



# INSIGHTS INTO THE WORLD OF PRIVATIZED FAITH-BASED RESIDENTIAL CARE FACILITIES IN MYANMAR



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WRITTEN BY REBECCA NHEP

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Last but not least, we would like to dedicate this research to all of the children we work with. We hope that this research project will contribute to our goal of ensuring that all children in Myanmar are cared for by safe and nurturing families.

Thanks again to each and every person who helped us throughout the year.

With gratitude,

Manan Naw Jar  
National Director, Kinected Myanmar  
On behalf of KM and ACCIR

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## 2. EXECUTIVE SUMMARY

The study was aimed at gaining insights into the operations of privately run, Christian faith-based residential care facilities<sup>1</sup> (RCFs) in Myanmar. Specifically, the study sought to better understand the operational mechanisms of these RCFs, including the characteristics of the directors and donors, the means and reasons for referral and admission of children into care, and how the interplay of these dynamics affect RCF stakeholders' willingness to engage in transition, the reintegration of children, and transition outcomes. The study employed a mixed methods approach and gathered data from 46 residential care facilities and 22 individual donors or donor groups, all of whom were involved in Kinnected Myanmar's transition and reintegration program. The outcomes of this analysis provide important insights to inform ongoing awareness raising, advocacy efforts, approaches to providing technical support and deinstitutionalization, and care reform strategies in Myanmar.

### Background

This study was conducted against the backdrop of the Myanmar government's increasing efforts to reform the country's child protection and care systems and move away from an overreliance on residential care services. Despite progress with legal and policy reforms, as well as the strengthening of the social service workforce and the piloting of foster care, the number of children estimated to be in residential care facilities remained high. 2019 estimates suggested up to 600,000 children were living in RCFs across the country, with the vast majority thought to be living in privately run unregistered RCFs, many of which were faith-based.<sup>2</sup> Concerns have long since been raised regarding the situation of children in residential care facilities and the safety and standards of care provided to children within them.<sup>3</sup> Unregistered RCFs continue to operate outside of the formal gatekeeping system introduced by the government and are known to recruit children directly from families and communities in order to populate their facilities.

The Kinnected Myanmar program was developed in response to the proliferation of unregistered faith-based residential care facilities in Myanmar and out of concern for the situation of the children in their care. It was first founded as a pilot project in 2013 under ACC International, an Australian faith-based international development agency, and was registered as a local non-government organization in 2018. Kinnected Myanmar's main aim is to encourage and support the transition of privatized faith-based residential care facilities, and to reintegrate children in the care of participating facilities back into families.

<sup>1</sup> Residential care facility is the term used by the Ministry of Social Welfare, Relief and Resettlement in Myanmar.

<sup>2</sup> UNICEF. (2019, August 16). *Myanmar: UNICEF delivering change for children: Programme brief - Child protection*. <https://www.unicef.org/myanmar/reports/programme-brief-child-protection>.

<sup>3</sup> Department of Social Welfare & UNICEF. (2011, August). *The situation of children in residential care facilities in Myanmar*. [https://static1.squarespace.com/static/5bbab8cbe666692d8fd5f481/t/5c42a51abba22367200f9815/1547871516154/Residential\\_Care\\_Survey\\_Report.pdf](https://static1.squarespace.com/static/5bbab8cbe666692d8fd5f481/t/5c42a51abba22367200f9815/1547871516154/Residential_Care_Survey_Report.pdf).



Over the eight years of implementing the Kinnected Myanmar program, social workers and project staff have amassed considerable learning and data, which gave rise to this opportunity to gain insights into how these facilities operate, and the situation of the children in their care. This study was therefore conceived as a means of capturing and analyzing the learning and data derived from the Kinnected Myanmar program and its stakeholders.

## Summary of Key Findings

### ■ 1. Residential care service transitions are largely donor influenced

The transition of privatized Christian faith-based residential care facilities was largely driven by donor interest in transition or a donor commitment to divest of funding residential care. Directors rarely initiated the transition and often demonstrated resistance to varying degrees. While directors were under no obligation to participate in and pursue transition, the volition of directors was curtailed by the power afforded to donors. This meant that directors invited by their donors to participate in the Kinnected Myanmar program often agreed, despite in many cases having no desire or intention to transition. Participation was initially seen as a means of managing donor relations through a demonstration of superficial cooperation. Some directors went on to agree with, or concede to, transition or closure at the point where they were otherwise unable to avoid a conflict between the principal donor's<sup>4</sup> express wishes and their own. For those who were able to avoid this conflict, transition or closure did not occur. In some cases, this was because the principal donor was not involved in the program and not independently pursuing divestment or transition.

This finding shows that directors primarily act to avoid conflict with their principal donors. Their full participation in a transition process is only feasible with the approval and active support of their principal donors.<sup>5</sup> Partial and temporary participation is often an adaptive strategy employed by directors to manage relationships with donors who are not their principal donors. However, at the point where their participation creates conflict with their principal donor, the directors will likely withdraw from the transition program or limit their involvement in ways that eliminate conflict.

This reinforces the importance of not only engaging donors in the transition process and donor awareness raising, but of identifying and engaging the principal donors. It also points to the need for improved regulation over funding streams, due to the role that funding plays in undermining systems reform efforts and driving the continued and inappropriate use of residential care.

<sup>4</sup> The principal donor is defined as the main or largest donor, or representative of the main donor or main fundraiser.

<sup>5</sup> Nhep, R., & van Doore, K. (2021, April). *Impact of COVID-19 on privately run and funded residential care institutions*. Better Care Network & Griffith University. <https://bettercarenetwork.org/sites/default/files/2021-06/Impact%20of%20COVID-19.pdf>.

## ■ 2. Active recruitment drives admission of children into residential care

Active recruitment of children into residential care facilities was found to be pervasive and the primary mechanism employed by privately run faith-based RCFs to populate their facilities. 99% of children under case management admitted into participating RCFs were recruited, most commonly by the directors or individuals in the directors' networks. Despite experiencing vulnerabilities that act as push factors, families rarely initiated the admission of a child into an RCF in the absence of recruitment. Rather, recruiters likely identified families experiencing known push factors, and offered residential care as a viable solution. It also suggests that families prefer to transfer children into RCFs with which they have relational connections, either through kin, fictive kin, ethnic, or clientelist networks. In doing so, families can access support offered through RCFs and alleviate stressors, without breaking customary and familial obligations towards the child.

However, as the levels of power and authority held by families and RCF directors are unequal to each other, the transfer of a child into care, particularly in the presence of recruitment, signals the subordination of the families' authority as guardians to the director who is seen as the 'benefactor'. It therefore impacts the ability of the families to exercise authority over their own child/ren in the future. In addition, the recruitment into specific residential care facilities along relational lines often results in the movement of children into RCFs that are located far away from their families. Along with the commonplace practice of RCFs discouraging family contact, this geographical distance can result in significant periods of little, if any, contact between children and families. This compounds the power differential that prevents families from exercising decision-making rights over their children's care. Family reconnection, as a part of the transition and reintegration process, was found to be critical in supporting parents and families to regain decision-making power, allowing them to act on improved awareness of what was in the best interest of their child/ren and to accept alternate forms of support. However, it often resulted in families circumventing the full and standard process of case management for reintegration. Instead, families often sought immediate reunification with their children during family reconnection visits, out of a fear that they would not have another opportunity to reclaim their children after they returned to the RCFs.

## ■ 3. Cultural factors and customary laws influence children's admission into residential care

Children from ethnic Chin communities and families face additional risks of being admitted into privatized and unregulated faith-based residential care facilities in Myanmar. The vast majority of the RCFs in the study cohort were founded and run by Chin directors, and most of the children in care were from Chin State or Sagaing Region, both areas where the majority population are Chin and Christian. Due to the relational nature of recruitment, including along kin and ethnic lines, these children are more likely to be targeted for recruitment and admission into these specific faith-based RCFs. In addition, Chin cultural and customary law norms pertaining to custody of children increase the risk of families seeking opportunities to send children to residential care in the event of death of the father, or divorce or separation. This stems from children

being considered the property of the father, and in the event of his death, custody is transferred to the father's family. The mother ceases to have any role or responsibility in the family, including with respect to her biological children. In the event of divorce or separation, the children remain with the father; however, if he is unable or unwilling to assume caregiving responsibilities, placement in residential care is preferred over other non-paternal family-based care options. These cultural norms similarly pose challenges for children's reintegration, particularly in cases when the most appropriate option for family-based care is reintegration with the mother or foster care. Both options are likely to be blocked by the paternal family, who would perceive such placement outside of the paternal extended family as a contravention of customary laws.

#### ■ 4. Poverty is the most common reason for children to enter into care

Poverty was found to be the most common push factor contributing towards children's admission into residential care. 97% of children had one or both parents alive and 1 in 2 children were referred to care for reasons associated with poverty. However, in most cases it was the combination of two or more stressors that led to families resorting to residential care. Poverty and the loss of one parent was the most common coupling of push factors, followed by poverty and access to education. While conflict was rarely cited as a push factor, most of the children in the study cohort came from conflict-affected areas of the country. In these areas, extended periods of insecurity have worsened poverty and stalled development of infrastructure, including the construction of new schools. In response, parents have often resorted to sending their children out of these areas to ameliorate these issues. As such, the indirect role of conflict on children's institutionalization cannot be discounted.

These findings show that at the heart of the issue of recourse to privatized residential care, are the interrelated issues of sustainable development and security, overlaid by culturally informed responses to adversity. This points to the importance of multisectoral collaboration in child protection and care reform efforts, particularly in strengthening at-risk families' access to social protection and education. This raises concerns regarding the increasing insecurity in response to the recent coup, and the impacts that further uprisings in these parts of the country may have on children's care. In the short term, the uncertainty of the 2020-2021 period has resulted in some children exiting residential care facilities to return to their families, even in these conflict-affected areas. However, in the medium to long term, without appropriate intervention, these issues may result in another influx of children into privatized residential care facilities.



## 3. INTRODUCTION

### 3.1 Background

The situation of children in residential care facilities in Myanmar is one that has yet to be sufficiently elucidated. The full extent of child institutionalization remains unknown. The majority of residential care facilities (RCFs) are privatized, and a significant proportion of privately run facilities remain unregistered and operate without oversight of the government.<sup>6</sup> Many of these are faith-based facilities<sup>7</sup> that are locally run but funded by overseas donors. Numerous reports released since 2006 suggest an alarming rise in both the number of residential care facilities in operation as well as the number of children in care. However, as none capture comprehensive data on both registered and unregistered RCFs, the exact extent is not clear. In 2006, the Department of Social Welfare reported 177 registered residential care facilities housing a total of 14,410 children.<sup>8</sup> This figure rose to 217 and 17,322 respectively in 2010.<sup>9</sup> In 2018, the Ministry of Social Welfare, Relief and Resettlement reported 280 registered residential care facilities housing a total of 36,000 children, which to some extent may have reflected efforts throughout this period to enforce registration of existing unregistered RCFs.<sup>10</sup> In 2019 UNICEF estimated up to 600,000 children were residing in residential care across the country.<sup>11</sup> This estimate included children in registered and unregistered RCFs; however, the report did not include the actual or estimated number of unregistered facilities in operation. A full quantitative and qualitative study of registered and unregistered residential care facilities has since been commissioned by UNICEF to address these gaps in knowledge and produce a more accurate baseline. At the time of this report, the findings were yet to be published.



<sup>6</sup> UNICEF. (2019, August 16). *Myanmar: UNICEF delivering change for children: Programme brief - Child protection*. <https://www.unicef.org/myanmar/reports/programme-brief-child-protection>.

<sup>7</sup> Madihi, K., & Brubeck, S. (2019). *Myanmar*. Martin James Foundation. <https://bettercarenetwork.org/sites/default/files/2019-08/MYANMAR.pdf>.

<sup>8</sup> Department of Social Welfare & UNICEF. (2011, August). *The situation of children in residential care facilities in Myanmar*. [https://static1.squarespace.com/static/5bbab8cbe666692d8fd5f481/t/5c42a51abba22367200f9815/1547871516154/Residential\\_Care\\_Survey\\_Report.pdf](https://static1.squarespace.com/static/5bbab8cbe666692d8fd5f481/t/5c42a51abba22367200f9815/1547871516154/Residential_Care_Survey_Report.pdf).

<sup>9</sup> Ibid.

<sup>10</sup> Aung, S. H. (2019, April 3). Alarming Increase in the number of orphans in Myanmar. *Myanmar Times*. <https://www.mmtimes.com/news/alarming-increase-number-orphans-myanmar.html>.

<sup>11</sup> UNICEF. (2019, August 16). *Myanmar: UNICEF delivering change for children: Programme brief - Child protection*. <https://www.unicef.org/myanmar/reports/programme-brief-child-protection>.



**72.6%**

of children in RCFs had one or both living parents

**1 in 2**

children were brought to the RCF by their parents/relatives

Concerns have also been raised about the conditions in residential care facilities in Myanmar and the quality and appropriateness of care provided to children. A survey of 147 RCFs, including government-run, privatized, faith-based, and unregistered facilities, was conducted by the Department of Social Welfare with support from UNICEF in 2011. The survey findings revealed a stark disparity between policy, minimum standards, and prevailing practice.<sup>12</sup> 72.6% of children in these residential care facilities had one or both living parents, and 1 in 2 were brought to the RCF by their parents or relatives.<sup>13</sup> The report found that most were admitted for reasons of education and/or poverty, highlighting weaknesses in Myanmar's gatekeeping system and the poor regulation of the use of residential care. Even though abuse was rarely a factor contributing to the child's admission into residential care, most RCFs did not facilitate or even encourage family contact and visits.<sup>14</sup> Significant concerns were also raised around health care, child protection, and safety. The physical standards of care varied widely, with some RCFs unable to provide sufficient food, bedding, or clothing.<sup>15</sup> Overall, the report painted a

bleak picture regarding the appropriateness and level of care provided to children. Notably, most (84.4%) of the surveyed RCFs were registered or pending registration.<sup>16</sup> As these facilities had met the conditions of registration and were subject to inspection and regulation, it is likely that on average, they were of a higher standard than their unregistered counterparts. This may mean that conditions could be considerably worse for children in the majority unregistered facilities operating across the country.

Encouragingly, government-led child protection and care reforms are underway in Myanmar. In 2014, in conjunction with the National Forum on the Prevention of Separation, the government announced a moratorium on the establishment of new residential care facilities.<sup>17</sup> In 2017, the Ministry of Social Welfare, Relief and Resettlement launched new Minimum Standards of Care along with guidelines for the registration of existing facilities that were unregistered, to improve oversight and regulatory control.<sup>18</sup> A child protection case management system was also introduced, along with social workforce training. It was initially piloted in a limited number of townships where the first cohort of government social workers were stationed. By 2019, it

<sup>12</sup> Department of Social Welfare & UNICEF. (2011, August). *The situation of children in residential care facilities in Myanmar*. [https://static1.squarespace.com/static/5bbab8cbe666692d8fd5f481/t/5c42a51abba22367200f9815/1547871516154/Residential\\_Care\\_Survey\\_Report.pdf](https://static1.squarespace.com/static/5bbab8cbe666692d8fd5f481/t/5c42a51abba22367200f9815/1547871516154/Residential_Care_Survey_Report.pdf).

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> Madihi, K., & Brubeck, S. (2019). *Myanmar*. Martin James Foundation. <https://bettercarenetwork.org/sites/default/files/2019-08/MYANMAR.pdf>.

<sup>18</sup> Ministry of Social Welfare, Relief and Resettlement of Myanmar & UNICEF. (2017, September 25). *Minimum standards of care and protection for children in residential facilities*. <https://bettercarenetwork.org/library/the-continuum-of-care/residential-care/minimum-standards-of-care-and-protection-for-children-msc-in-residential-facilities-in-myanmar>.

had been rolled out to 49 townships.<sup>19</sup> Under this system, the identification of children in need of protection, as well as gatekeeping responsibilities, were delegated to government social workers operating at the township level. In addition, the revised Child Rights Law was enacted in July 2019, and included a specific chapter on regulation of alternative care.<sup>20</sup>

Despite this positive progress, unregistered residential care facilities have remained prolific and continue to operate with little regard for the formal system and system strengthening efforts underway. Limited capacity, resources, and a lack of alternative services continue to hamper efforts to reduce reliance on residential care. These resource restrictions along with weak enforcement of existing laws, and a tendency towards out of court settlements, has resulted in a failure to respond appropriately to serious child protection issues and abuse occurring within RCFs, even when formally reported.<sup>21</sup> The lack of consequences for RCFs that fail to comply with legal and regulatory frameworks undermines the impact of reforms happening at the policy level, and in some cases, has left children in perilous situations, including in the proximity or care of child abuse offenders.

### 3.2 About the Kinnected Myanmar Program

The Kinnected Myanmar program was developed against this backdrop in response to the proliferation of unregistered faith-based residential care facilities in Myanmar and out of concern for the situation of the children in their care. It was first founded as a pilot project in 2013 under ACC International, an Australian faith-based international development agency, and in connection with the organization's care reform initiative Kinnected. In 2018, at the conclusion of the pilot phase, Kinnected Myanmar was fully localized and registered as a local non-government organization.

Kinnected Myanmar's main aim is to encourage and support the transition of privatized, faith-based residential care facilities, and to reintegrate children in the care of participating RCFs back into families and communities. Towards this goal, Kinnected Myanmar formed two working groups: one for directors of residential care facilities and one for overseas donors. These working groups were the mechanism by which both stakeholder groups were engaged and supported through the awareness raising, capacity building, and the planning and implementation phases of transition and divestment. In addition, a technical social work unit was established to implement case management and support the safe reintegration of children in participating RCFs, in conjunction with mandated authorities. Community awareness raising,

<sup>19</sup> UNICEF. (2019, August 16). *Myanmar: UNICEF delivering change for children: Programme brief - Child protection*. <https://www.unicef.org/myanmar/reports/programme-brief-child-protection>.

<sup>20</sup> Pyidaungsu Hluttaw Law No. 22/2019 – Child Law, Article 63(b) (2019). <https://www.myanmar-law-library.org/law-library/laws-and-regulations/laws/myanmar-laws-1988-until-now/national-league-for-democracy-2016/myanmar-laws-2019/pyidaungsu-hluttaw-law-no-22-2019-child-law-burmese.html>; UNICEF. (2019, July 24). *The enactment of the new Child Rights Law by the Government of Myanmar a landmark step*. <https://www.unicef.org/myanmar/press-releases/enactment-new-child-rights-law-government-myanmar-landmark-step-unicef>.

<sup>21</sup> Key informant interview

## Kinected Myanmar

46

privately run and  
funded Christian  
faith-based  
RCFs

22

individual  
donors or donor  
groups

846

children residing  
in participating  
RCFs

community development, and donor/volunteer advocacy initiatives were also developed as a part of the Kinected Myanmar program. These initiatives were designed to change mindsets and redirect the efforts of volunteers, donors, and local NGOs towards community and family-based services, rather than residential care.

Since its inception, Kinected Myanmar has worked with 46 privately run and funded Christian faith-based residential care facilities, and 22 individual donors or donor groups. Of the 846 children residing in participating RCFs, 179 received case management services directly from the Kinected Myanmar social workers, and an additional 109 children received case management services from social workers employed by a network of 3 RCFs, under the supervision of Kinected Myanmar social workers.

Over the eight years of implementing the Kinected Myanmar program, social workers and project staff have amassed considerable learning and data, which has given rise to a unique opportunity to gain insights into the how these residential care facilities operate, as well as the situation of the children in their care. This study was therefore conceived as a means of capturing and analyzing the learning and data derived from the Kinected Myanmar program and its stakeholders. The hope is that this analysis will shed some light on an otherwise opaque, somewhat inaccessible, and poorly understood segment of the care system in Myanmar; that of privatized Christian faith-based, largely unregistered, residential care facilities.



## 4. SCOPE AND METHODOLOGY

The study was aimed at gaining insights into the operations of privately run, faith-based residential care facilities (RCFs) in Myanmar. Specifically, the study sought to better understand the operational mechanisms of these facilities, including the characteristics of the directors and donors, the means and reasons for referral and admission of children into care, and how the interplay of these dynamics affect RCF stakeholders' willingness to engage in transition, the reintegration of children, and transition outcomes.

The study employed a mixed methods approach. Quantitative data was collected to enable the researchers to measure and compare practices across RCFs and identify trends. Qualitative data provided rich insights into practices, allowing the researchers to interpret the qualitative findings, delve into explanations, and provide illustrative examples.

### 4.1 Data Sources

Several data sources were accessed throughout the course of the study to compile the quantitative and qualitative data set. A primary data collection tool was developed, which then went through a testing and refinement process. This tool allowed for the collection of standardized data relating to 26 indicators. 15 of these indicators were quantitative and 11 were qualitative. These indicators were organized around two tiers:

1. Institutional level indicators

2. Child case level indicators

To complete this data set, data was drawn from a range of sources as outlined below.

#### 4.1.1 Case Management Data

Data related to the child case level indicators was extracted from Kinnected Myanmar's digital case management system, OSCaR. This process of data extraction was conducted by Kinnected Myanmar social workers and project staff, who received training and support from the researchers to complete this process. These staff all had prior authorization to access children's case files and confidential information due to their involvement in reintegration case work. The data extraction process complied with Kinnected Myanmar's confidentiality protocols, as signed by staff and social workers. Data was anonymized, and no identifying or sensitive information was included in the data set. These measures were employed to ensure that children's right to privacy and confidentiality was respected throughout the process.

#### 4.1.2 Child Intake Forms and RCF Rosters

Data related to the child case level indicators was also extracted from child intake forms and residential care rosters. This was also conducted by Kinnected Myanmar social

workers and project staff. This addressed gaps in the case management system data as well as enabled the collection of data that allowed for comparative analysis between unverified information (provided at the point of intake) versus verified information (verified through case management processes).

#### **4.1.3 Desk Review of Program Documentation**

ACC International Relief and Kinected Myanmar program documentation was reviewed to collect data related to the institutional level indicators. This included program frameworks, reports, working group meeting notes, and written communication with participating donors and directors.

#### **4.1.4 In-Depth Interviews**

Several in-depth interviews had been conducted over a period of time with Kinected Myanmar program staff, participating donors and, in one case, a former residential care facility director. Transcripts of these interviews were accessed under written agreements that granted both ACCIR and the Better Care Network permission to use the information for learning and non-commercial purposes. These interviews provided in-depth insights into a range of indicators included in the data set and provided the researchers with concrete examples.

In addition, the principal researcher drew on her own experience and knowledge of the project and the stakeholders to support the interpretation of the data and provide additional context.

#### **4.1.5 Staff and Social Worker Consultation Sessions**

Consultations were held with ACC International Relief and Kinected Myanmar social work and program staff over several months to source missing data as well as verify and resolve discrepancies in the data set. In some cases, this required contacting RCF directors or donors to request additional data.

#### **4.1.6 Personal Experience of the Researchers**

The principal and co-researchers drew upon their extensive experience of working with Kinected Myanmar, and on residential care facility transitions in Myanmar. This enabled researchers to include additional insights, information, and examples to supplement what was collected through other means.

## **4.2 Data Analysis**

Once compiled, the data set was reviewed and went through several rounds of verification and cleaning over an eight-month period. This was conducted in consultation with the social workers and project staff, and with technical support from the Kinected Myanmar National Director.



Quantitative data was analyzed using Microsoft Excel. Qualitative data was subsequently uploaded into Nvivo software and coded using a case classification matrix consisting of 23 attributes. This allowed for attributes to be quantified and cross-analyzed to identify trends and patterns. Once identified, in-depth qualitative information was consulted to unpack trends and identify explanations. External supporting literature and studies were also consulted and referenced in this process.

### 4.3 Validation of Findings and Review

The study results and findings, once drafted, were shared with the Kinnected Myanmar social work and project team and with key ACC International Relief personnel, and a validation consultation session was held. This provided an opportunity to sense check the findings, particularly the explanations for trends observed in the data, and for further context to be shared with the researchers. Further insights provided were integrated into the report before being shared with a panel of reviewers for feedback. The report was finalized once feedback was reviewed and integrated.

### 4.4 Limitations and Challenges

The data collection process was very challenging due to several situational factors. The research project was envisaged and initiated prior to the onset of COVID-19, and prior to the political instability and internal conflict that took place in Myanmar in 2021. These factors significantly altered the project design and complicated the data collection and cleaning process. The original project design included deploying an experienced research assistant through Australian Volunteers International to work directly, and in person, with the Kinnected Myanmar social work team during the data collection and cleaning process. This plan had to be abandoned with the onset of COVID-19 and the subsequent closure of international borders. An in-country researcher was then contracted to fulfill the role originally intended for the research volunteer, who commenced with data cleaning. This process also had to be abandoned when the political and security situation deteriorated in Yangon, and it was no longer safe or possible for staff to travel to the office or outside of their homes.

Data collection and verification was virtually impossible to progress from July 2020 to September 2021. When the situation began to improve, a decision was made to update the data set and incorporate additional domains to capture the rapid reintegration of children in response to either COVID-19 or the coup.

While the completion of the data set was achieved throughout this challenging period, due to the great determination and commitment of the Kinnected social work team, the issues described did result in some reliability issues with the raw data set. To address this, the data was triple verified until all errors and inconsistencies had been rectified before the analysis commenced.

The other limitation of the data set is that comprehensive data had not been captured on all residential care facilities engaged in the Kinnected program, nor on all children residing in the participating RCFs. Data on the 13 RCFs still in the onboarding process at the time of the research was more limited, and case management data was only available for 179 children out of a total of 846 that were residing in the participating facilities at the time of the onboarding. To compensate for this, the n=x rate differs for different parts of the analysis and are as follows:

***Participating institution data n=46***

***Onboarded institution level data n=33***

***Case management data n=179***

***Donor data n=22***



## 5. FINDINGS AND IMPLICATIONS

### 5.1 Characteristics of the Residential Care Facilities and Directors

In total there were 46 residential care facilities (RCFs) involved in the Kinnected Myanmar (KM) program since its inception in 2013. All were nationally founded and run. Most of the founders and directors of these RCFs were from ethnic minority groups. 84% were Chin, 6.5% were Karen, 2% were Kachin, and only one director (2%) identified as a Burmese national. All of the residential care facilities were Christian faith-based and were privately run and funded. A high proportion of the directors of the RCFs were also pastors of local churches, and many were additionally involved in running Bible schools. For many Christian pastors and leaders in Myanmar, this was considered the ministry trifecta, and in addition to the ascribed ministry value, the combination of a church, Bible school, and residential care facility was perceived as attractive to foreign Christian donors.

In all cases, the directors were the founders of the residential care facilities they operated. The situations that led to the founding of the participating RCFs varied. Several directors involved in the early stages of the Kinnected Myanmar program described having started their facility after receiving instruction from prominent faith leaders in their community as to how to establish their RCF, recruit children, and attract foreign donors. Some were founded after the director began to informally provide care for one or two children and subsequently decided to establish a residential care facility. In several cases, the RCF was started as a means of supporting the director's church planting efforts and of raising up Christian leaders. Others were founded as boarding facilities and one was founded in response to the devastation caused by cyclone Nargis.

#### 5.1.1 Location

The residential care facilities involved in the Kinnected Myanmar program were situated in six different states or regions across Myanmar, with the majority (65%) located in Yangon, which is the largest city and economic capital of Myanmar. The second greatest concentration of RCFs (24%) was in Sagaing Region in the city of Kalaymyo. Kalaymyo is one of the most Christianized towns in Myanmar with a high percentage of the population belonging to the majority Christian Chin ethnic group. The town is known as an epicenter for churches, many of which are also connected to Bible schools and residential care facilities. As a result, Kalaymyo has long since been a popular destination for visiting foreign missionaries, pastors, and church teams engaging in ministry trips and short-term missions, including in conjunction with residential care facilities. The remaining few RCFs in the program were in Shan State (6.5%), Chin State (2%), Mandalay (2%), and Bago (2%). The location of one residential care facility, which was in the early stages of the onboarding process, had yet to be documented at the time of the analysis.

46

RCFs involved  
in the Kinnected  
Myanmar  
program

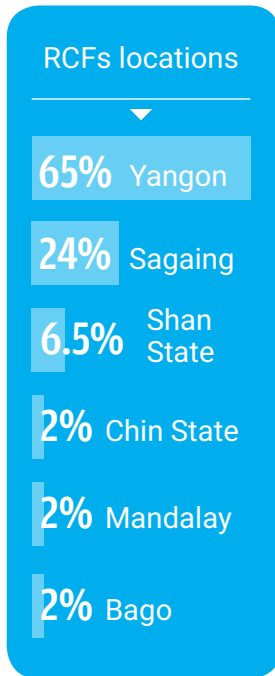
RCFs directors/  
founders

84% Chin

6.5% Karen

2% Kachin

2% Burmese

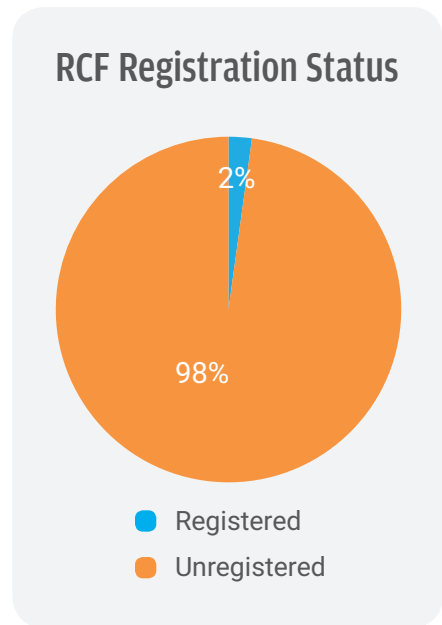


The geographical spread of the residential care facilities in the Kinnected Myanmar program was indicative of the general trend for privatized RCFs to be concentrated in urban areas frequented by foreign tourists and visitors. However, it may have also been influenced by a range of other factors, including:

- (a) the specific cohort of RCFs being Christian faith-based and funded by overseas faith-based donors, hence the concentration in Christianized urban areas popular with visiting pastors, missionaries, and short-term missions teams;
- (b) the geographical reach of the donor networks who were instrumental in inviting new RCFs into the program; and
- (c) the location of the working group meetings (Yangon and Kalaymyo); while these two locations were selected based on the concentration of RCFs in these areas, it may have influenced outreach to subsequent members due to proximity.

### 5.1.2 Registration Status

While voluntary organizations providing residential care services to vulnerable children have long since been required to be registered with the Department of Social Welfare (DSW)<sup>22</sup>, only one RCF (2%) involved in the program was registered with DSW and operating lawfully. Of the 98% that were not registered with DSW, some were registered as local NGOs or churches; however, they did not have the required permissions to operate residential care services. While it was beyond the scope of the study to quantify the reasons for such low rates of compliance with alternative care regulations, explanations given by directors during working group meetings focused mainly on inability or unwillingness to meet certain aspects of the government-mandated minimum standards. This included challenges meeting the required physical standards of facilities, reluctance due to the lengthy and bureaucratic nature of the registration process, and concerns regarding the requirement to allow and facilitate religious freedom in the residential care facilities. Many of the directors saw this requirement as a threat to their objective of proselytizing and raising children to be Christian leaders.



<sup>22</sup> Ministry of Social Welfare, Relief and Resettlement of Myanmar & UNICEF. (2017, September 25). *Minimum standards of care and protection for children in residential facilities*. <https://bettercarenetwork.org/library/the-continuum-of-care/residential-care/minimum-standards-of-care-and-protection-for-children-msc-in-residential-facilities-in-myanmar>.

### 5.1.3 Funding Situation

The funding situation of participating residential care facilities was difficult to accurately determine and quantify for a number of reasons: the informal and unstructured partnership arrangements in place with donors; a lack of financial transparency; little, if any, information available in the public domain; and director hesitancy to disclose detailed information about funding streams. What was ascertainable was that while many RCF directors were involved in other activities additional to operating residential care facilities, and likely had multiple income streams (donor funding and income-generating streams), participating RCFs were highly reliant on foreign funding to sustain the whole of their operations. 100% of the residential care facilities involved in the Kinnected Myanmar program received funding from overseas faith-based donors. In most cases, initial contact between RCF directors and donors was made while donors were on overseas mission trips to Myanmar. For 52% of RCFs, contact with at least one of their donors was initially made during a Christian leadership event in which the donor was a guest speaker/preacher and the RCF director was participating in their capacity as a pastor or church leader. These forums appeared to be conducive to, and instrumental in, forging relationships of trust, based on shared faith and positions of leadership. These relationships rapidly evolved into donor relations, often over the course of only a few days.

Foreign donors identified through the data collection process came from six different countries, including the United States, the United Kingdom, Australia, New Zealand, Hong Kong, Singapore, and South Korea. Some of the RCFs also received cash and in-kind donations from in-country donors, often in connection with local churches. Except for one RCF, these donations appeared to be sporadic and comprise only a minor portion of the RCFs' overall operating budgets. Some RCFs received microloans, also from foreign donors, to help their facilities achieve a level of financial self-sustainability. One participating donor reported providing microloans to 50 RCFs across the country. It is unknown to what extent funds generated through these means were contributing towards the operational costs of participating RCFs, in addition to providing income for the directors.

A limited number of RCFs also involved children in income-generating activities, most notably farming. In some, but not all cases, concerns were raised about child labor; however, directors generally claimed the purpose of involving children was to provide them with vocational training opportunities, rather than to seek profit. In one case where child labor concerns were raised, several children were living unaccompanied on a farm, which was located quite a distance from the RCF. It was clear, in this case, that the children's care and safety was being compromised, and there were indications of exploitation.

The lack of structure and transparency surrounding funding for residential care facilities made it challenging for donors to have a clear picture of the financial situation of their partner RCFs. It created an environment conducive to misunderstanding, misuse of funds, donor deception, and in some cases, exploitation of children for profit motives. 44 of the participating RCFs (96%) had at least one of their donors involved in the Kinnected Myanmar donor working group.<sup>23</sup> 39.1% of the RCFs received funding from only one of the donors involved in the KM program

<sup>23</sup> The two remaining RCFs were in the early stages of onboarding and data collection had not yet been completed.



**96%**  
of the participating RCFs had at least one of their donors involved in the Kinnected Myanmar donor working group

and 56.5% were funded by two or more participating donors. In most cases, where two or more participating donors were funding the same RCF, the second and subsequent donors were only disclosed and identified through the donor mapping exercises conducted as a part of the transition process. Once identified, these newly disclosed donors were approached to join the donor working group. This resulted in several new donors joining the Kinnected Myanmar program and collaborating to support their jointly funded partner RCFs to progress through the transition process. Nearly half of all onboarded RCFs (45.5%) continued to be supported by donors who were not involved in the KM program. These were either donors that could not be contacted due to insufficient information or who declined involvement. At least 9 (27.3%) onboarded residential care facilities were found to have intentionally withheld information from one donor

about the involvement of other donors in the financial support of their RCF. In almost all of these cases, donors were led to believe they were the sole donor. In one case, a somewhat shocked and disillusioned donor discovered that the RCF they supported had two different names; one name used by each of the donors who both believed they were the sole and founding donors of the RCF.

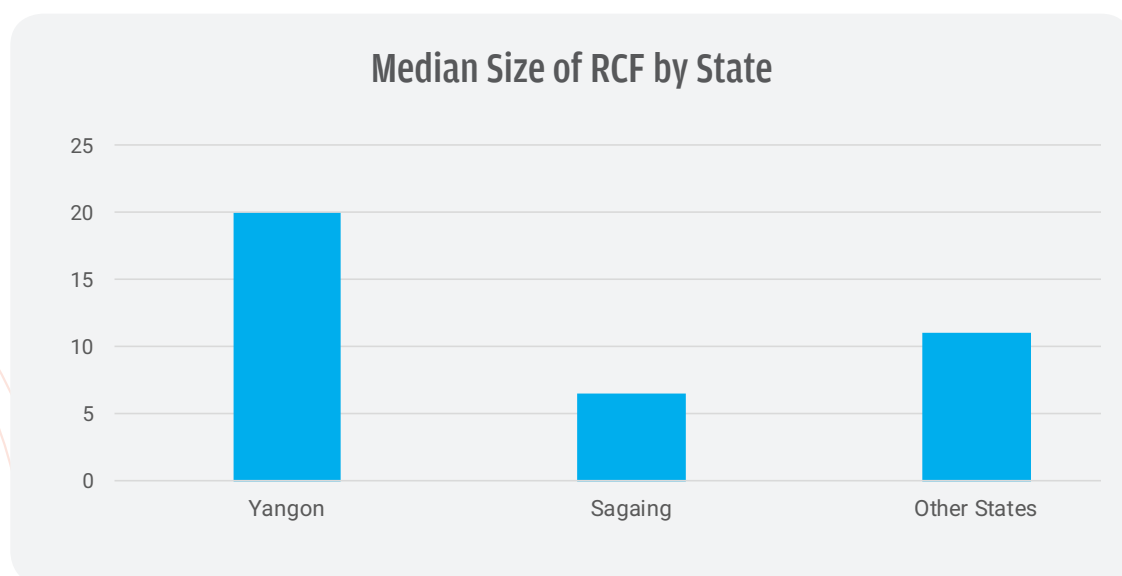
Financial agreements forged between individual donors and residential care facilities were unstructured and highly vulnerable to misappropriation. Funds were typically sent to the private bank accounts of individuals, sometimes to the directors and in other cases to brokers responsible for disbursing funds to networks of RCFs all funded by one donor. In most cases, funding levels were set based on a predetermined amount per child per month. Many were structured under child sponsorship arrangements. This created a financial incentive for children to be admitted into care and disincentivized reintegration. Where the RCF had multiple donors, this often translated into multiple sponsors per child. At the point in the transition process where social workers began to cross-check the children in care with the names on the RCF rosters, in preparation for setting up case management, other anomalies were also uncovered. These included those that were influenced by cultural and social obligation norms; for example, directors sometimes were found to have added their own children and nieces and nephews to the RCF rosters used to determine funding levels. Others could be described as opportunistic, such as retaining the names of children on rosters who had already exited care. More overtly deceptive practices were also uncovered, such as admitting new children under the names of children who had already exited care, often in preparation for donor visits. The siphoning of donor funds was also reported by donors and social workers alike. In one situation, despite funds being regularly sent by the foreign donor, social workers found the children alone in the residential care facility, without adult supervision or caregivers and without adequate food. The eldest child in care had assumed responsibility for the younger children, and neighbors reported that the children were frequently seen begging for food. The number of children found in care was markedly lower than the number being sponsored by the donor. It was clear that funds sent to the RCF were not being used for children's care.

It is important to note that the lack of transparent and structured financial systems, while pervasive across all RCFs, did not result in financial misappropriation in all cases. Two directors overseeing four RCFs were notably uncomfortable with the lack of financial accountability and were aware of their exposure to accusation as recipients of large sums of money into their personal accounts. They took steps to minimize their risk and kept meticulous, albeit simple, financial records, and retained all expenditure receipts and provided these to donors during visits. As such, it came down to the integrity of directors and their ability to maintain such integrity in the absence of rigorous checks and balances over sustained periods of time.

#### 5.1.4 Size of the Residential Care Facilities

Significant variance was observed in terms of the size of the residential care facilities involved in the Kinnected Myanmar program. There was a total of 846 children residing in 44 of the RCFs at the point of onboarding.<sup>24</sup> The number of children in 2 RCFs was unknown. The largest RCF housed 63 children at the point of entry into the KM program. The smallest housed only 3 children. On average, residential care facilities had 19 children in care and the median size was 14.5 children in care.

A correlation was noted between the average size of residential care facilities and their location. RCFs in Yangon, where 65% of all facilities were located, were typically larger. 82% of these housed 10 or more children and the median size was 20. In Sagaing Region, where 21.7% of RCFs were located, only 30% housed 10 or more children and the median size was 6.5. The remaining 13% of RCFs, which were spread across four other states, had a median size of 11 children in care. This was still notably lower than Yangon, despite 83% housing 10 or more children. This correlation between location and size is the product of, and interplay between, several pull and push factors that make Yangon an attractive location for directors establishing RCFs as well as for families sending children into residential care. This includes access to



<sup>24</sup> Children from two RCFs who were early in the onboarding phase when the data was collected were excluded from this count as the total number of resident children had yet to be ascertained.

higher quality education in the city as well as families' perceptions of Yangon-based RCFs being able to provide children with greater opportunities. The concentration of tourists, foreign volunteers, and visitors in Yangon also makes it easier for directors to connect with existing and prospective donors and raise funds. In addition, the commonly used child sponsorship model of funding, where funds are allocated based on the number of children in care, means more children must be admitted into residential care to access or expend higher sums of donor funding. In combination, these factors incentivize both more residential care facilities to be established in Yangon and for these RCFs to be larger in size.

### 5.1.5 Caregiving Ratios and Practices

Information gathered on caregiving was limited and only available (in part or in whole) for 63% of the participating residential care facilities. Despite this, it was sufficient to provide a general sense of practice and adherence to caregiving ratios, as set out in the national minimum standards, across participating RCFs. The lowest caregiver-to-child ratio recorded was 1:40 and the highest was 2:5. The average caregiver-to-child ratio was 1:9. The most common caregiving arrangement was care provided by the director and his/her spouse. This was the case in 16 RCFs (55%) with available caregiving data. Only 7 RCFs (24%) had paid staff employed in caregiving roles. Within those 7 RCFs, in most cases one staff person was hired to supplement care provided by the director who was listed as the primary caregiver. Only 1 RCF had two paid staff assigned to caregiving roles. In all cases, paid staff held other responsibilities in addition to caregiving, including cooking and cleaning.

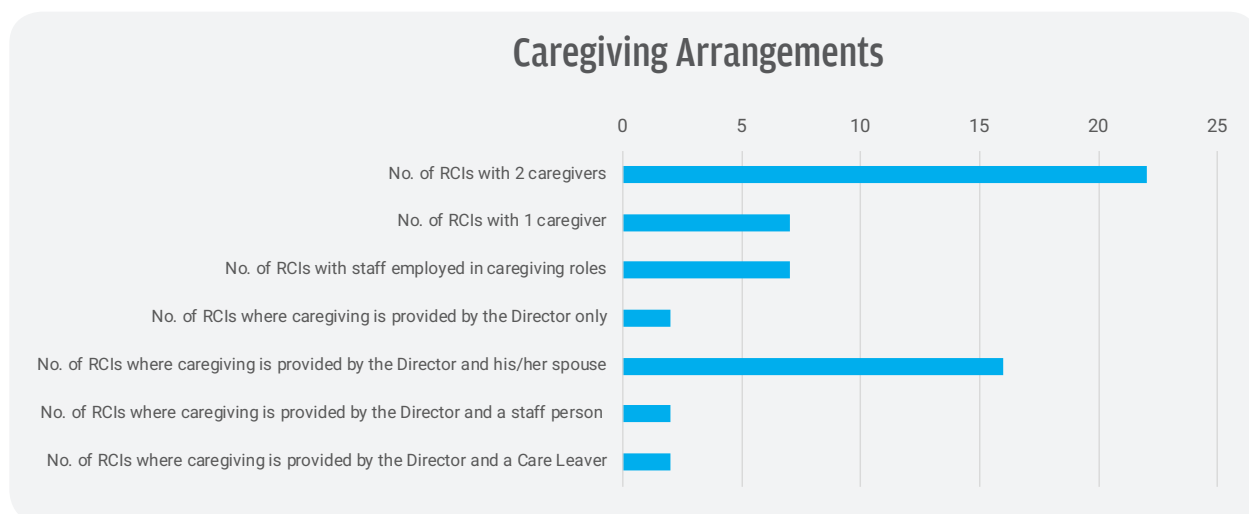
The national minimum standards for residential care in Myanmar set out a minimum number of caregivers that must be always on-site, based on the age of the children in care. They are as follows:

- ▶ Children between 0 and 2 years old: 1 caregiver to 3 babies
- ▶ Children between 2 and 3 years old: 1 caregiver to 5 children
- ▶ Children between 3 and 5 years old: 1 caregiver to 10 children
- ▶ Children over 5 years old: 1 caregiver to 15 children<sup>25</sup>

Based on the above requirements, the available data showed that 64% of residential care facilities met these minimum standards, while 36% did not. However, for many RCFs, this standard was only met when taking caregiving ratios at face value. In practical terms, 9 (40%) RCFs that met minimum standards for caregiver-to-child ratios were relying on directors as either the sole or primary caregiver. Directors almost always held other responsibilities inside and outside of the RCF that would preclude them from always being available to provide direct care and supervision to children. In addition, not all of the directors lived on-site. When adjusting for this, at best, only 24% of the RCFs met the minimum caregiver-to-child ratios. However, none had sufficient staff or personnel to enable shift work or cover periods of caregiver absence, meaning that there would inevitably be periods when these RCFs also fell below the required ratios. This

<sup>25</sup> Ministry of Social Welfare, Relief and Resettlement of Myanmar & UNICEF. (2017, September 25). *Minimum standards of care and protection for children in residential facilities*. <https://bettercarenetwork.org/library/the-continuum-of-care/residential-care/minimum-standards-of-care-and-protection-for-children-msc-in-residential-facilities-in-myanmar>.

is consistent with social workers' observations that it was common for children/youth to be left unsupervised when existing caregivers were off-site, traveling for extended periods of time, or on leave. In these cases, older children/youth were expected to assuming caregiving roles over younger children.



## 5.2. Characteristics of the Donors Involved in the KM Program

### 5.2.1 Type and Nationality of Donors

A total of 22 donors had engaged in the Kinnected Myanmar program and the donor working group in some capacity. 14 donors (63.6%) represented entities and 8 (36.4%) were individuals. Of the donors who represented entities, 10 (71%) were overseas charities/foundations from 3 donor countries (Australia, UK, US). One (7%) was a locally registered non-government organization that channeled foreign funds to local residential care facilities, and 3 (21%) were overseas churches from 2 donor countries (Australia and New Zealand). All of the donors identified as Christian faith-based.

Other overseas donors from Australia, the US, the UK, Singapore, Hong Kong, and South Korea were identified as financial partners of 15 of the participating residential care facilities; however, these donors were not engaged in the KM program in any capacity. Due to the general lack of transparency around funding streams, it was often difficult to ascertain whether the participating donor was in fact the principal donor to their partner RCF or whether another larger donor existed. Participating donors were confirmed as the principal donor<sup>26</sup> for 10 RCFs (22%). For 31 RCFs (72%), the principal donor remained unknown.

**63.6%**

of donors were entities

**36.4%**

of donors were individuals

**22%**

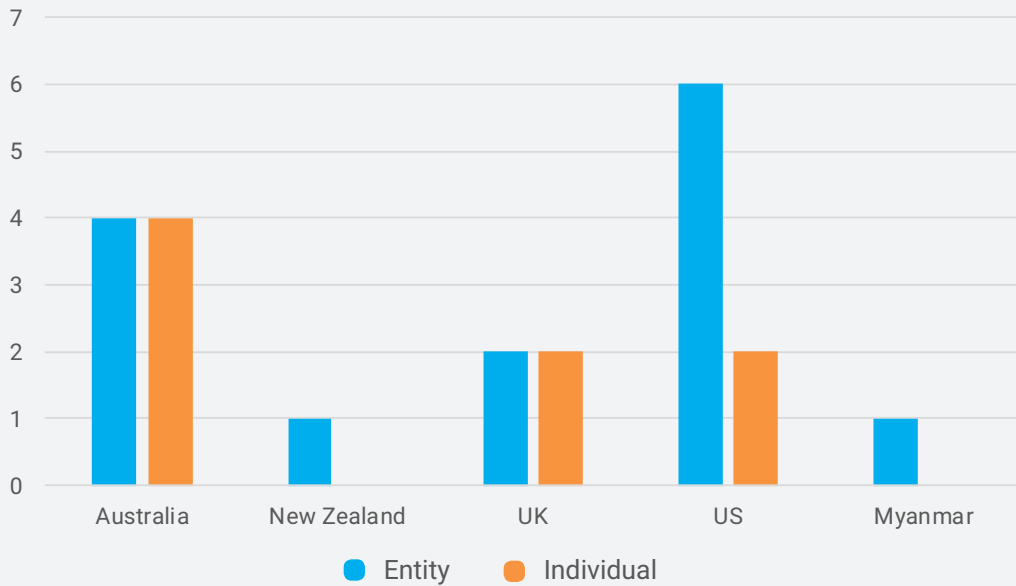
of donors confirmed as principal donors

**72%**

of RCFs did not disclose their principal donors

<sup>26</sup> Principal donor is defined as the largest donor. This is the case even if the principal donor is a fundraiser who collects and transfers funds from other individual donors.

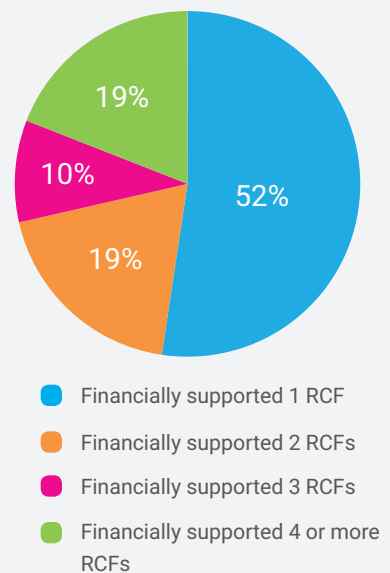
### Country of Origin of Participating RCF Donors



Australia and the US were the largest donor countries in terms of the number of donors (8 from each country). However, US donors were overall the more prolific funders, supporting a significantly higher number of participating RCFs when compared to donors from Australia or other countries. 20% of participating RCFs received funding from Australian donors compared to 74% who received funding from US donors. The largest US donor (who supported 19 RCFs in the program) reported sending more than US\$250,000 per year in financial support, and at their peak, sponsored over 800 children through an individual child sponsorship program. The sheer scale of support from this one US donor is illustrative of the findings of other studies that have sought to quantify and evidence the prolific financial support for overseas residential care facilities emanating from the US faith-based sector.<sup>27</sup>

There was wide variance in the number of participating residential care facilities each donor funded. 50% of donors only supported one residential care facility whereas the two largest donors (9%) each supported 19 RCFs. The two largest donors were affiliated foundations who jointly funded all partner RCFs, although at significantly different

### No. of RCFs Supported by Each Donor



<sup>27</sup> Barna. (2021). *Residential care: U.S. Christian giving and mission*. [https://www.faithtoaction.org/wp-content/uploads/F2A\\_Residential-Care\\_Report\\_Final\\_v.4.pdf](https://www.faithtoaction.org/wp-content/uploads/F2A_Residential-Care_Report_Final_v.4.pdf)



50%

of donors only supported one residential care facility

9%

(two largest donors) each supported 19 RCFs

levels. 23% (5) of participating donors supported other residential care facilities that were not part of the Kinnected Myanmar program. In all of these cases, their partner RCFs declined involvement in the KM program and were unwilling to transition. Three donors responded by divesting of these partnerships. One donor continued their support, and the remaining donors were yet to exhaust efforts to onboard their 11 partner RCFs at the time of writing. The relationship between levels of donor influence over residential care facilities and RCF participation and transition outcomes is an important dynamic, one that will be further elucidated in section 6.5.4 below.

### 5.2.2 Relationships Between Donors and RCFs

77% of participating donors traveled regularly to Myanmar to visit their partner residential care facilities and to meet with the directors.<sup>28</sup> Some donors supported other ministry activities the directors were involved in, including Bible schools, leadership

seminars, and church-based activities. At least 45% of donors were involved in bringing short-term mission teams on their overseas trips, and typically included visits to the RCFs as part of the teams' agendas. This practice was more common amongst churches and individual donors than in foundations or charities. Two further donors had historically facilitated short-term mission trips but had ceased doing so prior to their participation in the Kinnected Myanmar program.

At least 41% of the participating donors made initial contact with their partner residential care facilities (72% of all RCFs) while on an overseas trip to Myanmar. Unlike other situations, where orphanage tourism or volunteering has acted as the primary mechanism for facilitating contact between visiting prospective donors and RCFs, ministry events were found to be more instrumental for these donors. Events including pastors' seminars, crusades, and Bible seminary trainings acted as the platform through which at least 36% of connections between donors and RCF directors were made. Donors were typically guest speakers at these events and RCF directors were participants or facilitators. These initial meetings often led to an invitation for the prospective donor to visit the residential care facility; however, in at least one case, a partnership with 3 RCFs was formed without such a visit. In at least four cases, donors were introduced to a network of RCFs they proceeded to fund, after connecting with a prominent faith-based leader at such an event. These leaders acted as brokers for their networks of residential care facilities, receiving and disbursing funds and managing donor communications on their behalf.

77%

of participating donors traveled regularly to Myanmar to visit their partner RCFs

<sup>28</sup> This was unknown for the remaining four donors who were in the onboarding phase.

The nature of partnerships formed between donors and their partner residential care facilities were overwhelmingly informal and based on trust versus any contractual agreements. Many of the donors considered the director/s, or the brokers through which they partnered with RCFs, as their friends, and viewed this bond of friendship as sufficient to guide the partnership towards a common goal. One donor suggested that to require or request a structured partnership framework was to insinuate distrust and would appear to be dishonoring and offensive, especially considering the director's status as a Christian leader from a persecuted minority group, and as someone involved in ministry with vulnerable children.<sup>29</sup> Sentiments such as these led to a reluctance amongst donors to formalize their partnerships. This changed in instances where the trust at the core of the partnership was eroded due to the discovery of siphoning of funds, financial misappropriation, or the abuse of children in care, as well as inappropriate or inadequate responses to such abuse. This was the experience of 4 donors (18%) who collectively funded 54% of the participating residential care facilities. Three of these donors uncovered evidence of some of these practices prior to their participation in the Kinnected Myanmar program. They had made attempts to put in place more structure to improve accountability in response, with varied but generally unsuccessful outcomes. The discovery of these practices and erosion of trust was pivotal to the donors' decision to transition and join the KM donor working group for support. For the remaining one donor, these issues were only uncovered after, and because of, their participation in the KM program. Prior to this discovery, this particular donor remained reluctant to institute any agreements with their partners or more formally tie funding to outcomes. This changed once that trust had been eroded and the donor ultimately held their partner RCFs accountable when they failed to meet the conditions stipulated in their partnership agreements. For 6 other donors (27%), no such serious issues were uncovered, and the partnerships continued in an informal manner based on friendships and trust. Most of these donors (5) remained hesitant to put in place any agreements and were unwilling to hold their partners accountable to the Kinnected Myanmar program agreements, rendering them a formality with little influence. The implications of this were evident in the outcomes of these specific residential care facilities, an issue that will be further unpacked below.

## 5.3. Characteristics of the Children in Care

### 5.3.1 Factors Influencing the Size of the Case Level Data Set

The characteristics and profiles of children resident in participating residential care facilities were analyzed primarily using data derived from Kinnected Myanmar's case management system. However, case level data was only available for 21% (179) of all children who were listed as residing in participating RCFs. There were several reasons for this. Firstly, case management had not yet commenced for children in the 13 RCFs that were still in the onboarding process at the time of data collection. Secondly, case management did not commence for 11 RCFs that had been onboarded but exited the KM program prior to commencing the case management stage. Lastly, case management data was not available for an additional 3 RCFs that had reintegrated children prior to the development of the digital case management system. For these three facilities, a paper-based system was outworked by the RCF's own dedicated social work team with supervision and technical support provided by KM social workers and ACCIR

<sup>29</sup> Interview with key informant

project staff.<sup>30</sup> Due to challenges accessing and verifying this data at the time of collection, it was omitted from the data set. In addition to this, not all children or youth residing in the 19 RCFs that successfully progressed to the case management stage benefitted from case management services. In fact, this was the case for 79% of RCFs and was for a range of reasons including the following instances:

- ▶ Families came to collect their children prior to case management commencing, often in response to community awareness raising about the benefits of family-based care.
- ▶ Older children/youth returned to their families after concluding studies and prior to case management commencing.
- ▶ Directors dropped out of the program before case management commenced for all of the children/youth in the RCF.
- ▶ Directors refused to allow social workers to work with specific children/youth.

In cases where directors blocked case management for specific children or youth, it was typically based on one or more of the following criteria:

**Kin:** Directors were generally very reluctant to allow social workers to conduct assessments of children who were related to them. In almost all cases, the familial relationship between children and directors had not been disclosed to donors and this seemed to heighten directors' reticence to allow assessments to occur.

**Age:** Directors were more likely to permit social workers to work with older children and youth versus younger children. This was most common in residential care facilities that subsequently dropped out of the Kinconnected Myanmar program and continued running residential care. In these cases, directors tapped into the KM case management services to support the reintegration of older children or youth, particularly those they saw as problematic or who had aged beyond their 'target group' and no longer comfortably fit within their mandate. There were two exceptions to this. The first was one RCF that only permitted social workers to reintegrate one infant recently brought into care. This only occurred due to significant pressure applied by Kinconnected Myanmar and ACCIR project staff on the director, the donor, and the local authorities, out of extreme concern for the child's well-being. The second exception occurred in two RCFs that allowed young people to continue to reside in the RCF despite having jobs and earning their own income. In these cases, the names of the young people were kept on the child roster for funding purposes; however, in every other sense, the directors considered them as boarders versus 'young people in care' and declined offers of reintegration as a result.

**Favoritism:** Directors often blocked reintegration for children to whom they gave preferential treatment, including children who lived separately from the other children in the directors' own homes, despite being on the RCF roster. In some cases, these children were later informally fostered or adopted by the directors.<sup>31</sup>

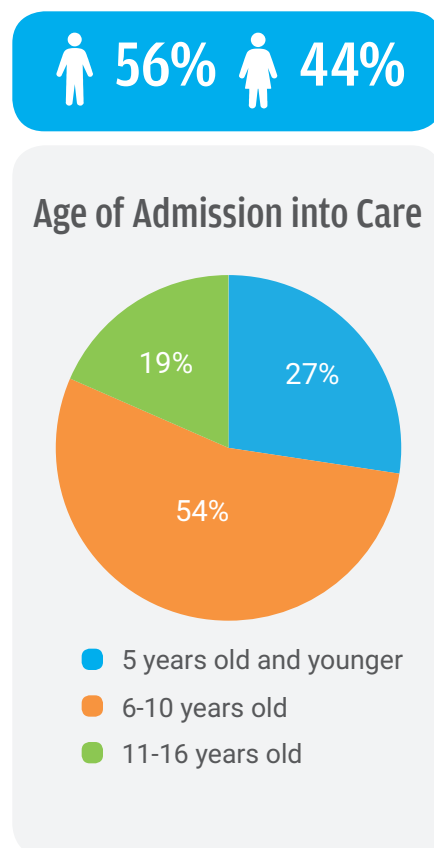
<sup>30</sup> These social workers accessed training, supervision, and technical support from the KM social work team.

<sup>31</sup> Informal adoption occurs at the local government level and involves adding the child/ren into the official family book registered with local authorities.

### 5.3.2 Age and Gender-Related Factors

Of all of the children under case management, 56% were boys and 44% were girls. As data on the full number of children admitted into participating residential care facilities was not disaggregated by gender, it was impossible to ascertain with any certainty whether this reflected gender differences in admission rates or a slight preference to reintegrate boys over girls.

Children were admitted into residential care at very diverse ages, with admission ages ranging from 0 to 16 years old. The average age of admission into care was 7.5 years old; however, nearly one-third of all children were admitted when they were 5 years old or under. This included a small number of children admitted as infants. While there was no notable difference between the number of boys or girls admitted in the 5 and under or 11+ age groups, boys were admitted into institutional care at a higher rate than girls between the ages of 6 and 10 years. The greatest gender disparity was noted with admission at the ages of 6, 7, and 8 years old, and correlated with poverty and education as push factors for admission. While an almost equal number of girls and boys (46.6% versus 53.4% respectively) were admitted into care where education was the primary verified push factor, this increased to a 16% point difference between girls and boys (42% and 58% and respectively) where poverty was the primary push factor and education was secondary. This was attributed to a prioritization of boys' education over girls' education, specifically within Chin families, and when faced with poverty that prohibits all children within a family from accessing education. This prioritization of the education of boys over girls relates to gendered roles ascribed to men and women within Chin culture, which create a perception of education being less critical for girls compared to boys.<sup>32</sup> A high proportion of children under case management were from the Chin ethnic group, which explains why this disparity was notable in the study findings despite Multiple Indicator Cluster Survey findings showing a gender parity index of 1.01 for both primary and secondary education across the country.<sup>33</sup>



<sup>32</sup> Mon, K. H. (2015, May 5). Health and education plan to support Chin women, children. *The Irrawaddy*. <https://www.irrawaddy.com/news/burma/health-and-education-plan-to-support-chin-women-children.html>

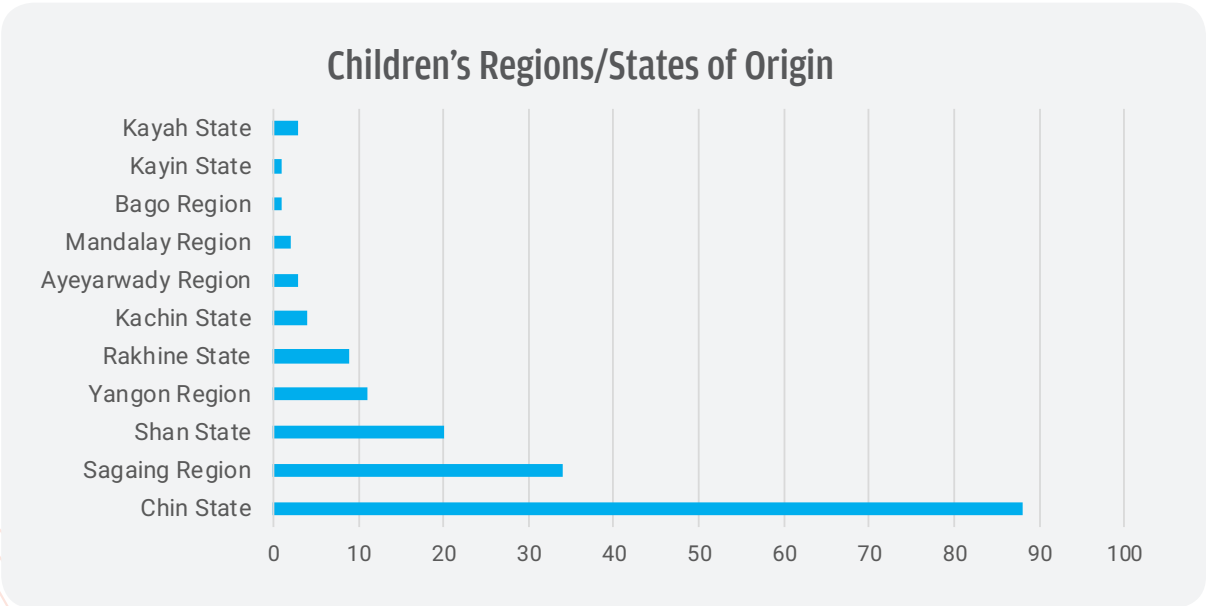
<sup>33</sup> Ministry of National Planning and Economic Development, Ministry of Health & UNICEF. (2011, October). *Myanmar: Multiple Indicator Cluster Survey 2009-2010*. [https://mics-surveys-prod.s3.amazonaws.com/MICS3/East Asia and the Pacific/Myanmar, Republic of the Union of/2009-2010/Final/Myanmar 2009-10 MICS\\_English.pdf](https://mics-surveys-prod.s3.amazonaws.com/MICS3/East Asia and the Pacific/Myanmar, Republic of the Union of/2009-2010/Final/Myanmar 2009-10 MICS_English.pdf)

### 5.3.4 Communities of Origin and Movement to RCFs

Children in participating residential care facilities originated from 11 different administrative divisions in Myanmar, with nearly half of all children (49%) originating from Chin State. The vast majority (85%) of children were residing in RCFs located outside of their state or region. This was despite the presence of RCFs in all of the children’s states or regions of origin. The movement of children across divisional lines is a result of the pervasive use of active recruitment in privatized faith-based RCFs in Myanmar. 99.4% of all children under case management had been recruited into residential care. For 93% of recruited children, recruitment was by the RCF director or individuals in the directors’ relational network. These relational networks connect children, families, local community leaders, and faith leaders in remote parts of the country to RCF directors and the facilities they operate, which are often located in urban centers or towns. In 22% of cases, children recruited into care via RCF directors and/or their relational networks were related to the director of the RCF. In cases where recruitment did not occur in connection with the director or his/her networks, it involved community leaders in 2% of cases, and ‘others’ in 5% of cases.

**99.4%**  
of children were recruited into residential care

**93%**  
were recruited by the RCF director or his/her networks



In addition to children originating from the 11 administrative divisions in Myanmar, three children were from the state of Mizoram in India and had been brought over to Myanmar for the purpose of admission into residential care. All three were related to the director of the RCF in which they resided. While only a small number of children under case management were from Mizoram, the admission of Mizo children into faith-based RCFs in Myanmar is not uncommon. In addition to porous borders, the Mizo tribe have deep ethnic, familial, and cultural ties with several Chin tribes.<sup>34</sup> They share a common language, are all majority Christian ethnic groups,

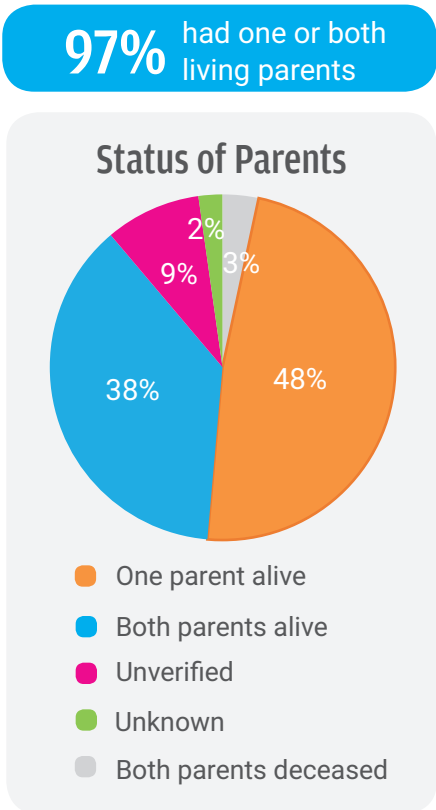
<sup>34</sup> Basavapatna, S. (2012, July 24). Chins in Mizoram: The case of borders making brothers illegal. *Journal of Borderlands Studies*, 27(1), 61-72. <https://doi.org/10.1080/08865655.2012.687209>

and have a decades-long history of migration and back and forth movement across the borders for ministry purposes, including church planting. This has created strong ties between Mizo and Chin churches that link families into the relational networks of Chin pastors running privatized faith-based RCFs in Myanmar. As articulated above, it is along these relational lines that Mizo children are referred and recruited into RCFs, often as far away as Yangon.

### 5.3.5 Children’s Families and Orphanhood Status

The overwhelming majority of children in care had at least one living parent. Only 3% of children were orphaned (defined as having lost both parents) and a further 48.6% had lost one parent. Of children in care who had lost one parent, the death of the father was more common, constituting 66% of all cases. In cases where one or both parents had died, the death of a parent was given as the primary reason for admission into care in 47% of cases, whereas in 32% of cases, poverty was listed as the main factor.

These findings largely reflect an aspect of Chin culture and customary law, under which children are considered the property of the father. In the event the father passes away, paternal relatives are obliged to take on the custody and responsibility for any children, while the mother loses all parental claims and rights.<sup>35</sup> If paternal relatives are unable or unwilling to provide long-term care, the family will typically refer the child to residential care. Admitting children into care is seen as preferable, and a viable means of fulfilling familial obligations, whereas placing the children in the care of the mother is considered tantamount to disownment from the paternal family line. This is because, under these customs, the mother ceases to be considered part of her husband’s family upon his death. She is expected to immediately leave the family home, which belongs to her husband or his family. She must leave behind all assets and belongings accumulated throughout the tenure of the marriage, including children.<sup>36</sup> This custom explains why a higher rate of children in the study cohort were admitted after the death of the father, as in these cases, children effectively lose both parents in terms of caregiving. As such, the death of one parent is recorded as the primary push factor in case management files. These customs also shed light on why poverty, rather than death of a parent, was more commonly listed as the primary push factor when the mother had died. Here, the father assumes care under customary law; however, if poverty precludes him from fulfilling this role, the child is referred into care, and poverty is listed as the cause. In addition to these cultural push factors specific to Chin tribes, the death of a parent is a common indicator used to identify and target families for active



<sup>35</sup> Hogan, L. (2016, December 5). Domestic violence: Customary law discourages divorce. *Democratic Voice of Burma*. <http://english.dvb.no/domestic-violence-customary-law-discourages-divorce/>

<sup>36</sup> Ibid.



recruitment. As evidenced above, recruitment is the primary means of facilitating children's admission into privatized faith-based residential care facilities. This interplay of customary laws and recruitment is highly significant to understanding the situations that lead to recourse to institutional care, especially given the strong connections between the Chin ethnic group and Christian faith-based RCFs found in this study.

**9.5%**  
of cases  
involved  
falsification of  
parental death

In most cases, the identity and status of children's parents was either documented in intake forms or determined through family tracing efforts. Information provided by directors and via intake forms was verified by social workers throughout the case management process and found to differ in 21% of cases. In some cases, this reflected changes in the parents' marital status since the time of admission of the child, or the discovery of information about a parent that was previously unknown. However, in almost half of these cases (17 cases or 9.5% of all children), verification uncovered falsification regarding the death of parents. In fact, the death of both parents was listed as the primary reason for admission for 15 children (8%) but was only verified in 3 of these cases and remained unverified in one further case.<sup>37</sup> It was found to be inaccurate in the remaining 11 cases (73% of all cases where it was listed) with either one or both parents still alive. For 3 other children, who were orphaned, the death of both parents had not been listed as a primary reason for admission, despite being verified. These children had been cared for in informal kinship care arrangements after the death of their parents, prior to admission into the residential care facility. Education, poverty, and conflict, in conjunction with active recruiting, were verified as reasons contributing to their admission into the RCF.

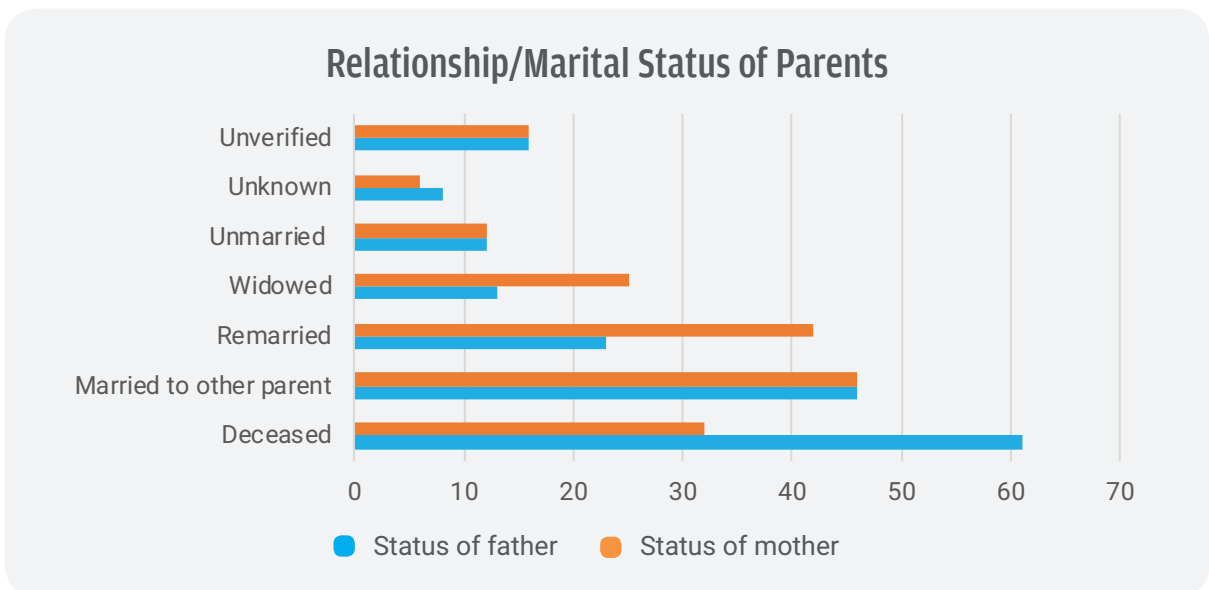
The findings on children's orphanhood status were consistent with global research that shows that most children in residential care are not orphans.<sup>38</sup> It also evidenced the practice of paper orphaning employed to create a false sense of legitimacy of admissions and to attract donors.<sup>39</sup> Many of the donors involved in Kinnected Myanmar reported being shocked to discover that the children they supported were in fact not orphans. Some described being intentionally deceived (provided with false information, including in sponsorship documents) whereas others described it as being misled, including through signage that included the terms 'orphanage' or 'home for orphans'. For many, this realization contributed significantly to their decision to pursue transition and reintegration. However, the degree to which donors were deceived or misled regarding children's orphanhood status was not fully reflected in the data captured on the status of parents and reasons for admission, as derived from RCF records and case management

<sup>37</sup> In the case of three other children whose parents had been verified as both deceased, other reasons for admission, including conflict, education, and poverty were listed, rather than the death of both parents.

<sup>38</sup> van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Duschinsky, R., Fox, N. A., Goldman, P. S., Gunnar, M. R., Johnson, D. E., Nelson, C. A., Reijman, S., Skinner, G. C., Zeanah, C. H., & Sonuga-Barke, E. J. S. (2020, August). Institutionalisation and deinstitutionalisation of children 1: A systematic and integrative review of evidence regarding effects on development. *The Lancet Psychiatry*, 7(8), 703-720. [https://doi.org/10.1016/S2215-0366\(19\)30399-2](https://doi.org/10.1016/S2215-0366(19)30399-2)

<sup>39</sup> van Doore, K. (2016, July). Paper orphans: Exploring child trafficking for the purpose of orphanages. *The International Journal of Children's Rights*, 24(2), 378-407. [https://www.researchgate.net/publication/305695283\\_Paper\\_Orphans\\_Exploring\\_Child\\_Trafficking\\_for\\_the\\_Purpose\\_of\\_Orphanages](https://www.researchgate.net/publication/305695283_Paper_Orphans_Exploring_Child_Trafficking_for_the_Purpose_of_Orphanages)

files. Most residential care facilities complicit in misleading their donors did not falsify their child admission records to support such misconceptions. In fact, all of the documented cases of falsified records were associated with only one participating RCF. This RCF had a formal policy of only admitting into care children who had lost one or both parents. This heightened the impetus for falsifying records in cases where admission was not in conformity with the policy. Claims were made by the director that discrepancies were based on families providing inaccurate information upon admission to meet the criteria and without her knowledge. While this may have been true in some cases, in other cases the children were recruited through the director or through the directors' network. In addition, some of the children were relatives of the director. In these cases, at least, the director would have known of the actual status of the parents and been complicit in the paper orphaning process. This finding suggests that while the misrepresentation of children's orphanhood status to donors is widespread, the practice of falsifying formal records or documents is more limited. In many cases, particularly where donors do not have visibility of, or access to, intake records, and children are admitted entirely outside of formal gatekeeping systems, falsification of documents is unnecessary and redundant.



**26%**  
have living parents  
and intact family

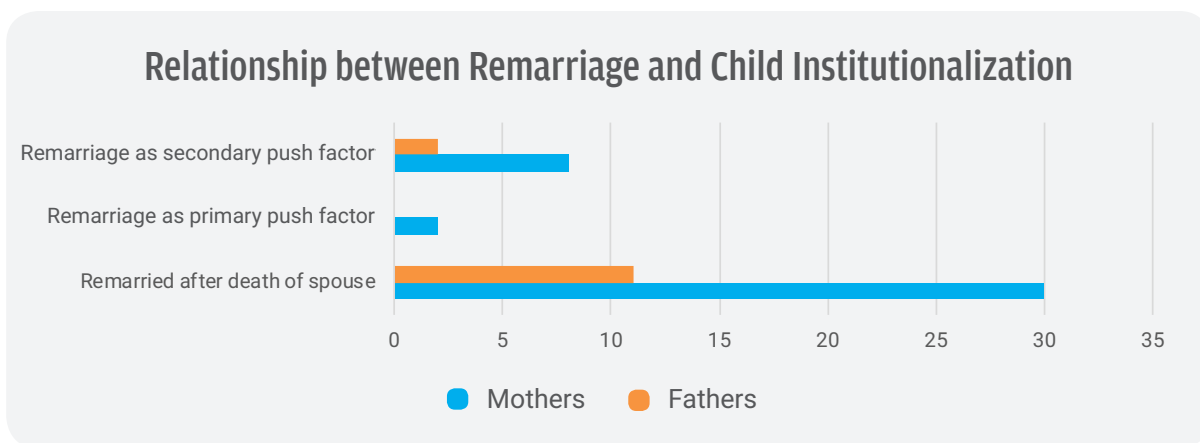
▼

**50%**  
sent to RCFs for  
education

**43%**  
because of poverty

Over one-quarter of the children (26%) came from families where both parents were alive and the family unit remained intact (no separation or divorce). In these cases, education was the main reason children were sent to RCFs (50% of cases) and poverty was the second most frequently verified reason (43%). 13% of children (23 cases) came from families where both parents were alive but had separated or divorced. Divorce or separation was found to be the primary push factor in 83% of these cases, whereas poverty was the main factor in only 13% of these cases. Remarriage, in the case of divorce/separation and after the death of a spouse, was common and was a factor that contributed towards children's institutionalization. However, more typically it was listed as a secondary rather than a primary push factor. Both parents had remarried in 17% of all divorce/separation cases, and one parent had remarried in an additional 74% of cases. Remarriage was only

identified as the primary reason for admission for 3 children of these cases (13%) compared to 8 cases (35%) where it was the verified secondary push factor. These findings suggests that referral of a child to residential care is more often triggered by divorce/separation than it is by remarriage.



Similarly, remarriage was rarely found to be a primary factor leading to the institutionalization of a child in the case of families where one parent had died, despite remarriage being relatively common in these cases. 23% of children came from families where one parent had remarried after the death of the other parent. Remarriage was more common in families where the father had died, rather than the mother, with 49% of all widowed mothers remarrying, compared to 34% of widowed fathers. Remarriage after the death of a spouse was only indicated as a primary push factor for 6% of these children (2 children under case management), and in both cases, in association with the remarriage of the mother. There were no cases where a father remarrying was the primary reason for the referral of a child to a residential care facility. When secondary push factors were examined, the disparity in the correlation between child institutionalization and the remarriage of a mother versus a father was more pronounced. Remarriage was a secondary factor contributing to the child’s referral to an RCF in 27% of all cases involving the remarriage of a mother versus in 18% of cases where the father remarried. These findings indicate the gendered nature of push factors contributing to the institutionalization of children in Myanmar, specifically amongst ethnic Chin families. The same Chin customary laws discussed above that place children in the custody of the father’s relatives upon his death also dictate that children remain with the father and his extended family in the event of separation or divorce. It is at this point, rather than at the point of remarriage, that a father or his extended family must negotiate new care arrangements for children and may resort to residential care. This explains why divorce, separation, or the death of one parent (the father) was more commonly listed as a push factor for children’s institutionalization than remarriage.

**13%**  
of children’s parents were alive yet divorced/separated

---

**83%**  
listed divorce as the primary push factor

## 5.4. Mechanisms and Reasons for Admission into Residential Care

### 5.4. Mechanisms and Reasons for Admission into Residential Care

56%

Poverty

33%

Death of One  
Parent

26%

Access to  
Education

13%

Divorce or  
Separation

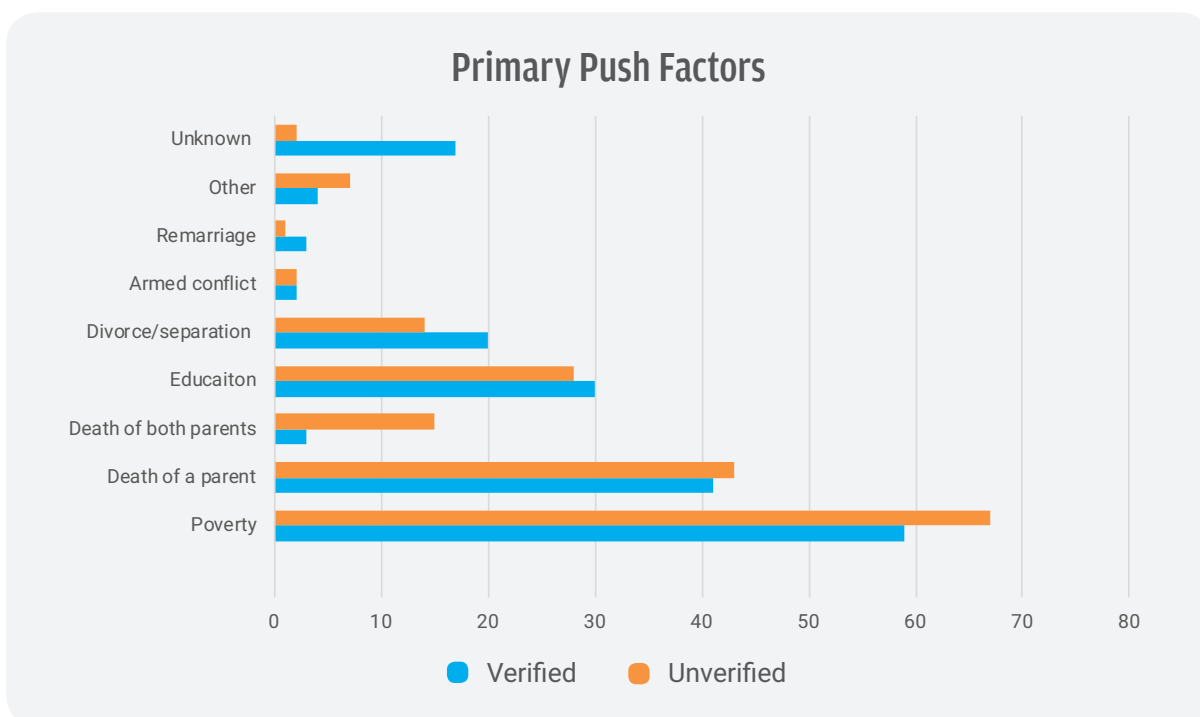
A range of push factors was found to contribute to children's institutionalization, including poverty, education, the death of one or both parents, divorce/separation, remarriage, and armed conflict. For a small number of children, the primary push factors were unknown, either due to an absence of data or the listing of 'other' as the push factor in children's case files. Poverty was overwhelmingly the greatest push factor and contributed towards the institutionalization of 56% of all children. It was the primary push factor in 32% of all cases and the secondary factor in 23% of all cases. The death of one parent was the second most common push factor, contributing towards the admission of children in 33% of all cases. It was a verified primary push factor in 23% of cases and a secondary factor in 10% of cases. Education was a push factor in 26% of all cases and was primary in 17% of cases and secondary in 9% of cases. Divorce or separation was a push factor in 13% of cases and was the primary factor in 11% of cases and secondary in an additional 2% of cases.

As has been recognized in other studies, a family's decision to relinquish a child into residential care can rarely be attributed entirely to one factor. More typically it is the interplay between a range of push factors that place stress on the family, and family and community attitudes towards residential care.<sup>40</sup> Where residential care facilities are perceived favorably, and as sites of opportunity, families experiencing stressors are more likely to relinquish their children into residential care. In addition, the findings of this study suggest that another

important yet often overlooked contributing factor is the involvement of active recruitment in negotiating children's admission into care. Active recruitment occurs when RCF personnel or brokers identify and approach families with the suggestion or offer of admitting their child to a residential care facility. Recruiters typically target families experiencing stressors that are known push factors for child institutionalization. Active recruitment facilitates linkages between families and specific RCFs, which creates pathways for referral that bypass formal gatekeeping mechanisms and objective determinations of necessity, suitability, and best interests of the child. The involvement of active recruitment can provide a partial explanation as to why some families experiencing similar stressors resort to transferring or relinquishing their children into residential care facilities, whereas others do not. It furthermore helps to elucidate how unregulated RCFs come to access the children who reside in their facilities, despite operating outside of the formal gatekeeping and referral mechanisms.

<sup>40</sup> Ministry of Social Affairs, Veterans and Youth Rehabilitation. (2011). *With the best intentions: A study of attitudes towards residential care in Cambodia.* [https://www.thinkchildsafe.org/thinkbeforevisiting/resources/Study\\_Attitudes\\_towards\\_RC.pdf](https://www.thinkchildsafe.org/thinkbeforevisiting/resources/Study_Attitudes_towards_RC.pdf)

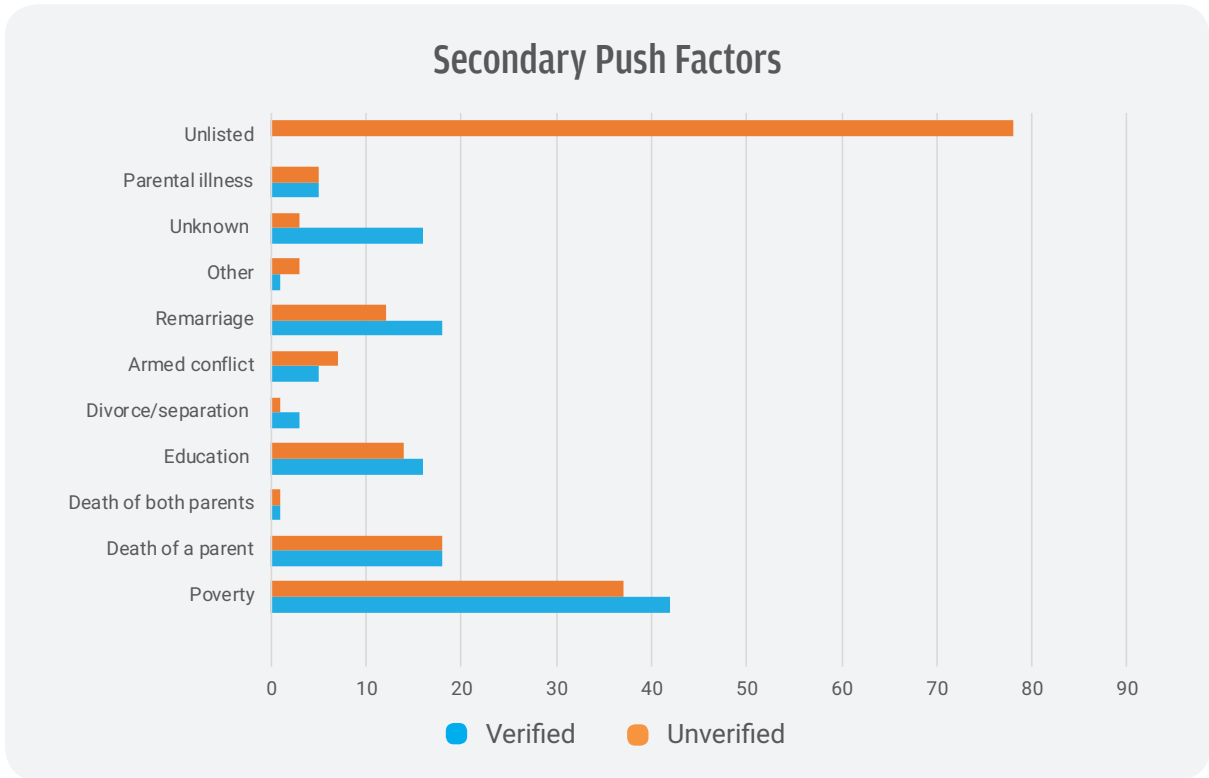
For children included in this study, a sole push factor was identified in 30% of cases, whereas two or more push factors were identified as contributing to the child’s institutionalization in 61% of cases. Poverty and the loss of one parent was the most common coupling of verified push factors, accounting for 22% of all children. Poverty in conjunction with education was the next most common combination of push factors, accounting for 13% of all children. However, a significant finding was the additional involvement of active recruitment, which was present in all of these cases. In fact, recruitment was noted in 178 out of 179 cases (99%) of children under case management, regardless of the combination of push factors evidenced. As previously stated, recruitment involved the RCF director or his/her networks in 93% of cases, community leaders in 2% of cases, and ‘others’ in 5% of cases. In the one case where recruitment had not been evidenced, the push and pull factors were yet to be verified by social workers. As such it is inconclusive at this point as to whether recruitment did or did not occur.



In a small number of cases, armed conflict was identified as the reason for the child’s admission into the residential care facility. Internal conflict, involving violent clashes between various armed ethnic organisations and the Armed Forces of Myanmar, known as the Tatmadaw, has been occurring in parts of Myanmar for decades.<sup>41</sup> Conflicts have been documented in a number of states or regions, with those classified as major conflicts centered around Shan, Rakhine, Kachin, and Kayin States.<sup>42</sup> In total, 34 children came from these ‘major conflict’ affected states; however, armed conflict was only identified as causal to the institutionalization of these children in 21% of cases (7 cases). It was a primary push factor in 2 cases and a secondary push factor

<sup>41</sup> Thang, R. H. (2019, July). Secularism and religious nationalism: A historical study of ethnic conflict in Myanmar. *The Indonesian Journal of Southeast Asian Studies*, 3(1), 25-43. <https://doi.org/10.22146/ikat.v3i1.44955>.

<sup>42</sup> Gender Concerns International. (n.d.). *Ethnic minorities and conflict*. Retrieved November 14, 2021, from <http://www.genderconcerns.org/country-in-focus/myanmar/Ethnic-Minorities-and-Conflicts/>



in 5 cases. As with children from other parts of the country, education and/or poverty were the most common verified push factors for children from conflict-affected provinces. 50% of all children from Shan State were admitted into RCFs to access education, and a further 15% of children were placed in care due to poverty. 33% of all children from Rakhine State were admitted for education reasons and 44% due to poverty. Although conflict may not have been a common direct cause of child institutionalization, instability in conflict-affected states and regions has contributed significantly to the lack of infrastructural development in these parts of the country, including with respect to education. Government primary schools exist in many conflict-affected areas but are often overcrowded, of lower quality, and lack basic learning resources.<sup>43</sup> There are fewer secondary schools available, and insecurity often makes it unsafe for children to travel to access them.<sup>44</sup> Outbreaks of fighting have also reportedly disrupted the building of new schools as well as teaching in existing schools.<sup>45</sup> As such, conflict is likely to be more of an indirect cause of admission into residential care for children originating from conflict-affected areas than the data suggests, particularly in cases where education was a verified push factor.

<sup>43</sup> UNOCHA. (2021, January). *Humanitarian needs overview: Myanmar*. [https://reliefweb.int/sites/reliefweb.int/files/resources/mmr\\_humanitarian\\_needs\\_overview\\_2021\\_final.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/mmr_humanitarian_needs_overview_2021_final.pdf)

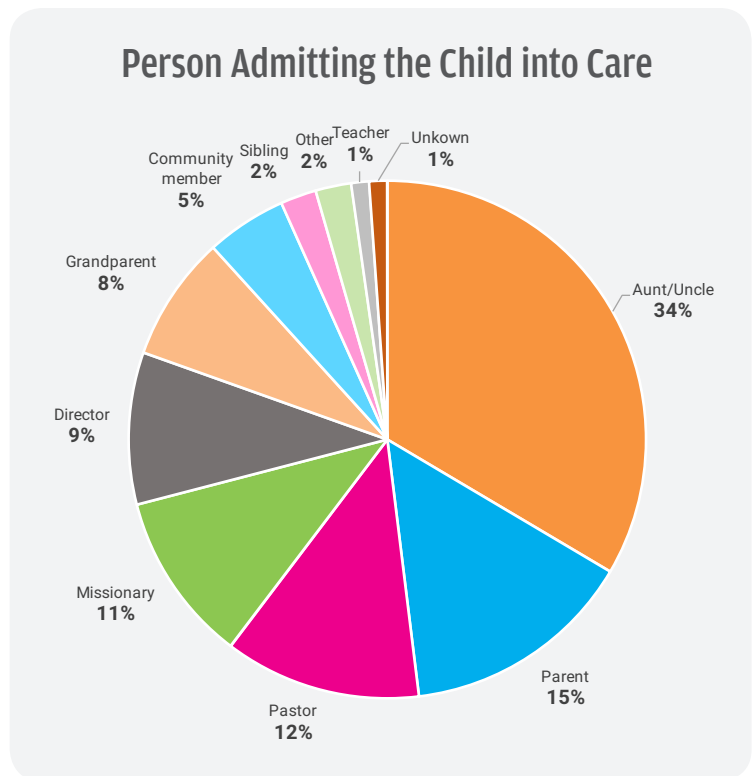
<sup>44</sup> Ibid.

<sup>45</sup> South, A., & Lall, M. (2016, February). *Schooling and conflict: Ethnic education and mother tongue-based teaching in Myanmar* (Policy Dialogue Brief Series No. 15). USAID. [https://asiafoundation.org/wp-content/uploads/2016/12/Policy-Brief\\_Schooling-and-Conflict-Ethnic-Education-and-Mother-Tongue-Based-Teaching-in-Myanmar\\_ENG.pdf](https://asiafoundation.org/wp-content/uploads/2016/12/Policy-Brief_Schooling-and-Conflict-Ethnic-Education-and-Mother-Tongue-Based-Teaching-in-Myanmar_ENG.pdf)



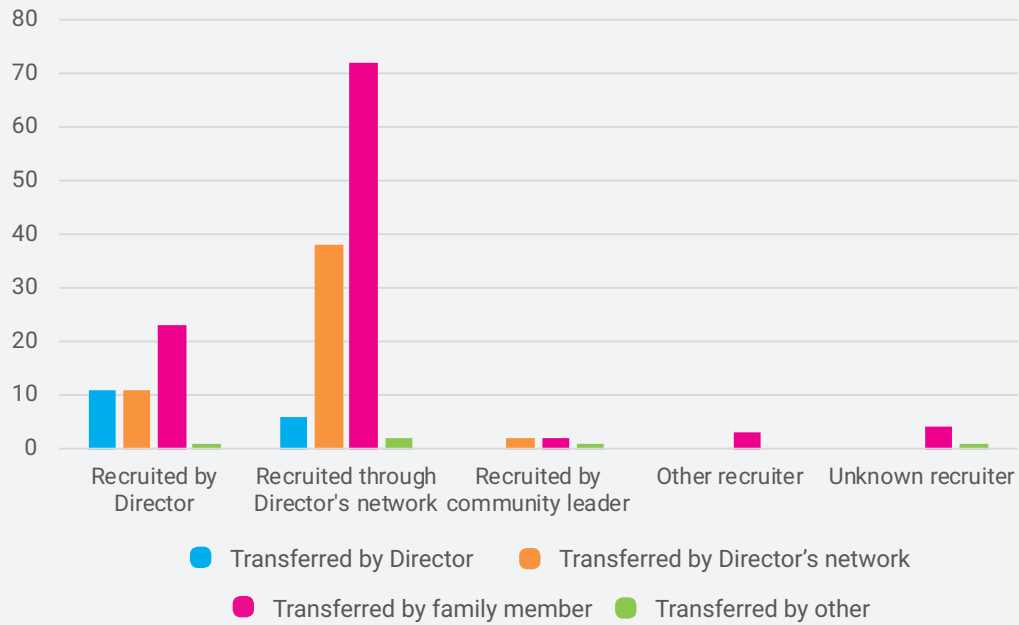
### 5.4.2 Process of Transfer

To gain a better understanding of the mechanisms of admission employed by privatized, largely unregulated, faith-based residential care facilities, the process of transfer of children from families to the RCFs was examined. A range of persons was found to facilitate the actual transfer of the child into the RCF. This included parents, other family members, religious leaders, RCF directors, members of the community, and teachers. In a few cases, the person admitting the child was unknown. Aunts/uncles were involved in the transfer of the child into the RCF in over one-third of all cases (33.5%) and tended to be more involved in the transfer of children in cases where the children's parents were still alive (40% of all cases where both parents were still alive). On the other hand, parents were only involved in the transfer of their child in 4 cases where both parents were alive (6% of these cases) and 18 cases (21%) where one parent was deceased.



In 27.5% of cases where recruitment occurred, there was an overlap between the person recruiting the child and the person transferring the child into the residential care facility. Directors were found to both personally recruit and transfer the child into the RCF in 6.2% of cases, whereas individuals in the directors' networks were involved in the recruitment and transfer in 21.3% of cases. In 72.5% of all recruitment cases, the process of transfer involved someone other than the recruiter. In 81% of these cases (104 children or 58.4% of all cases), the transfer was enacted by a family member, with aunts and uncles being the most common family members involved. In a further 13% (17 cases), recruitment and transfer was outworked cooperatively by the directors and members of their networks, with the director personally recruiting the child while a member of his/her network enacted the transfer, or vice versa. In the remaining 6% (8 cases) where the recruiter and person transferring the child did not overlap, the child was transferred by a community member. This distinction between the elements of recruitment and the transfer of children, and the persons involved, is an important distinction to make and to evidence. It has significant legal and strategic repercussions, particularly for children admitted into RCFs outside of formal regulatory and gatekeeping systems, and where trafficking or exploitation has occurred.

## Persons Involved in Recruitment and Transfer



## 5.5. Transition of Residential Care Services

### 5.5.1 Progress of RCFs through the Stages of Transition

As described in the background section of this report, the primary aim of the Kinnected Myanmar program is to support privately run and funded residential care facilities operating in Myanmar to undergo a transition process, and to ensure children being reintegrated out of transitioning RCFs access appropriate case management services to aid in the process. Other goals include supporting donors to divest and working with organizations involved with RCFs to redirect their support or efforts to non-institutional programs.

The program structure progressed residential care facilities through the various phases of transition, including onboarding, engagement in working groups, social work and the implementation of case management, and post-transition program redesign and implementation. Donors were led through a similar process and engaged in a dedicated donor working group. The desired end goal for RCFs was full transition or closure of the residential care facility and service, after the safe reintegration of all children in care had concluded. The desired end goal for donors was safe divestment of residential care services, ceasing of their involvement in orphanage tourism and volunteering, and reinvestment in non-residential services. These goals aligned with both service and systems level objectives as outlined in the Transitioning Models of Care Assessment Tool and as shown in the diagram below.<sup>46</sup>

<sup>46</sup> Nhep, R., & Won, H. (2020). Transitioning models of care assessment tool. Better Care Network & ACC International. <https://bettercarenetwork.org/sites/default/files/2020-09/Transitioning-models-of-care-Interactive7.2.2.pdf>

# Stages of Transition

## Stage 1 Engagement



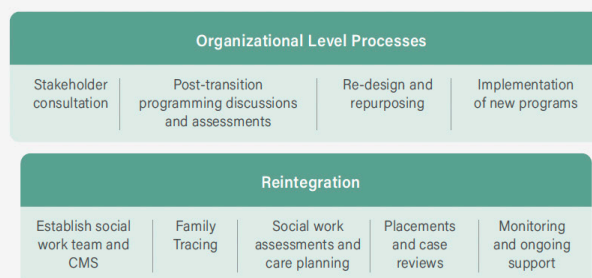
## Stage 2 Preparation & On-boarding



\*when required as indicated by assessments

## Stage 3 Active Transition Stage

### Option 3a Full Transition



### Option 3b Safe Closure/ Divestment



Diagram 1: Stages of Transition

Data was captured on the progression of residential care facilities and their donors through the phases of transition and towards the stated goals, and analyzed as a part of this study. It is important to note that the participation of RCFs and their donors in the program was voluntary, to the extent that it was not mandated by authorities and none of the RCFs were subject to forced closure orders. RCF directors were free to participate and free to exit the program at any point. However, as the findings in this section show, the notion of ‘volition’ in the transition of privatized RCFs is highly nuanced and critically linked to the retention of RCF directors in the programs and outcomes. This will be unpacked further below.

At the time of writing, 13 residential care facilities (28.3%) were still in the onboarding phase, whereas 33 RCFs (71.7%) had progressed to the active involvement and implementation phases. The onboarding process generally concluded with the signing of a tripartite agreement between the donor, the RCF director, and Kinnected Myanmar, following a period of ongoing participation in the working groups. It was at this point that formal buy-in was considered secured, with all parties having agreed to the shared goal of transition, the reintegration of children, and to their respective roles and responsibilities throughout the process.

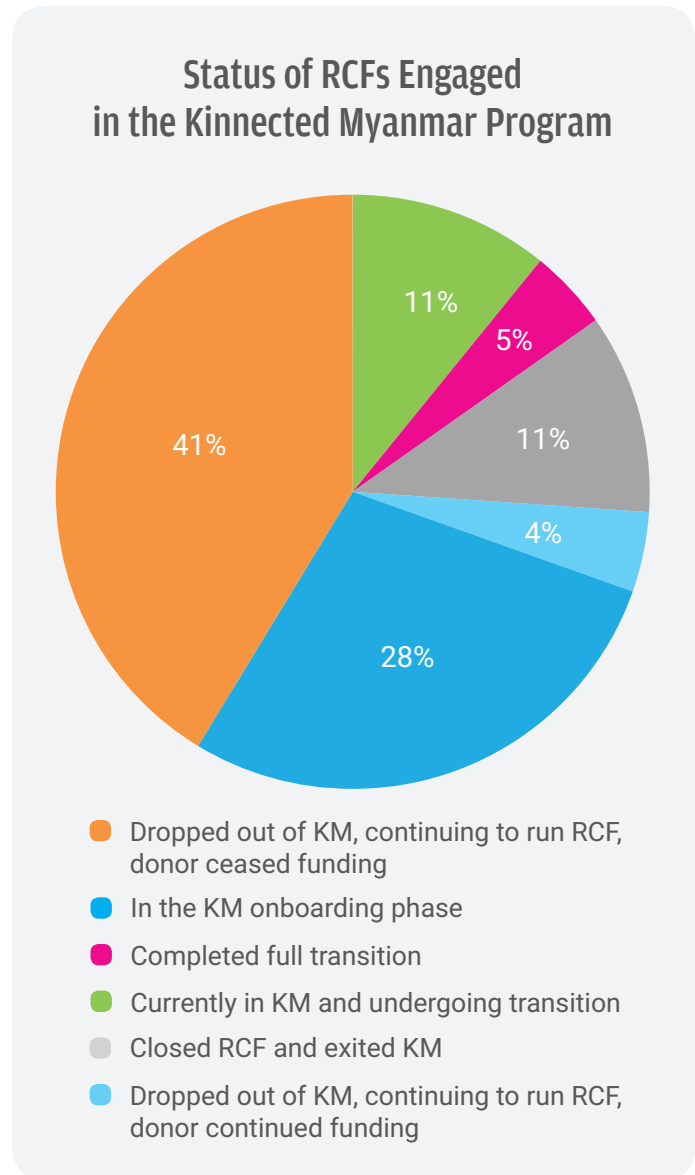
This process of securing buy-in took 15 months on average and included numerous in-depth discussions to unpack the rationale for transition, as well as to clarify the process and various steps of transition and the approach to case management for the reintegration of children. Yet

despite this lengthy process and the formal agreement, 'secure buy-in' was only legitimately achieved with 1 in 3 directors. In fact, 63.6% of onboarded directors dropped out of the program at varying points in the implementation phase and continued running long-term residential care services. In 90.5% of these cases (19 RCFs) the donor ceased funding and terminated their partnership with the RCFs at this point. As such, divestment, being one of the program objectives, was achieved in these cases. Only 2 donors (9.5%) continued funding their partners post-exit from the KM program. This demonstrates a considerable disparity in buy-in between donors and RCF directors, with a significant proportion of directors giving little weight to formal agreements.

Directors' buy-in and RCFs' progression through the stages of transition was found to be influenced by three primary factors: the pre-existing nature of the partnerships between donors and directors, how and by whom transition was instigated, and the level of donor commitment to transition. These factors will be unpacked individually below.

### 5.5.2 Pre-Existing Nature of the Partnership

One of the most notable influences was the pre-existing nature of the partnership between the director and the donor. Most partnerships, if not all, were unstructured and informal in nature. Within these partnerships, RCF directors had a wide berth of discretion and little accountability. Donors had poor visibility of, and little influence over, the actual operations of the RCFs. Under such partnerships, donors reported that it was not unusual for agreements, made verbally or in writing, to be discarded and without consequence. This lack of repercussion gave permission for such conduct to continue unabated in the partnership. Unsurprisingly, this conduct and these expectations were carried over into their partnership with Kinnected Myanmar, resulting in directors demonstrating a willingness to sign agreements without intention to adhere to them, or any expectation of enforcement. In effect, and as a result, buy-in was often superficial rather than legitimately secured.

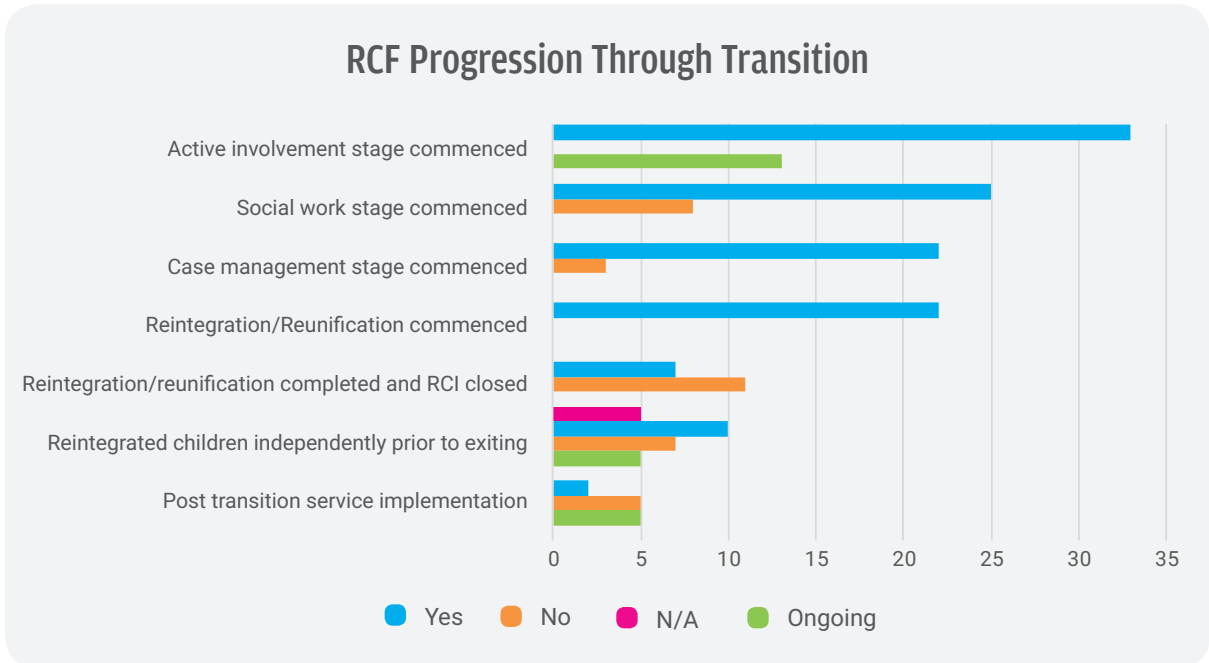


### 5.5.3 Instigation of Transition

The security of buy-in and the disparity between director and donor buy-in was also heavily influenced by the process through which transition was instigated. Transition was initiated by the director in the case of only 1 out of the 33 RCFs that progressed beyond the onboarding stage. This RCF was one of only two facilities that went on to fully transition and provide non-residential services to children and families to prevent family breakdown, indicating a high level of buy-in and commitment to the transition goals. In 97% of cases (32 RCFs), transition was initiated by the donor, with RCF directors invited to participate in the Kinected Myanmar program by their donors. In these cases, donors were in the process of exploring divestment or had already made a commitment to divest of residential care services, and were therefore attempting to influence their partners towards the same end. In most of these cases, directors had not bought in to the merits of transition but agreed to participate in an effort to manage donor relationships, expecting to be able to do so without having to fully commit to the process. This suggests a power disparity between donors and directors in one sense while also revealing the adaptive mechanisms that have been traditionally employed by directors to manage the power disparity without relinquishing control over their RCF operations. As donors progressed through the program, most increasingly made their ongoing financial support conditional upon demonstration of progress in accordance with the formal agreement to transition. Directors' responses to this increasing pressure to implement steps in the transition process varied and influenced the length of time they remained in the program as well as the progress made. Some directors tried to maintain the status quo for as long as possible and remained in the program until they could find other donors, at which point they exited. Others utilized the social work team to scale back their residential care services to a level they could sustain without the financial support of the divesting donor. In some cases, directors decided to reintegrate all of the children and close their RCF after realizing that donor sentiment towards residential care was shifting and it became clear that the long-term financial viability of the model was under threat.

**97%**  
of RCF  
transitions  
were initiated  
by the donor

The desire to retain funding yet full control over their RCFs created a tension that directors sought to resolve in a range of ways. Many employed stalling techniques to prevent social workers from progressing with trust building exercises with the children or conducting assessments with children and their families. For some, this was short lived, after which point directors chose to cooperate with social workers and allow transition and reintegration to proceed. Other directors cherry-picked certain children for reintegration (typically older children) while blocking social worker access to other children whom they wanted to retain in care. This was typically to ensure the future viability and fundability of the RCF by retaining younger children who would assumedly spend longer periods of time in care. In the more extreme cases, directors and staff were found to be manipulating and coercing children and families to sabotage reintegration efforts. Full and unbridled cooperation was only exhibited with one director, who without coincidence happened to be the same director who self-initiated transition for his own RCF.



#### 5.5.4 Principal Donor Commitment to Transition

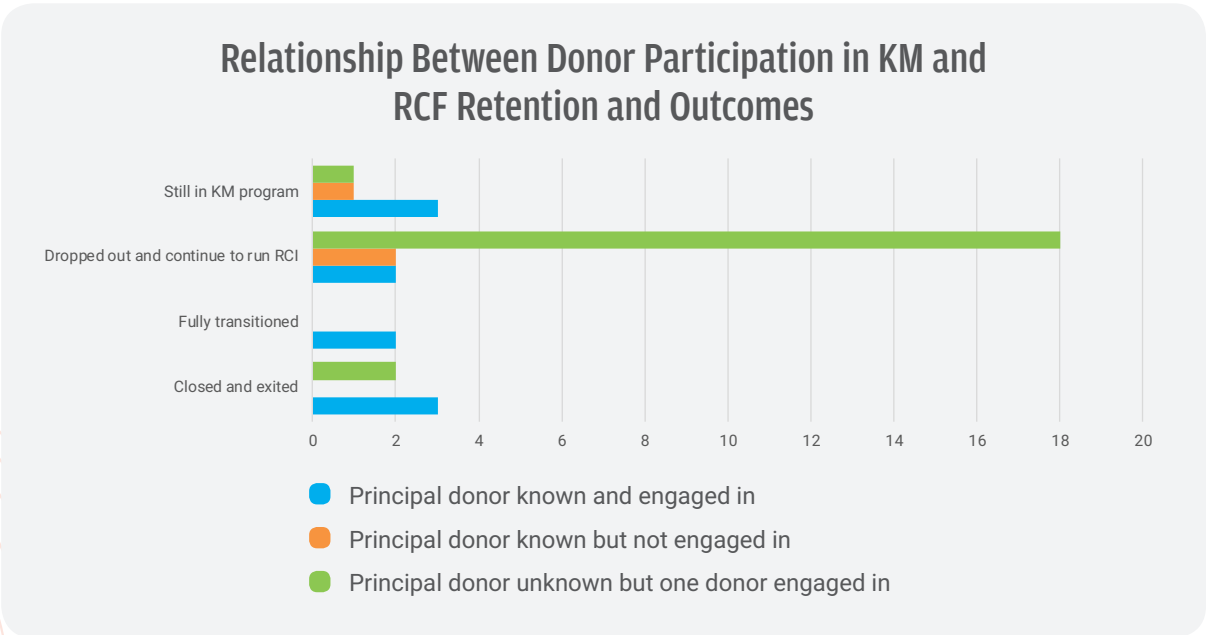
While the aforementioned factors demonstrate in general terms the influence of funding and donors on transition, the analysis additionally showed that not all donors carry equal influence. In fact, the strongest correlation and greatest determinant of transition outcomes was the commitment of the principal donor to divestment and transition. For 10 (30%) of the RCFs that had progressed beyond onboarding at the time of the analysis, the principal donor was both known and engaged in the Kinnected Myanmar program. In 2 further cases (6%), the principal donor was known but not engaged in the KM program. In the case of 21 RCFs (64%) who chose not to disclose detailed donor information, KM staff had been unable to ascertain who the principal donor of a participating RCF was. In some of these cases, the participating donors of these RCFs were aware that their funding levels were insufficient to make them the principal donor and therefore it was marked unknown. In other cases, the participating donors had formerly believed that they were the principal or sole donors of the RCF but had become aware of the existence of other significant donors through their involvement in the KM program. In these cases, and where it was impossible to know which donor was the principal donor, it was also marked unknown.

In the 10 cases (30%) where the principal donor was known and involved in the Kinnected Myanmar program, the outcomes were overwhelmingly positive and aligned with the objectives of deinstitutionalization efforts; that is, the reintegration of children, the scaling back of the use and number of residential care facilities in operation, and the divestment and redirection of resources. In 3 cases, the RCFs remained actively involved in KM and were progressing with reintegration at the time of writing. In 2 cases, the RCF had completed a full transition, remained in the KM program, and were involved in advocacy and the provision of non-residential services for children and families. In 3 further cases, the RCF had closed and exited the program once all children had been reintegrated. There were only 2 cases where an RCF whose principal donor



was known and involved in KM dropped out prematurely and continued with long-term residential care services. In both of these cases, while the donor was willing to support transition, they were unwilling to make a commitment to divest/transition as a donor independently, irrespective of the decision made by their partner RCF to transition or not. As such, they continued to fund their partner RCF to run long-term residential care services post-exit from the KM program. There were 2 cases where the principal donor was known yet not engaged in the transition program. In one of these cases, the outcome was the same as the above in that the RCF abandoned transition efforts, prematurely exited the program, and continued to receive funding to run long-term residential care services. In the remaining case, the director was in favor of transition but the principal donor was not. The RCF was still actively involved in the KM program but was only pursuing the reintegration of young adults in care under a Care Leavers Support Program. The lack of principal donor buy-in had prevented the director from pursuing full transition and the reintegration of the younger children.

Transition was similarly infrequent for residential care facilities who had at least one donor in the KM program, yet for whom the principal donor was unknown and not involved. Out of the 21 RCFs (64%) in this position, only 2 (9.5%) closed and exited the program after all of the children were reintegrated, 1 (4.5%) remained actively involved at the time of analysis, whereas the remaining 18 (86%) abandoned transition efforts and dropped out of the KM program. In all 18 of these latter cases, the donors involved in the KM program terminated their partner's funding upon their exit, thus achieving one positive outcome (divestment and redirection of resources) despite falling short of the optimal goal of full transition or closure.



These findings show a marked difference in retention rates and outcomes for residential care facilities involved in transition, based on the variables of principal donor involvement and independent commitment by the donor to transition/divest. For RCFs without principal donor involvement, the rate of retention and/or progression through to a positive outcome was 12.5%. This increased to 80% in cases where principal donors were involved, and 100% in cases where principal donors were involved and had also made an independent decision to transition/divest

and communicated this commitment to their RCF partners. This suggests that the greatest determinant of transition outcomes in the case of voluntary transitions in Myanmar is principal donor support, involvement, and commitment to divest. It shows the critical importance of donor engagement in transition efforts, illustrates the significant influence donors hold in affecting or discouraging transition, and lends support to the existing notion of residential care and its ongoing use being, at least partially, a donor-driven phenomenon. It suggests that even in voluntary transitions, directors rarely transition of their own volition. Rather, their decisions are often either compelled or constrained by the power afforded to principal donors. This works both for and against transition, as donors committed to transition/divestment can cause a reluctant director to concede, or conversely, disinclined donors can override directors who are otherwise willing to transition.

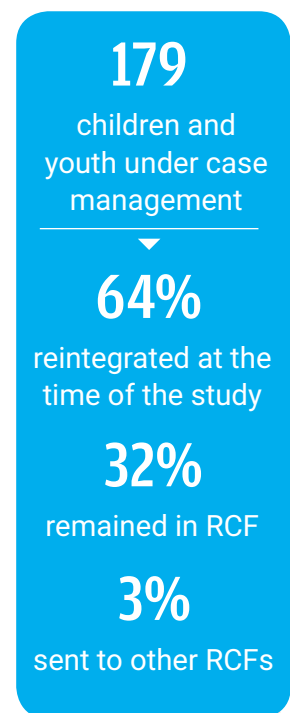
The implications of this are as vast as they are ethically complex and will inevitably give rise to concerns from donors who seek to support rather than control their partners. However, it is important to recognize that to the extent that the privatized residential care sector remains donor-driven, it may need to be donor-reformed. In addition, exerting power through the funding stream, including through regulation thereof, to enact safe closures and transition of residential care facilities that are operating as businesses may be necessary to ensure children are reintegrated under due process and with support, especially in environments that remain underregulated. As such, exerting influence through the funding stream is arguably a more ethical option than simply cutting off demand to reduce supply.

## 5.6 Reintegration Outcomes for Children

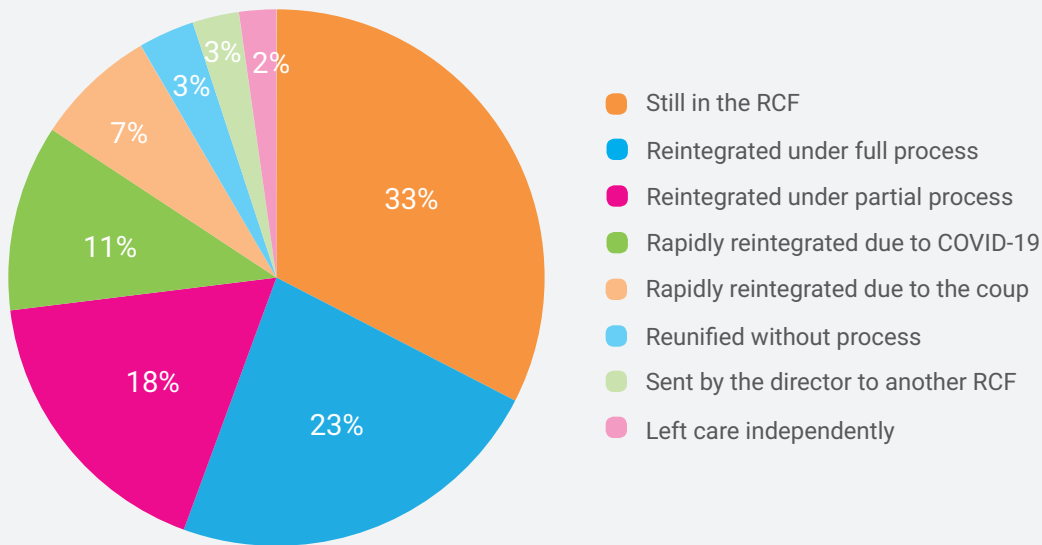
### 5.6.1 Number of Children Reintegrated

Of the 179 children and youth under case management, 64% (115) had been reintegrated at the time of the study. 32% remained in the residential care facility and an additional 3% of children/youth had been sent to other RCFs by the directors. Sadly, one child died in care. Of the 32% who remained in care, only 12% (7) were in the process of reintegration. The other 88% of these children (51) were in RCFs that had exited the transition program. It is unknown if any of these children left care during throughout the period of COVID-19 or the coup.

Of the 64% of children/youth who had been reintegrated, 36% (41) had been reintegrated under full process, meaning the full case management process leading up to placement or reunification had been outworked. 27% (31) had been reintegrated under partial process and 29% (33) were rapidly reintegrated.



## Reintegration Status of Children



### 5.6.2 Reintegration under Partial Process

Reintegration under partial process occurred due to a range of reasons, with the most common being children remaining with family after a scheduled family reconnection visit (15), directors dismissing children/young people from the residential care facility due to the child's behavior and sending them home (8), and families removing their children from the RCF (6). This sometimes occurred after families had participated in awareness raising seminars, and in other cases was at the request of the director and due to the child's behavior.

In cases where reintegration under partial process was due to the family's decision to immediately resume care of their child, it was often prompted by a combination of interventions that removed practical and psychological barriers. Firstly, family visits had been facilitated by Kinected Myanmar as a part of family reconnection efforts and to strengthen bonds in preparation for reintegration. For some families, such visits had previously been discouraged or prohibited by the RCF. This was typically in cases where directors saw family visits as disruptive or where unlawful contracts had been instituted to strip families of their parental/guardianship powers. As such, not only did these visits provide important bonding opportunities, they also gave parents the opportunity to exercise parental decision-making powers over their children, as these powers had been inadvertently or intentionally stripped from them by the care arrangements in place. Many families who were in this position were understandably reluctant to return their children to the RCF to complete the case management process and chose to immediately re-assume care of their children. Furthermore, in 93% of these cases, the reasons for admission were poverty and education. Efforts by KM social workers and project staff to raise awareness, at the community and family level, of the harms of residential care, began to change community attitudes and erode parents' perceptions of RCFs as a viable means of meeting children's physical or educational needs. These changing attitudes towards residential care made families more receptive to exploring other family- and community-based solutions

with social workers. At this point, the offer of tangible alternative services or reintegration support was the final factor required to empower families to act on their increased knowledge of what was in the best interest of their children.

Families with more complex relationship dynamics to work through were more likely to see the case management process through to completion. For families where one-off and/or ongoing material support could resolve push factors related to poverty and education, they were more likely to seek immediate reunification. These findings provide interesting insights into what enables family decision making. In addition to considerations typically given to addressing push factors and families' attitudes to residential care, these findings also suggest that efforts to support parents to resume the care of their children must also consider the power dynamics between families and RCF directors, particularly in cases where they have been controlling or coercive.

### **5.6.3 Impact of COVID-19 and the Coup on Children's Reintegration**

During the time in which case management services were being implemented, two crisis situations unfolded in Myanmar and triggered the rapid reintegration of some of the children and young people in care. In early March 2020, COVID-19 was declared a global pandemic, causing widespread restrictions and lockdown measures. Schools in Myanmar closed as of March 2020, varying levels of restrictions were imposed on workplaces, and stay-at-home orders were issued in April 2020, extending through to November 2021.<sup>47</sup> Transmission remained low throughout much of 2020, spiking in the last quarter before receding again. However, the country lost control over the spread of COVID in mid-2021, with new 'reported' cases reaching daily highs of over 5000 in July.<sup>48</sup>

The situation was significantly compounded by the second crisis; that is, the political coup that resulted in the military seizing control in February 2021 and the ensuing widespread protests and violence, particularly in Yangon. The concurrence of these two emergencies triggered a health, economic, and security crisis with devastating effects. Testing and treatment for COVID was scarce and challenges related to access to medical care were compounded by the military targeting of the medical fraternity due to their participation in protests. Violence in Yangon made leaving home to secure basic supplies, including food, perilous. The collapse of the finance system made it impossible for organizations and individuals to access funds held in bank accounts and for funds to be sent into the country from overseas. The impact of these two crises on residential care facilities and children in care are difficult to disentangle; however, they jointly resulted in the rapid reintegration of 18% of all children under case management. For some children in Yangon, rapid reintegration was triggered by directors who, when faced with resource restrictions, elected to focus their attention on protecting their own families and thus returned some of the children in their care to rural parts of the country where the situation was

<sup>47</sup> COVID-19 Tracker. (n.d.) *Myanmar*. Reuters. Retrieved December 2, 2021, from <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/myanmar/>

<sup>48</sup> Naw, T. (2021, July 19). Myanmar plunges into deadly third COVID-19 wave. *The Diplomat*. <https://thediplomat.com/2021/07/myanmar-plunges-into-deadly-third-covid-19-wave/>

less dire. For other children, families fearing the general insecurity wanted their children nearby and sought their return. In some cases, directors requested support from Kinnected Myanmar social workers to rapidly reintegrate children with their families, while in other cases they did so independently. For children rapidly reintegrated out of Yangon-based RCFs, the coup was cited as the primary reason in 71% of cases, rather than COVID. For children rapidly reintegrated out of RCFs outside of Yangon, the opposite correlation was observed, with COVID-19 cited as the primary reason for rapid reintegration in 84% of cases. A higher proportion of children admitted into care for education reasons were rapidly reintegrated due to COVID when compared to children admitted due to other push factors. 70% of all children residing in participating RCFs in Shan State were rapidly reintegrated due to COVID, with 64% of these children having been admitted for the primary reasons of accessing education. This was attributed to the closure of schools, which reduced the utility of RCFs in the eyes of families, coupled with families' general unease at having children separated at a time of such insecurity and uncertainty.

#### 5.6.4 Children's Placements

The most common type of placement for children/youth reintegrated out of participating residential care facilities was biological reunification. Of the 115 children and young people who had been reintegrated at the time of writing, over 60% (69) had returned to the care of their parent/s. 56% (37) of these children/youth were reintegrated back into the care of both biological parents who remained married at the time of reunification. These parents had overwhelmingly admitted their children into care in response to poverty and limited access to education. 23% of children/youth (27) were reintegrated back into the care of one biological parent. In 15 of these cases, one parent was deceased and the surviving parent who resumed care remained single. In 10 cases, the surviving parent had remarried and therefore the child/young person was reintegrated back into the care of a biological parent and step-parent. Poverty was once again the main reason cited for these children's admission into care. The death of a parent was only listed as the primary push factor in 1 in 4 of cases where one parent had died. In the remaining 7 cases of reintegration into parental care, the level of information provided was insufficient to determine the exact circumstances and composition of the family.



Kinship care was the second most common placement type for reintegrated children/youth, accounting for 33% (38) of all placements. Half of these children/youth had been in informal kinship care prior to their admission into the residential care facility; however, it was unknown whether they returned to the same or a different family member upon reintegration. The most common reasons given for their admission into the RCF were the death of one parent or divorce/separation, in combination with remarriage. While these push factors explain the circumstances leading to the child's placement in informal kinship care, they do not elucidate the decision made by extended families to admit these children into RCFs. All but one of these children were recruited, which may suggest that families providing informal kinship care are amongst those targeted by recruiters seeking to identify and refer children to RCFs in their networks.

### 5.6.5 Age at the Time of Reintegration

**70%**  
of reintegrated  
children/youth are  
over the age of 15

A disproportionate number of reintegration cases occurred amongst adolescence or youth, with 70% (80) over the age of 15. This largely reflected a preference amongst RCF directors to put forward older children/youth for reintegration. However, it also reflected the situation of residential care facilities that expressly set out to retain children until matriculation, yet without any reintegration strategy or transition support, continued to house young people well past this point.

Even though a significant proportion of youth were, at the time of reintegration, of the age where supported independent living is often considered more feasible than family reunification, only 4 young people transitioned into independent living. Most adolescents and youth reintegrated back into their biological families, whether nuclear or extended. This was despite the majority spending significant lengths of time in residential care, and in an urban setting, vastly different from the rural communities into which they reintegrated. This is an interesting finding, and one that appears at odds with concerns often raised about the feasibility of family reunification for older children and youth, especially under these conditions. The findings suggest this was related to the utility ascribed by families to RCFs in Myanmar, coupled with the relational means by which many children are identified and recruited into care, and norms of reciprocity between parents and children. Taken together, these factors suggest that admission of a child into residential care does not signal a severance of family ties or a breakdown in the relationship between children, parents, and the wider family. Therefore, it is expected that once residential care's purpose has been exhausted, the child will return to the family, irrespective of their age.

As the findings regarding push factors show, most children are admitted into residential care due to reasons associated with poverty and access to education, sometimes in conjunction with the death of one parent. It is rare for children to be admitted into care due to an actual and total deficit of caregivers. In fact, not one child in the study cohort was admitted due to abandonment or was without any known family connections. Rather, children were admitted by their biological families to access support, and importantly, that support was offered to them by individuals to whom their families were connected relationally. This means that from the perspective of the families, the transfer of a child into residential care is best interpreted as a means of tapping into an informal support system that normatively flows along hierarchical relational network lines; that is, a system in which individuals enter into a patron-client relationship with those who have more access to resources, in order to secure long-term support.<sup>49</sup> It is therefore an example of how, within the Myanmar context, the poor access resources and opportunities through kin, fictive kin, and clientelist networks.<sup>50</sup> As it carries no association with abandonment or intent to sever family ties, it stands to reason that once the need has been ameliorated, most families and children/youth expect and pursue biological family reunification, regardless of age or length of the period of separation. In addition, reciprocal intergenerational obligations between parents

<sup>49</sup> Scott, J. C. (1972, March). Patron-client politics and political change in Southeast Asia. *American Political Science Review*, 66(1), 91-113. <https://doi.org/10.2307/1959280>

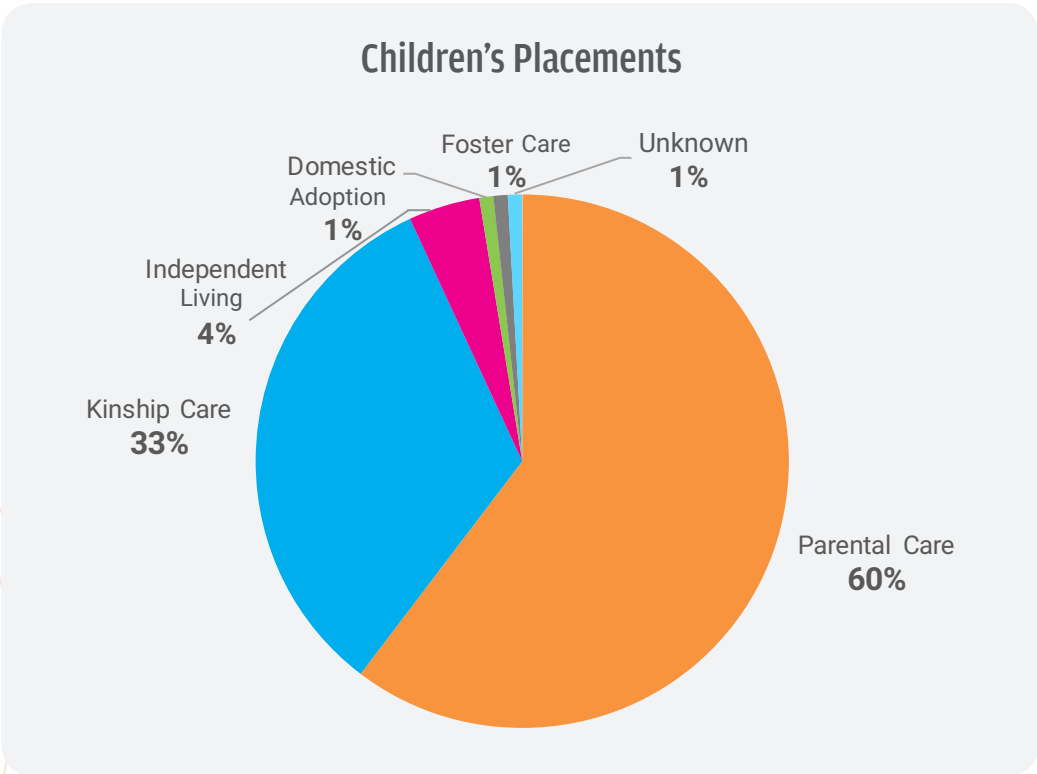
<sup>50</sup> Griffiths, M. (2018). Networks of reciprocity: Precarity and community social organisations in rural Myanmar. *Journal of Contemporary Asia*, 49(4), 602-625. <https://doi.org/10.1080/00472336.2018.1542450>



and children withstand periods of separation and placement in residential care. Therefore, the expectation that children will return to contribute to the family, often economically, remains intact. This is the case even when parents and children withstand periods of separation and placement in residential care. Therefore, the expectation that children will return to contribute to the family, often economically, remains intact. This is the case even when parents fulfilled their obligations to provide for their children through admission of their child into care. This is an area where further research and analysis is warranted, particularly longitudinal research that examines the outcomes over time for these young people and the durability of their placements back with family. It may well be that many relocate back to urban centers in pursuit of further education or work post-reunification with family. However, what is yet unknown and needs to be understood is the long-term significance, if any, of first returning to the family unit before any subsequent pursuits or movement.

### 5.6.6 Placement Outside of the Biological Family

Reintegration into other non-relative forms of family-based care was very rare, with only one child under case management placed in foster care and one adopted domestically. In the one case of adoption, the child was adopted by the director and this was arranged directly by the director with local authorities. It was therefore only semi-formal and did not involve the courts. Neither foster care nor domestic adoption were widely accessible options at the time of the study, with formal government-run foster care only being piloted in two geographical areas of the country at the time of writing. The majority of children who were not yet able to reintegrate back into their families of origin remained in the RCFs under case management.



### 5.6.7 Support for Reintegration

83% of families (95 cases) received some support to enable reintegration. 36% of these received one-off support, 64% received reoccurring support, and 45% received both one-off and reoccurring support. The type of support provided included education, living costs, medical needs, transport, food, clothing, and income generation. 1 in 2 families required multifaceted support, which typically included support for living costs, transport, and ongoing education. The need for multifaceted support was more common amongst families who had admitted children into care in response to the death of one parent (56%) or due to poverty (40%), when compared to families who had admitted children due to divorce or separation (30%) or to access education (20%).

The type of support provided to families did not always correlate to the push factors listed as causal to the child’s institutionalization. In some cases, this was due to changes in the family’s circumstances during the period the child had been living in the residential care facility. In other cases, push factors were no longer relevant or no longer had the same impact on family functioning, due to the age and life stage of the child/young person at the time of reintegration. This was particularly the case for adolescents and youth reintegrating back into families in cases where education was the original primary push factor. In addition to this, some families received support packages even when it wasn’t indicated by assessments.

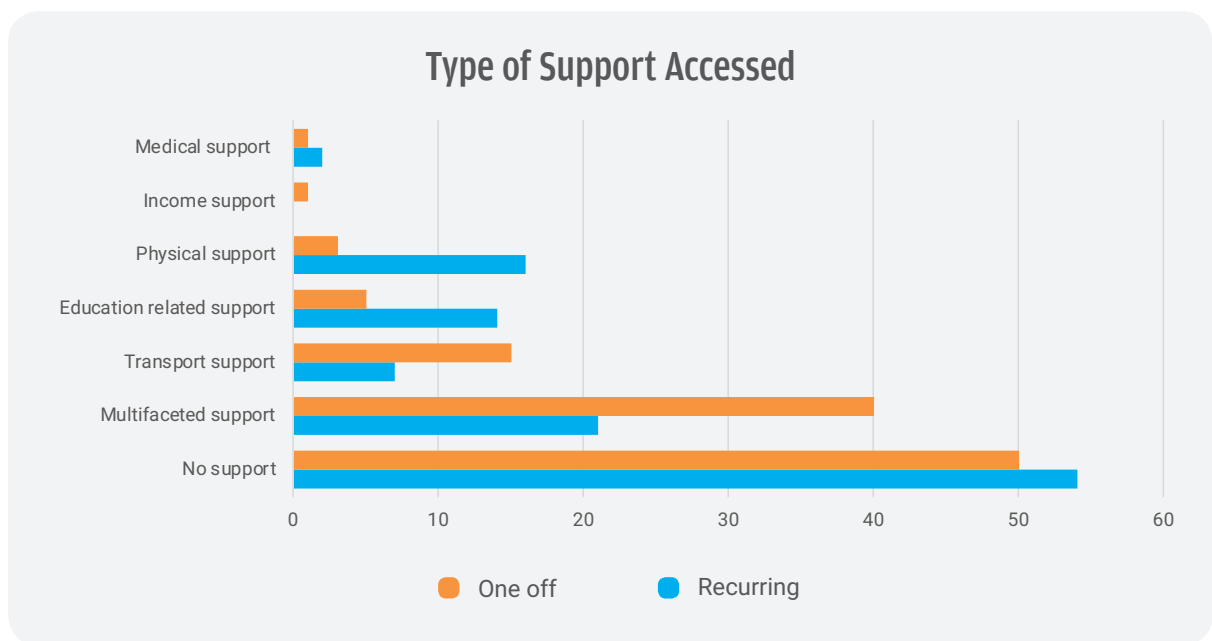
**83%**  
of families received support for reintegration

▼

**36%**  
received one-off support

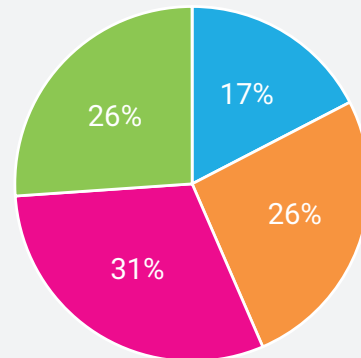
**64%**  
received reoccurring support

**45%**  
received both



The decision to provide support in these cases was made by social workers to remove barriers to reintegration that stemmed from the relationships between the RCF director and the family. Where kin, fictive kin, or patron-client relationships existed between the children's families and the RCF director, directors often demonstrated a reluctance to reintegrate children or outright blocked reintegration efforts. This was because the director's ability to provide support and resources to the family, in line with their social obligations as a patron/benefactor, was contingent upon the child residing in the RCF. Reintegration therefore posed a threat to the foundations of these relationships, and one that needed to be removed through a renegotiation of support that could continue to flow to the families through the director, without requiring the institutionalization of the child. This enabled directors to fulfill their social obligations, save face, and retain their status. It also alleviated concerns amongst families that reintegration signaled the severance of these relationships, upon which they were reliant. When left unaddressed, these concerns were observed to interfere with reintegration, particularly with respect to the integrity of family assessments. Providing support to families throughout the reintegration process, as a means of disentangling patron-client obligations from residential care services, therefore proved to be a necessary strategy to clear the way for some children's reintegration back into family.

### Category of Support Accessed (one-off or reoccurring)



- Recurring support provided only
- No support provided
- One off support provided only
- Recurring and one off support provided



## 6. SUMMARY OF IMPLICATIONS AND RECOMMENDATIONS

### 6.1 Residential care service transitions are largely donor influenced

The study revealed that the transition of privatized Christian faith-based residential care facilities was largely driven by donor interest in transition or a donor commitment to divest of funding residential care. Directors rarely initiated the transition and often demonstrated resistance to varying degrees. While directors were under no obligation to participate in and pursue transition, the volition of directors was curtailed by the power afforded to donors. This meant that directors invited by their donors to participate in the Kinected Myanmar program often agreed, despite in many cases having no desire or intention to transition. Participation was initially seen as a means of managing donor relations through a demonstration of superficial cooperation. Some directors went on to agree with, or concede to, transition or closure at the point where they were otherwise unable to avoid a conflict between the principal donor's express wishes and their own. For those who were able to avoid this conflict, transition or closure did not occur. In some cases, this was because the principal donor was not involved in the program and not independently pursuing divestment or transition. As such, the directors in this position were able to align themselves with their principal donors who were external to the Kinected Myanmar program and not pursuing transition or divestment. These directors eventually dropped out of the KM program or chose to remain only to reintegrate some of the children in their care. In other cases, the conflict was avoidable as the participating principal donor had not independently committed to divestment. These donors were willing to continue supporting the director regardless of their decision regarding transition. These directors also dropped out and continued to run residential care services. In the one case where transition was self-initiated by the director, it was with the full support of their principal donor who had also made an independent commitment to divest. As such, it was without conflict and highly successful, resulting in one of only two full transitions.

This finding shows that directors primarily act to avoid conflict with their principal donors. Their full participation in a transition process is only feasible with the approval and active support of their principal donors.<sup>51</sup> Partial and temporary participation is often an adaptive strategy employed by directors to manage relationships with donors who are not their principal donors. However, at the point where conflict with their principal donors emerges and becomes unavoidable, the directors will likely withdraw from the transition program or limit their involvement in ways that eliminate conflict.

This reinforces the importance of not only engaging donors in the transition process and donor awareness raising, but of identifying and engaging the *principal* donors. It also points to the need for improved regulation over funding streams, due to the role that funding plays in undermining systems reform efforts and driving the continued and inappropriate use of residential care.

<sup>51</sup> Nhep, R., & van Doore, K. (2021, April). *Impact of COVID-19 on privately run and funded residential care institutions*. Better Care Network & Griffith University. <https://bettercarenetwork.org/sites/default/files/2021-06/Impact%20of%20COVID-19.pdf>

### 6.1.1 Recommendations

- Funding stream analysis and donor mapping should be considered to identify the sources of financial support for privately run residential care facilities in Myanmar. This would better enable targeted donor awareness raising, donor engagement, and coordination of efforts where multiple donors are involved in the support of specific RCFs.
- Consider scaling up donor advocacy and awareness raising efforts, targeting overseas faith communities who are significant supporters of residential care in Myanmar. In addition to understanding the harms associated with residential care, donors would benefit from improved awareness of the situation of children in privatized residential care facilities. The findings of this study showed that dispelling myths regarding orphanhood and improving financial transparency were critical to donors deciding to pursue transition and/or divestment of residential care.
- Sending countries should examine ways in which they can regulate the overseas activities of their domiciled entities, particularly where these entities are funding residential care facilities that are unregistered, unlawfully operating, and violating the rights of children as enshrined under international law.

## 6.2 Active recruitment drives admission of children into residential care

Active recruitment of children into residential care facilities was found to be pervasive and the primary mechanism employed by privately run faith-based RCFs to populate their facilities. 99% of children under case management admitted into participating RCFs were recruited, most commonly by the directors or individuals in the directors' networks. Despite experiencing vulnerabilities that act as push factors, families rarely initiated the admission of a child into an RCF in the absence of recruitment. Rather, recruiters likely identified families experiencing known push factors, and offered residential care as a viable solution. It also suggests that families prefer to transfer children into RCFs with which they have relational connections, either through kin, fictive kin, ethnic, or clientelist networks. In doing so, families can access support offered through RCFs and alleviate stressors, without breaking customary and familial obligations towards the child.

However, as the levels of power and authority held by families and RCF directors are unequal to each other, the transfer of a child into care, particularly in the presence of recruitment, signals the subordination of the families' authority as guardians to the director who is seen as the 'benefactor'. It therefore impacts the ability of the families to exercise authority over their own child/ren in the future. In addition, the recruitment into specific residential care facilities along relational lines often results in the movement of children into RCFs that are located far away from their families. Along with the commonplace practice of RCFs discouraging family contact, this geographical distance can result in significant periods of little, if any, contact between children and families. This compounds the power differential that prevents families from exercising decision-making rights over their children's care. Family reconnection, as a part of the transition and reintegration process, was found to be critical in supporting parents and families to regain decision-making power, allowing them to act on improved awareness of what was in the best interest of their child/ren and accept alternate forms of support. However, it

often resulted in families circumventing the full and standard process of case management for reintegration. Instead, families often sought immediate reunification with their children during family reconnection visits, out of a fear that they would not have another opportunity to reclaim their children after they returned to the RCFs.

The findings also showed that recruitment and transfer are distinct steps in the process of admission of children into these residential care facilities. Overlap between the person recruiting and the person enacting the transfer of the child into the RCF was only noted in 27.5% of cases and was most common when recruitment and transfer involved individuals in the directors' network, rather than the directors themselves. More often than not, family members, including aunts, uncles, grandparents, and parents, were involved in the actual transfer of children. This can mask the involvement of recruiters in the process of children's admission into residential care and can result in an incomplete understanding of what really drives the admission of children into these RCFs. It is imperative that recruitment and transfer are understood as distinct activities, and that the links, where they exist, are further investigated. This understanding could assist with the development of more effective strategies to prevent the separation of children from families and provide recourse to residential care. In addition, this understanding is important to the development of strategies to detect, prevent, and prosecute orphanage trafficking, which can involve recruitment and/or transfer, and which has been documented as occurring in Myanmar.

### 6.2.1 Recommendations

- Further research and inquiry should be conducted to better understand the mechanisms of recruitment occurring in relation to the admission of children into privatized faith-based residential care facilities in Myanmar.
- Community-level awareness aimed at changing mindsets towards residential care should address the issue of recruitment so that parents and community leaders are equipped to identify and curtail recruitment practices and/or the effect of recruitment on families' decisions regarding their children's care.
- Registration of residential care facilities should be required by law and all RCFs should be brought under the regulatory control and oversight of the government and mandated authorities. Gatekeeping needs to be strengthened, enforced across all RCFs, and outworked independently of residential care service providers. All RCFs should be subject to regular inspections by mandated authorities. Regulations should set out the conditions and powers to enact forced closure of RCFs that fail to register or are non-compliant with relevant minimum standards and other relevant regulations.
- Consideration should be given to introducing penalties and offences for serious breaches of child protection laws and alternative care policy, including unlawfully operating an RCF and unlawful removal of a child from parental custody or guardianship. These are critical to curtailing recruitment practices, preventing irregular admission of children into care, ending impunity for RCF operators or others who violate children's rights or perpetrate abuse, and to safeguard children against orphanage trafficking and exploitation in residential care settings.



## 6.3 Cultural factors and customary laws influence children's admission into residential care

The study findings identified that children from ethnic Chin communities and families face additional risks of being admitted into privatized and unregulated faith-based residential care facilities in Myanmar. The vast majority of the RCFs in the study cohort were founded and run by Chin directors, and most of the children in care were from Chin State or Sagaing Region, both areas where the majority population are Chin and Christian. Due to the relational nature of recruitment, including along kin and ethnic lines, these children are more likely to be targeted for recruitment and admission into these specific faith-based RCFs. In addition, Chin cultural and customary law norms pertaining to custody of children increase the risk of families seeking opportunities to send children to residential care in the event of death of the father, or divorce or separation. This stems from children being considered the property of the father, and in the event of his death, custody is transferred to the father's family. The mother ceases to have any role or responsibility in the family, including with respect to her biological children. In the event of divorce or separation, the children remain with the father; however, if he is unable or unwilling to assume caregiving responsibilities, placement in residential care is preferred over other non-paternal family-based care options. These cultural norms similarly pose challenges for children's reintegration, particularly in cases when the most appropriate option for family-based care is reintegration with the mother or foster care. Both options are likely to be blocked by the paternal family who would perceive such placement outside of the paternal extended family as a contravention of customary laws.

### 6.3.1 Recommendations

- Further research and investigation on the intersection of ethnic minority group customary laws and child institutionalization should be conducted. Elucidation of this important nexus is critical to understanding the risks of child institutionalization for certain populations of children and for informing prevention and targeted awareness raising strategies.
- Care reform champions from within the Chin community should be identified and supported to engage in dialogue with religious and community leaders around caregiving practices and to identify culturally sensitive pathways towards a reduced reliance on residential care.
- Child protection, family strengthening, and social protection policy formation and practice should adopt a dual gender and culturally sensitive approach. The degree of ethnic and cultural diversity across Myanmar means that community attitudes and practices vary greatly between ethnic groups, as do risks to children being outside of family care.

## 6.4 Poverty is the most common reason for children to enter into care

Poverty was found to be the most common push factor contributing towards children's admission into residential care. 97% of children had one or both parents alive and 1 in 2 children were referred to care for reasons associated with poverty. However, in most cases it is the combination of two or more stressors that lead to families resorting to residential care. Poverty and the loss of one parent was the most common coupling of push factors, followed by poverty and access to education. While conflict was rarely cited as a push factor, most of the children in the study cohort came from conflict-affected areas of the country. In these areas, extended periods of insecurity have worsened poverty and stalled development of infrastructure, including the construction of new schools. Parents, in response, have often resorted to sending their children out of these areas to ameliorate these issues. As such, the indirect role of conflict on children's institutionalization cannot be discounted.

These findings show that at the heart of the issue of recourse to privatized residential care, are the interrelated issues of sustainable development and security, overlaid by culturally informed responses to adversity. This points to the importance of multisectoral collaboration in child protection and care reform efforts, particularly in strengthening at-risk families' access to social protection and education. This raises concerns regarding the increasing insecurity in response to the recent coup, and the impacts that further uprisings in these parts of the country may have on children's care. In the short term, the uncertainty of the 2020-2021 period has resulted in some children exiting residential care facilities to return to their families, even in these conflict-affected areas. However, in the middle to long term, without appropriate intervention, these issues may result in another influx of children into privatized residential care facilities.

### 6.4.1 Recommendations

- Efforts to reform the care system in Myanmar must be multisectoral and target underdeveloped areas of the country that have been impacted by protracted insecurity.
- Improving the access of ethnic minority groups in conflict-affected areas to social protection and education should be at the center of strategies to prevent unnecessary separation of children from families. This may require the mainstreaming of child protection and care issues into education and social protection policy discussions and reform agendas.
- Sufficient support to address poverty and education access should be factored into reintegration plans and strategies. Organizations implementing reintegration need to take a flexible approach to developing support packages for reintegration. Solutions should be tailor made with families and include innovative ways of addressing structural barriers to education that are likely to continue to exist in the short to medium term. Consideration should be given to supporting and strengthening alternative models of education at the community level where they exist and are capable of addressing current gaps in the state system.



## 7. CONCLUSION

The study examined the operating environment of privately run Christian faith-based residential care facilities operating in Myanmar, including the characteristics of directors, donors, the children in care, and the mechanisms of admission and funding. The study provides important insights that could be used to shape care reform policy and inform strategies regarding the transition of these privatized faith-based residential care services.

The study showed that a significant number of Christian faith-based residential care facilities were run by directors from majority Christian ethnic minority groups, most notably the Chin and Kachin ethnic groups. These RCFs were founded due to a multifaceted array of factors and motivations. These included ministry ideals, which afford high status to Christian leaders who have a church, Bible school, and residential care facility under their oversight. RCFs were perceived as attractive to foreign donors and a means of securing personal support in addition to funds to run other ministry activities. Directors also saw RCFs as legitimate ways to provide support to children and families, many of whom were part of the directors' kinship, fictive kin, or ethnic group. Directors often acted as benefactors to these families, which located children's care within complex and asymmetrical patron-client relationships. Almost all children were recruited into these privatized RCFs and along these relational lines. Families facing multiple stressors, including poverty, the death of one parent, and poor access to education, perceived RCFs as a viable means of ameliorating these issues; however, these stressors almost never instigated the transfer of a child into an RCF without the involvement of a recruiter. This suggests that recruiters identify and approach families experiencing these known push factors, and they broker access to RCFs that are connected to them via social networks. These networks were found to span the country, which resulted in children being placed in RCFs far away from their communities of origin. Placements were generally considered long term, and in some cases, families were prohibited from seeking their child's return and were required to sign or agree to contracts upon admission. In other cases, the distance and lack of facilitation of family contact by RCFs, despite it being a requirement under the national minimum standards, was sufficiently prohibitive and resulted in children remaining in care long term, even when parents desired their return. These findings show the importance of strengthening alternative care regulation, ensuring it is enforceable and bringing all RCFs under the regulatory oversight of mandated authorities. Directors' discretionary powers to admit or dismiss children from care should be appropriately curtailed through the implementation of formal gatekeeping mechanisms that aim to regulate the exceptional use of residential care and promote safe reintegration of children.

The findings also have implications for funding stream reforms and donor engagement strategies. All of the RCFs in this study received funding from overseas faith-based donors. In most cases, donors connected with their RCF partners via overseas trips to Myanmar. In other cases, they were introduced to the directors by other donors or known associates. Partnerships were forged based on trust and were relational rather than contractual in nature. Large sums of money were transferred, often into the personal accounts of directors or brokers, with little oversight or accountability. The lack of transparency and accountability in these partnerships, in addition to the child sponsorship funding models employed, created an incentive for children to be institutionalized and disincentivized reintegration.

Donors often initiated transition after discovering discrepancies in the use of funds or in the stories of the children in the care of their partner RCF. The discovery that most of the children had parents, and were not in fact orphans, was a significant turning point for many donors and catalyzed their interest in transition and reintegration. In all but one case, transition was initiated by donors rather than by directors. Donors had significant power to influence their RCF partners to engage in the transition program; however, only principal donors were able to influence directors to complete the transition and/or close their RCF after all of the children were reintegrated. This was because directors acted to avoid conflict with their principal donors, and therefore the principal donor's position and commitment to transition was the greatest determinant of the outcome. This reinforces the importance of donor engagement and awareness raising in the transition process, and of the redirection of donor funds as a component of care reform efforts. It also highlights the importance of donor countries taking a more active role in regulating funds sent to overseas residential care facilities, and the importance of international cooperation in achieving country level care reforms. Unless this is addressed, foreign donor funds will continue to undermine the efforts of the Myanmar government to deinstitutionalize the country's care system and to promote family-based care.



## 8. REFERENCES

- Aung, S. H. (2019, April 3). Alarming Increase in the number of orphans in Myanmar. Myanmar Times. <https://www.mmtimes.com/news/alarming-increase-number-orphans-myanmar.html>
- Barna. (2021). Residential care: U.S. Christian giving and mission. [https://www.faithtoaction.org/wp-content/uploads/F2A\\_Residential-Care\\_Report\\_Final\\_v.4.pdf](https://www.faithtoaction.org/wp-content/uploads/F2A_Residential-Care_Report_Final_v.4.pdf)
- Basavapatna, S. (2012, July 24). Chins in Mizoram: The case of borders making brothers illegal. *Journal of Borderlands Studies*, 27(1), 61-72. <https://doi.org/10.1080/08865655.2012.687209>
- COVID-19 Tracker. (n.d.) Myanmar. Reuters. Retrieved December 2, 2021, from <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/myanmar/>
- Department of Social Welfare & UNICEF. (2011, August). The situation of children in residential care facilities in Myanmar. [https://static1.squarespace.com/static/5bbab8cbe666692d8fd5f481/t/5c42a51abba22367200f9815/u1547871516942/Residential\\_Care\\_Survey\\_Report.pdf](https://static1.squarespace.com/static/5bbab8cbe666692d8fd5f481/t/5c42a51abba22367200f9815/u1547871516942/Residential_Care_Survey_Report.pdf)
- Gender Concerns International. (n.d.). Ethnic minorities and conflict. Retrieved November 14, 2021, from <http://www.genderconcerns.org/country-in-focus/myanmar/Ethnic-Minorities-and-Conflicts/>
- Griffiths, M. (2018). Networks of reciprocity: Precarity and community social organisations in rural Myanmar. *Journal of Contemporary Asia*, 49(4), 602-625. <https://doi.org/10.1080/00472336.2018.1542450>
- Hogan, L. (2016, December 5). Domestic violence: Customary law discourages divorce. *Democratic Voice of Burma*. <http://english.dvb.no/domestic-violence-customary-law-discourages-divorce/>
- Madihi, K., & Brubeck, S. (2019). Myanmar. Martin James Foundation. <https://bettercarenetwork.org/sites/default/files/2019-08/MYANMAR.pdf>
- Ministry of National Planning and Economic Development, Ministry of Health & UNICEF. (2011, October). Myanmar: Multiple Indicator Cluster Survey 2009-2010. [https://mics-surveys-prod.s3.amazonaws.com/MICS3/East Asia and the Pacific/Myanmar, Republic of the Union of/2009-2010/Final/Myanmar 2009-10 MICS\\_English.pdf](https://mics-surveys-prod.s3.amazonaws.com/MICS3/East Asia and the Pacific/Myanmar, Republic of the Union of/2009-2010/Final/Myanmar 2009-10 MICS_English.pdf)
- Ministry of Social Affairs, Veterans and Youth Rehabilitation. (2011). With the best intentions: A study of attitudes towards residential care in Cambodia. [https://www.thinkchildsafe.org/thinkbeforevisiting/resources/Study\\_Attitudes\\_towards\\_RC.pdf](https://www.thinkchildsafe.org/thinkbeforevisiting/resources/Study_Attitudes_towards_RC.pdf)

- Ministry of Social Welfare, Relief and Resettlement of Myanmar & UNICEF. (2017, September 25). Minimum standards of care and protection for children in residential facilities. <https://bettercarenetwork.org/library/the-continuum-of-care/residential-care/minimum-standards-of-care-and-protection-for-children-msc-in-residential-facilities-in-myanmar>
- Mon, K. H. (2015, May 5). Health and education plan to support Chin women, children. The Irrawaddy. <https://www.irrawaddy.com/news/burma/health-and-education-plan-to-support-chin-women-children.html>
- Naw, T. (2021, July 19). Myanmar plunges into deadly third COVID-19 wave. The Diplomat. <https://thediplomat.com/2021/07/myanmar-plunges-into-deadly-third-covid-19-wave/>
- Nhep, R., & van Doore, K. (2021, April). Impact of COVID-19 on privately run and funded residential care institutions. Better Care Network & Griffith University. <https://bettercarenetwork.org/sites/default/files/2021-06/Impact%20of%20COVID-19.pdf>
- Nhep, R., & Won, H. (2020). Transitioning models of care assessment tool. Better Care Network & ACC International. <https://bettercarenetwork.org/sites/default/files/2020-09/Transitoning-models-of-care-Interactive7.2.2.pdf>
- Pyidaungsu Hluttaw Law No. 22/2019 – Child Law, Article 63(b) (2019). <https://www.myanmar-law-library.org/law-library/laws-and-regulations/laws/myanmar-laws-1988-until-now/national-league-for-democracy-2016/myanmar-laws-2019/pyidaungsu-hluttaw-law-no-22-2019-child-law-burmese.html>
- Scott, J. C. (1972, March). Patron-client politics and political change in Southeast Asia. American Political Science Review, 66(1), 91-113. <https://doi.org/10.2307/1959280>
- South, A., & Lall, M. (2016, February). Schooling and conflict: Ethnic education and mother tongue-based teaching in Myanmar (Policy Dialogue Brief Series No. 15). USAID. [https://asiafoundation.org/wp-content/uploads/2016/12/Policy-Brief\\_Schooling-and-Conflict-Ethnic-Education-and-Mother-Tongue-Based-Teaching-in-Myanmar\\_ENG.pdf](https://asiafoundation.org/wp-content/uploads/2016/12/Policy-Brief_Schooling-and-Conflict-Ethnic-Education-and-Mother-Tongue-Based-Teaching-in-Myanmar_ENG.pdf)
- Thang, R. H. (2019, July). Secularism and religious nationalism: A historical study of ethnic conflict in Myanmar. The Indonesian Journal of Southeast Asian Studies, 3(1), 25-43. <https://doi.org/10.22146/ikat.v3i1.44955>
- UNICEF. (2019, July 24). The enactment of the new Child Rights Law by the Government of Myanmar a landmark step. <https://www.unicef.org/myanmar/press-releases/enactment-new-child-rights-law-government-myanmar-landmark-step-unicef>
- UNICEF. (2019, August 16). Myanmar: UNICEF delivering change for children: Programme brief - Child protection. <https://www.unicef.org/myanmar/reports/programme-brief-child-protection>



- UNOCHA. (2021, January). Humanitarian needs overview: Myanmar. [https://reliefweb.int/sites/reliefweb.int/files/resources/mmr\\_humanitarian\\_needs\\_overview\\_2021\\_final.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/mmr_humanitarian_needs_overview_2021_final.pdf)
- van Doore, K. (2016, July). Paper orphans: Exploring child trafficking for the purpose of orphanages. *The International Journal of Children's Rights*, 24(2), 378-407. [https://www.researchgate.net/publication/305695283\\_Paper\\_Orphans\\_Exploring\\_Child\\_Trafficking\\_for\\_the\\_Purpose\\_of\\_Orphanages](https://www.researchgate.net/publication/305695283_Paper_Orphans_Exploring_Child_Trafficking_for_the_Purpose_of_Orphanages)
- van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Duschinsky, R., Fox, N. A., Goldman, P. S., Gunnar, M. R., Johnson, D. E., Nelson, C. A., Reijman, S., Skinner, G. C., Zeanah, C. H., & Sonuga-Barke, E. J. S. (2020, August). Institutionalisation and deinstitutionalisation of children 1: A systematic and integrative review of evidence regarding effects on development. *The Lancet Psychiatry*, 7(8), 703-720. [https://doi.org/10.1016/S2215-0366\(19\)30399-2](https://doi.org/10.1016/S2215-0366(19)30399-2)