

# **COUNTRY REPORT:**

# **THAILAND**

# Thailand Country Report

## I. Situation of HIV/AIDS affected children

There are some reports on estimation of AIDS orphans in Thailand. The report 'Children on the Brink 2002' was done by UNAIDS, USAID, UNICEF (latest version in 2004). The report (2002) estimated that the number of orphans due to AIDS was 34.8% of total orphans. See table below

### THAILAND: Orphan Estimates by Year, and Cause

Year	Number of Children (x 1000)	Total Orphans as a Percentage of All Children (%)	Total Number of Orphans (x 1000)	Total Number of Orphans due to AIDS	Orphans Due to AIDS as a Percentage of Total Orphans (%)
1990	17,437	5.1	886	< 100	0.0
1995	16,828	5.4	904	63,000	7.0
2001	16,752	6.3	1,048	289,000	27.6
2005	16,787	6.5	1,094	380,000	34.8
2010	16,635	6.3	1,054	374,000	35.5

Source: UNAIDS, USAID, Unicef, Children on the Brink 2002: a Joint Report on Orphan Estimates and Program Strategies, July 2002

The report estimates on the parent(s) lost (maternal orphan, paternal orphan, and double orphans), showed that the largest group was paternal orphans, followed by maternal orphans, and double orphans. It was estimated that in 2005 there were 320,000 orphans who have lost fathers, 84,000 orphans who have lost mothers, and 30,000 orphans who have lost both fathers and mothers. See table below

### THAILAND: Orphan Estimates by Type

Year	Maternal			Paternal			Double		
	AIDS	Non-AIDS	Total	AIDS	Non-AIDS	Total	AIDS	Non-AIDS	Total
1990	< 100	274,000	274,000	< 100	650,000	650,000	< 100	38,000	38,000
1995	< 100	253,000	261,000	58,000	625,000	683,000	4,000	36,000	40,000
2001	54,000	210,000	264,000	251,000	583,000	835,000	21,000	30,000	50,000
2005	84,000	183,000	267,000	320,000	562,000	882,000	30,000	25,000	54,000
2010	95,000	156,000	251,000	303,000	551,000	854,000	30,000	21,000	51,000

Source: UNAIDS, USAID, Unicef, Children on the Brink 2002: a Joint Report on Orphan Estimates and Program Strategies, July 2002

A survey on HIV/AIDS related child abandonment in 1992-1994 found that the ratio of child abandonment after birth among HIV infected mother and non-HIV infected mother was 5.4 per 1,000 deliveries. See table below

**Ratio of abandonment after birth among HIV+ and HIV- mothers per 1,000 deliveries, 1992-1994**

Year of Birth	Ratio of Abandonment after Birth among HIV Infected Mother per 1,000 delivery	Ratio of Abandonment after Birth among Non-HIV Infected Mother per 1,000 delivery	Ratio of Abandonment after Birth among HIV infected Mother and Non-HIV Infected Mother per 1,000 delivery
1992	3.48	0.56	6.2
1993	3.39	0.64	5.3
1994	2.79	0.57	4.9
Total	3.16	0.59	5.4

**Source: Sombat Thanprasertsuk et al, HIV/AIDS Related Child Abandonment: a Survey in Government Tertiary Care Hospital, 1992-1994**

AIDS cases in children, adolescents and young adults reported to the Bureau of Epidemiology, Department of Disease Control, MOPH from September 1984 to April 2005, are as follow:

**Report of AIDS children and youth cases, during September, 1984  
- 30 April 2005**

Age group	พ.ศ. 2527-2544		
	male	female	total
0 -4	4,289 (53.16)	3,779 (46.84)	8,068 (100.00)
5-9	1,460 (51.99)	1,348 (48.00)	2,808 (100.00)
9-14	222 (39.93)	334 (60.07)	556 (100.00)
15-19	963 (45.06)	1,174 (54.94)	2,137 (100.00)
20-24	14,198 (58.74)	10,512	24,710 (100.00)

The Thai Working Group on HIV/AIDS Projections have estimated that in a baseline scenario without intervention, there were 24,662 children living with HIV/AIDS in 2005. In addition, 3,006 new HIV infections and 2,697 new AIDS cases in children were estimated during 2005. See table below

**Pediatric HIV, AIDS and deaths  
in the baseline scenario assuming no intervention**

Year	Pediatric Living w/HIV and AIDS	Pediatric Annual new HIV	Pediatric Annual new AIDS	Pediatric Cumulative HIV	Pediatric Cumulative AIDS	Pediatric Cumulative AIDS deaths
1985	0	0	0	0	0	0
1990	586	496	87	698	117	112
1995	8,818	3,498	1,173	12,172	3,413	3,354
2000	20,052	4,185	2,332	32,961	13,026	12,909
2005	24,662	3,006	2,697	50,620	26,093	25,959
2010	22,780	1,713	2,456	61,684	39,027	38,904
2015	17,525	833	2,005	67,404	49,979	49,879
2020	11,759	434	1,509	70,210	58,526	58,451

Source: The Thai Working Group on HIV/AIDS Projection,  
Projection for HIV/AIDS in Thailand: 2000- 2020, 2001

## II. AIDS affected children' problems

1. There were 10,328 children aged 0-14 years who tested HIV positive. (Statistics from September 1994 to 31 March 2004, Division of Epidemiology, Department of Disease Control, MOPH)
2. The estimation of HIV-infected children in 2006 will be 53,400 cases (Estimated figures from The Thai Working Group)
3. The estimated orphans of both parents from AIDS in 2005 will be 300,000 cases (Estimated by Grally and Tismaeus, 2002)
4. Integrated focus on both groups with and without impact from HIV should be developed and the activities should be proactive and started before the children get HIV.
5. Immigrant and migrant workers impacted by HIV/AIDS didn't have access to services and were largely ignored. It has been suggested that there be volunteers to take care of these children.
6. Those who worked with children and HIV/AIDS were scarce. Teaching activities on giving knowledge and sex education was held over a short time periodically. Working with children should be a quality process and continuously followed.
7. Weakened family capacity and risky community environment presented challenges for support for children.
8. Children were sensitive, suffered loss of self confidence, lacked experience on problem solving and didn't recognize their value.
9. Social value was a hindrance to sex education. There is a need for media that works to protect and build value.

## Problem among AIDS affected Children

Children with HIV+	Children with HIV-
1. Health such as AIDS illness, nutrition, etc.	1. Health such as neglected about food, vaccine, living or lack of carer, etc.
2. Emotion such as lack of taking care, grief from loss of parent, feeling about take pills or often stay at hospital, etc.	2. Emotion such as grief from loss of parent, feeling from knowing HIV status of parent.
3. Education and learning such as risk to quit from school, lack of learning due to illness and delayed development, etc.	3. Education and learning such as risk to quit from school, lack of parent to prepare or support their learning development, not intend to study, etc.
<b>III. Thailand UNGASS Report 2004</b> 4. Rights such as discriminate to receive services due to AIDS, etc.	4. Rights such as heritage, discriminate to study as other children (especially little children), sexual exploitation, etc.

<b>NATIONAL COMMITMENT &amp; ACTION</b> <ol style="list-style-type: none"> <li>1. National Composite Policy Index</li> <li>2. Government funds spent on HIV/AIDS</li> </ol>	\$ US 36,629,182.08
<b>NATIONAL PROGRAMME &amp; BEHAVIOUR</b> <p><b>Prevention</b></p> <ol style="list-style-type: none"> <li>3. % of schools with teachers who had been trained in life-skills-based education and who taught it during the last academic year</li> <li>4. % large enterprises/companies that had HIV/AIDS workplace policies and programmes</li> <li>5. % of HIV + pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT</li> </ol> <p><b>Care/Treatment</b></p> <ol style="list-style-type: none"> <li>6. % of patients with sexually transmitted infections at health care facilities who were appropriately diagnosed, treated and counselled</li> <li>7. % of people with advanced HIV infection receiving ARV combination therapy</li> </ol> <p><b>Knowledge/Behaviour</b></p> <ol style="list-style-type: none"> <li>8. % of respondents, 15-24 years of age, who both correctly identified ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission or prevention (Target: 90% by 2005; 95% by 2010)</li> <li>9. % of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner</li> <li>10. % of injecting drug users who had adopted behaviours that reduced transmission of HIV (<i>where applicable</i>)</li> </ol> <p><b>Impact alleviation</b></p> <ol style="list-style-type: none"> <li>11. Ratio of orphaned to non-orphaned children 10-14 years of age who were currently attending school</li> </ol>	<p>37.9-48.8%</p> <p>50.9 % (TBCA: 2005 research project result) 85.7% (1<sup>st</sup> Oct 2004- 30<sup>th</sup> Sept 2005): PHIMS</p> <p>70.17%</p> <p>45.2%</p> <p>66.8% in urban slum community 59.5% in rural community 55.8% in work places 54.3% in schools</p> <p><b>Male</b> 67.2% in school 72.4% in community (slum area) 74.2% in community (district area) 35.1% in work places</p> <p><b>Female</b> 36.7% in school 57.1% in community (slum area) 66.7% in community (district area) 4.6% in work places</p> <p>25% (Thanyarak Institute)</p> <p>No data available*</p>
<p><b>IMPACT</b></p> <ol style="list-style-type: none"> <li>11. % reduction of young people, 15-24 years of age, who were HIV infected (Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)</li> <li>12. % reduction of infants born to HIV infected mothers who were infected (Target: 20% reduction by 2005; 50% reduction by 2010)</li> </ol>	<p>- 57.9%</p>

\* No Nationwide data system available

#### IV. Lessons learned and country experience in promotion of adherence to antiretroviral therapy in children \*

Children have difficulty in taking drugs and since adherence is a key determinant for the success of antiretroviral therapy, they have to adhere strictly to life-long drug taking disciplines. Most are orphans with psychosocial and economic problems, they have to rely on

caregivers to assist them. We developed strategies to help children understand their disease and to live happily in their society and promote adherence in HIV-infected children.

Antiretroviral (ARV) therapy for children was initiated in June 2002. A multidisciplinary health team was formed including PHA, who had changed their role from care receivers to care givers. They filled gaps between patients and health care workers. They were trained about basic knowledge of HIV, ARV and how to cope with psychosocial problems, do home visits to all children.

Preparation of both children and caregivers was the initial intervention strategy before starting ARV drugs. We prepared caregivers by 2 sessions of group process and children through children's activities.

In group process, knowledge about HIV, opportunistic infection, ARVs and their side effects, the importance of adherence, and treatment plan were given to caregivers.

Children played games and were told the Devimon Virus fairy tale, which enabled them to understand basic information about disease process in simple language they could understand. Playing was a way to communicate with children. PHA also taught them how to take pills.

Criteria for starting ARV drugs was when  $CD4 < 20\%$ , or children were symptomatic (Category A, B or C) and readiness of children and caregivers. Cotrimoxazole and fluconazole were given for 2 weeks as a test for adherence.

We set our goal for adherence to be more than 95%. Children should not miss more than 3 doses of ARVs for each monthly visit and should take at exact time 12 hours apart, and should not delay more than half an hour.

If the adherence was good, children received first line ARV regimen consisting of 2 NRTIs and 1 NNRTI. Some ARV drugs were in syrup formulation; others were in tablets or fixed dose combination forms used for adults.

During monthly follow-up visits, children are grouped according to age to participate in different activities. Various tools were used at each session while waiting for physical examination: books, games, modeling with practicing, drawing, painting, video cartoons, diaries, calendars and stickers. Books for small children contained fairy tales mostly with pictures in vivid colors told by the health team; those for older children aimed to encouraging life skills and strengthen the children's own potential, promoting adherence and disclosure. Games provided encouragement and introduced the concepts of healthy food, the virus, and how to take ARV drugs correctly. The activities were conducted by nurses and PHA; each session lasted about 1 hour.

Laboratory parameters were followed at regular intervals, CD4 every 3 months and viral load every 6 months.

Other simple adherence tools were:

1. **Unit dose:** PHA prepared ARV drugs in unit dose for each meal.
2. **Calendars and stickers:** Children put stickers of famous cartoons for each dose of ARV drugs taken; they could write side effects on the calendars.
3. **Drug diaries:** For older children, they recorded ARV drugs in the diaries.
4. **Alarm & cue dose:** Children used clocks or specific events as reminders for ARV drugs, for example, national anthem in the morning or headline song in the TV evening news.
5. **DOT:** ARV drugs were taken under the observation of caregivers.
6. **Home visit:** Home visit was very important to further assess adherence and psychosocial issues.
7. **Recreation:** Recreational camps outside the clinic were held every 3 months.

8. **Disclosure** : Adherence was maintained after disclosure.

Sixty-three children participated in the activities. Small children enjoyed games and role plays, cooperated with medication taking, realized the importance of adherence and formed good relationships with others, while older ones could exchange ideas and experiences, help each other, increase their potential and life skills to have positive ideas in living in society. All of them were willing to attend the clinic without losing to follow-up. At the same time, the health team discussed with caregivers for any psychosocial problems. The mean adherence was 96% by various methods of assessment.

**Evaluation of adherence**

1. **Pill counts:** 96%.
2. **Self-report:** 98%, from asking questions, calendars and diaries.
3. **Intention to attend hospital visit:** 100%. No one missed any hospital visit.
4. **Home visit:** 96%. Two children had inadequate adherence.
5. **Labs:** Mean percentage of CD4 and log viral load was 5%, 5.0 before treatment and 34%, 1.7 after.

Resistance developed in 2 ARV-experienced children.

**Lessons learned**

Multiple strategies are needed to promote adherence in children. Preparation of caregivers and children by multidisciplinary approach is essential before ARV therapy. First line ARVs are easy, effective and safe. PHA are essential parts of a team, they are living tools for adherence, they fill gaps between patients and health care workers. Children's tools designed to be suitable for each age group are effective in communicating with children. They are entertaining, but more importantly can be used as psychological tools to explore children's minds and ideas. Support by their family caregivers helps reach the ultimate goal of promoting adherence.

**Obstacles and challenges to pediatric ARV therapy**

**Obstacles**

1. Children in families with low socioeconomic status: Due to parental loss, most children were under the care of elderly members in family, relatives and foster home as 40%, 30% and 10% respectively.
2. Social unpreparedness: Nearly all of our children experienced at least once rejection by their friends, neighbors or even their teachers. They face difficult questions of discrimination and stigmatization that discourage their participation at school.
3. Few suitable formulations for children: Only 4 ARV drugs were in syrup formulation, others were in tablets or capsules that might cause a problem of drug taking especially in small children.
4. Inadequate number of personnel in the team: It was difficult to persuade health personnel to participate in ARV Project since they were overwhelmed by their routine work. Our staff worked in HIV clinic on voluntary basis; they wanted to help these disadvantaged children.
5. Economic support for PHA: Most of the PHA who were members in our team had no career by which they could earn their living. They needed economic support so that they could work for us to be a part in the health team.

**Challenges**

1. Disclosure should increase adherence: Disclosure is a difficult task for both caregivers and health care workers for fear of stigmatization and serious implications possibly affecting adherence. In our setting disclosure in children should be encouraged as soon as they can understand their illness. Cooperation between caretakers and health team is necessary to reduce psychological impact on children.
2. Fixed dose combination: Children have to take drugs from the adult formulation since there are very few preparations that are appropriate for them. Four ARV drugs are in syrup formulation, others are in tablet forms used for adults. Children do not like to

take syrup because of bulky volume. Fixed dose combination may be a solution for children.

3. Teaching media: Communication can build understanding between children and their caregivers and it is effective as a means to help them understand their disease and disclose to them with a supplemental support from the health team. Psychosocial problems are relieved and children can live happily in the society. We should develop more communicating tools that are simple and inexpensive.
4. Increase the coverage of PMTCT: The effective and practical strategy to reduce the number of children with HIV is to prevent transmission of mother to child. Education is important to make people understand HIV and how to prevent infection.

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\*\* Rawiwan Hansudewchakul Chiang rai hospital, Thailand

## V. Policy on AIDS affected children

- The Thai Prime Minister Dr.Thaksin Shinawatra has stated that solving poverty with success and sustainability requires giving an opportunity for education to all, especially children and youth in difficulties, along with other measures.

- The Thai government has a policy to share the benefit of government lottery to provide scholarships for poor children and children in difficult situation. The Thai cabinet has approved a resolution and appointed the committee on strategic development to solve problems among poor children and children in difficulties. (Information from website; [www.rakdek.co](http://www.rakdek.co), and [www.moe.go.th/scholarship\\_essay/schlarship\\_essay\\_1.htm](http://www.moe.go.th/scholarship_essay/schlarship_essay_1.htm))

- The Thai Prime Minister Dr.Thaksin Shinnawatra, in his speech about policy and direction of HIV/AIDS prevention and alleviation in Thailand at the 15<sup>th</sup> International AIDS Conference, on July 15, 2004, included the issue of HIV/AIDS affected children. D Thaksin announced that the Thai government will provide ARV treatment for HIV/AIDS infected children and scholarships for 13,000 AIDS orphans. (Report on the 15<sup>th</sup> International AIDS Conference, July 15-17, 2004)

### Government implementation for poor children and children in difficulties

**Background:** On March 2003, the Thai Prime Minister assigned Deputy Prime Minister Chaturon Chaisaeng to invite all relevant organizations for a workshop on how to provide scholarships for children and youth in poor families and in difficulties. This workshop submitted a proposal to the Thai cabinet, which was approved on July 8 and September 5 2003, to invest some benefits of the government lottery in education. AIDS affected children are one of the 7 groups of the poor or people in difficulties that should benefit.

In 2004, there were 6 large governmental projects to address the problem of poor children; 4 projects of the Ministry of Education and 2 projects of the Ministry of Social Development and Human Security. In addition, there were many small projects submitted by other organizations, including NGOs addressing street children, handicapped children, and AIDS affected children. The budgets were released during 2 rounds; 1<sup>st</sup> round for 23,929,191 Baht, and 2<sup>nd</sup> round for 29,586,796 Baht.

For AIDS affected children, the Ministry of Public Health received the afore-mentioned budget from the government lottery to provide scholarships for 1,100 children on April 22, 2005. A total of 8,000 scholarships are in process to support education for AIDS affected children.

### 1. The Ministry of Social Development and Human Security

The Ministry provides social support for PHA and their families through the following:

- 1) 4 institutions for HIV infected children, orphans, neglected children due to HIV infected father and/or mother at Chiang Mai, Bangkok, Udorn Thani, and Songkla.

2) Financial and in-kind support for children in HIV infected families (father and/or mother). The financial support depends on the needs and appropriateness and varies from 1,000-2,000 Baht per family with 1 child up to 3,000 Baht for more than 1 children.

3) Assistance for children in family and community

3.1) Services for children in family: The services are counseling for children, mother, father and parents, or help in vocational funding, occupation, educational support for children, etc.

3.2) Foster Family

4) Child Adoption

## **2. Ministry of Education**

The Ministry of Education provides compulsory education for all children free of charge, and is currently implementing an improved sex education curriculum, as well as extending the coverage of the curriculum to all schools.

## **3. Ministry of Interior**

- Local Governance is supporting HIV/AIDS activities in coordination with other organizations in community to care and support PHAs and their families including children affected by HIV/AIDS. However, the capacity and involvement of Local Governance are different in each area and depends on several factors e.g. HIV/AIDS situation, financial capacity, strong community network on HIV/AIDS, etc.

## **4. NGOs and PHA Groups**

In Thailand NGOs and PHA Groups have an active and important role in care and support for HIV/AIDS affected children:

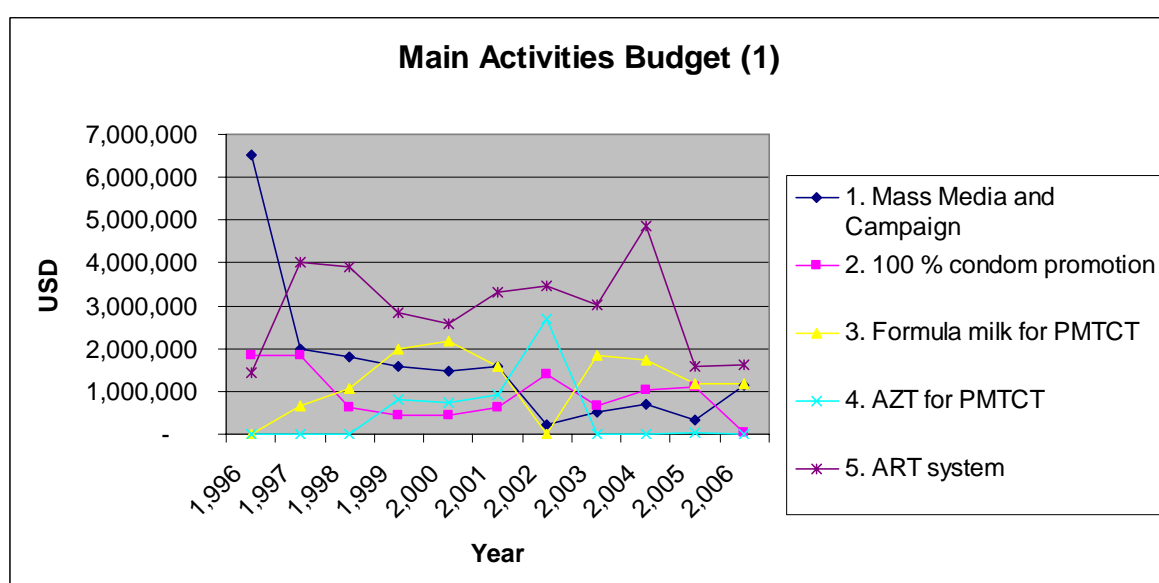
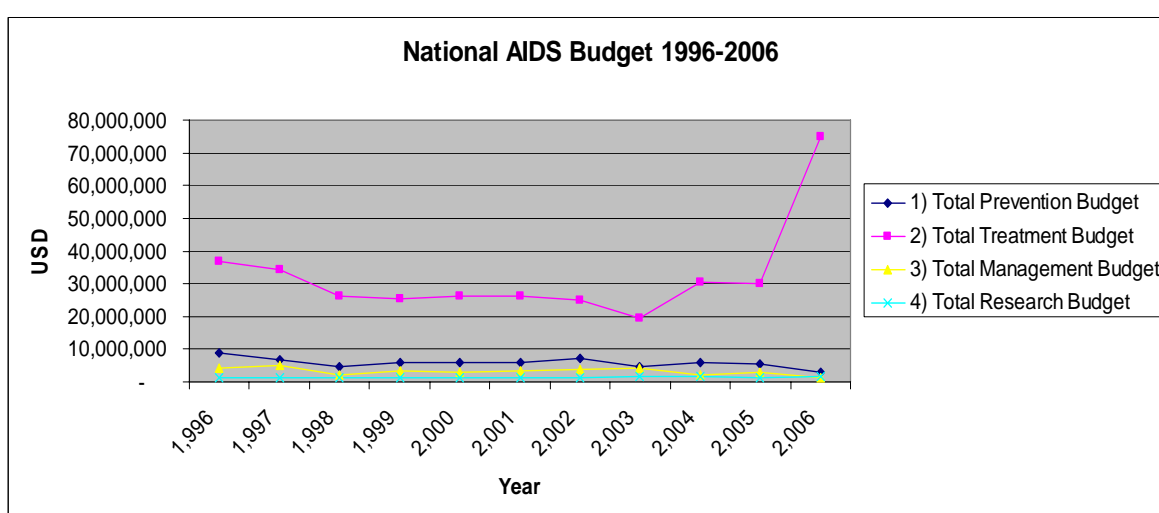
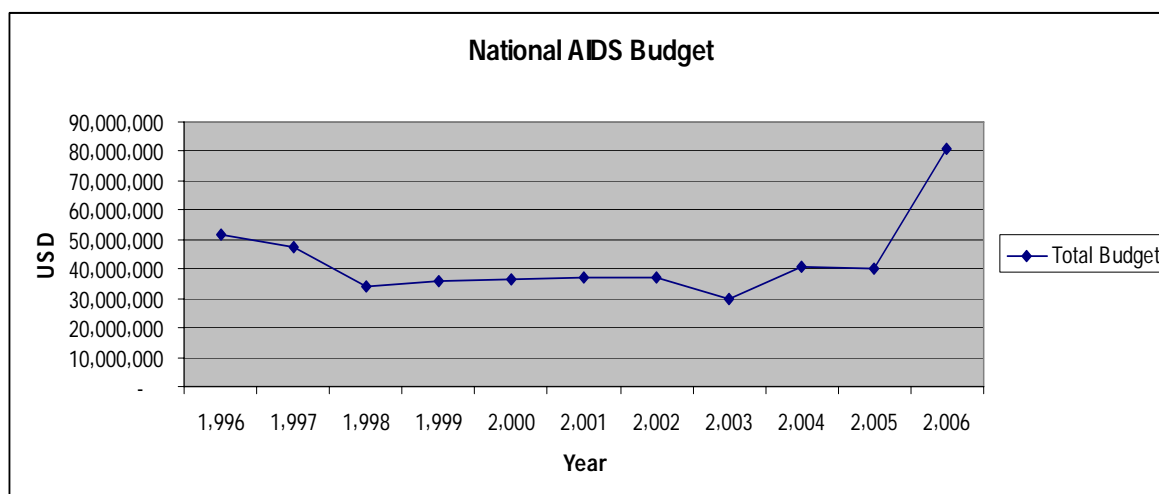
- Educational support in order to maintain these children in school such as financial support, counselling to guide their scholarship, etc.
- Sex education through groups, camp activities
- Development of care model to support emotional problems among these children
- Families support to take care of these children e.g. skills training, counseling, etc.

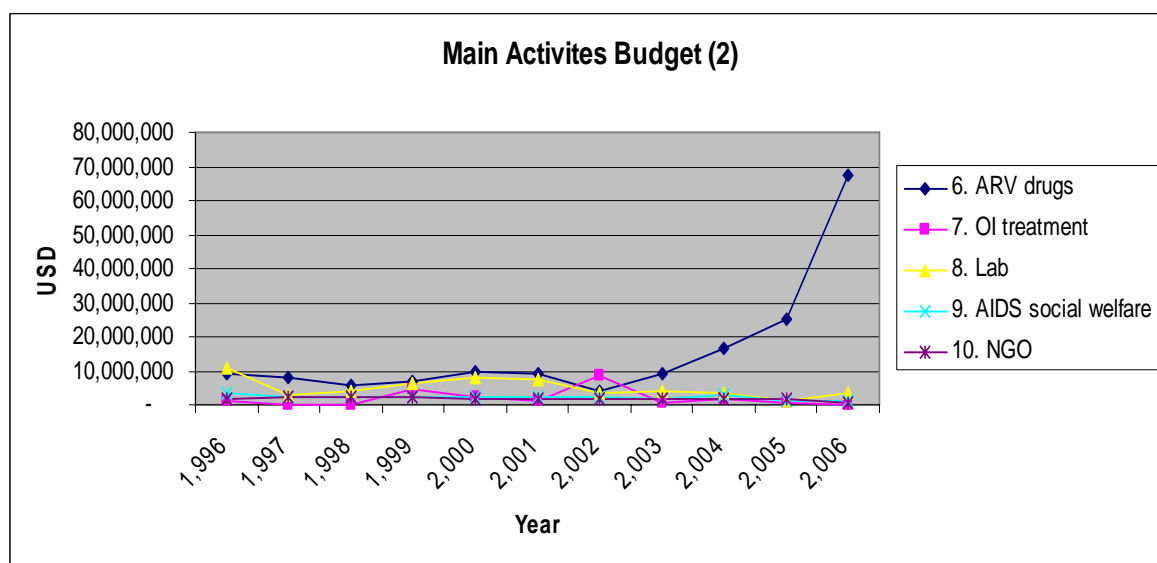
## **VI. Thai National Strategic Plan on HIV/AIDS Prevention and Alleviation during 2002-2006**

The Thai National Plan on HIV/AIDS Prevention and Alleviation mentions that providing educational support for HIV/AIDS affected children is an important social welfare measure, which can assure self-reliance among these children in the future. However, support should not discriminate and separate the AIDS affected children from children in general.

### **National AIDS budget**

Level and trends in government AIDS program spending reveal a loss in momentum in the late 1990s. Total government funding for AIDS programs declined by 8% between 1996 and 1997 and by 27 % since the economic crisis (1997-1998). In 1998, the Royal Thai Government spent \$ 37.9 million from its national AIDS program budget, which included budget lines to prevent transmission of HIV, care for and treat AIDS patients, mitigate the impact of AIDS, and support AIDS research. From 1999-2002 the national AIDS budget was stable between \$35.98-37.17 million. After 2002, the government integrated \$12 million for AZT, PMTCT and OI treatment of the AIDS budget into the 30 Baht Health scheme so that, in 2003, government funding sharply dropped to \$7.11 million following by a gradual increase to \$11.04 million, in 2004. and an increase from 2003 to \$9.84 million in 2006 (see below).





## VII. Challenges and Recommendations for strategy on children affected by HIV/AIDS

Orphans and other children; such as, street kids affected by HIV/AIDS are facing difficulties, because often they are neglected; not receiving good care and have been abused in many ways. In addition, these children are vulnerable and do not have good opportunities in their lives. Especially, children who do not have parents, they will be easily led to drugs, sex industry, and HIV infection. To tackle such problems, collaboration in the network is needed continuously. The system will provide support to enable children to strengthen their capacity and live effectively in society in the future.

Recommendations for strategy of HIV prevention and solution for children affected by HIV/AIDS during 2007-2011 should be focused on;

1. Creating social immune systems for children at an early age since they are entering primary school, for example by increasing their self-esteem.
2. Improving surveillance system to update and report on HIV/AIDS affected children's problems; to provide appropriate support, and prevention; and to strengthen their capacity.
3. Promoting networking among the government, private sector, school, and community at all levels.

Reviewing past experiences working with children affected by HIV/AIDS both policy, implemented activities and working process found that the work has been far from successful. These challenges include;

- Most policy and implementation development is based on adult-oriented supervision. No holistic approaches as well as still vague in policy;
- Lack of information on both prevention as well as self esteem building in youth;
- Most of the implemented activities have been developed for adults but only quite rarely for youth, for example ARV treatment which was designed for adult PHA. Moreover, youth coordination has been limited - some adults feel that working with youth is complicated and quite limited in regard to effective resources for working with youth more effective. This illustrates insufficient HIV/AIDS awareness among youth.
- Policy and strategies have not been clearly spelled out, particularly lack of support policy for school continuation of children affected by HIV/AIDS

- Limitation of collaboration among related agencies, for instance children's rights organizations. Although the responsible agencies exist, there is no linkage or proper referral system.
- Limited well-working experiences for children affected by HIV/AIDS, especially at provincial level. Working on HIV/AIDS has been separated from the other youth organizations which resulted in no connection and sharing experiences.
- It needs long term working strategy in order to build youth self esteem. Enabling environment from family and social level is crucial.
- Parent attitude should be improved in order to provide comprehensive information for young people in family. Information emphasize on prevention, but still lack of skill building.
- No government commitment on young people issues which require long term commitment

### **Recommendations for HIV affected children's strategy**

#### **1. Service system**

##### *1) Health service unit*

- Make ARV treatment accessible for all who need it
- Strengthen capacity of medical personnel, referral and monitoring system.
- Promote PHA involvement in taking care of HIV affected children
- Improve regimen appropriate for children
- Strengthen health system to get children's care providers and children to be well prepared for treatment.
- Make a counseling and HIV testing for pregnant women continuously and effective to prevent HIV infection.
- Organize activities for AIDS children who are hospitalized

##### *2) School*

- Develop Child-Friendly teaching system
- Train teachers to understand HIV/AIDS and children so that they have HIV/AIDS knowledge, positive attitude, and counseling and communication skills and can apply them to provide support to children.
- Develop systems that provide immediate and effective support to HIV infected and affected children. Teachers or social workers with counseling skills are needed.
- Improve teaching system to be consistent with the existing problems for children such as AIDS children who cannot go to school. (Not only for education in school)
- Increase HIV awareness of school's executives to organize HIV activities
- Organize activities that strengthen capacity and self-esteem of children.

##### *3) Social welfare unit*

- Promote occupational activities between HIV positives and negatives (for example the "Positive Partnership" project implemented by PDA)
- Support and expand "Foster care" for children affected by HIV
- Provide aggressive counseling services to children and youth. (not only provide the service in the health center)

##### *4) Rights protection unit*

- Raise awareness on children's rights and responsibilities to provide protection to children among relevant personnel.
- Emphasize on networking to exchange experiences.
- Expand "Core Volunteer" system and children's rights protection group to provide support to children.
- Raise awareness on current problems in the general public, and policy level to make clear and continuous movements.
- Integrate protection activities for children's rights with existing protection systems of Ministry of Social and Human Security Development.

## 2. Community

- Encourage communities to mobilize its resources in providing care, social welfare for children and family affected by HIV/AIDS. This approach will become long-termed sustainable.
- Strengthen community economic capacity which leads to other development and problem's solution. A variety of relevant agencies are needed.
- Establish a center to provide support and referral services in the community level (Who should be responsible, how to establish)
- Encourage communities to take a role in providing support to children without stigma and discrimination.
- Set up working groups or networking to provide an effective monitoring and referral system in community level; such as, hospitals, health centers, PLWHA groups, core volunteers, and schools. Most important issue is how to strengthen community's capacity to;
- Work collaboratively with networks or working group in the community level. Confidentiality system is needed. (Not disclose HIV status of PHA)
- Have knowledge, understanding, attitude and awareness on living together with PHA, and skills in providing support to children. The intervention should not be only training courses, but also includes other activities that provide continuous learning process and positive concept of capacity of PHA.

## 3. Family

- Promote capacity of family to understand children's problems and to provide care, and counseling

## 4. Children/Young people

- Enable children to access to information, prevent to themselves from problems, and to improve their capacity.

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