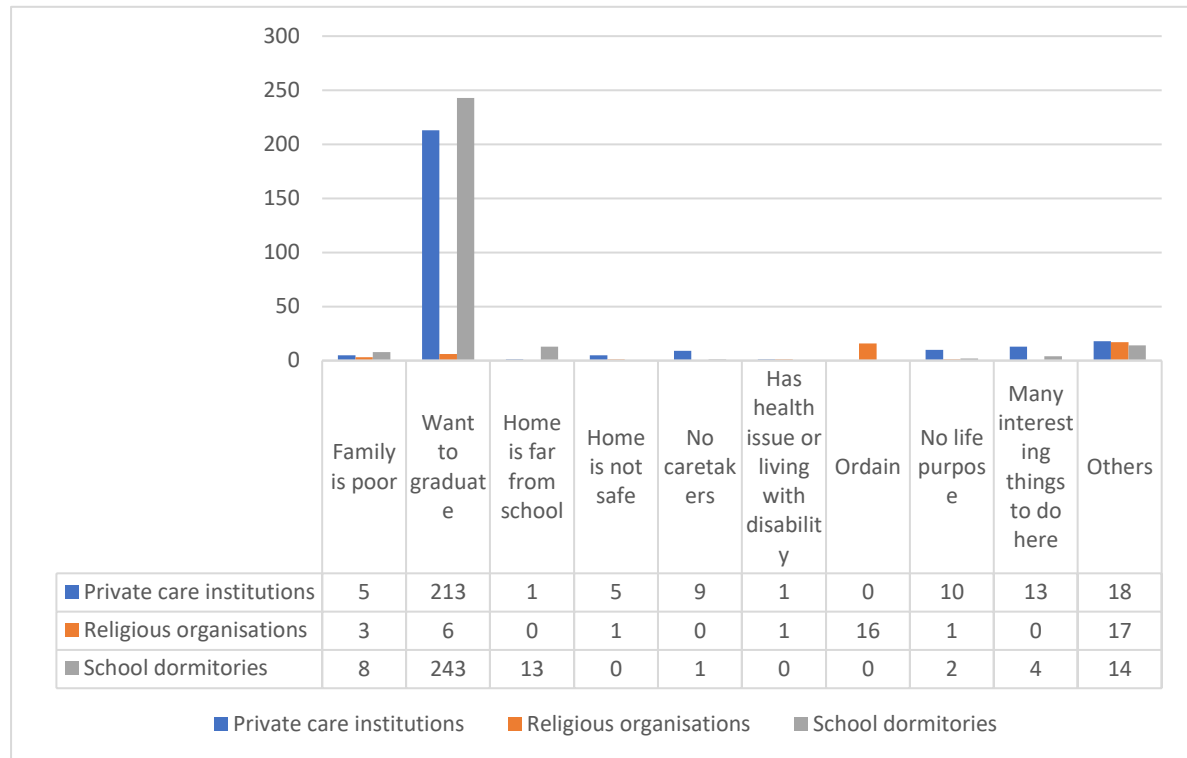
Some children may not be comfortable talking about any problems at home or unpleasant circumstances they have experienced, especially in an interview situation with a stranger. For this reason, they may have given other reasons for why they need to stay in residential care.

In summary, among all of the residential care facilities, only two private children's homes seem to see a connection between residential care and the safety of children. The others appear not to question the use of residential care for children from low-income families or to make access to education more accessible.

If children were being separated from their parents only when all other options have been exhausted, the number of children who need to be assessed and case managed by a gatekeeper would only be a small fraction of the number of children currently in residential care.

The following graph emphasizes this point further. The 606 children aged ten or older who took part in interviews were asked what age they hoped to remain in residential care until they were asked why.

Figure 9: The main reason to stay in residential care, by different groups of residential care



In response to the same question, caretakers said 154 children needed to remain in residential care because they had no primary caregiver. Among these 154 children, only seven of them shared the caretakers' view and selected this as the reason they needed to remain in residential care. Seventy of these children had been visited by family in the last 12 months, and 66 visited family.

With children remaining in residential care for many years, high staff turnover rates, and poor record-keeping, reasons for children to continue living in residential care became vague, even to the children themselves. The need for qualified and impartial assessment, quality record-keeping and participation in decision making is evident.

Many children and their families are very grateful for the educational opportunities that residential care have given them. However, given the choice of adequate support, how many of these families would choose to care for their own children? Although several private children's homes said they offer support to families, such as food support, none offer long-term education scholarships despite this clearly being the primary need of children in residential care.

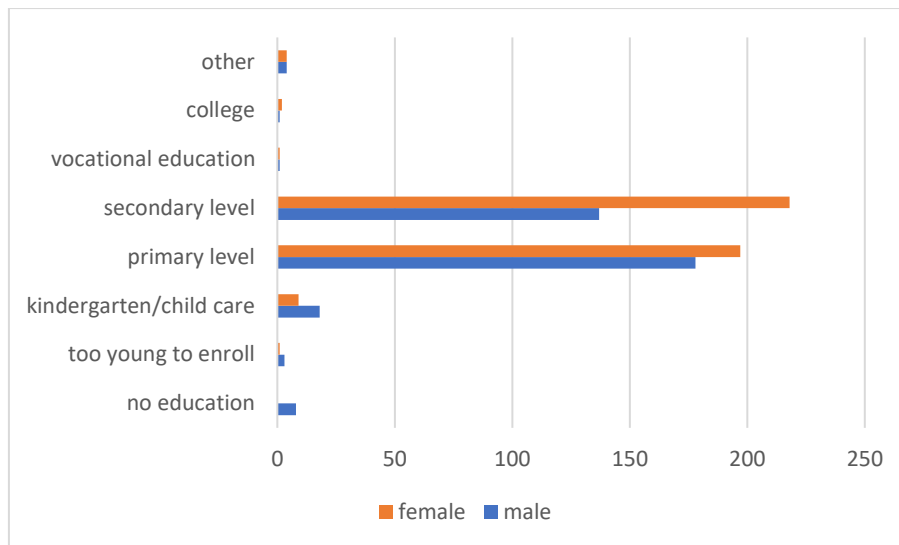
In a similar vein, among the 130 children staying at the high school dormitory, the majority said that their home was too far from school to travel every day. We asked each student where they lived, and in 50% of cases, they live in villages where other children at the same school travel from every day. It seems the real reason to stay at the dormitory might be poverty and prohibitive costs of transport to school and daily money for lunch.

Sadly, the amount of money spent to keep these children in residential care is almost always higher than the amount of financial support their families need to care for them.

2.8. Gender and education: a large gap between girls and boys in education

Education and poverty are the primary reasons for children to enter residential care. The situation is affecting girls and boys differently. Here we see the education status of all children in residential care and the growing gap between girls and boys in the later school grade years:

Figure 10: Enrolling education of children in residential care, by gender

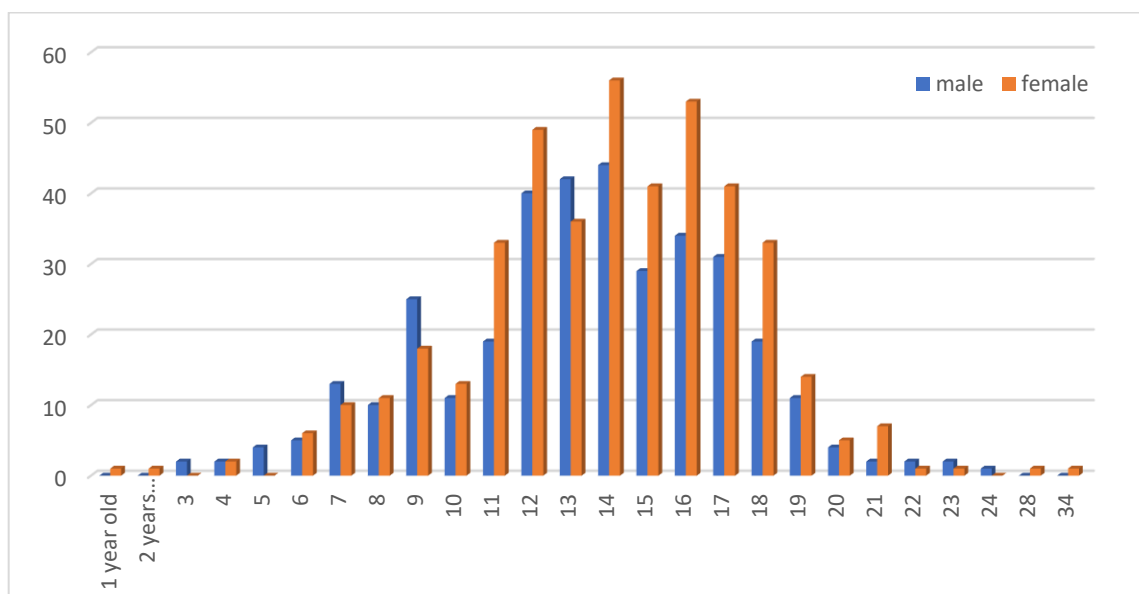


There are more boys than girls in kinship Care (52/48%), yet more girls than boys in residential care (55/45%). As age increases, the gap between the number of girls and boys are more significant.

Table 10: Percentage of gender representation, by types of residential care

Private residential		Religious places (temples)		School Dormitories	
Girls	Boys	Girls	Boys	Girls	Boys
61.5%	38.5%	0	100%	56%	44%

Figure 11: Gender of residential care dependents, by age



Interestingly, a similar picture of the gap between girls and boys is also presented in the local school. Below is the enrollment data of Sangkhlaburi High School at the time of this research. This is the only high school serving the area. (The next closest is 40km away) At the school, the percentage of girls are about twice as much as the number of boys.

Table 11: Number of grade 10-12 students enrolled in the district high school, by gender

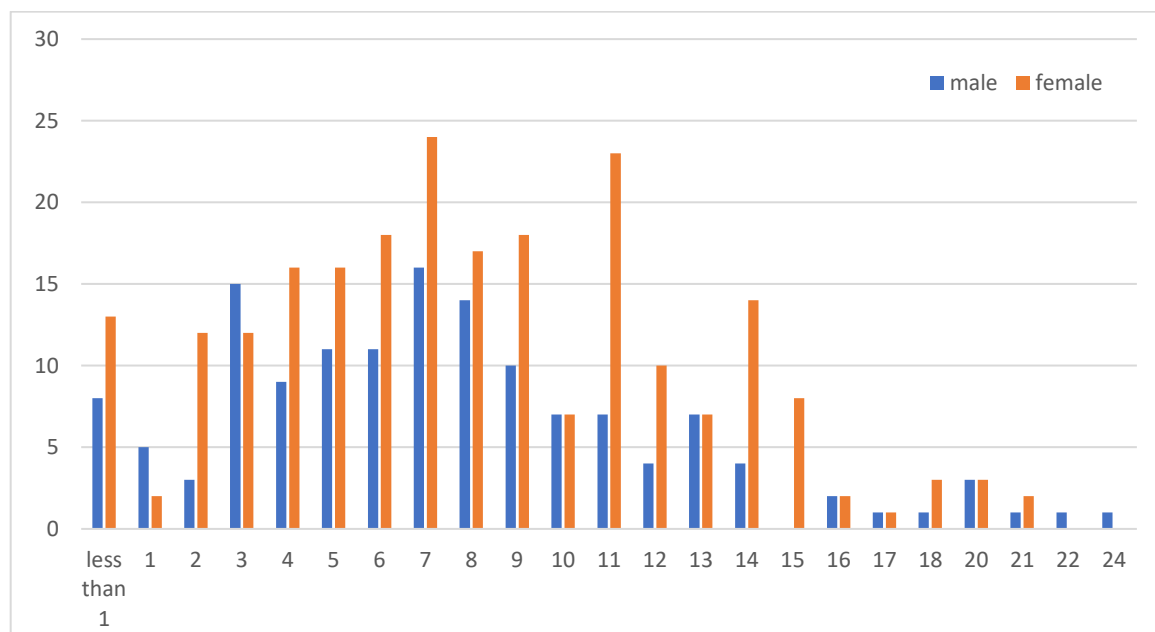
	Boys	Girls	Total
Grade 10	125	188	313
Grade 11	77	189	266
Grade 12	67	157	224
TOTAL	269 (33.5%)	534 (66.5%)	803

At the time of the research, 751 children were enrolled in grade one in all of the primary schools in Nong Lu, with boys and girls equally present. It is not only Nong Lu but also neighbouring subdistricts that form the high school's catchment area. Therefore, the dropout rate of boys is expected to be higher than suggested by the figures here. While some children move away to the provincial capital and other places to attend high school, it is clear that many children are not making it to the end of their High School education. It appears that boys are more seriously affected than girls.

MICS data also shows more girls than boys in high school at the national level. (National Statistical Office & Unicef, 2020) However, the disparity is much smaller than in Sangkhlaburi. National data for grades 10, 11 and 12 show 55% girls and 45% boys compared to 66.5% and 33.5% in Sangkhlaburi. There are two possibilities; either a large group of boys leaving residential care before finishing high school, or more girls than boys entering residential care at high school age, or both.

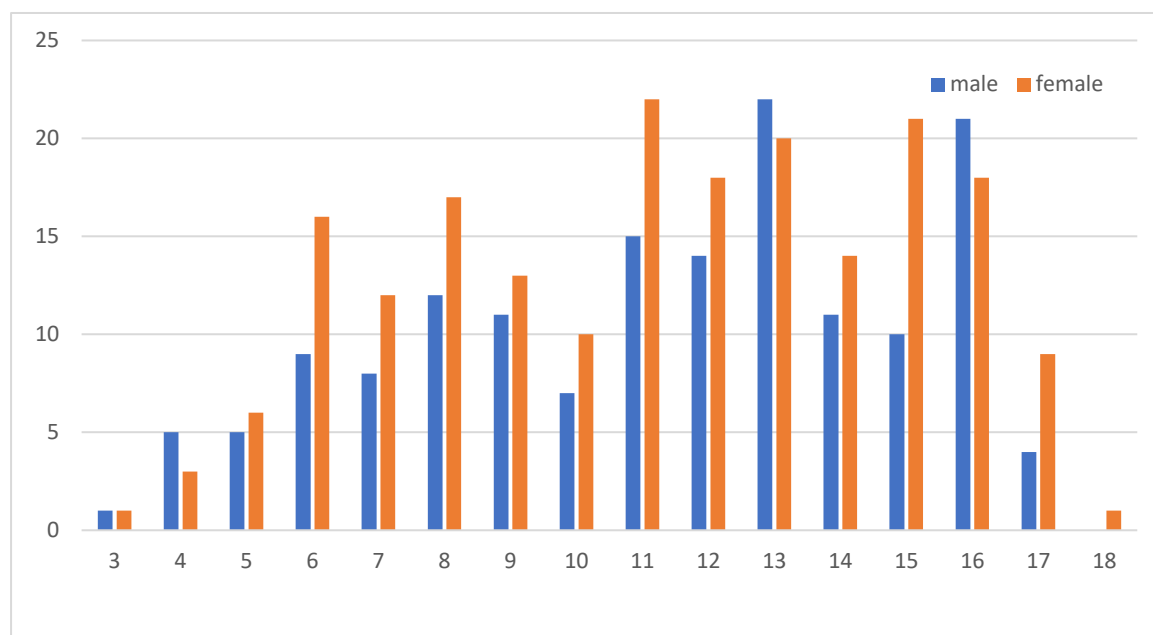
For private residential care institutions, there are more girls than boys entered at almost every age. As age increases, the number of boys entering drops off while the number of girls stays high until well into teenage years.

Figure 12: First entry age of dependents of private care institutions, by gender



For school dormitories, there is a similar pattern with more girls than boys entering at each age. However, there is less drop off among older boys compared to girls.

Figure 13: First entry age of dependents of school dormitories, by gender



The question persists; where are the boys? To understand this situation better, the research team contacted high schools in other districts to ask about their students from the research area. There are 110 students from Sangkhlaburi district studying at Romklat Kanchanaburi School in neighbouring Thongphaphum district, 50 boys and 60 girls in Grade 7-12. At Rajaprajanugroh 45 School², a government boarding school in Phanom Thuan close to the provincial capital, there are 173 students from Sangkhlaburi district; 92 Boys and 81 girls in grades 1 to 12.

While identifying the movement of children out of Sangkhlaburi and into residential care elsewhere offers some explanation for the children not in High school, it does not account for all of the missing boys. It also confirms that we do not know the actual number of children from the research area living in Alternative Care. The two out of area schools mentioned here are not the only schools Sangkhlaburi children are sent to.

Staying in residential care helps many children finish high school, but it is more effective for girls than boys. In this high migration area in an isolated part of Thailand, a crisis regarding boys education needs urgent attention.

A deep examination of this issue was beyond the scope of this research; however, it remains relevant to the findings that there are more girls in residential care and more boys in kinship care. Some suggestions that might have been explored further by the research team had the covid situation not hampered the qualitative element of the research would be:

²Rajaprajanugroh 45 School is a Thai government boarding school with 1,050 students stay at school in dormitories. This is one of 51 government boarding schools hosting almost 50,000 children throughout Thailand. (Unicef, 2015b)

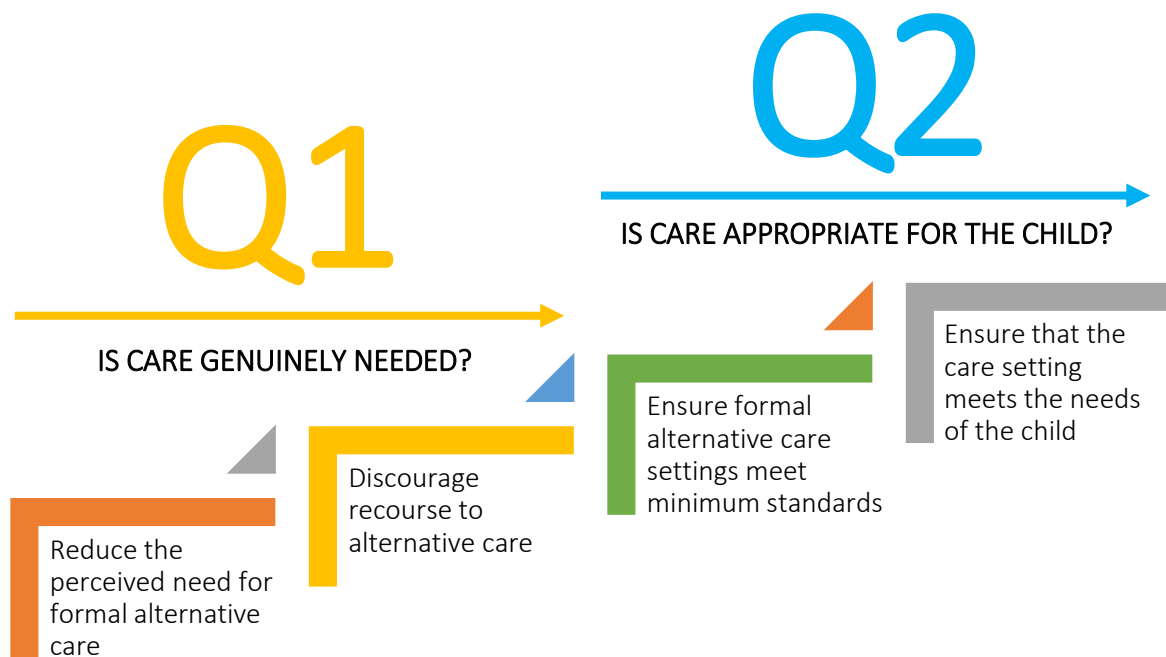
- Is there a greater expectation for boys to work at a younger age as they are seen as physically able to?
- Do parents seek out schools in other areas, or do these schools recruit children from high poverty areas like Sangkhlaburi? Are they better funded than schools in Sangkhlaburi?
- Do some parents feel their daughters are safer from sexual abuse in residential care than in kinship care and have less concern about this for their sons?
- Do migrant girls adapt more successfully to a second language than boys (many migrant families speak an ethnic language at home, while children study in the Thai language at school).
- MICS identified that boys aged 1-14 years were more likely to experience psychological aggression; physical punishment, and any violent discipline than girls. (National Statistical Office & Unicef, 2020) It would be interesting to explore the experiences of groups of boys and girls in Sangkhlaburi to see if they agree that this is true and whether it is a factor in so fewer boys completing High School.



3. Characteristics of alternative care

In studying the standards of alternative care practices, this research applied the two key principles of necessity and suitability as the framework for the study. The questionnaires were designed to gauge the unmet needs of children and families that lead children into alternative care. This research aims to assess the standard of care practised in each setting for children already in care and determine if the children’s best interests are upheld.

Figure 14: The principles of necessity and suitability (Cantwell, Davidson, Elsley, Milligan, & Quinn, 2012)



3.1. Family-based care

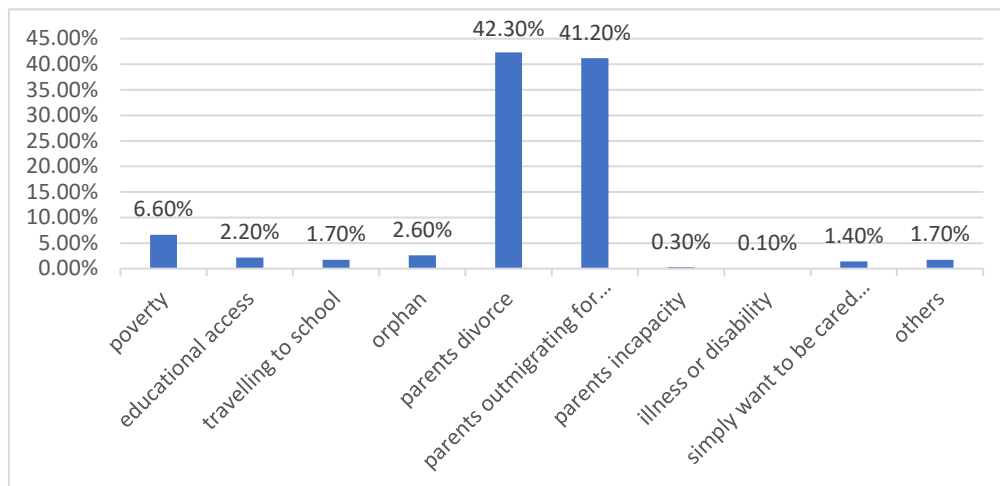
No formal kinship care or foster care was found during this research. By definition, informal care is not systemic in nature. The arrangements were not determined by any competent authority but between the parents and the caretakers; 98.1% of whom are relatives. However, we can identify some of the trends and commonalities regarding how informal kinship arrangements are established.

In Thailand, around 24% of children are living in kinship care, rising to 26% in rural areas. (National Statistical Office & Unicef, 2020) In this research, however, kinship care is accountable for 10.32% of children in the area, which is less than 50% of the national average. Here are the key findings of the informal kinship care found in this research.

3.1.1. Parents are divorced and out-migrated

Based on our interviews with a sample of 80 children, not one of the kinship children is a double orphan. 76.3% of them still have both father and mother. However, 19% of them are single orphans.

Figure 15: Percentage of reasons given for the lack of parental care of children in family-based care

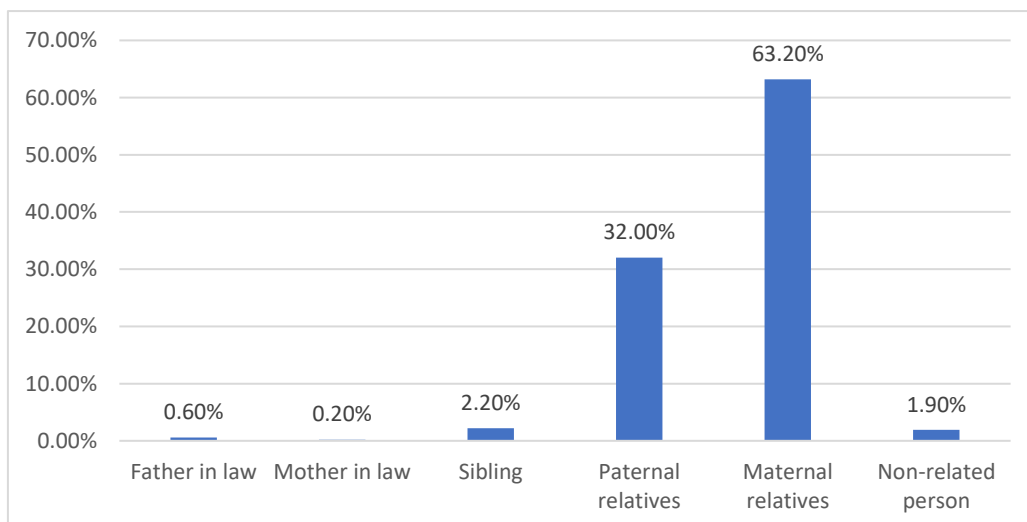


42.3% of all 1,090 kinship children have divorced parents. 41.2% indicated that their parents worked somewhere outside Sangkhlaburi. Extended interviews with a sample of 80 children found that 50% of the kinship children’s fathers and 85% of the mothers live in other areas in Thailand. This implies in-country outmigration, which resonates with the finding of the 2020 migration survey that 29.9% of households experience migration for work, including to find new jobs, for promotions, or more income. (National Statistical Office, 2021, p. 15)

3.1.2. Children are left with relatives, particularly maternal grandparents

In Thailand, 80% of divorce or separation ends with the mother being the primary caregiver for any children. (UNFPA Thailand & NESDB, 2016, p. 73) In this research, 85% of the mothers of kinship children were living outside of the area. 63.20% of the children were left with maternal relatives, almost twice as much as the children residing with paternal kins.

Figure 16: Percentage of primary kinship carer, by their relationship to the child



Among kinship caretakers, 71.6% of the household heads are women. The age range of the carers was evenly distributed from 26 years old up to 72 years old. One carer was 80 years old. The average age is 55.88 years old. 61.8% (21) are married or living with partners. Five are widowed, and one is single. Two are divorced, and four are living separately from their spouse because of work or other

reasons. Considering that most children are with maternal relatives, it can be assumed that maternal grandmothers are the primary kinship caretakers

From 34 caretakers interviewed, 94.1% (32) are female. Fifteen gave their ethnicity as Karen, seven as Mon, 6 Thai, 5 Laos and 1 Burmese. This differed slightly from the children's responses, where Thai ethnicity was the most common answer with 46% and Karen second with 20%.

97.1% of the kinship carers are Buddhist.

3.1.3. Kinship carers and families are facing several challenges

Nationality and limited access to support services

Thailand is a super-aged society, but ageing is not the only challenge these kinship caretakers with an average age of 55 years old have. 14.7% of the carers could not participate in the interview in the Thai language and required translation. Only 38.2% (13) said they are Thai citizens. 58.8% (20) had some form of Thai government-issued documents, and one had no documentation.

Interestingly, 38% of these kinship carers are Thai nationals, whereas 62% of the 80 children in their care are Thai nationals. The percentage of Thai nationals among children in residential care is lower at 38%.

In the interviews with the 80 children about their mother: 49 children said she is a Thai national, 29 said no nationality and two did not know. About their fathers: 40 children said he is a Thai national, 20 said no nationality, two said other nationality, and 18 did not know.

Through three generations, the number of family members with Thai citizenship and other government-issued documentation is increasing. The success of these families in establishing themselves in Thailand and gaining documentation for their children is likely to be an important factor in maintaining children in kinship care and not relinquishing them to residential care. The ability to work legally, confidence to engage with authorities, schools and healthcare, ability to own land, a house and a vehicle are examples of the added security that families gain with citizenship. These factors can make a big difference for families at the very bottom of the income ladder.

While 32.4% of the kinship caretakers have a chronic illness, particularly blood disease and diabetes, more than half of them have challenges accessing welfare and family support services.

Poverty

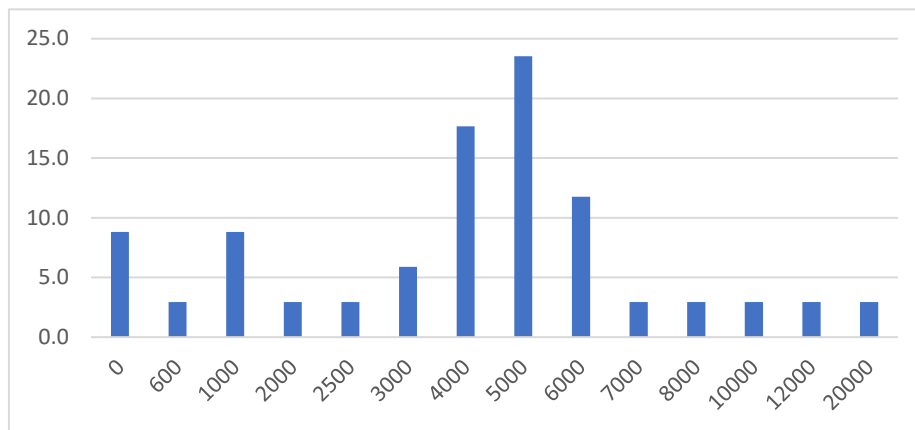
At the national level, kinship carers were identified in the MICS 2019 data as being at high risk of poverty. "Of the children who live with neither biological parent, 39% are in the lowest wealth index quintile and 30.4% in the second tier." (National Statistical Office & Unicef, 2020)

In this research, the 34 kinship carers interviewed take care of 100 children; 80 as kinship carers and 20 as parents. The number of children in their care ranges from one to six. The total household size ranged from three to nine people, with the average being 5.3 (179 people in 34 households).

Income

The average household income was 4,680 Baht (USD 146) or 883 Baht (USD 28.30) per person. The total monthly income of all 34 households was 159,100 (USD 5,099). If divided by 179 people, this gives a per-person amount of 889 Baht (USD 28.49). The range of monthly household income was from zero to 20,000 Baht (USD 640) per month.

Figure 17: Percentage of kinship families, by average monthly household income in Thai Baht



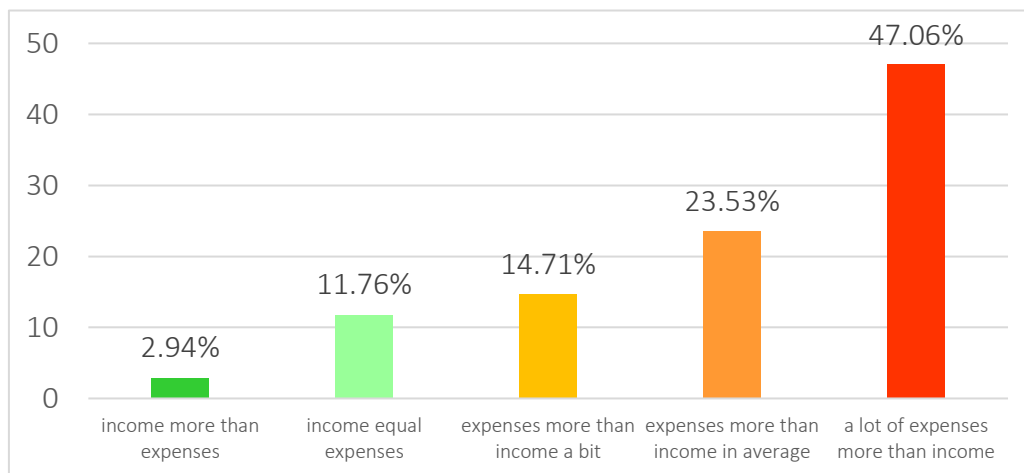
To compare, the average monthly household income for the central region of Thailand (excluding Bangkok) was 25,780 Baht (USD 826). (Statista Research Department, 2021) However, this average could be misleading as Thailand has huge polarity between the richest and poorest. The very significant wealth of a small minority could make this average higher. Still, the average income of kinship families interviewed is significantly less than the regional average.

The minimum wage for Kanchanaburi is 320 Baht (USD 10.26) per day. (Kanchanaburi Provincial Labour Office, 2021) The wage gives some guide as to what level of income the government believes is the minimum to get by. Working 20 days per month at 320 Baht would provide 6,400 Baht (USD 205) per month. This is significantly higher than the average income per household among the kinship carers interviewed, which was about 4,680 Baht (USD 150).

67.6% of the kinship carers interviewed have not had a formal education; hence, fewer opportunities for steady income. While outside the scope of this research, it is widely acknowledged that very few people in Sangkhlaburi achieve this level of pay, especially those who are migrant workers. There are cases that migrant workers in Sangkhlaburi earn as little as 100 Baht (USD 3.20) per day in local garment factories and plantations.

The minimal income received cannot cover the expenses most families have. 85.3% of kinship families indicated that they have more expenses than income, implying household debts. 47.6% said they have a lot more expenses than income, which means a very high financial vulnerability.

Figure 18: Percentage of kinship caretakers' perception of the differences between their income and expenses



Top expenses and living condition

With such low incomes, many families prioritized food and essential items for the money they have. Nonetheless, it is clear that education for children is vital and comes in a close second after the essential items for survival.

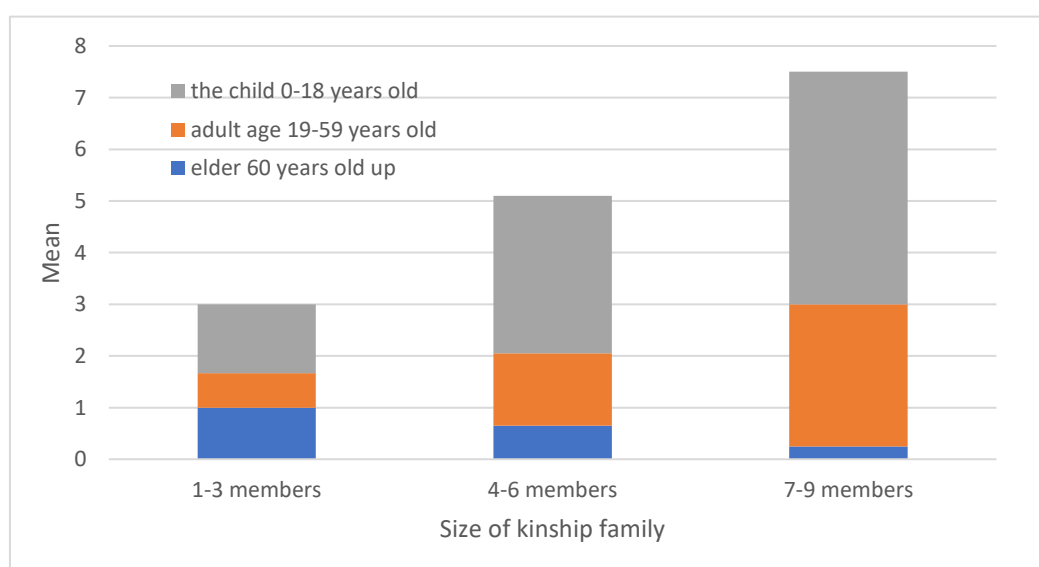
Table 12: Prioritised expenses of kinship carers

Description	How many chose as their top priority	How many chose as their second priority	How many chose as their third priority	Did not select In their top three
Food	22	7	4	1
Medical costs	0	1	2	31
Clothing	0	1	0	33
Nonfood essentials	7	14	8	5
Work costs (buy tools etc)	0	0	2	32
Children's education costs (10 children not of school-age yet)	2	11	12	9

Living standards varied among the 34 households of the kinship carers interviewed. One said that their house had an earth/soil floor, five said their house was made from bamboo, 11 from wood and 17 from cement and bricks. Three said their house has no electricity, and six rely on a neighbouring house for an electricity supply. Nine use wood or charcoal for cooking, while 25 use propane gas. Twenty-three have a refrigerator, and 11 do not. Seventeen have a TV, and 17 do not. No household had a computer. Two households had a car, and 23 had a motorbike, with 11 households having no vehicle.

While Kanchanaburi province has an average of 3.3 people per private household (National Statistical Office, 2012), this research found that a kinship family is larger with an average of five people to feed; generally, three of them are children. Also, 20.6% of the kinship families have at least one elderly or person with a disability or chronic illness who needs special care. The data from this research shows that many kinship families are highly vulnerable and could benefit from additional support services.

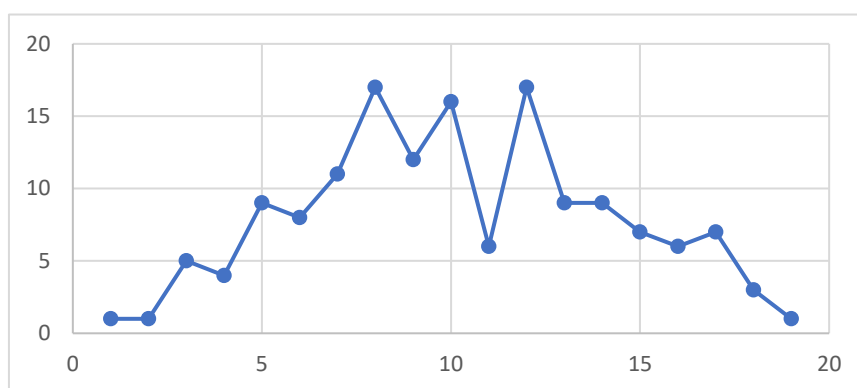
Figure 19: average number of kinship families members categorised by age, in different family size



Help needed and insufficient support provided

A local NGO has calculated the monthly cost for children in the outer lying villages of Nong Lu to attend high school to be 1,200 Baht (USD 38.46). This covers transportation to school, 20 Baht (USD 0.62) per day for lunch, school fees (including insurance), and school uniform. This financial gap between household income per person and the cost of keeping children in education fits with the much larger number of younger children found in kinship care, contrasting to the profile of children in residential care who mostly are older, high school-aged children. As they progress through education and the costs increase, and with no offer of financial support, many children have to choose residential care if they want to stay in school. 38% of children leaving kinship to residential care did so between 9-13 years old.

Figure 20: Age children left kinship and entered residential care



Lunch is free in Thai primary schools. There are many more primary schools, so most people live close to one. With a walkable distance for children, many walk to primary schools, reducing transport costs. The uniform requirements are minimal compared to High School in Thailand, which requires a different uniform for each day of the week. Almost 60% of the 34 kinship carers said their house was within 3km of a primary school, whereas only 23.5% said their house was within 3km of a high school.

Among the 34 kinship households, 13 receive some form of government welfare. This includes nine (69%) of the 13 carers who said they are Thai citizens and 4 (25%) of 16 carers said they have some form of Thai issued card. The carer, who has no documentation, said they did not receive any government welfare. In addition, nine said they receive some support from private organisations.

Table 13: Number of kinship care receives different types of government welfare

Government welfare schemes	No of carers who said their family receives this
Old age allowance 600 to 900Baht per month depending on age	4
Subsistence allowance for low-income individuals (monthly)	5
Poverty relief grant (one time support from Por Mor Jor)	0
Monthly support for disability card holders 800 Baht per month	1
Subsidy for village health volunteer	0
Loan for livelihood for elderly people	0
Child support grant	0
Subsidy for foster in patronizing family	0
Child allowance for foster care (non-kinship)	0
Other supporting money	5

The Thai government offers 2,000 Baht (USD 64) per month per child to a limited number of kinship carers. This amount has been the same for over a decade, and requests have been made for a review. Nong Lu subdistrict (official population 35,316) is within Kanchanaburi province (population almost 1 million). Forty-five children are currently supported with this government welfare grant in Kanchanaburi province. None of the 1,090 children in kinship care in Nong Lu is supported by this scheme.

Regarding financial support from private organisations. Seven carers said they receive support for one child, one received help for three children and one for four children.

Table 14: Number of kinship care receives different types of support from private organisations

Support provided by private organisations	No of carers who said their family receives this
Cash support	2
Money to support employment	5
Food and consumables	2
Scholarship	6
Skills training	0
Counselling	0
Housing/rental fee	0
Support for medical treatment (fee/transportation)	0
Other	1

At the time of the data collection, the COVID-19 pandemic had reduced economic activity significantly. The community in the research area began to see a dramatic decrease in tourists, who are among the primary sources of income. The economic situation is expected to worsen due to the pandemic. Large kinship families are most at risk, and our data shows there is already an increase in children entering residential care from the general population and kinship care families.

In this economically challenging time, kinship families need extra support. None of the families receives the specific kinship care welfare grant from the government. 61.8% said they did not receive any support from the government, and 73.5% shared that they did not get help from any private organisations. 67.6% only receive help from their relatives (usually the children’s parents).

Income is spent on necessities, with the top three household expenses identified as food, consumer products, and education-related costs for children. This finding is in line with the 2020 national migration survey data, which shows that 95% of remittances were spent on daily expenses and 4.6% on educational-related expenses. (National Statistical Office, 2021, pp. 18-19)

3.1.4. Disciplining of children in kinship care

Among the 34 kinship families interviewed, it was found that 73.52% discipline the children by verbal reprimand. However, 32.35% still resort to physical punishment.

A previous study by UNICEF and Mahidol University had findings relevant to our research. While non-violent means to discipline a child, such as explaining or deviating the children’s attention to do something else, are most common, aggressive punishments are not unusual. (Institute for Population and Social Research & Unicef, 2016)

Psychological aggression was also common, however, such as shouting, yelling or screaming at the child (at 80–88 per cent); calling the child dumb, lazy or other

names was also reported by about one in five of the caretakers (20–22 per cent). ... The in-depth interviews revealed that using physical violence as a discipline method, such as spanking with a bare hand, was commonly practised, especially by grandparents, and most of the time it was approved by the parents. The interviews also suggest greater acceptability of physical punishment in disciplining children in households with both parents absent. (Institute for Population and Social Research & Unicef, 2016)

In addition, the Multiple Indicator Cluster Survey (MICS) 2019 for Thailand found that:

53% of respondents thought that physical punishment is necessary and 44% of children age 1-14 years said they had experienced physical punishment. Female parents and carers were more likely than their male counterparts to use physical punishment, and the lower the educational level of the carers, the more likely they were to use violence. (National Statistical Office & Unicef, 2020)

Among the group of 34 carers interviewed in this research, 32 are women. Twenty-three carers said they had not received any education, nine completed primary school, and two completed lower secondary school. It seems surprising that only 11 out of 34 kinship carers (32%) said they use physical punishment. It is possible that they were afraid to admit this to the interviewers, who were all teachers from the local high school.

3.2. Residential care

From 36 residential care providers in the research area, 34 had children in their care at the time of the research, and of these, 26 were willing to participate. However, one of them participated only in the first section of the data collection and withdrew. Here are the key findings.

3.2.1. Status and size of residential care facilities

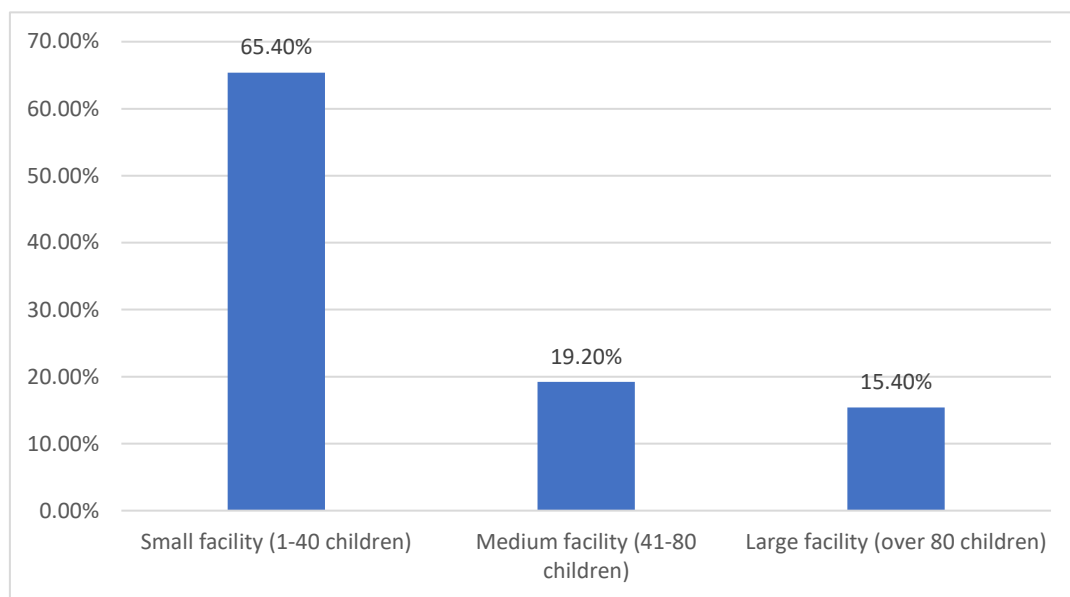
69.2% of all care facilities have registered with the government. 36% have registered as a foundation, the status of a non-governmental organisation in Thailand granted by the Ministry of Interior. Another 40% of care facilities have other types of legal registrations, including schools and temples.

None has been given an orphanage license from the Ministry of Social Development and Human Security as per the legal requirement. The reasons given for not applying for orphanage licensing are varied; 46.2% assume that their facility does not operate as an orphanage, 11.5% do not know that the license is needed, and 7.7% have not been able to meet the licensing requirements with the requirement for land ownership being a particular challenge.

The number of children normally residing in the 26 participated residential care facilities is 947, but the number of children presented during the data collection period was 786. The number of children in the residential care facilities ranges from 1³ to 147. The average number of children in all types of residential care is 36.42, which is less than the national average size of private children's homes of 58 children. (CRC Coalition Thailand, 2016)

³ Only facilities which have provided care for more than six children at a time were included in this research, regardless of the current number of children under their care which was below six in some cases.

Figure 21: Percentage of residential care facilities, by size



3.2.2. Residential care operators

The residential care facilities are all located in five of the ten villages in the research area. Some are long-established, and others are new with the first year of operation. They were founded between 1963-2019. The average length of operation for all types of residential care is 15.84 years, and for private orphanages is 12.47 years.

92.3% of interviewees hold the highest position in their care facility; hence, they are the major decision-makers. 11.42 years is the average length of time the interviewees had been working with their respective residential care facilities.

61.5% of all directors of residential care facilities are foreigners. If considering only the private residential care or orphanages, almost all (93.3%) of the directors are non-Thai. However, only 66.7% of the foreign directors live at the care facilities or in the local area, compared to 80.8% of all residential care providers.

Table 15: Percentage of nationality and location of primary residential care providers

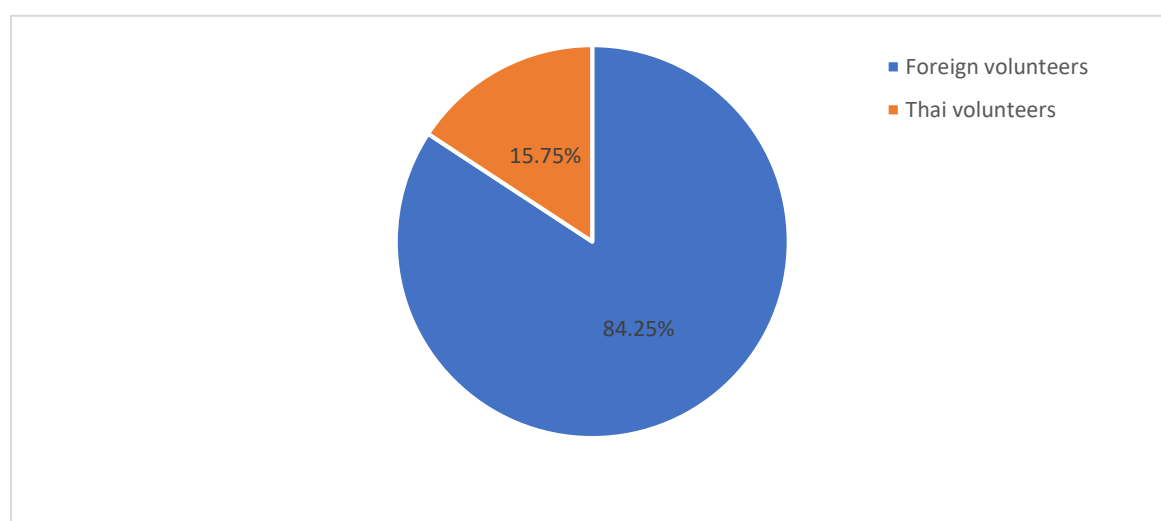
Types of care facilities	Nationality of director		Living location of director	
	Thais	Foreigners	Outside of the area	Inside the area
All types of residential care facilities	38.5%	61.5%	19.2%	80.8%
Only private children's homes	6.7%	93.3%	33.3%	66.7%

3.2.3. Volunteers and staffs

3.2.3.1. Number and child to caretaker ratio

57.7% of all types of residential care receive volunteers. 26.9% of care facilities accept short term volunteers who can commit 1-3 days of their time. The average number of volunteers received in the past twelve months is 21.60 people per care facility, although two care facilities did not have any volunteers in the past 12 months. Two hundred seventy-three foreign and 51 Thai volunteers visited all care facilities in the past twelve months. 57.7% of the volunteers helped teach English to the children.

Figure 22: Percentage of volunteers received by all types of care facilities in the past twelve months



The average number of staff is 7.85 per care facility. The total number of staff given by all care facilities is 204, but conflicting answers were given when asking specifically about the nationality of staff. The total number then decreased to 194. 70.10% (136) are Thai, and 29.90% (58) are foreigners. The percentage of foreign staff is less in large residential care than in small and medium-size facilities.

Figure 23: Proportion of Thai to foreign staff in residential care facilities, by size

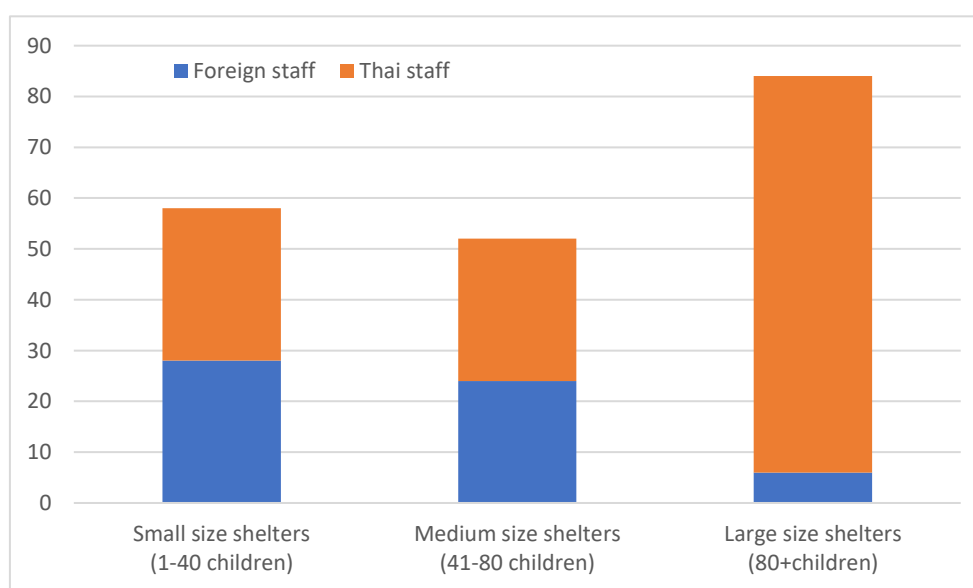


Table 16: Data of staff in residential care facilities, by size

	Small size shelters (1-40 children)	Medium size shelters (41-80 children)	Large size shelters (80+children)
No. of shelters	17	5	4
Number of Foreign staff	28 (48.27%)	24 (46.15%)	6 (7.14%)
Number of Thai staff	30 (51.73%)	28 (53.85%)	78 (92.86%)
Total number of staff	58	52	84
Number of staff directly caring for children	48	18	28
Percentage of staff directly caring for children compared to total number of staff	82.75%	34.61%	33.33%
Average child to caretaker ratio	5.06 children : 1 carer	13.94 children : 1 carer	16.17 children : 1 carer

This research collected the number of staff directly caring for children to determine the child to caretaker ratio. 65.4% of all care facilities have less than a 10:1 ratio. The average ratio for small size shelters is 5:1. Although this ratio sounds better than the larger facilities, the smaller facilities have an average of only 3.41 staff; about half foreigners and half are Thais. Possibly due to the language barrier, the average number of staff directly caring for children is only 2.82. This must make it difficult for staff to have time off compared to larger facilities where some or all staff probably live off-site and are able to take time away from their work. This finding raised a concern that despite an ideal child to caretaker ratio, the children might be less likely to receive quality individual care due to the very high demand posted on the staff.

3.2.3.2. Legally required professional staff

In Thailand, the laws require all private facilities caring for more than six children to register as an orphanage. One of the licensing registration requirements is professional staff. Types of staff required are different according to the different groups of children under care. These professional staffs include nurses, social workers, and psychologists.

69.2% of all participated residential care facilities have not had previous experience working with any professional staff in assisting vulnerable children and families. Only one facility said they have a social worker and a nurse. There was no psychologist. Only 11.53% of residential care has para social workers, and 23.07% has basic medically trained assistants. No evidence of staff qualification was requested. Only the interviewees' responses were recorded.

3.2.3.3. Staff training

On average, residential care staff have minimal knowledge and training in caring for children or children's rights. Only 8% of all residential care facilities train all staff on *The Convention on the Rights of the Child*, and only 15.4% of care facilities said all of their staff had been trained on the *Country's Child Protection Act*.

This is alarming. Given that these answers were from the directors of residential care facilities and were not cross-checked to determine the level of knowledge actually held by staff, the percentage of care facilities that have all staff trained in each key topic could be even less. Some care operators who indicated that no staff were trained on some topics also openly shared to the interviewers that

they have never heard of the terms even. This revelation alone prompts the relevant stakeholders to consider a training program where all direct caretakers will learn about essential concepts regarding caring for children.

Table 17: Percentage of staff trained on key topics relating to caring for children

	No staff were trained	Some staff were trained	All staff were trained
Child Protection Act	53.8%	30.8%	15.4%
The Convention on the Rights of the Child	64.0%	28.0%	8.0%
The United Nations Guidelines for the Alternative Care of Children	76.9%	19.2%	3.8%
Individual Case Management	88.5%	3.8%	7.7%
Family strengthening	69.2%	19.2%	11.5%
The best interest of the child	65.4%	26.9%	7.7%
Child development	50.0%	30.8%	19.2%
Child Psychology	61.5%	23.1%	15.4%
Positive discipline	57.7%	26.9%	15.4%

3.2.4. Physical facilities

The current private orphanage registration requirements in Thailand pre-date the *United Nations Guidelines for the Alternative Care of Children*. They focus on the physical environment rather than the systemic aspects of child care. Despite having no license to operate as an orphanage, all residential care scored reasonably well in our assessment of their facilities.

42.3% have full permanent fencing, 76.9% have separate areas for boys and girls, 80.8% has a cement wall and floor in the bedrooms. The average space is 8.82 square metre per child, and the air capacity is 32.66 cubic metre per child. For small shelters having not more than 40 children, the mode number of toilets for children is 2, and the average is six toilets. Medium size shelters, with around 41-80 children, have ten toilets on average. For more extensive facilities, they have on average 21 toilets for children.

Table 18: Average space, air capacity, and number of toilets for children in residential care, by the size of residential care

	Small size shelters (1-40 children)	Medium size shelters (41-80 children)	Large size shelters (80+ children)	Every residential shelters
Average space in square metre per child	8.62	13.93	3.32	8.82
Average air capacity in cubic metre per child	23.96	79.32 ⁴	11.31	32.66
Average number of toilets available for children	6.06	10.40	21.25	9.23

⁴ This average (mode) is very different from the median, which is 11.

3.2.5. Financial management and promotional materials

84.6% of residential care operators maintain records of income and expense and submit a financial report, no matter how simple, to mostly parent organisations (57.1%), donors (19%), government agencies (14.3%) and others (7.7%). However, only 53.8% have their financial record audited.

3.2.5.1. Funding sources

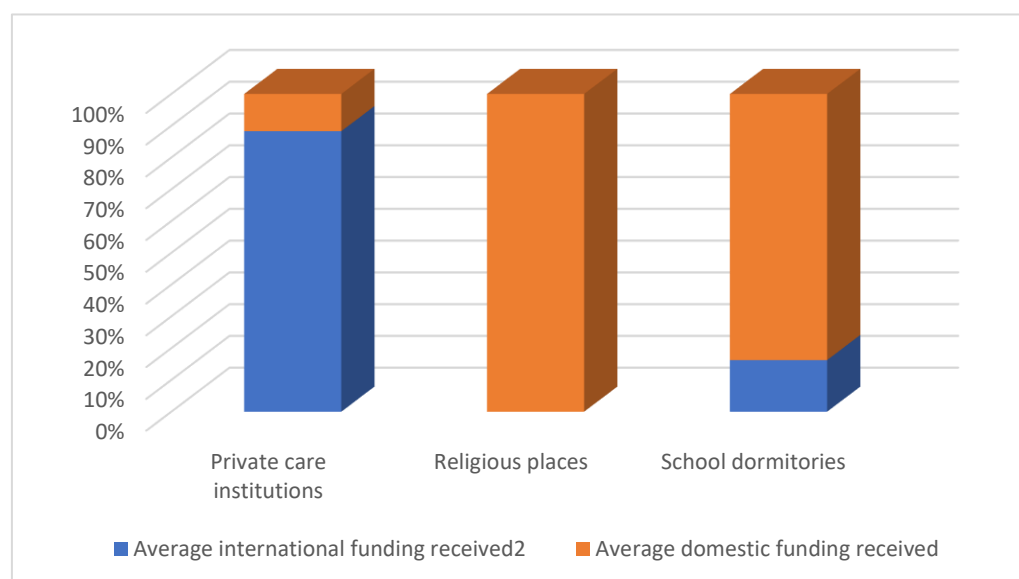
34.6% of all residential care facilities received fundings solely from domestic sources. Another 11.5% of residential care have more than 90% of their income from sources within the country. In total, 46.1% of all residential care receive their most funding in-country. The main domestic financial supporters are the government (35.7%), religious organisations, and individual donors.

38.5% of all residential care facilities operate with international fundings alone. Another 15.3% receive more than 90% of their income from sources outside Thailand. In total, 53.8% of all residential care depends primarily on international funding. The leading international funders are religious organisations (35.7%), individual donors, foundations or non-governmental organisations, and minor donors.

When categorised by types of residential care, it is found that international donations are more prominent for private care institutions. They receive an average of 87.50% of their funding from international sources. However, 83.75% of funding for school dormitories came from within the country, presumably government funding.

Table 19 and Figure 24: Average percentage of funding received from domestic and international sources, by types of residential care

Types of residential care	Average domestic funding received	Average international funding received
Private care institutions	11.62%	87.50%
Religious places	100%	0%
School dormitories	83.75%	16.25%

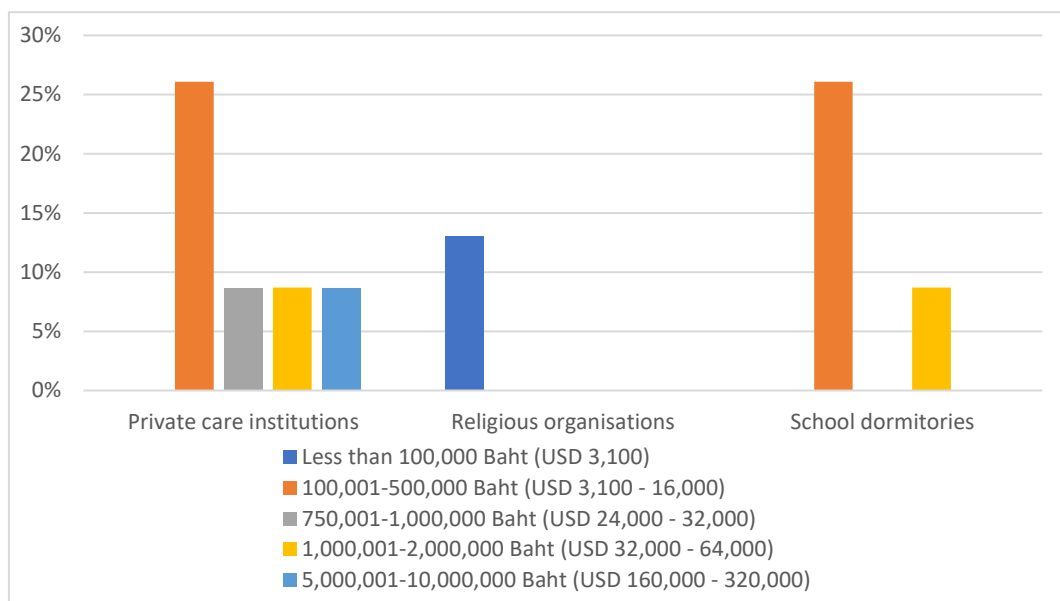


When looking only at private care institutions, the dependence on international support is more striking. 66.7% of children’s homes received more than 90% of their income from outside of Thailand. 33.3% of all support came from religious organisations, while 25% were from individual donors; many of them are connected to the care operators via religious connections.

3.2.5.2. Average annual expenses and the average cost per head

This research asked the residential care operators to estimate the annual expenses of 2019 spent on the child care program. 50% of all residential care facilities have a budget of around 100,000-500,000 Thai Baht (Approximately USD 3,100 – 16,000). Only 19.2% use less than 100,000 Thai Baht (Approximately USD 3,100) per year, while 23.1% spent more than 1 million Baht (Approximately USD 32,000).

Figure 25: Estimated 2019 annual expenses for child care program, by types of residential care



Because the questionnaire was designed to ask only the range of budget spent to avoid intrusion, the median of each range was used to estimate a total combined budget. It is estimated that the amount of money spent for alternative residential child care in Nong Lu Subdistrict, Sangkhlaburi district alone is over 27 million Baht per year. If considering private care institutions alone, about 21.8 million Baht is used to operate these care institutions annually.

The estimation was also used to calculate the cost per child. It is found that the average cost for private care institutions is the highest at 4,830 Baht (USD 155) per month per child. This approximate number is reliable because interviewees answered this question using their comprehensive annual budget covering all expenses relating to child care.

However, for Buddhist temples and school dormitories, the figures given by interviewees are not fully comprehensive. For example, utility costs will be left out of the calculation because they paid out of the temple and school budget, not from the residential care budget. Similarly, the teacher salaries are included in the general school budget and not counted in the cost of providing residential care. It seems that no salary or staffing costs are considered in the provision of temple based care, and food maybe be donated rather than purchased. Hence, the average cost per head for school dormitories is 1,187 Baht (USD 37), and for Buddhist temples is 245 Baht (USD 8) per month per child, but these figures need do not equate to the total costs as shared by private children’s homes.

3.2.5.3. Promoting care facilities

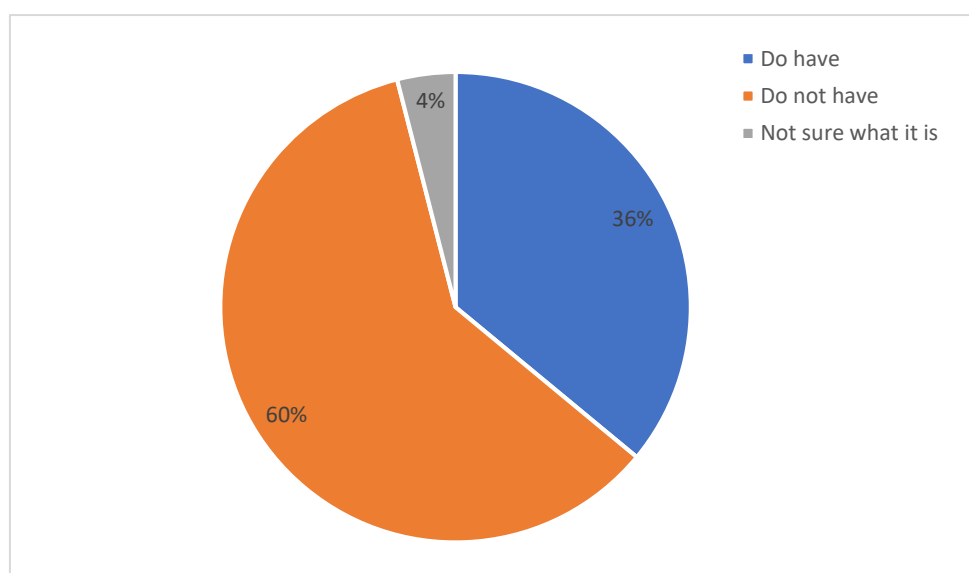
80.8% of residential care operators have promoted their work to supporters; 38.9% of those doing so is via newsletters, 44.4% via reports, and 50% also have other communication materials. Only 30.8% promote their work to the public; 75% of those doing so via social media platforms, 37.5% through websites, and 12.5% used video clips for the purpose. No care operators indicated using printed materials or an annual report to promote their work in the public sphere.

The only care facilities that do not promote their child care work to the public are religious places or Buddhist temples.

3.2.6. Child protection policy

3.2.6.1. Written child protection policy

Figure 26: Percentage of residential care facilities having written child protection policy



57.7% of care operators said their organisation does not have a written child protection policy. Surprisingly, 4% (1) of the care operators does not know or is not sure what a child protection policy is. For those with a written policy, 40% require every staff and 7.7% every volunteer to sign it. This means most staff and volunteers caring for children in the research area have not signed a written child protection policy and probably have no knowledge of the risks to children and their role in reducing those risks. It also leaves the standard of behaviour expected of staff and volunteers towards children completely undefined. Combined with an unqualified workforce, neither children nor staff can set and manage safe boundaries in their interactions and relationships. This enhances the power of unrelated adults over children in their care and leaves these children extremely vulnerable to abuse and exploitation.

36% of residential care facilities said that they also have a written policy or guidelines for visitors. When probed further, 4 of them inform the visitors using pamphlets, 3 of them inform the visitors verbally before meeting the children, and 2 of them use other means. The researchers noted that no written policy was seen during the interviews. All answers were from the residential care directors. In this case, the answers are more favourable than those on staff training and thus do not align. Only 15.4% of care facilities said that they train all staff on the *Child Protection Act*. Only 8% of them said that they train all staff about the *Convention of the Rights of the Child*.

Practical knowledge and insight about child protection seem lacking. For example, 19.2% of all care operators said they had used children's names, photos and stories to promote the organisations to the public. With a general lack of awareness of child protection issues and confidentiality, an examination of the online and printed materials used by residential care facilities might well reveal that this problem is bigger than indicated by the responses of the residential care directors.

About half of private care institutions and half of the school dormitories do not have a written child protection policy, while no Buddhist temples have one. Among those who do have, 80% said they had reviewed the policy in the past twelve months.

3.2.6.2. Staff and volunteers background check

Residential care directors were asked how they selected or checked the background of staff applicants. 4 out of 26 said they do not check. All of them are small size residential care with a few staff. All but one respondent have worked in their respective care facility for more than seven years.

Only one director mentioned checking the criminal records of Thai and foreign staff. Nine care operators (34.61%) said they asked for references, and three of them asked for recommendations. Two answered that they know the applicants personally for many years, such as from the church congregations.

For volunteer applicants, only one director mentioned a criminal check for Thai volunteers, while three of them required the check for international volunteers. Two directors checked references, while seven checked recommendations of volunteers. Six directors indicated that they looked for recommendations for volunteers from sending organisations. Religious affiliations were also mentioned in the interviews regarding the staff background checks. One care operator mentioned that he tends to look at the volunteers' faith and trusts those associated with a certain faith.

3.2.6.3. Disciplining children

Twenty-five residential care directors answered this question. One director of a religious place said that the children had not broken any rules, so he cannot answer the questions on disciplining the children. The remaining 24 indicated verbal reprimand as one of the first means of disciplining children. 17 (65.4%) of them asked the ill-behaved children to leave. Interestingly, ten care facilities said they ended care for children with behavioural problems after three warnings had been given.

Half of the directors mentioned other positive discipline measures such as reducing playtime, decreasing daily allowances, or not allowing children to watch TV or use computers. Two of them said they gave a time-out of at least 10 minutes. Half of the operators gave more chores and responsibilities to children. Seven directors said they use physical punishment.

3.2.6.4. Response to abuse cases

23 from 25 residential care directors insisted that they have never had a child abuse case. When asked about their response, if one happens, 13 directors said they would call the police. Six care operators would assign a person to investigate the matter. Two of them would allow the accused to explain. Nine care providers would dismiss the staff if found guilty. There are other measures mentioned by the operators whose care facilities have not had an abuse case. Among them are to seek the counsel of others, including professional workers (psychologists, social workers, nurses), a staff of a local non-governmental organisation, village head, and religious leaders.

Two directors admitted that there had been at least one child abuse case in their facilities, while five residential care operators said their organisation had experienced abuse case allegations.

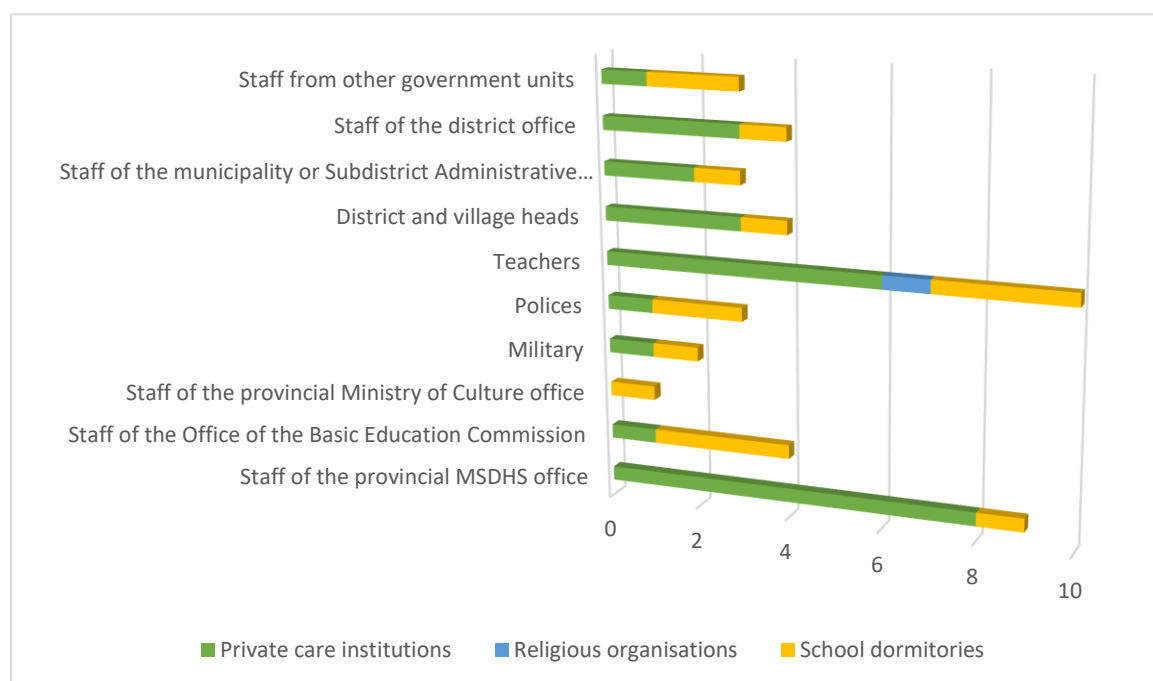
3.2.6.5. Supervisory and accountability

The most common government personnel to visit care facilities to inquire about the child care practice are teachers. This is because all government school teachers must visit all their pupils at home once a year. Only one religious place had been visited by any government staff, and this was by a teacher.

The government authority responsible for supervising private child care facilities is the provincial office of the Ministry of Social Development and Human Security (MSDHS). With an active director of the provincial MSDHS unit starting his posting within twelve months before the interviews, the provincial MSDHS staff visited eight private residential care institutions; slightly more than half of all the private children’s homes participated in this research.

Seven private care facilities, three private children’s homes, two religious organisations, and two school dormitories were not visited to inquire about child care practice in the past twelve months before the interviews. The total number of children living under the care of these facilities is 119.

Figure 27: Number of visits made by the different local and provincial authority on child care in the period of twelve months, by type of shelters



Residential care operators were asked if they had informed any authority or people involved when they accepted a child into their care to understand their accountability level. Three of them informed the subdistrict or village heads verbally, seven of them in writing. Only one director informed the municipality, sub-district administrative, or district officer. Similarly, one care provider informed the local child protection officer of the newcomers. Not one of them informed the provincial office of the Ministry of Social Development and Human Security, though that is the primary government unit responsible for supervising them.

3.2.7. Child care practices

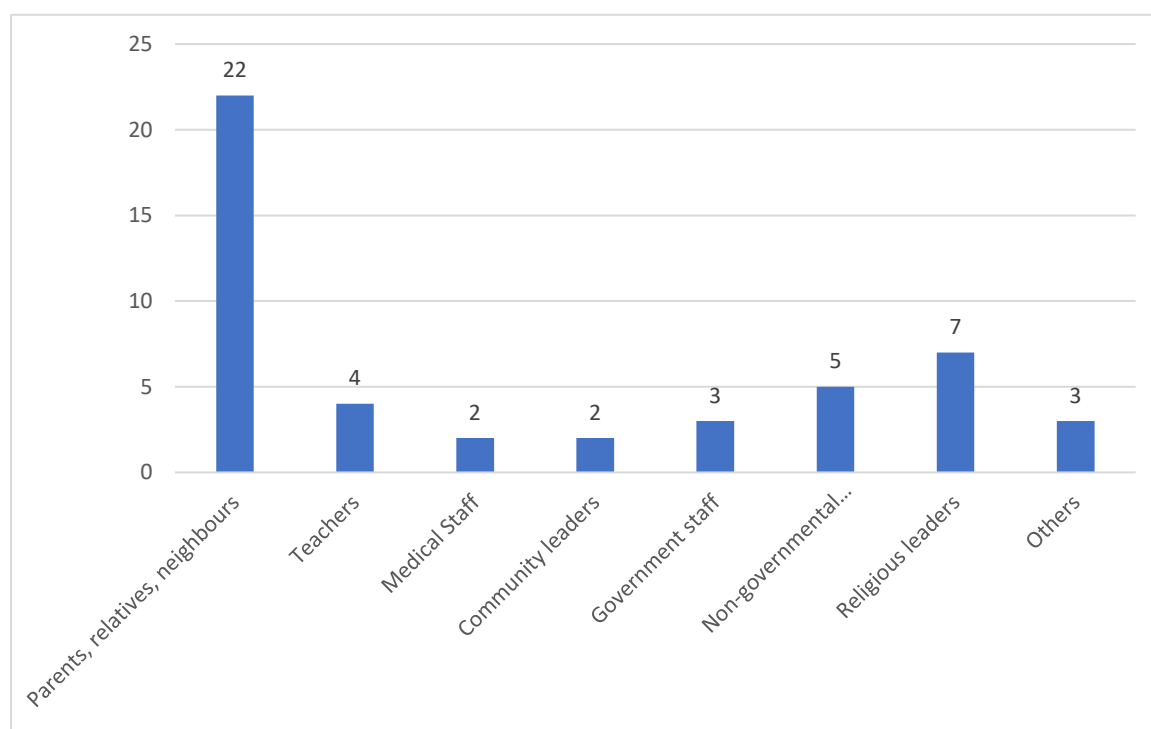
The questionnaires were designed to assess the practices of residential care against the necessity and suitability principles. Practices in three key alternative care concepts were identified; gatekeeping, individual care plan, and family reintegration.

3.2.7.1. Accepting children into care

Seventeen residential care facilities generally accepted children who were referred to their care. The majority of those sending or referring children to residential care are parents, relatives, and neighbours. When comparing this to responses of children in care during their interviews, their answers confirm that in most cases, those closest to the children are the ones who relinquish them into residential care. At least 72.6% of residential care dependents were brought to the respective facilities by their parents and relatives.

Another group mentioned by 26.9% of care directors as people referring children to them were religious leaders.

Figure 28: Number of residential care operators mentioned each group of people referring children into residential care



The data shows that residential care facilities were known mainly by word of mouth (mentioned by 20 directors) and by information shared by children living or who used to live in the care facilities (stated by 11 care operators).

To describe the process of deciding if a child will be accepted into residential care, family members or those referring a child to the care facilities were the primary people consulted by 19 residential care facilities. Ten care operators said they ask the children, and nine made home visits as part of the process.

However, not all children who applied were accepted into residential care. Eighteen directors said they rejected some children. The top three reasons for the rejection were the lack of compelling reason to have the child live in the care facility, the child still has someone to care for them, and the child is either too young or too old to be accepted into residential care. The other two reasons mentioned were that the child has a behavioural problem or has a special need that the residential care staff do not have the capacity to address.

3.2.7.2. Individual care

Guardianship

Five of the 25 fully participated residential care facilities did not keep records or collect documents on the children's health and education or other legal documents. Of the 20 care facilities that do keep some records, 19 of them collected only basic individual documents.

When asked to specify what documents they keep on file, only three of them mentioned a signed relinquishment form from parents and guardians. These three were private residential care facilities and together account for 139 dependants. Some respondents may have overlooked this important issue in their reply. This means that a further 238 children in private residential care have an unclear legal status regarding who their guardian is.

In the absence of a signed relinquishment document, it might be expected that parents or guardians would be consulted regarding every significant decision concerning a child. However, there is no mention of such a system of review meetings attended by parents and records signed by parents. In fact, some residential care facilities do not allow parents to visit without prior arrangement. Some parents and guardians complying with such directions may well have no idea what their legal status is in regards to their own children or what rights they have when interacting with those taking care of their children.

For government school dormitories and religious places, we assume that there is a legal framework in place. In government school dormitories, the state does not assume guardianship of any resident children meaning that parents are still the key decision-makers in any significant decisions concerning their children. However, this is an assumption. Further clarity could be helpful for religious places such as temples where the difference between ordained and unordained children might also need clarification regarding where that leaves legal guardianship.

Individual care plan

No residential care director mentioned creating an individual care plan or family reintegration plan.

After accepting a child into care, 11 of them reviewed the main reasons for the child to live in the care facilities; 4 of them reviewed the necessity for children to be in residential care at least once a year. A director indicated that the reasons to necessitate children's stay was reviewed every day, which is less likely. This came rather from a misunderstanding for the review's purpose.

While some private care facilities have adopted positive language, such as reviewing children's cases, it is unlikely that a review will find that anything has changed in the absence of any care plan or family reintegration plan. This passive approach seems to hinge around parents or guardians finding their own solutions to improving their situation, allowing them to care for their own children or identify potential kinship carers for their children. A residential care facility working in the spirit of the UN Guidelines would be proactive in working with parents to build a range of options for discussion in regular review meetings about children's care.

While this research found 150 children in residential care who had previously been kinship care, it found no children who had left residential care to enter kinship care, suggesting that there is currently no investment in this goal among the residential care providers.

Maintaining the relationship between the children and their families

Eighteen residential care facilities (69.2%) allowed a family to visit their child at the care facility anytime and without any limitations on the length of time allowed. However, 16 of them do not allow the family to stay overnight within their premises.

Seventeen directors (65.4%) only allowed children to visit their families during school breaks; five said it could be any time, whether school break or not; 14 had no limitations at all, but 11 had certain restrictions on the length of time allowed. Twelve residential care facilities provided transportations for children to visit their families.

Sixteen care operators (61.5%) allow children to communicate with their family anytime, while nine allowed only at a designated time. Nineteen directors (73.1%) do not impose any limit on the length of the communication. Almost all communications were phone calls.

It is unclear how parents know about any of the limitations in place concerning access to their children as no reference was made to signed agreements with parents. As described above, many parents may be disempowered and unaware of their rights when communicating with residential care facilities about their children.

Regarding the relationship between residential caretakers and the dependents, there were different ways children called the carers; father or mother (10), teacher (10), by religious titles (7), brother or sister (5), uncle or aunt (5), and other terms (1). Nine (90%) of the facilities whose dependents called the caretakers mother and father were private institutions.

Four residential care facilities gave some children new names, and their explanation was because their original names were either unknown or hard to pronounce. Two private residential centres described this, along with one private dormitory and one government school dormitory. It is of note that the three private facilities that said they change children's names are all faith-based or ideology-based. Anecdotal evidence about name changing did not match the explanation of "hard to pronounce or children's names were not known". In fact, a number of NGO colleagues who grew up in some of these four facilities have taken back the names their parents gave them once they were independent of the care facility. (personal communication, 20 January 2021)

Identity preservation and children's participation

When the directors were asked how did they promote children's cultural identity, different answers were provided. Fifteen of them (57.7%) encouraged the use of traditional languages, 13 (50%) promote the use of traditional clothing, and 10 (38.5%) allow residential care dependents to participate in their traditional festivals.

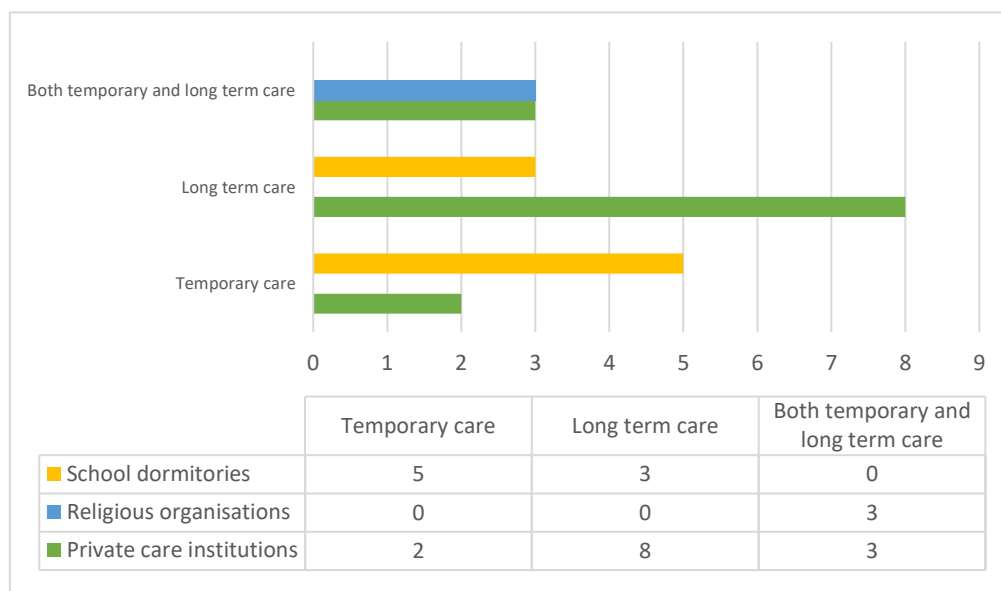
Thirteen directors (50%) said children (and youth) participated in the decisions about their daily routine. At the same time, 15 of them (57.7%) said children could share opinions on extra activities such as the places for them to go for a trip together.

Sixteen care operators (61.5%) allowed children (and youth) to invite their friends to the premises, but only two directors allowed them to stay overnight. The care operators were more relaxed with allowing those in their care to visit their friend's houses. Eight directors set a condition that the child (or youth) had to be over 13 years old to visit their friend's.

3.2.7.3. Ending care

Eleven residential care facilities (42.3%) had a policy only to provide long term institutional care; eight were private institutional care facilities. Each school dormitory had a clear policy if they provided temporary or long term care. For religious places or Buddhist temples with a summer novice program indicated that their care provision was only temporary.

Figure 29: Number of residential care facilities, by their policy on the length of care given



The reasons residential care directors gave for ending care were: a child has repeated behavioural problems (21), involved with drugs (20), and parents want their child back (18). Additionally, the care will be ended when a child graduates (17) particularly high school, a child got pregnant (11), both a child and the family are ready for reintegration (11), a child reaches legal age (becomes an adult) (4), and for other reasons (6). In making decisions to end care, the key decision-makers were residential care management (23), committees (10), and caretakers (10).

Seventeen care facilities (65.4%) said children had left their care in the past twelve months. The total number of care leavers in the past twelve months was 126. Among only private residential care facilities, the number of care leavers was 34.

Although beyond the scope of this research, it would be interesting to explore what becomes of children forced to leave for the reasons listed above. Troubled children with behavioural problems, drug problems and who become pregnant might be the very children that some would think residential care facilities would want to help. Who does help these children and what the outcome for them warrants further investigation as such children could be highly vulnerable to exploitation and abuse.

If a child had behavioural problems, some preparations were made before ending care. Sixteen directors would inform the parents, and 11 would inform the child beforehand. However, only two directors would prepare the child, including preparing their education before they leave.

Only three care facilities had worked with the family to prepare them to receive their children back. Two of them indicated that they provided psychological advice for the family, including moral support, conflict reconciliation, and other preparations. However, when asked if the organisation had worked with the community, other families, and other vulnerable children apart from those

residing in the care facilities, 14 (53.8%) of residential care directors responded positively. Examples of community and family strengthening work include giving in-kind assistance (10), providing other special activities (9), and providing educational support (5).

Sixteen residential care directors (61.5%) had a follow-up plan for care leavers. Thirteen would contact the careleaver via phone calls and other online applications, six would make a home visit, and five via social media platforms.

3.2.8. Faith affiliation

Seventeen (65.4%) residential care facilities self-identified as faith or ideology-based organisations. All 17 indicated that their faith or ideology influences their lives in the care facilities, particularly regarding daily routine and diet.

All 17 directors reported having a high percentage of staff and volunteers of the same faith or ideology present in the care facilities. 13 of these 17 care facilities (76.5% of faith or ideology-based organisations) said over 95% of their staff are of the faith and ideology they are associated with.

In addition, 15 faith or ideology-based facilities also had priests or clergy as founders, committee members, or management positions.



4. Welfare and supports for children and families

This research included 34 kinship caretakers who care for 100 children, 80 in kinship care, and 20 parents. 38.2% of them indicated that their family receive some form of government welfare. 14.7% receive the subsistence allowance for low-income individuals, another 14.7% receive other supporting money, and 11.8% receive an old-age allowance. When asked if they received any help from private organisations, 26.5% said they do. Among the assistance received from the non-governmental organisations are grants, scholarships, food and essential items.

This section summarises the different types of welfare services available to children and families in the research area. People can access different services according to their legal status.

There are three main immigration profiles in Sangkhlaburi.

1. *Factory workers crossing the border daily* – On the Thai-Myanmar border near Three Pagodas Pass, there is an area with many factories whose workforce is primarily non-Thai workers who commute daily from Myanmar. According to an NGO staff working on health issues at the border, there are an estimated 85 factories with around 6,500 workers; 25% are believed to be children under 18 years old. (personal communication, March 15, 2017)
2. *Migrants settling in the area* – Some are without any identification documents. In contrast, others who live in Thailand long enough may have different documents or even citizenship. According to a migrant who has been granted citizenship, the process has become faster and more professional than before. The assessment process is also more rigorous but has become cheaper. (personal communication, April 1, 2021) This group of migrants often maintain contact with their families and relatives in Myanmar. Many visit and also send money. Some send their children to be with relatives in Myanmar, and others bring children from Myanmar to be in Thailand under their care.
3. *Migrants working in other areas of Thailand* – Among the top destinations are Kanchanaburi, Ratchaburi, Nakhonpathom, Samutsakorn, Bangkok, and some Southern provinces. Some have an initial intention to stay in Sangkhlaburi but later decide to leave for other opportunities. As one Mon migrant explained, there are not many jobs available in Sangkhlaburi, so they need to look for work elsewhere. (personal communication, January 17, 2020)

Birth registration

About 53.89% of all children who participated in this research have Thai citizenship. 24.94% are non-Thai but have government-issued documents, while the other 21.90% have no documents. This is a sharp contrast to the self-identified data that 77.25% of all children in alternative care were born in Thailand.

Figure 30: Types of identification documents held by children in alternative care

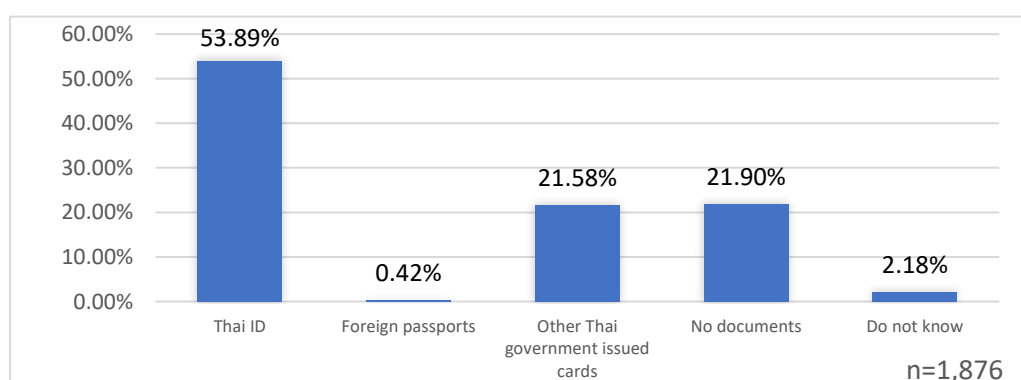
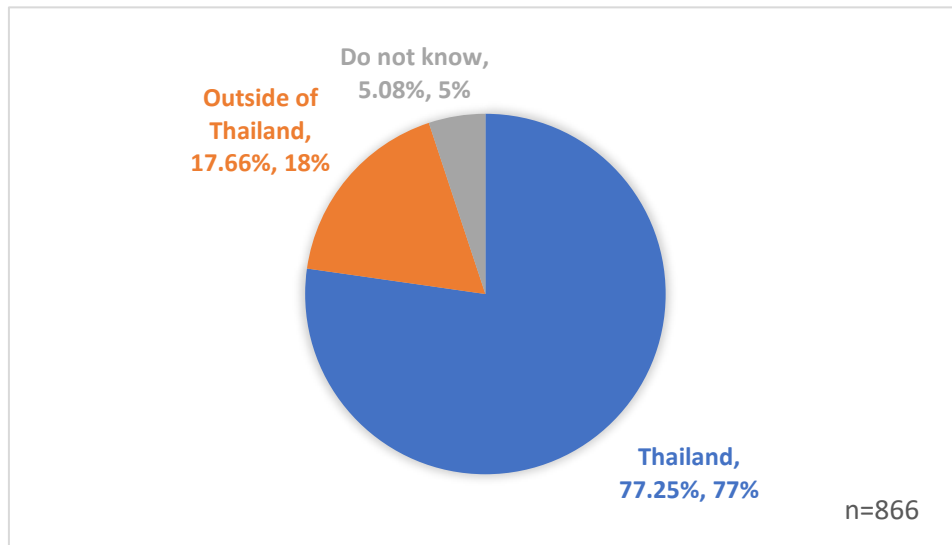


Figure 31: Percentage of place of birth of children in alternative care



There is a common misunderstanding within the migrant community, which leads to non-registration. Every child who was born in a Thai hospital will be issued a birth recognition letter. The parents need this letter to notify the local authorities about their child's birth to receive a birth certificate. However, mothers and their children are sometimes discharged from the hospital without birth notification. A 28-year-old woman from Songgalia village said her mother and grandmother thought the birth recognition document is the full birth certificate; this is another common misunderstanding. (personal communication, March 10, 2021) Another 26-year-old woman from Baan Mai Pattana Village indicated that her family thought if the parents are not Thai, they cannot register the birth of their children legally. (personal communication, March 3, 2021)

However, there have been cases where children were born in Thailand even though their parents did not live in Thailand. In 2018, there was an influx of pregnant women from Payathonzu (in Myanmar) to Sangkhlaburi to deliver their babies after hearing of an announcement that district offices will register every child born in Thailand. These mothers had never had health registration with a Thai hospital and did not have a child and mother health record, which created an extra workload for the local health system.

Health

The Universal Health Coverage Scheme offers a wide range of treatment and healthcare for a fixed price of 30 Baht. However, it does not cover all groups of people. For more expensive treatments not covered by the 30 Baht scheme, non-Thai and Thai who cannot afford to be treated are often assisted financially by the charity for the disadvantaged patient scheme, which is determined on a case by case basis. For Thai patients, it is also common for hospital staff to contact the local office of the Ministry of Social Development and Human Security to ask for an allowance to pay for transportation and food while being in a hospital. Additionally, non-governmental organisations partner with hospitals to promote health issues in the community and help patients who cannot access medical services due to their legal status.

For non-Thais who do not have any legal status and are not covered under the Universal Health Coverage Scheme, another option is to buy an insurance plan with the hospital. The annual cost is 2,700 Baht (USD 90) per person or 365 Baht (USD 12) for children age 0-7 years old. However, the person that the insurance is for must be deemed healthy at the time they buy the insurance, and some forms of treatment such as mental health care are excluded from this scheme.

It should also be noted that informal, case by case, help is available for both disadvantaged Thais and non-Thais.

When a patient does not have any document, we often treat them for free. Even when we have to refer him/her to another hospital, we will find ways to do so without cost. Sometimes, we even make sure that another hospital will also help treat the patient. – (a nurse, personal communication, January 17, 2021)

Education

More than 98% of children in alternative care receive an education. It is well-known among the migrant community that their children have education rights in Thailand. The schools are registering migrant children without issues. Nevertheless, poverty is still a significant obstacle for children's access to education. Despite not having to pay for tuition fees, there are additional expenses each family needs to pay. For example, at high school, each pupil is given one set of school uniform but must have several, including a scout uniform, a PE uniform, and traditional clothing to wear on different days of the week. Some schools may have an additional requirement for a specific school uniform and white clothing to wear on Buddhist holy day. Each family has to pay up to 2,000 Baht (around USD 65) per child for a complete uniform set. If they have more than one child, the expenses increase. This expense comes at the beginning of the school year and is a significant amount for family earning income daily.

The free lunch scheme available for all children in primary schools. To have young children at school with free meals provided is a great help to the caretakers who need to work. However, once the children finish primary school, families often reevaluate to see if they can afford to have them go to high school since there are more expenses involved, especially for food and transportation. Every village has its own primary school, but the children need to commute further or to the district centre for secondary schools. Depending on the distance, transportation costs range between 300-1,000 Baht (around USD 10-30) per month per child. This expense alone can deter many from sending their children to schools and could contribute to the number of children sent to residential care. Apart from poverty and lack of educational access, another 18.7% of children above 10 years of age indicated the main reason they are in institutional care is that their home is far from school.

Another reason some older children are not getting an education is the need to help their family financially. Young children can be seen as a burden, but they can help parents in different ways once they grow up. Children are working in the fields and babysitting their siblings. In Sangkhlaburi, there used to be children entertaining tourists on the famous wooden bridge by jumping off the bridge for a photo opportunity. More capacity to benefit the family and the higher expenses of secondary and high school increases children's risks of not getting an education, particularly boys.

My mother just delivered my brother. If I go to school, there would be no one to care for him. If she cares for the boy herself, she cannot go to work, and we will not have any money. (13-year-old girl, personal communication, February 15, 2021)

There are different educational opportunities provided for both Thais and non-Thais in the research area. In addition to government schools four private primary schools, two with tuition fees and two without, are admitting non-Thai children. Additionally, other non-governmental organisations give scholarships, food allowances, transportation fees, and other expenses for schooling.

Table 20: Summary of welfare and supports for children and family at risk with different legal status in Sangkhlaburi

Type of welfare and services	Providing agents	Beneficiaries' individual legal status – types of documents held		
		No legal documents	Other government-issued documents	Thai ID card
Health	Local hospital	Vaccination for newborn – 12 years old		
		Have to buy a health insurance program	Covered by the Universal Health Coverage Scheme. If not, have to buy a health insurance program	
		Disadvantage non-Thai patients are treated and referred to another hospital if needed without the cost (case by case basis)	Disadvantage Thai patients are given 2,000 Baht (USD 63) allowances for food and transportation while in a hospital, not more than three times/year	
	A religious organisation	Has funds to help with food, transportation, and medical treatments		
NGOs	<ul style="list-style-type: none"> Promote health and well-being of mothers and children on the move along the border Work with people living with HIV in caring for themselves and family planning Provide insurance program for pregnant women who are not covered in any health schemes Assist with medical expenses, food, transportation cost, and provide interpreters 			
Education	Local governments	Child development centres (prioritising children in the service area and some do not receive children without any legal documents)		
	Ministry of Education	Free 15-year basic education for all (prioritising children in the service area)		
	Private schools	Kindergarten to primary schooling with free lunch and transportation		
	A religious organisation and NGOs	Scholarships		
	Private institutional care	Room and board for students		
Other supports	Ministry of Social Development and Human Security			Child Support Grant for 0 – 6 years old 600 Baht (USD 20) per month
				Monthly support for disability cardholders 800 Baht (USD 26) per month
				Old age allowance 600 to 900 Bath (USD 20-30) per month depending on age
	NGOs	<ul style="list-style-type: none"> Assist those qualified to obtain citizenship Assist children and adults with disability Promote education for children with special needs Help people with special needs to receive specific treatments 		
	Provide shelter, food, consumer goods, and other necessities for disadvantaged families			



5. Recommendations

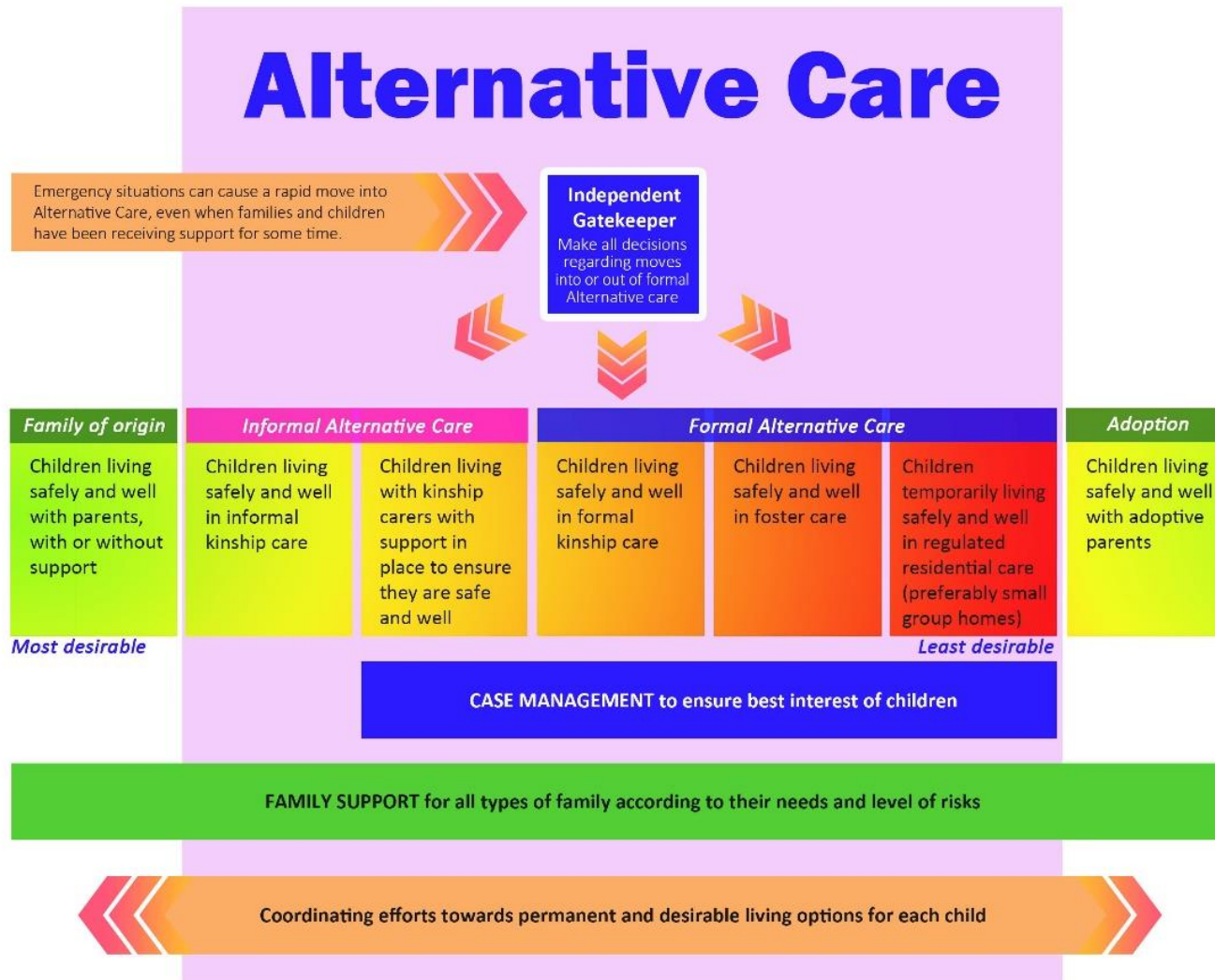
This research aims to inform recommendations on alternative care for policy and implementation at the national and local levels. Therefore, changes needed and the rationale behind them are given to both national and local stakeholders.

It is clear that in the research area, and presumably in other areas of Thailand, many children who are living in residential or institutional types of Alternative Care could be living with their families or extended families. This is achievable if the available resources were applied for the child's best interest rather than towards the provision of residential care.

When Alternative Care is necessary, desirable options like family-based care are not effectively available. There is a lack of support for kinship carers and no formal foster care in place in the research area, although it is being developed in some other areas of Thailand. Entry to residential and institutional types of care was found to be geared towards permanence. There was no evidence of mechanisms to make such placements temporary by seeking out and supporting reunification or family-based options such as kinship care. Similarly, parents are largely sidelined once their children enter residential care. This research found very minimal evidence of mechanisms to address the support for parents to resume their responsibility of caring for their children.

The UN Guidelines for the Alternative Care of Children are straightforward. All efforts to support parents to care for their own children should be exhausted before considering Alternative Care. If a child does need to be removed temporarily, efforts to equip parents to return as primary caregivers should be continued. When Alternative Care is necessary, family-based Alternative Care is more desirable than residential care. This is highlighted in the continuum of care that shows the spectrum of most through to least desirable living arrangements for children. The more desirable options provide more possibility of children's individual need for love, care, and attention to be met.

Figure 32: Most to least desirable child care options and framework of alternative care



5.1. Increase the amount and variety of family support services by enhancing government services and by redirecting the private sector towards support for families and kinship care families

This research identified the vulnerability of kinship families in the community through insight into kinship households' situations in the research area. On average, each family has five members. 20.6% of the families include a member other than the household head who is an elderly person, a person with a disability or a family member with chronic illness. 32.35% of household heads themselves have a chronic illness. 67.65% of them did not receive any formal education, indicating limited options for employment. The average monthly household income is 4,679.41 Baht (USD 150). 85.3% of families do not have enough income to cover their expenses. About half of all the families indicated that they have a lot more expenses than income, implying a high household debt level. None of these kinship families receives the government's kinship care monthly allowance at the time of this research.

61.7% of the household heads are non-Thai. For these families, the average monthly household income is lower at 4,261.90 Baht (USD 135). However, the expenses are higher, particularly on medical insurance. With multiple vulnerabilities, children are more likely to be relinquished into residential care. That is why slightly over 50% of residential care dependents are non-Thais. Unless the families are assisted to care for their children, more children, particularly non-Thais, will be sent to institutional care due to the financial incapacity of the caretakers. The percentage of children in kinship care is about 42% of the national average, whereas children in private residential care are nine times the national average. This confirms the hardship that many kinship families are facing and the need for support to avoid the relinquishment of children into residential care.

Support that helps increase their income is a necessity. More services are required to support families to raise children in safe and nurturing environments. In Sangkhlaburi, family support services are mainly provided as scholarships, food allowances and grants for medical expenses. There is not enough psychological support or support for the carer to help them build more stable and positive environments for the children in their care.

The lack of tailored family strengthening support may be due to the high cost of providing such services. However, the problem is not the lack of funding. Significant funding is spent on residential care rather than for the benefit of children and their families. This research estimated that 27 million baht (USD 861,000) is spent providing alternative care in Sangkhlaburi each year. If we calculate only the budget of private orphanages, it is around 21.8 million baht (USD 695,000) annually. The average funding spent per child per month in private care institutions is 4,830 Baht (USD 154) which is slightly higher than the average monthly household income of a kinship family from the same area.

Private residential care operators should consider developing projects to provide more informal social support services to all types of families. With the same amount of money, there will be more beneficiaries and greater sustainability as the community's collective capacity is slowly enhanced. Fortunately, this is not a new idea for residential care operators. 53.8% indicated that they have worked with the community and other groups of vulnerable children and families. In addition, at least 57.7% of the shelters offered help for children and families before accepting the child into their care. Focusing more resources on this support for families would help prevent children from being in residential care unnecessarily, especially when their parents or relatives can still care for them.

Alongside significant international funding going to private residential care facilities, the Thai government is spending money to maintain children in school dormitories and boarding schools. Several government schools with dormitories and one government boarding school elsewhere in the province receive children from Sangkhlaburi district. Phone calls to just two of them identified 284 children from Sangkhlaburi.

Adding these children to the 300 children living in government school dormitories in Nong Lu (usually higher than this but reduced due to covid) gives a total of 584 children. Without a covid situation, this number would be higher. If children from Sangkhlaburi among all other schools in the province are traced, this number could increase a lot. It is clear that the government is meeting the cost of keeping very large numbers of children in residential care. It seems likely that this picture is repeated throughout the country. The amount of money could help a lot more children stay in education if it was directed at supporting families.

Recommendations at policy level

Develop and maintain a child and family welfare services list

Several government departments provide services to support families, such as those within the Ministry of Interior, the Ministry of Education, and the Ministry of Public Health. The Department of Children and Youth or the Ministry of Social Development and Human Security should seek their collaboration to develop and maintain a child and family welfare services list.

The updated list will help case managers and others who work for children and their families to access the appropriate resources for the need assessed in each case. Additionally, a solid evidence base is provided in this research for government agencies to utilize in developing new support services for families to help reduce the number of children being relinquished into alternative care.

Reallocate government budget

Government school dormitories are taking in large numbers of children from low-income families, as we have seen in Sangkhlaburi. To rethink this approach could enable the same budget to help many more children stay in education without being separated from their families; by supporting their families and developing innovative education support schemes, especially for boys (who are absent from education settings in greater numbers than girls). Such a change would require inter-ministerial cooperation at the highest level, particularly with the Ministry of Education.

The government budget reallocation towards family support services and family-based alternative care, when necessary, is the key to child care reform. The budget can be reallocated for different purposes, such as increasing the foster care monthly allowances and the number of kinship care welfare payments. The government budget allocation can be done in parallel with the gradual change of the government's position from direct service provider to regulator of child protection and alternative care services implemented by the private sector.

A firm political will to promote family support and family-based care when necessary is needed to reallocate the government budget and reform the care system for children's best interest.

Identify mechanisms to detect, report and support children at risk at the local level

A loving and nurturing family is more desirable for a child than institutional types of care. While this is the general rule, we must also remember that not all families provide loving and nurturing environments. For example, not all kinship carers will be prepared or willing to provide an optimal environment for their relatives' children who stay with them. Therefore, mechanisms to identify children at risk at the local level have to be identified and prepared.

All children in Thai schools are visited at home by their homeroom teacher once a year. This unique mechanism could be further developed to identify children at risk and families in need of support. Basic training for teachers would include identifying children in kinship care and whether any additional support is needed. Most schools have child welfare committees. They are often able to make effective responses in support of their students. However, less clear is the formal mechanism through which a teacher or school might refer or report a child or family to other government departments such as the Ministry of Social Development and Human Security provincial office.

The inter-agency system and available resources are set up to respond when a child is in a crisis but not so much to identify a growing risk that once addressed could prevent a crisis from occurring. Thailand is strong in the provision of universal services for children, such as education and healthcare. Also, the country has a national mechanism to respond to children in crisis with a national helpline and a local government shelter in each province. However, there is a significant gap in services and welfare support for children and families, which would prevent a crisis from happening. The global movement for so-called "deinstitutionalisation" hinges around directing investment away from residential and institutional type care and into these support services for children and their families.

The MICS 2019 data suggests that as many as 4 million children live in kinship care in Thailand, making this type of Alternative Care by far the most common. Thus, even a small percentage of the children in kinship care living without adequate care and attention represents a large number of children in need of social service intervention. In addition, raising public awareness to identify and report children at risk is another way to ensure children are better protected from harm.

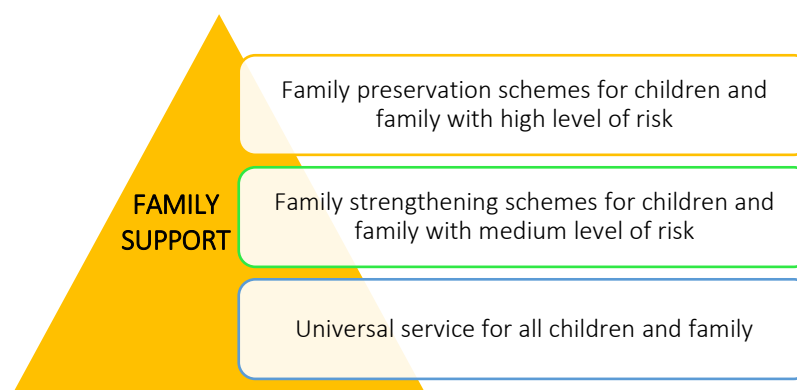
Recommendations for local implementation

Develop and maintain a local child and family welfare service list

Local actors such as the district child protection committee, competent officers, or non-governmental organisations can create a list of child and family welfare services and promote it among vulnerable families or those working with them. Often, there are services available, but vulnerable children and families do not know about them.

The "menu" should include a range of services to cater for families in different situations and children facing different levels of risk. The families with low-risk levels require general welfare services, mainly financial support, translation (for migrants who could not communicate well in Thai), and advocacy. In contrast, a medium-risk family might need more specialized services, including counselling and coaching, to address their issues.

Figure 33: Schemes of family support for different levels of risks of children and family



Raise awareness and redirect the services of residential care operators

Responsible agents, particularly the Ministry of Social Development and Human Security provincial office, should actively engage with the private residential care operators. Among the key concepts needing to be addressed are the best interest of children and how to best use funding and resources in line with this universal child-centred and child rights-based concept.

This would involve encouragement to invest more in families and the community through providing family support services. 53.8% of private residential care indicated that they have already worked with the community and other groups of vulnerable children and families. Thus, there is some foundation for them to continue and expand their family support services. However, more knowledge and skills are needed. 65.4% of shelters have no staff that have been trained on strengthening families. Content on family strengthening with other critical concepts on alternative child care should be added to awareness-raising and capacity-building schemes for residential care operators.

Another approach to redirect the services of private institutions towards family support is through engaging with their donors. While the leading domestic financial supporter is the government (who gives a budget for public schools with dormitories per the number of children), the primary foreign funders who are the main supporters of private residential care are religious organisations. These funders will be engaged most effectively through assertiveness from the government as a duty bearer. Fortunately, several international schemes are addressing this particular issue on foreign funding for orphanages. The campaign content available can be used in the awareness-raising and capacity-building schemes for residential care operators.

Conduct workshops to identify contextualised alternative care prevention, particularly for over-represented groups of children

Poverty and education are the reasons for most children to be in residential care. All stakeholders should identify more ways to solve poverty and education access without separating children from their families. Regarding Sangkhlaburi, the provincial office of the Ministry of Social Development and Human Security would be the ideal host and facilitator of such a workshop. The impact of COVID-19 on the movement of children into residential care should be included in the discussion.

Also, Karen community leaders must be included in the workshops. From this research, Karen and Christian children are consistently over-represented in residential care in the area. Therefore, the views of Karen and Christian community leaders must be captured. Different ways that family support can be made more effective within their communities should be explored. Many community leaders may not have considered other options and could be advising struggling families to give their children up to residential care facilities.

Provide tailored and targeted family support services

Stakeholders can utilize the research findings to design and provide targeted services to different families and children more effectively. This research identifies groups of families at high risk of relinquishing children into residential care. They need tailored services to reduce this risk. Two major ones are skipped-generation (grandparents as kinship carers) and single-parent families. It is also clear that more innovative support services are needed to help boys stay in education.

Regarding skipped-generation families, this research found that 63.18% of kinship caretakers are maternal relatives. 71.6% of kinship household heads are female. Their average age is 55.88 years, and 61.8% of them are married. While the maturity of caretakers is valued in child-rearing, the generation gap and deteriorating physical strength are challenges in parenting their grandchildren. Therefore, family support services targeting this group of carers are needed at the local level.

A survey of migrant and undocumented kinship carers should be undertaken to identify what other support, beyond financial assistance, would strengthen their ability to care for children and reduce the number of children moving from kinship into residential care.

5.2. Further Development of Formal Family-based Care options for children

Despite the very high numbers of children identified in residential alternative care settings in the research area, no children were found in formal kinship care or foster care. The lack of these more desirable family-based alternative care options is a significant gap to be closed to achieve the vision set out in the UN Guidelines. While government or licensed private actors could provide formal family-based alternative care options, a systemic change led by the government through policy development is the first priority. Until such systemic frameworks are in place, most recommendations made for local implementation are limited to laying the groundwork for such policy to occur at the local level.

Recommendations for Kinship Care

Informal Kinship Care in Thailand is very common. Although there are a limited number of kinship families receiving government monthly welfare support, the care is informally arranged, and the families applied for the financial support themselves. They are not kinship placements decided by the state, which is the definition of formal kinship care.

The current approach of both the government and private systems of alternative care placement appear to bypass the seeking out of kinship care options and family-based care altogether. This research finds no evidence of efforts to support parents in taking their children back or identifying and developing kinship placements for children. Instead, the movement into residential care is almost always a long term one. This is further confirmed by the lack of individual care plans, absence of active parental involvement in decision-making, and lack of regular and meaningful case reviews for children in residential care.

If family-based care is prioritised and supported, more children will be prevented from separating from their families unnecessarily. For example, most children at the High School dormitory saying they had to stay there because it was too far to travel every day from their village. However, a simple survey showed that 50% came from villages where other children travel from every day. The lack of money to pay for the transportation costs was the real reason they stayed in a school dormitory. With support given, many children will live with their parents or relatives instead of going into institutional care.

- **Equip gatekeepers to prioritise family-based care** – After identifying those who could implement gatekeeping mechanisms, such as competent officials, training on family tracing and family strengthening skills should be provided. This would ensure that kinship opportunities are sought and their suitability assessed when a child needs to enter alternative care.
- **Administer individual care plans towards family reintegration** - For children already in residential care, individual care plans detailing the efforts to find a suitable family-based care option for the child must be administered. This would include supporting parents to deal with the issues that led to the child's separation, family tracing and assessment of potential kinship placements, and seeking out suitable foster care placements for each child. The primary concern for such administration is the lack of a skilled social service workforce to carry this out.. However, the government's efforts to develop foster care placements for children in government shelters has already set a precedent for this type of work.
- **Expand foster care standards to include formal kinship care** – The government's current partnership with the private sector to develop foster care standards should be expanded to include formal kinship care placements. These placements should be monitored and regulated in the same manner that foster care placements are now being managed.
- **Encourage private actors to support families** – As a duty bearer, the government can direct and encourage private actors to provide financial and other types of support to kinship families. Going beyond redirecting the services of private residential care operators, the government can engage all NGOs to respond to the needs of children and their families, contribute to the social safety net for the vulnerable, and increase the local oversight of formal and informal kinship care.

Recommendations for Foster Care

Thailand relies heavily on residential care. More foster care options have to be made available as alternatives to institutional care to reform the child care system. However, there are socio-cultural biases against fostering and adoption. A public perception that a safe and nurturing family is the best child care environment is crucial to attracting more prospective foster parents.

- **Raise public awareness on family-based care** – A significant number of potential foster carers and adopters in Thailand have not yet been engaged. A campaign to promote the importance of family and a positive image of foster care and adoption to the general public is essential to utilise this resource. Ideally, when alternative care is necessary, the goal is to have formal family-based care as a default option for all children if informal kinship care has not naturally solved the problems or is not suitable to provide care for the children.

- **Revise foster/kinship care monthly allowances** – The current monthly allowance for foster/kinship care has not been revised for decades. The economic downturn resulting from the global pandemic would increase the financial burden to the already vulnerable families. Without adequate support, more families are slipping into poverty and have a higher tendency to relinquish their children as a result. Therefore, the meagre 2,000 Baht (USD 66) foster care monthly allowance, which is also given to registered kinship care, must be reconsidered. This is a vital step to testify to the government’s effort in improving alternative care services for the best interest of children.
- **Partner with the private sector for foster care provision** – Foster care has to be made available in all areas of the country in order for it to be the default option for alternative care in Thailand. However, the current government child care system is not large enough to reach all children without parental care. Partnership with the private sector is necessary to increase the number of qualified foster care placements. This partnership will require the engagement, training, licensing and monitoring of the private sector alongside government provision.

At the time of writing, the provincial office of MSDHS, in partnership with a local NGO, is establishing a foster care program in Sangkhlaburi District. The impact of adding a formal family-based care option for children in the area should be closely monitored and shared with UNICEF and the Department for Children and Youth. If successful, this private/government partnership model should be encouraged in other areas of Thailand dealing with high levels of children in residential care.

Implement impartial and Standardised Gatekeeping and Case Management prioritising family-based care

The gatekeeping process has to be conducted impartially. In countries where progress towards the vision of the UN Guidelines is advanced, private residential care operators are not the decision-makers about whether a child should be brought under their care. This conflict of interest is avoided by the involvement of a gatekeeper who is not connected to any of the possible alternative care placements under consideration for a child.

The gatekeepers have to gather all the relevant information available, including the views of parents and children. The information is to be used in deciding on the placement of a child in their best interest. All information should be regularly updated, and the decision about the child’s placement regularly reviewed to ensure it is still the best option available.

Such a gatekeeping system is intertwined with the child protection system. All efforts are made to separate children from their parents only when necessary; for their safety and wellbeing. Each child’s specific individual needs are then considered to select the most suitable alternative care placement for them. A child-centred individual care plan is drawn up for each child that includes goals to work with their family or extended family if there is a chance of reintegration back to the family or kinship family.

If the vision of the guidelines is to be realised in Thailand, the private child care operators cannot continue to self regulate. The government system and parallel private system of child care have to merge into a single system. Standards and processes must be followed to ensure children’s best interest. In doing so, most children for whom alternative care is necessary can be directed towards family-based care options such as formal kinship care and foster care, as they are being developed.

Family-based care is a more desirable care setting compared to institutional care. Smaller in size, children have more possibilities to be given the individual love and attention needed for their healthy development. Just like any alternative care environment, family-based placements can also pose risks to children. However, this research did not identify any children for whom carefully assessed and monitored family-based placements would be less desirable than the institutional types of care they currently reside in.

5.3. Overhaul the private residential care system in Thailand

A high number of unregistered private orphanages in Thailand implies that private organisations' provision of child care services has essentially been allowed to develop without direction or meaningful regulation by the government. This results in many private organisations working with children in Thailand not responding to their needs but having institutional care as a fixed solution to all problems.

The *UN Guidelines for the Alternative Care of Children* (“the guidelines”) were issued in 2009 and accepted by all UN member states, including Thailand. However, the Thai government can only claim to be working towards the vision set in the Convention on the Rights of the Child (CRC) and the guidelines when they have a strategy to engage private organisations effectively. As a duty bearer, the government must exercise authority over private organisations working with children and direct them to work in children's best interest.

Throughout this section, we describe both strategies of enforcement and partnership. The best outcome is to work with all private actors towards a new system of care based on the guidelines. However, the ability and willingness to stop those who are not working in the best interest of children and who do not want to operate in line with the guidelines must be present to achieve national care reform.

The recommendations for private residential care can be summarized as follows:

- **Survey the needs of children** in Thailand and direct government and private sector resources to meet those needs. This will involve generating an evidence base to establish what services are needed and where. The Multiple Indicator Cluster Survey (MICS) 2019 is a rich source of information already available to start this process.
- **Establish the state's role as overseer** of the care of all children in private residential care facilities, including state-licensed gatekeeping and case management supervision by suitably qualified professionals who are independent of the facilities receiving children (competent officials, for example).

To emphasize the state's role as overseer of care provision, a system of partnership with private care providers has to be identified. It has to be made clear that standards and care systems must operate within the government framework and under the government's supervision. Private care facilities persisting in working in isolation and following systems and standards other than those set by the government must be closed. The assessment tool developed in this research project can be used to set out the expected standards and systems and measure individual care facilities' performance to see if they are reaching the required standards.

- **Update the requirements to register and run a private care facility** for children so that they are in line with the core principles of the *UN Guidelines for the Alternative Care of Children* and also clearly set out minimum standards for child safeguarding procedures.

- **Review the definition of residential care** in the Thai context so that thousands of children in schools dormitories, boarding schools, temples, churches, mosques, and boarding houses are not excluded from the care reform process.
- **No children under five years old to be taken into institutional types of alternative care** (a family-based option should always be available instead). This is an achievable milestone towards enabling all children in Thailand to grow up in a safe and nurturing family environment.
- **Effective and impartial gatekeeping and case management** for all forms of residential care
- **Clarify the legal status of duty of care and guardianship** within all aspects of Alternative Care and especially for children moving into and out of private residential care facilities. Also, establish the concept of a duty of care whereby all adults involved in the care of children are legally obliged to make decisions in the best interest of the children at all times.

Detailed explanations of these key recommendations

Survey the needs of children in Thailand and direct government and private sector resources to meet those needs.

The survey of children's needs is to establish what services are required and where. At the national level, there is a considerable variation in the services provided for children. Some regions have very high numbers of private residential care facilities, and others have very high numbers of children in kinship care. Several provinces have no private residential care facilities, whereas others have over one hundred. This variation has to be explored in light of the real needs of children.

The private sector is an essential resource currently dispersed very unequally in Thailand. Without guidance and direction from the government, most private organisations working with children in Thailand have established themselves as residential and institutional care providers concentrated in certain areas and locations. Their combined efforts have resulted in a national picture of heavy reliance on institutional care, which contrasts with the vision of the UN guidelines. Changing this picture requires strong government leadership to begin the reform process and set clear goals on the journey towards full implementation of a system that operates on the core principles of the guidelines and children's best interest.

The current system provides a government licence to operate a private orphanage to any organization that meet the requirements, regardless of whether there is a need for another residential care facility in that location. This approach has allowed staggering numbers of private children's homes to open in some provinces while there are no private children's homes at all in others. This phenomenon appears to be more closely linked to the places that foreigners in Thailand find more desirable to live in, rather than any variation in the needs of children between different areas. Similarly, the government spends large amounts of money to keep children in school dormitories, boarding schools, and boarding houses despite cheaper options of providing financial support directly to families, which will help more children with the same amount of budget.

The data from a national survey could be used to inform an evidence-based approach by the government to redesign the alternative care system and redirect available resources based on children's needs.

Establish the state's role as overseer of the care of all children in private residential care

As a duty bearer, the state already has a role in providing care for children with inadequate parental care. However, there has been a lack of active supervision of the state over the private sector, resulting in a proliferation of private institutional care.

In this research, there has been some activity by government officials to visit the care facilities, but it has been minimal. 34.6% of residential care facilities were visited by the local staff of the Ministry of Social Development and Human Security in the past twelve months from the interview date, mostly only once. Although care operators have been receiving guests for merit-making by giving meals to children (pre-Covid), 26.92% of residential care were never visited by any official or authority regarding their child care practice in the past year. The distance of 221 kilometres (about 137 miles) from the provincial government office to the district makes it inconvenient for staff to visit regularly. However, local administrators are not aware of their responsibilities toward the children in alternative care. Thus, very few officials visited the care facilities regarding their child care practice. Hence, the residential care operators can run the care facilities without any accountability to anyone.

These residential care facilities have to be made accountable in order to improve the care system. In doing so, the state's role as overseer of care provision has to be firmly established. The government has to exercise authority more firmly and not shy away from adequately regulating the private sector. A database of private care facilities is among the first steps in improving the care system, followed by assessing and grading care providers. However, a strong policy on deinstitutionalisation is essential, and the mechanisms both at the central unit and local level have to be identified and equipped. This will lay a foundation for state-licensed gatekeeping and case management supervision by suitably qualified professionals independent of the facilities receiving children (competent officials, for example) to be put in place.

- **Exercise government authority more firmly and regulate the private sector**

From this research, all types of residential care in the research area operate without adequate supervision from the responsible parties. None of the private institutional care facilities has a license to operate an orphanage. Only two facilities have applied but have not yet been granted one. They are among at least 240 private children's homes in Thailand operating without a license. (Alternative Care Thailand, 2021)

Thailand has a non-confrontational culture. When it comes to the relationship with private children's homes, government staff tend to use a personal relationship to seek the operators' willingness to cooperate. While friendly connection helps, it also undermines the role of the government as a duty bearer. The government should firmly exercise their responsibility, insisting on the need for private residential care to be supervised.

The current legislation for the registration of private care facilities is a good example. It describes imprisonment or a fine for those operating a children's home without a licence. However, it also allows for "a promise to begin the registration process", providing a comfortable way out for both parties. In fact, previous research in Sangkhlaburi led the director of the provincial office of the Ministry of Social Development and Human Security to address all of the children's homes there in April 2015. In the meeting, all of the children's home operators promised to begin the registration process. Several directors of

the provincial office of MSDHS have rotated since that time, and only two children's homes have tried to register.

Nevertheless, it is not the view of the research team that the provincial office of the Ministry of Social Development and Human Security should revisit their 2015 request to all private residential care facilities in Nong Lu to complete the legal registration process. Instead, we recommend that the requirements of the registration process are reviewed at the national level. The current registration requirements predate the 2009 *United Nations Guidelines for the Alternative Care of Children* by some years. Even if all the residential care facilities in Nong Lu were able to meet the current registration requirements, it would do little to bring the local child care system closer to the vision of the guidelines and its core principles of necessity and suitability.

While the registration cannot guarantee quality child care, it creates accountability in caring for vulnerable children; when the appropriate criteria are set. Standards and systems of care must operate within the government framework and under the government's supervision. In this, private care facilities persisting in working in isolation and following systems and standards other than those set by the government must be closed. Therefore, a form of registration and active supervision is indispensable and has to be tightened to emphasize the role of the state as overseer of care provision.

An incentive for registration or notification by private residential care facilities should be considered. Since the government will regulate more than provide services directly, capacity enhancement programs can be provided as an incentive for care providers. The program's content has to reflect the UN Guidelines on Alternative Care but at the same time consider the local context. Training and workshops to raise awareness of the harm of institutional type care for children and introduce a child-centred approach to case management should be offered to all private residential care providers.

From this research, we see that more than 50% of the residential care providers do not have staff trained on the *Convention on the Rights of the Child*, *Child Protection Act*, the child's best interest, and positive discipline. In addition, 88.5% of the shelters do not have staff who have been trained in individual case management. These are the topics that should also be prioritized in the capacity building program.

A clear policy direction from the government for more robust and more effective supervision of private residential care is needed. Without such a directive, there is no mechanism to control the quantity and the quality of private alternative care necessary to ensure children's best interests are upheld. A positive but firm relationship between the duty bearer and the private care operators will foster the long term development plan of alternative care service provision.

- **Update database of private residential care**

The provincial office of the Ministry of Social Development and Human Security should have an updated database of all private residential care in the area. As a secretariat of the provincial Child Protection committee, this should be seen as within their remit. The database of the care facilities, operators and children will help inform the local policy to ensure the best interest of children is being upheld in different care settings.

In doing so, the questionnaire collecting data from residential care operators developed for this research can be used. The questions were designed to collect essential information

of the residential care facilities and determine the quality of their child care practice, having the UN guidelines as a frame of reference. The essential information includes, for example, the number and types of children, information on staff and volunteers, including professionals, institution management, facility, written child protection policy and the personnel/visitors acknowledgement of it, abuse or potential abuse cases, referral system, identity preservation and life skill enhancement, the maintenance of the relationship between the children and their families, and preparing families for reintegration.

In addition, the accompanying mechanism to log the movements of all children already exists. It is the mechanism used within the government's own children's homes that requires the approval of the head of the provincial child protection committee to separate a child from their parents for more than 28 days in the absence of parental agreement.

However, the database alone will not be effective unless local stakeholders understand the importance of providing quality care to children without adequate parental care. Therefore, the provincial office and the local child protection committee should consider an awareness-raising scheme for stakeholders; so policy implementation will be better adhered to. Additionally, the capacity enhancement program is also important for encouraging the care operators to fulfil the individual and specific needs of vulnerable children and their families using a range of methods and skills.

- **Assess/grade private residential care providers for system improvement**

The assessment tool developed for collecting data from residential care operators in this research can serve as an assessment tool for private residential care. The questionnaire was designed with *the United Nations Guidelines for the Alternative Care of Children* as a reference. It aims to measure effectiveness in ensuring the use of residential care temporary by examining the efforts made in family reconnection and the movement of children back to their family or into family-based Alternative Care whenever possible.

The private residential care assessment tool draft should be developed further, especially the grading system, to grade the system of care in each facility. Once graded, care facilities can be ranked into groups depending on their quality. A tool like this will be helpful for the country's effort to control the number of private residential care operators to be in line with the level of needs of children and families in each area. The tool can help identify quality residentialfamily-like care qualified to be in the alternative care system. It will also help prioritise support for families, with family-based Alternative Care being the preferred option when children cannot remain with their biological family.

However, even without the grading system, the questionnaire is ready to be utilised for the assessment of child care practice of private residential care facilities and to identify the areas for improvement.

This assessment is part of a considerable effort to engage with the private sector and provide support and guidance to foster change. However, the government also has to be willing to exert authority over those who do not engage with these aims. The assessment tool can be used to make fair and transparent decisions, but when concerns are found, there must be a system in place to address the child care operators who are unable or unwilling to achieve the minimum standards despite the chances given.

- **Deinstitutionalisation policy for private institutional care**

Although the government has issued a policy to deinstitutionalize public residential care, a similar policy direction for private institutional care should be in place. However, such a policy would need additional development due to the scale of the private sector, the varied range of actors and projects within it, and the myriad of local situations they are responding to in their support of children.

A multi-faceted strategy is required in harnessing and directing the expansive and previously unregulated private sector. The policy has to steer the service providers towards a child-focused, needs-based approach to supporting families rather than running institutions. Such a strategy would confirm the government position towards care reform and prioritising family-based care over institutional care. In addition, a strong message of intent by the government would help local-level actors to build momentum for change. A policy statement on the deinstitutionalisation of private institutional care will highlight the direction for the care providers and make them aware of the government's intention to tackle unnecessary placements of children into private residential care in Thailand.

Most importantly, deinstitutionalisation policy has to be communicated to the stakeholders with great care. There is a place for quality residential care in the alternative care system. However, with the current heavy reliance on residential care, Thailand has to reform the care system and minimise the use of residential care where possible.

- **Establish an alternative care central unit and identify and equip active local mechanisms**

To initiate and foster the supervision of private residential care, a central unit on Alternative Care is critical. The unit will act as a centre for collaboration on alternative care for all children without adequate parental care, including migrant children. It would serve as a policy centre issuing related policies and carrying out or coordinating their implementation. This includes defining a mechanism and developing tools to supervise private residential care in different settings. The process could be conducted in parallel with or after the review of the orphanage registration requirements and the national survey of children's needs.

One of the mechanisms that can be used is the provincial and district child protection committees and child protection officers. In order to supervise and monitor private residential care more effectively, an active local mechanism is vital. In Sangkhlaburi, the district child protection committee can serve as a supervisory agent in collaboration with the provincial MSDHS office. If empowered to do so, the committee can ensure that alternative care services are provided according to the necessity and suitability principles.

The district child protection committee will need to have a database of residential care facilities in the area and children currently living in them. To reduce the amount of lost information and avoid loss of contact with parents, a standard format for recording the personal details of every child, including their parents and family, should be introduced to all residential care facilities. The district child protection committee can hold copies of these documents.

The district child protection committee is also a key entity to provide active supervision to local private residential care. In practice, they are the leading group to make regular monitoring visits and maintain a line of connection with the care providers. Their finding

can be reported to the provincial MSDHS office responsible for the registration of private residential care. The care providers are to report the number of children and a summary of cases to the committee for transparency. In summary, the child protection committee should take an active role in overseeing child care practice and giving advice to direct care providers in responding to the needs of children in ways that uphold their best interest.

- **Child protection concerns**

While the systemic change is being considered and taking place, this research found specific child protection concerns which need to be addressed more urgently.

First, there are care facilities labelled differently but essentially providing institutional care for children. For example, the very high numbers of children boarding at one primary school were of particular concern, as most children are older than primary school age. Data from the assessment tool shows that this primary school dormitory has become a children's home for children of all ages. Also, it provides very low levels of supervision and care. Supervision from the relevant authority (in this case, the Ministry of Education) is needed to ensure that quality alternative care is provided.

Second, a foreign national who previously admitted physical abuse of children and was on probation for two years is once again operating a residential child care facility. Court papers are available to confirm the case, and a local NGO claims to have documented further evidence of child trafficking by the same person to gain financial benefits from paying volunteers. The Ministry of Social Development and Human Security provincial office and the locally based competent official in Nong Lu should urgently investigate the matter.

Update the requirements to register and run a private care facility

The current private orphanage registration requirements in Thailand pre-date the *United Nations Guidelines for the Alternative Care of Children*. They focus on the physical environment rather than the systemic aspects of child care. Despite having no license to operate as an orphanage, all residential care facilities examined in this research scored reasonably well in our assessment of their physical facilities. For example, 42.3% have full permanent fencing, 76.9% have separate areas for boys and girls, 80.8% have a cement wall.

However, all the types of residential care examined in this research have low scores when measured against the core systemic principles of necessity and suitability, which are at the heart of the UN Guidelines. Consistent care standards for children in their best interest can only be achieved by introducing policy and legislation that sets minimum standards according to the international guidelines.

- **Required to work with licensed impartial gatekeepers**

Alongside the requirements for the internal running of each care facility, achieving the vision set out in the guidelines requires an external operator licenced by the government to impartially assess the necessity and suitability of each initial child placement and regularly review the necessity of its continuation. This so-called "gatekeeper" must be independent of the facilities receiving children to avoid a conflict of interest. This would be a significant systemic change for Thailand, requiring investment and realignment of the child protection system.

In the registration requirements revision, means to ensure that private residential care providers will work with designated gatekeepers have to be identified. An active local mechanism will play an essential role in this regards.

- **Maintain the involvement of professional personnel**

Despite the legal requirement under the current registration criteria for private orphanages, only a few residential care facilities can afford professional personnel. In this research, only one facility had a social worker and a nurse. There was no psychologist. Despite the attempts of different stakeholders to have all residential child caretakers trained on the essential knowledge and skills to care for children, not every facility has such staff. Only 11.53% of residential care has para social workers, and 23.07% has basic medically trained assistants.

There is evidence that having professional staff is crucial to developing a child-centred approach and making decisions in children's best interest. A skilled social worker who actively engages in the care operation can help orphanages develop their policy and change their care practices to align with the necessity and suitability principles. (CRC Coalition Thailand, 2018) Therefore, in revising the registration requirements, a clear expectation of their role in upholding children's best interest should be incorporated.

However, as systemic change and the registration requirements revision is taking place, the authority should ensure that care operators have enough knowledge and skills to provide family-like care arrangements for children. Training for parasocial workers should be considered as a mean to improve the current care practice.

- **Insist on child protection policy and case management process**

The registration requirements revision should aim for a child protection policy and a case management process geared towards residential care's necessary and temporary use. 65.21% of residential care examined in this research do not have a written child protection policy. In fact, there was a case where the residential care operator had not heard of and did not understand what it is. The government already has a written policy that can be introduced as an example of policy and practices expected from all child caretakers across all types of residential care. Training and facilitation are needed to ensure all involved in child care understand the risks to children and the steps needed to reduce that risk.

The Ministry of Social Development and Human Security provincial office and the provincial children and families shelter can introduce a child protection policy as an example of policy and practices expected from caretakers in all types of residential care; orphanages, school dormitories, religious places, and boarding houses. Training and a toolkit to develop their own child protection policy are ideal for getting engagement and ownership in practice. A sample toolkit is available and can be adapted to the Thai context. Local partners, whether the local administration offices or non-governmental organisations, can contribute to this attempt to promote child protection among those closest to children.

Evidence of the implementation and constant development of child protection policies within all organisations working with children, whether residential care or family support focused, should be monitored by the provincial child protection committee. Clear and meaningful actions need to be predetermined for when such policies are found absent or inadequate. This is how a duty of care can be established whereby those working with

children are accountable to the state for their actions and decisions with serious consequences if they are found to have failed in their duty of care.

Additionally, an alarming number of staff and volunteers are being given access to vulnerable children without references or background checks and little to no child safeguarding training. By international standards, this is deeply concerning. Abuse of children at one children's home in the research area already led to a court conviction, yet there was nothing in place to stop the abuser from opening a new and even more extensive children's home in the same area. Urgent attention is needed to address this situation.

Apart from a child protection policy, case management should also be introduced as mandatory for all children in private residential care. The case management process should include individual care plans for all children and work with children and families on family reconnection, reintegration, and family strengthening. Training and facilitation are needed to raise awareness about these areas and their importance.

- **Utilise existing government working group to revise the requirements**

The current government Alternative Care Working Group is a prime mechanism to address the revision of the legal aspects of the Alternative Care system, given that the revised registration process will be applied to different alternative care settings. Comprised of representatives from different government agencies, it accommodates their different views, which allows the revision to be beyond just the child care practices in orphanages and to include measures on family support. The working group is also well placed to consider how the revised legal aspects such as private children's home registration criteria will be enforced. The private residential care assessment tool developed in this research can serve the working group in establishing revised criteria for registration due to its design which incorporated the core principles of the *UN Guidelines for the Alternative Care of Children*.

Review the definition of residential care in the Thai context

It is clear that there are residential child care facilities operated in different settings. This research took an approach to include school dormitories, religious temples, and boarding houses as types of residential care. In the local context, these institutions function as residential care for children without adequate parental care. They care for more than six children overnight for a period of time, not for recreational purposes but due to the incapacity of parents to provide for the children.

Each care arrangement, such as school dormitories or temples, has its purpose and regulated under different authoritative bodies. Thai laws regard these institutions differently. Religious places like Buddhist temples, churches, mosques, and religious schools are registered under the Ministry of Culture. Schools are registered under the Ministry of Education. Some boarding houses and institutional care facilities are registered under the Ministry of Interior as foundations, often mistaken with the license to operate an orphanage.

Unfortunately, there is inadequate attention towards care practices for children without parental care in these settings. This research found that most current care practices are not aligned with the international standards and guidelines. When there is a child abuse case, the Ministry of Social Development and Human Security staff will address it regardless

of the care setting. However, there are no preventative measures to reduce risks to children in these different alternative care settings.

For the children's best interest, alternative care standards and practices should be introduced to these care facilities functioning already as residential care. But first, the definition of residential or institutional care has to include them, so all stakeholders have a common understanding of the situation. Without a broader definition of residential care, thousands of children in schools dormitories, boarding schools, temples and boarding houses will be excluded from the care reform process. This means the ministries under which these facilities operate would also be absent from the care reform process.

If this research did not include these other types of residential care, 52% of the children would not have been taken into account. This research also shows that in the research area in the past three years, over 50% more children entered school dormitories than private institutional care. Therefore, it is essential to broaden the definitions of alternative care environments to cover these child care settings.

Reviewing and revising the definitions of alternative care and the care environments is one thing; putting the broadened definition into practice is another. Close collaboration between different government ministries is vital. Different viewpoints are required to clarify the scope of the alternative care environments and ensure that all children under the care of non-related adults are protected and the risks of harmful practices are minimised. These viewpoints should be collected from both local and national actors to ensure a final system that makes sense to everyone involved in the care system for children in Thailand.

In Article 23 of the Child Protection Act 2003, it is mentioned that the guardian has to provide a minimum standard of child care. However, without relinquishment of guardianship by parents, they remain the legally responsible adult for their children. This grey area needs further exploration. Some countries have successfully developed a legal framework around "duty of care" to address this issue and make it a legal requirement that all adults involved in the care of children act in the best interest of those children at all times. This solution helps when parents are the legal guardians but other adults have important roles in children's daily lives, such as a teacher responsible for running a school dormitory for children from mountain villages who cannot reasonably travel to school every day because of distance or unsafe road conditions.

In practice, it is hoped that broader alternative care definitions and active collaboration across ministries would enable people, like temple Abbots and school directors responsible for dormitories, to recognise their role as primary caretakers. With active engagement, the care providers of these different settings should understand the parent's and children's rights as well as the means to protect them from possible harm. It will also ensure that no children are left behind in the reform of the care system by including all forms of alternative care in that process.

No children under five years old to be taken into institutional types of alternative care

Following the international guidelines, children under five years old should not be in institutional care. Instead, all children under five years of age to be case managed by the local child protection committee to ensure the minimum possible length of stay in residential care.

It is surprising to see children under five years of age being taken into government school dormitories, especially before they begin formal school. However, the research team are not aware if the Ministry of Education has any policy or guidelines on the minimum age of children coming to live at such dormitories. The government and international government agencies should look into this issue.

This research suggests that it should be possible to prevent any child under five years old from entering residential care for the long term in Sangkhlaburi. We recommend that all residential care facilities are required to report any children under five years old that are admitted to their care to the Sangkhlaburi Child Protection committee.

The district head, who is also the committee head, will instruct qualified professionals within the committee to investigate each case and assess the suitability for family support, kinship care and foster care as an alternative to residential care. The committee should ensure that detailed and accurate records are kept regarding all the decisions made about these children and the evidence used to make those decisions. The committee should be encouraged and supported to visit and learn from similar pilot models in Thailand.

Effective and impartial gatekeeping and case management for all forms of residential care

This research found no indicators of robust gatekeeping measures despite confirming the global statistics that most children in residential care still have at least one living parent. Only 4.3% of residential care dependents are double orphans. When added to the number of dependents who do not know about their parents' whereabouts, only 9.92% of all those living in residential care are double orphans or could be. Therefore, over 90% of children living in residential care still have at least one living parent.

When examining why children are in residential care, both the children themselves and the caretakers ranked poverty and lack of access to education as the top reasons, reinforcing the need for more family support services (see recommendation 5.1). It shows that many children are in residential care unnecessarily. Although, in some cases, residential care staff have enquired about the children and family situation before deciding to accept a child, the necessity principle is not upheld. This is because most residential care staff lack adequate understanding and skills as well as access to the resources needed to support children within their families.

For the private orphanages, the decision to accept a child is made solely by themselves. Only 38.5% of them informed the village head by a written letter, 23.1% verbally, and only one institutional facility informed the district or subdistrict office verbally. The complete autonomy of residential care operators undermines the possibility of reunifying children with their family. When 42.3% of residential care operators confirm the review of reasons necessitating the children to remain under their care, it is an apparent conflict of interest.

65.4% of all residential care operators state that they provide long term care and no evidence was found of the movement of children out of residential care into kinship care despite substantial movement of children into residential care from kinship care. Unlike foster care, kinship care is an entirely normalized concept in the research area. However, none of the residential care facilities had mechanisms or resources to seek out and develop kinship placements for the children who came into their care.

In the absence of a clear policy direction, implementation, and active supervision, this research found no indicators of robust gatekeeping measures. In some cases, there could

be a conflict of interest or perverse incentives if the operators receive financial support as per the number of children residing under their care. The government has to exercise their authority to regulate and thus ensure that children are not deprived of their right not to be separated from their parents unless necessary.

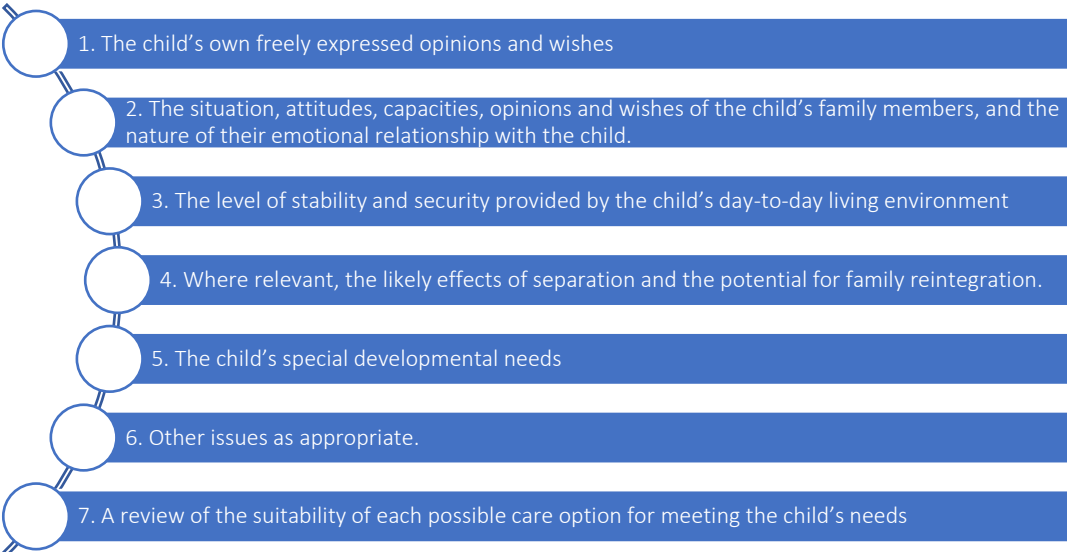
The Department of Children and Youth has begun to work towards gatekeeping and is obliged to continue doing so among private residential care. However, the conditions, process, and mechanisms to implement gatekeeping have to be identified more clearly. One of the existing mechanisms which should be promoted is the competent officials. By definition, they are gatekeepers with authority but need capacity building schemes and support to perform more confidently and effectively in such a role.

Eventually, an independent, qualified, and government-licensed gatekeeper should be put in place to oversee the cases of children with more complex problems. When necessary, the most suitable form of Alternative Care available can be selected for each child. The gatekeeper will also provide regular reviews of placement with the aim of reintegration to family or kinship care whenever possible. The existing mechanism of competent officials could be adapted to absorb this role.

The movement of all children into or out of residential care should be regularly monitored. In the research area, it is estimated that with awareness-raising on the unnecessary causes for family separation, at least 65.13% of separations could be avoided by giving family support instead. Such cases should not need to be brought to the attention of a gatekeeper.

In this way, the percentage of children at risk who need a gatekeeper to evaluate their situation and manage their case will not be many. Case management should be introduced for all children that do enter residential care. This ensures a care plan for each child specific to their needs and includes actions aimed at a reintegration to family or kinship care whenever possible. Children and parents should be involved in care planning and review of the care plan. As suggested in the Moving Forward Handbook, the following list of issues should be covered in the assessment by qualified professionals before making any decision.

Figure 34: List of issues considered in an assessment before making a decision on children (Cantwell et al., 2012)

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1. The child's own freely expressed opinions and wishes
 2. The situation, attitudes, capacities, opinions and wishes of the child's family members, and the nature of their emotional relationship with the child.
 3. The level of stability and security provided by the child's day-to-day living environment
 4. Where relevant, the likely effects of separation and the potential for family reintegration.
 5. The child's special developmental needs
 6. Other issues as appropriate.
 7. A review of the suitability of each possible care option for meeting the child's needs

Clarify the legal status of duty of care and guardianship

Legal guardianship needs to be clarified in different alternative care arrangements. However, this research suggests that this issue should first be included in revising the requirements for private actors to care for children without parental care in Thailand. In the absence of a solid legal framework to determine guardianship, many children and parents are left to depend on the private children's home directors, whose interpretation of the law, understanding and skill in determining a child's best interest may be in doubt.

Many parents are sidelined after their children enter residential care facilities in Thailand. In some cases, they have signed a relinquishment paper. In others, they have not signed any agreement. Although many parents may not understand the meaning and significance of guardianship, they may well believe that the decision making about their child now lies with other people. This is not true, even if a relinquishment has been signed and is additionally saddening when poverty and access to education are most commonly the reasons for parents giving up their children to a care facility rather than a lack of care.

This research found a lack of measures to engage parents in the ongoing care and decision making about their children. In some cases, the whereabouts of parents was no longer known. In cases where children are asked to leave a residential care facility, for example, for bad behaviour, it is unclear to whom they are relinquished and how legal guardianship can be determined, especially when parents are no longer involved.

The same issue lies within the current child protection system. Two routes are described for separating and transferring guardianship of children from parents or other caregivers to the state. One route involves agreed relinquishment and the other forced removal. The relinquishment route is even referred to as "the welfare route", implying that poverty is a valid reason for separation. An agreed relinquishment is often preferred, even in abuse cases. This is because it is less complex and less confrontational than taking action against parents and guardians. However, this practice weakens the protection system as an informed abuser might realise they can withdraw their agreement for relinquishment at any time.

A legal case regarding an inheritance found that the biological parents still had legal guardianship rights for a child who had been through the national adoption process (personal communication with Childline Thailand legal adviser, 10 May 2021). Such cases add further confusion to this area. An urgent review is needed to clarify guardianship of children while also establishing a legal framework for the duty of care that binds all adults involved in the care of children to make decisions in the best interest of each child at all times.

All countries that have progressed towards full implementation of the guidelines have done so by enforcing the government's position as overseer of all private care for children. Although using regulatory authority causes some discomfort within the Thai cultural context, any other way to implement the Guidelines may not be an option.

The concept of child safeguarding applies to all services and activities for children and is broader than the Alternative Care sector. A national child safeguarding system requires the state to establish a legal duty of care or similar for all people who work with children. A duty of care can be described as "the duty which rests upon an individual or organisation to ensure that all reasonable steps are taken to ensure the safety of a child or young person involved in any activity or interaction for which that individual or organisation is

responsible.” (Tameside Metropolitan Borough Council, 2021) Within such a system, all people and organisations are answerable to the state for upholding their duty of care to children. For this reason, state oversight of child safeguarding is essential.

Requiring all organisations to have child safeguarding policies and mechanisms in place is the first step; however, in the absence of state oversight of these mechanisms, the accountability remains within each organisation. The powerful duty of care concept is then nullified. In the past, the absence of state oversight left only the internal accountability of institutions that led to the mass abuse of children in institutional care. The move away from institutional types of care and the establishment of a legal framework for child safeguarding based on the concept of “duty of care” have been direct responses to the investigations of historical abuse of children in institutional care in many countries.

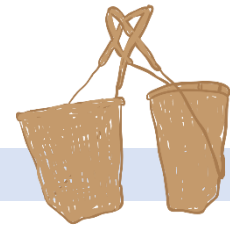
The duty of care concept also seeks to empower children by stating that “Any person in charge of, or working with children and young people in any capacity is considered, both legally and morally to owe them a duty of care.” (Tameside Metropolitan Borough Council, 2021) This major shift in thinking did not come without challenges in countries like the UK, where traditionally, children were to be “seen but not heard”. Taking such a step to empower children in Thailand would also face challenges. It would require a change from the current sense of obligation on the part of children and parents towards those running care institutions and emphasise that they too are obliged to meet their duty of care towards children. In fact, they are legally bound to so.

In Thailand, there is a situation where state oversight or duty of care is absent. There is a legal requirement for private children’s homes to register with the government. Once registered, each home should be inspected annually by the provincial office of the MSDHS to continue its registration. Although the content of annual inspections seems vague and inconsistently applied, it is the basic government oversight mechanism. However, a large number of private children’s homes remain unregistered and appear not to fall under any government department’s responsibility.

A duty of care would compel the Ministry of Social Development and Human Security to inspect even unregistered private children’s homes once they have been brought to their attention. This safety mechanism would identify any places where children are at immediate risk so children can be removed to safety and these facilities closed. Other homes would be given support and time to meet registration requirements but would be eventually closed if they were not able to reach the required standards.

Parents are usually the legal guardian of a child. In most countries, changing this requires a legal action by a judge and usually resulting from child protection concerns, the death of both parents or other serious situations. A guardian plays an important role in a child’s life. He or she is charged with many responsibilities that ensure the well-being of the child, from both a physical and emotional standpoint.

The legal guardian becomes the primary duty bearer. In Thailand, the transition of legal guardianship is insufficiently defined and understood. If a private children’s home takes on guardianship, they also take on a legal duty to ensure the child’s wellbeing. If a legal duty of care has been established, then any guardian failing their duty of care is committing a criminal offence and is answerable to the state. Most of the countries with comprehensive child safeguarding systems use this framework. This approach relies on effective government oversight and enforcement to all people and organisations working with children.



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มูลนิธิวันสกาย
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สำนักงานพัฒนาสังคมและความมั่นคงของมนุษย์ จังหวัดกาญจนบุรี