Review of Alternative Care in Thailand

Policy to Implementation with Special Focus on Children Affected by HIV/AIDS (CABA)

May 2015

Synthesis Report

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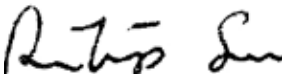
Message from the Management

Thailand has ratified the Convention on the Rights of the Child (CRC) since February 1992. The Convention details the fundamental rights that all nations must guarantee for their children. These include children's rights to survival, development, protection, and participation. Emphasize is made to family-based caretaking of children, prevent separation, and provide foster homes when appropriated.

The Review of Alternative Care in Thailand is a collaborated effort between the Ministry of Social Development and Human Security, and UNICEF. It aims to analyze factors that send children to alternative care system, make them a success, as well as other challenges of HIV-infected children. In addition, the project's objectives also include analysis of consisting measures, review of related policies and legal framework, in order to improve alternative care systems in Thailand with the best interest of children at heart.

The Department of Children and Youth, Ministry of Social Development and Human Security, as the main agency responsible for children's welfare, would like to give heartfelt thanks to UNICEF who acted as the main sponsor, as well as gave academic information and advice, including the budget needed. In this regard, The Department of Children and Youth fully realizes the issues and challenges that emerged from this study, as some legal framework and policies are still not complying to the CRC, and there is still insufficient resources needed for good governance. As such, the Department of Children and Youth will use such information to help improve the quality of alternative care in Thailand for the future.



Mrs. Rarinthip Sirorat
Director - General
Department of Children and youth
May 2015

FOREWORD

Every day children continue to be separated - sometimes temporarily but too often permanently - from their families. Many factors contribute to this, including abuse and neglect, the death of the parents, poverty, HIV/AIDS or other health issues, emotional or behavioural difficulties, and migration.

The United Nations Convention on the Rights of the Child (UNCRC) stresses the importance of family in children's lives and emphasises the direct responsibility of governments to promote family care and reunification, and to provide appropriate alternative care for all children who have lost the care of their parents. The "Guidelines for the Alternative Care of Children" that were approved by the UN General Assembly in 2009 along with several child development studies conducted over many years and multiple settings, all confirm the value of a family upbringing and suggest that alternative care be seen as a last resort, once all other means of keeping them with their parents or extended family have been explored and excluded. The selection of the type of care forthese children is also crucial and the authority in charge needs to be able to match the care setting with the individual child's needs. This means that countries must invest in the development of family-based and other care settings to provide the most appropriate option for each child.

UNICEF Thailand recognises and deeply appreciates the commitment and leadership of the Ministry of Social Development and Human Security, especially the Department of Children and Youth, in conducting the "ReviewofA/ternative Care in Thailand: Policy to Implementation with Special Focus on Children Affected by HIV/AIDS (CABA)" The review enhances understanding of the current situation of children deprived of parental care in Thailand and of how different types of care are managed and provided.

UNICEF Thailand is confident that the result of the review will both inform and inspire government agencies, organizations and practitioners to develop the best possible rights - based solutions; to ensure the best possible care of these children and to ensure that their rights are fulfilled.

Bijaya Rajbhandari
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ACKNOWLEDGEMENTS

The Review Team at the School of Global Studies, Thammasat University appreciates the opportunity given by UNICEF to conduct critical research on the situation of children in various forms of alternative care. We wish to sincerely thank the UNICEF staff, particularly, Mr. Robert Gass, Ms. Sirirath Chunnasart, Ms. Patricia Lim Ah Ken, Ms. Beena Kuttiparambil, Ms. Victoria Juat and Mr. Peter Gross who have provided valuable insight, comments, and support throughout the implementation of this study. Equally critical to the completion of this study is the guidance given by the Technical Working Group and Steering Committee members that composes of a complementary mix of vital players in this field who have extensive and knowledge on this matter.

Lastly, this study would not have been possible without the contribution and participation by the staff involved in various fields of alternative care and child protection. We are grateful for their patience and tireless effort in providing us with information and insights into their work, which serve as the foundation in which we were able to draw conclusions and make appropriate recommendations.

The content of this report primarily reflects the analysis and views of the authors based on the data collected through the review.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BMR	Bangkok Metropolitan Region
BWCPW	Bureau of Woman and Child Protection and Welfare
CABA	Children Affected by HIV/AIDS
CAC	Child Adoption Centre
CBO	Community-Based Organisation
CPCR	Centre for the Protection of Children's Rights
CPMS	Child Protection Monitoring System
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisations
DSDW	Department of Social Development and Welfare
FBC	Family Based Care
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IDP	Individual Development Plans
M&E	Monitoring and Evaluation
MDT	Multi-Disciplinary Team
MOE	Ministry of Education
MOI	Ministry of Interior
MSDHS	Ministry of Social Development and Human Security
NGO	Non-Government Organisation
NSO	National Statistics Offices
PSDHS	Provincial Social Development and Human Security office
SN	Special Needs
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children's Fund

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GLOSSARY OF WORKING DEFINITIONS

Alternative care is when children are cared for by institutions or individuals other than their biological parents – this can include care by facilities such as orphanages or shelters, or by family systems such as foster families or wider kinship networks (for example, the child's grandparents). Alternative care may take the form of:

> ***Informal care:*** any private arrangement provided in a family environment, whereby the child is looked after on an ongoing or indefinite basis by relatives or friends (informal kinship care) or by others in their individual capacity, at the initiative of the child, his/her parents or other person without this arrangement having been ordered by an administrative or judicial authority or a duly accredited body;
> ***Formal care:*** all care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measures. [1]

Biological Parents: A father and/or mother who is connected to their child by direct genetic relationship

Case Management: As our findings point to the need to address complex webs of vulnerabilities affecting children and their families through a system approach, these working definitions of case management appear particularly useful:

*"**Case management** encompasses referral mechanisms and requires an individualised and time sensitive perspective from early detection, management of referrals across sectors and services and follow-up. **Community case management** refers to mechanisms building on the community as being the main entry and focal point for case management, referring to identification of vulnerable children, detection of needs, referrals to services and following up. **Case management with a family focus** emphasises that the needs and vulnerabilities are not independent of those from other family members and that the response to the individual child should go hand-in-hand with a response to the family as a whole."* [2]

Child: A person below 18 years of age, but does not include those who have attained majority through marriage [3]

Child sensitive social protection (CSSP): Definitions of the concept of CSSP primarily emphasise addressing multiple vulnerabilities children and their care-givers face, human capital investment and make reference to target groups and mechanisms. For example, Temin (2008) refers to the term of child sensitive social protection as *"the range of economic and noneconomic social protection interventions that need*

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[1] UN (2010). Guidelines for the Alternative Care of Children. United Nations, Geneva.

[2] Institute for Development Studies and Centre for Social Protection (2012). Pathways to protection – referral mechanisms and case management for vulnerable children in Eastern and Southern Africa. Lessons Learned and Ways Forward. (page 3)

[3] Child Protection Act, 2003 (2003). Kingdom of Thailand.

to be strengthened if the most vulnerable children and [their] families are to benefit. These include (but are not limited to) cash transfers, social work, early childhood development centres and alternative care." [4] **CSSP requires** a shift in focus from a primarily 'welfare' response to broader socio-economic and cultural concepts of vulnerability. Ultimately this means a focus on measures to reduce social inequities.

Children Affected by HIV/AIDS (CABA) includes two categories:

Children affected but not infected – A child who have lost parents to AIDS, as well as those individual boys and girls whose wellbeing or development is threatened because they live in HIV- affected households and communities [5]

Children living with HIV - Children who are infected with Human Immunodeficiency Virus

Children with Special Needs: children who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various attitudinal and environmental barriers, hinders their full and effective participation in society on an equal basis with others [6]

Children with Multiple Special Needs: Children who may have more than one long-term physical, mental, intellectual or sensory impairments [7]

Foster Care: Family-based care provided by a person/s who take on and care for a child as their own offspring; [8] situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family other than the children's own family, that has been selected, qualified, approved and supervised for providing such care. [9]

Government Boarding School: Provides basic education and special assistance for children with limited opportunities. This includes groups of children who face various problems, children who come from unsuitable living environments, or children who need special social assistance. Such assistance is intended to develop their lives and well-being in accordance with their age and full potential. More specific target groups include trafficked children, child laborers, street children, child prostitutes, abandoned children, orphaned children, abused children, extremely poor children, ethnic minorities, children with drug addiction, children affected by HIV/AIDS, children with chronic diseases, children from juvenile correction centres, and children from child and youth protection centres. [10]

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[4] Temin (2008), Expanding social protection for vulnerable children and families: learning from an institutional perspective. Prepared by the Interagency Task Team (IATT) on Children and HIV/AIDS: Working Group on Social Protection

[5] UNICEF (2011). Taking Evidence to Impact: Making a Difference for Vulnerable Children Living in a World with HIV and AIDS, UNICEF, New York.

[6] Adapted from UN (2007). Convention on the Rights of Persons with Disabilities. United Nations. Retrieved on 1 May 2015 from http://www.un.org/esa/socdev/enable/faqs.htm.

[7] Adapted from UN (2007). Convention on the Rights of Persons with Disabilities. United Nations. Retrieved on 1 May 2015 from http://www.un.org/esa/socdev/enable/faqs.htm.

[8] Child Protection Act, 2003 (2003). Kingdom of Thailand.

[9] UN (2009). Guidelines for the Alternative Care of Children. United Nations, Geneva.

[10] Ministry of Education. Self-sufficiency Economy. Retrieved on March 15, 2015 from file:///C:/Documents andSettings/Administrator/Desktop/โรงเรียนศึกษาสงเคราะห์.pdf.

Individual Development Plans: An Individual Development Plan (IDP) is a plan created and agreed by those people most closely involved with supporting a child or young person including parents/carers. As much as possible, the development of an IDP should involve the child. An IDP may include but not limited to:

- Child's name, date of birth, gender, age and other demographic information as necessary.
- Any special need or challenges the child may have e.g. for specialist medical care and how this will be provided.
- Who has a dedicated professional responsibility to support the child and her/his family or care-givers.
- Roles and responsibilities of those who have a dedicated professional responsibility to support the child and the family; how they will coordinate and record data.
- What information parents, carers and the child provide to support the plan e.g. the child's interests.
- Why a plan is needed, what it hopes to achieve for the child & family (e.g. reintegration into family-based care, developing specific emotional and social competencies e.g. managing disclosure of their HIV status, managing safely becoming sexually active, etc.)
- Activity ideas and experiences that would engage & extend the child's interest and development.
- Resources that may be needed e.g. access to social protection, information/preparation for the child and the family or care-givers.
- Settings where the plan will be implemented with a focus on encouraging interactions of the child with other children and the community.
- Expected time line with milestones.
- When the plan will be reviewed and how (who will be involved), including documenting progress and ways forward, and how to ensure the child's involvement.

Institutionalisation: this can be defined in terms of the practices that characterise residential care facilities. International reviews have shown that residential care tends to create institutionalisation if it focuses on practices such as:

- isolating or limiting participation of children from the mainstream community, providing little opportunity for inclusion in normal everyday life and experiences;
- housing relatively large groups of non-family members who are compelled to live together in regimented ways;
- resulting in prolonged periods of separation from the child's family, friends and community;
- organizing daily life according to a regimented routine that cannot respond to the individual needs and wishes of the children; and
- separating children from the community due to a diagnosis of disability and/or chronic illness. [11]

[11] Mulheir G. Deinstitutionalisation – A Human Rights Priority for Children with Disabilities. The Equal Rights Review, Vol. Nine (2012, 117-137)

Kinship Care: Family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature, [12] [13]

Reintegration into family-based care/settings: This can include returning the child to his/her biological parents, integrating the child into foster or kinship care systems, or adoption.

Residential Care: Care provided in any non-family based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other forms of short and long term residential care facilities, including group homes [14]

Within the context of Thailand, government residential care is further defined by the following categories as stated in the Child Protection Act, 2003:

Reception Centre: A place where a child is temporarily sheltered and cared for with the intention of tracing and observing the child and his or her family so as to develop guidelines for appropriate provisions of assistance and safety protection to each individual child

Welfare Centre (Home for Children): A place which provides care and development for over six children in need of assistance

Welfare Protection Centre: A place, which provides education, discipline and occupational training to a child who is in need of protection in order to correct his or her behaviour, and provide treatment and rehabilitation for the child's physical and mental conditions

Development and Rehabilitation Centre: A place, school, institution or centre established for the purpose of treatment and rehabilitation of the physical and mental conditions of a child who is in need of special welfare assistance or protection, as well as providing such child with education, guidance and occupational training.

Often defining residential care for children tend to focus on the number of children living together in one building. This does not always provide a complete picture: a small group home with 15 children might have a staffing structure and principles which means it functions in a family-like and inclusive way, whilst another with eight children might maintain an isolated, rigid and regimented system similar to that in a large institution. However, what is most important is the practices that determine whether a facility result in institutionalisation of children (please refer to the definition of institutionalisation above).

Family Separation: Within the context of this Review, 'separation' refers to situations when children no longer live with their biological parents and are instead cared for either by institutions (government or private) or by relatives (e.g. grandparents), neighbours, friends or by other families who may not have had a previous connection with the biological parents (e.g. adoptive families). [15]

[12] UN (2009). Guidelines for the Alternative Care of Children. United Nations, Geneva.

[13] Subcommittee for Alternative Care Strategy (2011). The National Strategy on Alternative Family-based Care: Draft. Thailand.

[14] UN (2010). Guidelines for the Alternative Care of Children. United Nations, Geneva.

[15] Working definition developed by the Alternative Care in Thailand Review Team, 2014.

Inequity: avoidable inequalities between groups of people [16]

Risk: exposure to separation and/or institutionalisation [17]

Social Protection: Social protection is the set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation [18]

Disclaimer:
It is also important to clarify the use of special needs (SN) and children affected by HIV/AIDS (CABA) terminology in this study: UNICEF, the TWG and the Review Team are cognizant of the potential risk of contributing to stigma and discrimination through use of labels to define population groups. The SN and CABA terms reflect current international practice and were agreed with UNICEF and the TWG only for the purpose of describing the issues underpinning vulnerability for these children. Therefore, these terms point to specific issues that the social context should address to ensure children's well-being and do not imply to confine or stigmatize any child within limiting social or individual labels.

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[16] WHO (2015). Social Determinants of Health. World Health Organization. Retrieved on 19 May 2015 from http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/.

[17] Ibid.

[18] UNICEF (2012) Integrated Social Protection Systems. Enhancing Equity for Children. UNICEF Social Protection strategic Framework. NYHQ

EXECUTIVE SUMMARY

Over the last 15 years, Thailand has made significant progress towards placing alternative care for children within the broader legal and policy context of child protection. However, there are still significant challenges in the content of the legal framework and the operationalization into policy. This situation is largely due to the fragmentation of the current legal and policy framework governing child protection that results in an insufficiently coordinated multi-sectoral approach, confusion of roles, responsibilities, and accountability at all levels.

The inadequate harmonization of the current legal framework with the Convention on the Rights of the Child is evident in the 2003 Child Protection Act (Art. 33) which in principle allows long-term institutionalisation– up to 24 years of age – and thus undermines efforts to prioritize family-based care. This runs counter to the principles of the UN Guidelines of necessity, suitability as well as the best interest of the child and substantially undermines gatekeeping practices. These legal and policy weaknesses reinforce socio-cultural perceptions of residential care and long-term institutionalisation as a necessary and often only option to provide care for children in need of alternative care, especially children living with or affected by HIV/AIDS (CABA) and children with special needs. In a context in which stigma associated with HIV and disability is still pervasive, especially in government schools, these children are particularly at risk of long-term institutionalisation.

Additionally, due the disproportionate focus on meeting standards of care (such as shelter, food, clothing, cleanliness) and the emphasis on assessing residential care facilities on meeting such standards, there is still insufficient focus on prioritizing re-integration into family-based care. Reintegration efforts are further undermined by the fragmentation of the alternative care systems in which many different authorities have responsibilities for different aspects but without any formal guidance defining roles and responsibilities, mechanisms for coordination and most importantly for accountability. In such a context everybody is responsible but nobody is ultimately accountable.

The private sector, especially for residential care, and both registered and unregistered, operates with very limited accountability to government authorities. It appears to function as a parallel system with its own standards of care and management processes which vary significantly facility by facility. This lack of oversight is due to the fragmentation of the legal and policy guidance which results in private sector facilities being registered sometimes with both the MSDHS and the MOI for different purposes but receiving very limited or no oversight by either of these authorities. This is particularly concerning as private facilities tend to care for a higher proportion of children living with or affected by HIV/AIDS. A similar situation characterises boarding schools which are under the jurisdiction of the MOE and that tend to function as residential care facilities, often accepting children referred by government facilities that cannot provide care for children living with HIV or with other special needs, and especially ‘behavioural problems’ which often are not precisely defined or diagnosed.

In contrast to the principles of the UN Guidelines, both in the government and private sectors most of the resources for alternative care is being used for residential care with limited focus on preventing family separation or supporting family based care. The ceiling-based design of the formal kinship care system is in itself a structural barrier to prioritizing family-based care because it limits access to support to 5,000 children at any given time and allows these children to receive support for many years till they reach the age of 18 as long as their care-givers continue to meet assessment criteria. This means, very few new children are able to officially enter the formal system each year and in order to support more children, authorities involved in formal kinship care end up reducing the official allowances without any official guidance or criteria to guide their decisions. This strategy clearly raises concerns in terms of equity and sustainability. The limitations in the formal kinship care programme represent a missed opportunity in Thailand where traditionally kinship care is largely accepted and practiced and significant numbers of children live in informal kinship care situations.

Foster care remains at the margins of the alternative care system due to socio-cultural biases against non-kin related care that appear to be reflected in the current policy framework. Foster care remains confined at the periphery of the alternative care system and limited to a few small programmes, which are fragmented and have never been fully integrated with kinship or residential care. In practice, this cultural and policy marginalization precludes consolidating foster care as one of the components of alternative care.

These issues compound social drivers of family separation and institutionalisation, which include poverty, abandonment, abuse and neglect, and ageing care-givers among others. The current system tends to be reactive with limited focus and resources on preventing separation. Moreover, it tends to focus on individual drivers and it is not designed to prevent or mitigate complex webs of vulnerabilities resulting from the intersections of multiple drivers. The reactive nature of the system is reflected in the social protection available for alternative care that mostly consists of limited financial and material welfare provisions. There is a lack of child-sensitive social protection focused on building resilience of children, families and communities to cope with complex vulnerabilities. This is reflected in the lack of community-based alternative to institutionalisation, support networks, and services such as affordable day care and respite for care-givers. There is a general lack of information sharing across actors and even within the government sector due to the fragmentation of the alternative care system. Most agencies report internally and although they may use the same tools for collecting some of the data, there is a lack of standardised processes to use such tools and to manage the data. This situation hinders identifying children at risk and contributes to perpetuate the reactive nature of the system.

All the components of alternative care, both in the government and private sectors, are generally under-resourced and understaffed. There is a widespread lack of qualified personnel, especially social workers, which hinders provision of individualised care and consistent case management, thus jeopardizing re-integration and de-institutionalisation. Once again the policy framework is at the core of this problem because it appears to be informed by a limited appreciation of the high level of professionalism required to provide quality alternative care from a child development and child protection perspective, and the need to resource alternative care accordingly in order to have a strong focus on prevention and re-integration. This is evidenced by an institutional trend in government facilities which in some cases have become self-taught

specialist facilities: due to the pressure to accept children living with HIV or with disabilities or other special needs for which these facilities have limited capacities to provide care, these facilities find ways to learn by themselves when training is not available or does not meet their care challenges. This trend has evolved in a system based on reactive response, and reinforces this approach. In practice, this institutional trend may reinforce a focus on tertiary prevention. As the policy framework has limited focus on primary prevention of separation and at operational level most of the resources are used for residential care, vulnerability to long-term institutionalisation of children living with HIV increases. Their vulnerability is compounded by perceptions that their special needs (such as medical care) are better met through institutionalisation. However, the insufficient resources available to recruit qualified personnel limit the development of social and emotional competencies for managing complex issues as these children grow such as disclosure of HIV status, inner stigma, adherence to treatment, and developing safer intimate relationships. Instead of community-based programmes to facilitate reintegration of these children, the response still appears to be focused on long-term institutionalisation in stark contradiction with good practice guidance.

In general there appears to be very limited involvement of children in decision-making about their future. Interviews with former residents showed that involvement of children is mostly equated with telling or convincing children to accept decisions made on their behalf.

Examples of good practice exist both in the government and in the private sector, but they have not been scaled up and remain localized. These examples include:

- **Support network for parents living with HIV – supported by Daughters of Charity**
  In Phayao, parents living with HIV and who are from disadvantaged socio-economic backgrounds are part of a peer support network, which is in turn supported by a Christian NGO, Daughters of Charity. [19] This network aims to provide support to parents to care for their children, as well as assistance for children living with or affected by HIV/AIDS as well as children from disadvantaged socio-economic situations. Although initially focusing on people living with HIV, the network has now expanded to assist other families and children affected by poverty, family problems, etc. This programme is an example of community-based primary prevention of separation and institutionalisation by focusing on addressing multiple vulnerabilities and building resilience of families.

- **Holt Sahathai Foundation/Viengping – foster care programme, including HIV+ children**
  Respondents very often cite the Holt Sahathai Programme and Viengping Residential Care Facility collaboration as model of good practice in terms of reintegrating children into family-based care. Emphasis is placed on the reintegration of children into their original families as well as linking children in residential care into foster homes. Respondents also described the social workers who were trained through this programme as providing strong support to families, and being key to the

[19] The NGO Daughters of Charity also supports similar peer support networks for parents living with HIV elsewhere in Thailand. However, the research team visited and met with members of one such support network in Phayao.

successful reintegration of children into family-based care. The Viengping foster care programme can be considered a model of good practice in terms of reintegrating children into family-based care systems – this programme is inclusive of younger and older children, and focuses particularly on children living with HIV.

- **Welfare and community support systems in the Deep South**
  There are currently examples of good practices in the South in terms of welfare and support systems for vulnerable children and families. In particular, there are currently "packages" of assistance for CABA, with the PSDHS collaborating with the Provincial Public Health Office in order to identify and provide scholarships to CABA; this support is significantly more than support provided in other areas, and can act as a strong preventative mechanism, reducing the tendency for CABA to be placed in residential care facilities.

Recently the MSDHS completed a restructuring of some of the key departments involved in alternative care. While it is too early to determine the impact that these changes may have on alternative care, this exercise cannot resolve the fragmentation of the policy framework and its implementation. However it indicates sensitivity to the need of making improvements. As the Child Protection Act has never been revised since it came into force in 2003, the current restructuring by the MSDHS may provide impetus for a broader and thorough policy review, which may benefit from being contextualized within the UN Guidelines on Alternative Care.

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PART 1

INTRODUCTION AND METHODOLOGY

1.1 INTRODUCTION [20]

The purpose of this research was to capture more accurate and detailed information regarding children in various forms of alternative care in Thailand, as well as the legal, policy, management and oversight environment surrounding them in order to plan and programme more strategically in the area of alternative care, and simultaneously contribute to the global evidence base for international findings and recommendations on alternative care.

The review covered the following types of registered alternative care for children: [21] Residential Care, Foster Care, and Kinship Care.

While the scope of the review focused on all children in alternative care settings, special focused was placed on children affected by HIV and AIDS living in these settings. Providers of care covered through the review included government and private sectors providing residential care, government and privately sponsored foster care, and government supported kinship care. Adoption as a form of alternative care was not reviewed in this study.

Findings and recommendations aim to feed into improved programme and policy environments in the area of alternative care, and contribute to defining work plans for future efforts in this area in Thailand.

It is important to emphasise that this study focused primarily on formal alternative care systems and services in Thailand, although efforts were made whenever possible to collect information about informal and unregistered residential care settings. It was beyond the scope and resources of the study to collect primary data on the informal alternative care settings, specifically informal kinship and foster care.

[20] UNICEF (2014). Terms of Reference: Review of Alternative Care in Thailand. UNICEF, Thailand.

[21] Some interviews were conducted with non-registered alternative care settings.

1.2 METHODOLOGY

Qualitative Data: In-Depth Interviews and Focus Group Discussions

This research was primarily guided by qualitative data collection. Primary data collected during the research included qualitative information derived through In Depth Interviews (IDI)s or Focus Group Discussions (FGDs) with: key informants (at national, provincial and local levels), representatives of institutions involved in the provision of alternative care (including public and private institutions), NGOs, civil society members, families who are part of the registered kinship and foster care systems, and former residents of residential care facilities (some of whom had also been part of official foster care programmes).

Quantitative Data: Research Design and Variables

Quantitative data utilised in this Review included secondary data available nationally or provincially, as well as data resulting from a self-administered survey targeting registered residential care facilities. The variables considered in the review and analysis of quantitative data included:

1. Types of alternative care settings including residential care, foster care, and kinship care
2. Geographical distribution of alternative care setting
3. Children placed in alternative care settings including age, sex, nationality, ethnicity, HIV, and special needs
4. Resources including budget allocation and geographical resources distribution

Site Selection

The study focused on five research sites, comprising provinces that were identified based on selection criteria and corresponding indicators. These included, but were not limited to, the presence of government or private residential care facilities, families in registered kinship care or foster care, cumulative numbers of deaths due to HIV/AIDS or numbers of people who are living with HIV/AIDS, adolescent delivery rate, poverty rate, and migration rates. These five research sites correspond to the 4 different regions of Thailand plus the Bangkok Metropolitan Region (BMR). It should be noted that throughout this report, ‘site’ corresponds to a region or BMR; and each ‘site’ may comprise of more than one province. Sites included:

1. Bangkok Metropolitan Region: Bangkok, Nonthaburi, and Pathumthani
2. Northern Region: Chiang Mai and Phayao
3. Central Region: Chonburi and Lopburi
4. Northeastern Region: Khon Kaen
5. Southern Region: Songkhla, Narathiwat, Pattani, and Yala

Respondent Types

For IDIs and FGDs, criterion sampling was applied. This strategy involves basing the sample on individuals who meet a certain set of criteria, or experiences, which in this study meant using the Inclusion Criteria detailed below.

- Key Informants from public and private Residential Care Facilities
- Families who are part of registered Foster or Kinship Care systems
- Persons over the age of 18 who had previously spent time in Residential Care
- Key Informants from Provincial Shelters for Children and Families
- Key Informants from Provincial Social Development and Human Security Offices
- National Key Informants with experience in Alternative Care
- Local Key Informants working in Alternative Care or Child Protection

Table 1: Number of Respondent Types Interviewed through IDIs and/or FGDs in each Study area

Respondent / Region	BMR (Bangkok, Nonthaburi, Pathumthani)	North (Chiang Mai, Phayao)	Central (Chonburi, Lopburi)	Northeast (Khon Kaen)	South (Narathiwat, Pattani, Songkhla, Yala)	Total
Residential Care (Government & Private)	11	10	8	3	5	37
Kinship and Foster Caregivers	8	12	4	4	5	33
Former Residents of Residential Care (18+ yrs)	4	6	2	3	2	17
Boarding Schools	0	1	1	1	0	3
Provincial Shelters for Children and Families	3	2	1	1	4	11
PSDHS Offices	2	2	1	1	3	9
CBOs/NGOs	1	3	1	0	1	6
National Key Informants	17	3	0	0	0	20
Total	46	39	18	13	20	136

1.3 LIMITATIONS

Potential limitations to the information obtained through qualitative and quantitative data collection include:

- Information obtained from In-Depth Interviews and Focus Group Discussions may have limited generalisability to a whole population, particularly among respondents with a small sample size such as Boarding Schools.

- Respondent selection in public and private residential care facilities was determined by the personnel that exists in those places, as well as the availability and willingness of personnel to participate in the data collection activities.
- There is a scarcity of existing information about unregistered care facilities and settings, and it was difficult for the Review Team to access and gain information on this hidden population.
- Certain areas pertinent to this study do not have consistent data available at national, regional and provincial levels; existing data sets sometimes did not disaggregate by age, gender, nationality, ethnicity, religious background, and special needs (including CABA).
- Data from the National Statistics Office comprised national and regional estimates; therefore, provincial levels estimates could not be derived from this data.
- The survey data was dependent on the adequacy and accuracy of the responses provided by respondents, as well as their willingness to participate in the survey. Due to low response rates among respondents, some of the survey data may lack validity.

1.4 DATA MANAGEMENT

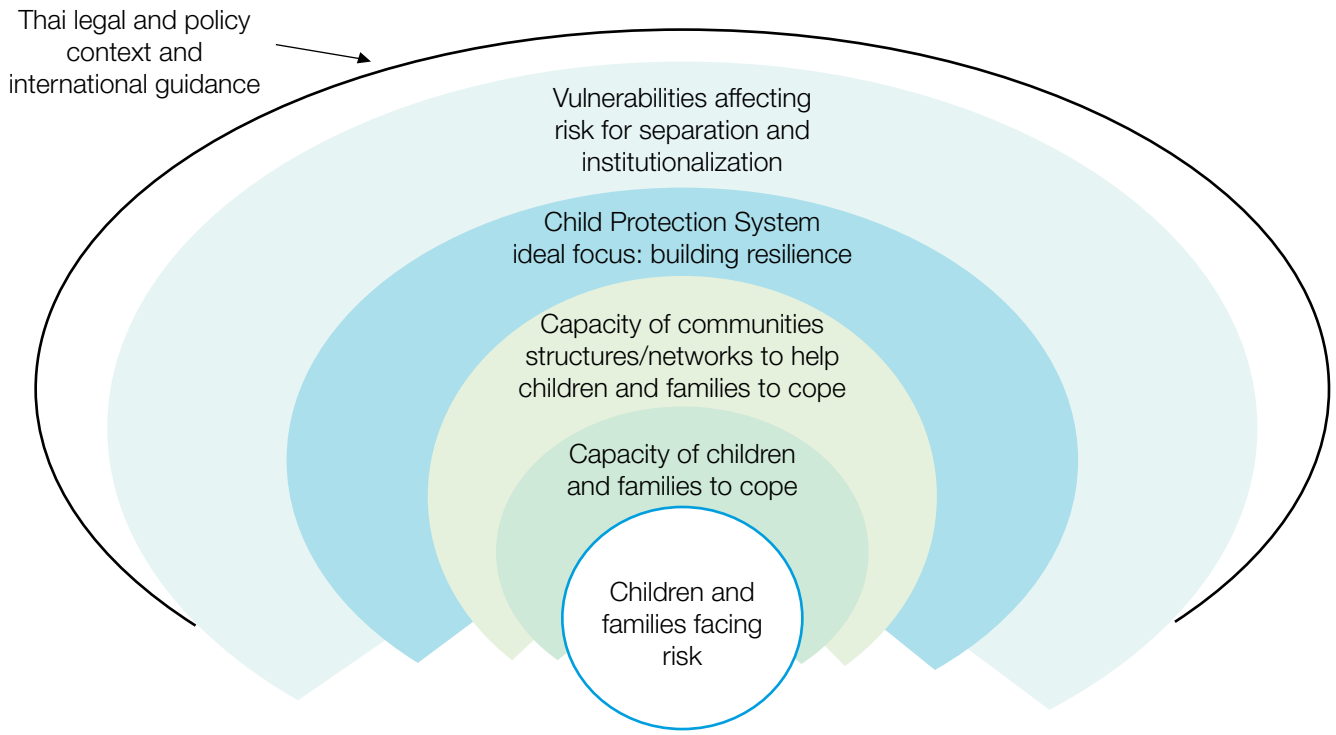
The Review Team adopted the following approach in order to improve the validity and reliability of the study results, taking into account the data constraints described above.

Data triangulation: Data triangulation involved crosschecking information and conclusions through the use of multiple procedures or sources, and through careful comparison of information and conclusions obtained through these different procedures and sources.
Investigator triangulation: Investigator triangulation involves using multiple investigators/researchers in collecting, coding, analysing, and interpreting the data.
Member checking: Member checking entailed asking research participants how they view the credibility and validity of research findings. The Review Team members presented findings/conclusions and other key information from the research project back to respondents and key stakeholders, asking them to comment on accuracy and credibility.

1.5 CONCEPTUAL FRAMEWORK

The findings in this report are presented within the context of the guidance provided by the UN Guidelines and 2012 MOVING FORWARD: Implementing the 'Guidelines for the Alternative Care of Children' with the aim of helping stakeholders to identify useful and realistic actions to adapt the principles of the UN Guidelines and improve the situation of children in alternative care in Thailand. To guide analysis of findings, the study team developed the following conceptual framework:

Figure 1: The social ecology of the risk of separation and institutionalization



In this ecology, study findings are analysed to help identify problems and possible ways forward in order to strengthen the role of alternative care in contributing to a system approach to child protection. The ultimate purpose is to help improve the design and operationalization of alternative care to build resilience, this can be summarised as:

"that children must never be placed in alternative care unnecessarily, and where out-of-home care must be provided it should be appropriate to each child's specific needs, circumstances and best interests." [22]

There are at least three important inter-related conceptual reasons for focusing on webs of vulnerabilities:

1. There is extensive evidence that shows negative developmental impacts on children placed in residential care facilities but globally an estimated 8 million children are presently in different types of care institutions. Common reasons for institutionalisation include orphaning, abandonment due to poverty, abuse in families of origin, disability, and mental illness. [23] This knowledge points to the importance of focussing on prevention of drivers of separation rather than a reactive approach.

[22] Cantwell, N.; Davidson, J.; Elsley, S.; Milligan, I.; Quinn, N. (2012).Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children' (page 14).

[23] Anne E Berens, Charles A Nelson (2015). The science of early adversity: is there a role for large institutions in the care of vulnerable children? Retrieved on April 2015 from http://dx.doi.org/10.1016/ S0140-6736(14)61131-4.

2. The 2009 UN Guidelines for the Alternative Care of Children (henceforth the UN Guidelines) and the guidance for their implementation [24] emphasise designing alternative care on:

   - The necessity principle which first involves preventing situations and conditions that can lead to alternative care being foreseen or required such as material poverty, stigmatisation and discrimination, barriers to reproductive health, insufficient parent education and other family support measures, and inadequate services or community structures to which referrals can be made, and a gatekeeping system that can operate effectively regardless of whether the potential formal care provider is public or private;

   - The suitability principle: if alternative care is necessary, it must be provided ensuring that all care settings meet general minimum standards, for example conditions and staffing, regime, financing, protection and access to basic services (notably education and health). A range of family-based and other care settings are in place, so that a real choice exists, and there is a recognised and systematic procedure for determining which is most appropriate ('gatekeeping') for which child.

   - The 'best interests of the child'. However, what this means should be clearly defined according the guidance for the implementation of the UN Guidelines. [25]

3. In order to achieve the aim of keeping children in family-based care, there must be an explicit policy and operational focus on prevention of separation. This in turn requires addressing prevention at primary level by ensuring the general population's access to basic services, social justice and the protection of human rights without discrimination; at secondary level by ensuring a safety net targeted at individuals and families (and sometimes groups) who are identified or have declared themselves as being vulnerable, and for whom, for whatever reason, primary prevention measures have proved inadequate. For example in the case of parents or caregivers who feel they need support to care for their child and seek welfare support as a solution; and at tertiary level, that is actions needed when neither primary nor secondary prevention have succeeded, and a child enters into alternative care. Efforts at this stage focus on securing conditions enabling a positive re-start and preventing a return to alternative care

We recognise that drivers may have underlying causal factors nested in a missing dimension of this ecology: the broader socio-economic and policy context of the country. The social ecology model we use recognises that child protection services, of which alternative care is a component, per se cannot be realistically expected to resolve the complex web of social vulnerabilities stemming from inequities. Rather, a system approach to protecting children- informed by a rights and equity perspective and implemented by a multi-sectors - is essential to prevent and mitigate risk of separation and institutionalisation.

[24] CELSIS (2012). MOVING FORWARD: Implementing the 'Guidelines for the Alternative Care of Children'.

[25] Ibid.

PART 2

FINDINGS

2.1 FAMILY SEPARATION AND INSTITUTIONALISATION

2.1.1 Social drivers creating a web of multiple vulnerabilities to separation and institutionalisation

> *"Most children who are at the residential care have multiple problems; poverty, inappropriate parenting, negligence, etc. — these factors cause children to be in very risky situation." (Social Worker, Government Residential Care facility, BMR)*

There are almost 50,000 children living in various residential care settings in Thailand as of 2014. The majority of the children, or 67.4%, reside in the 51 government boarding schools throughout Thailand that in many cases function as residential care, followed by government residential care facilities (14.7%), registered kinship care (10%), private registered residential care (4.7%), non-registered private residential care (1.8%), provincial Shelters for Children and Families (0.9%), and foster care (0.5%).

The data shows that the current implementation of alternative care in Thailand contradicts the UN Guidelines and Moving Forward which recommend prioritizing family-based care and stress that in general residential care should be a measure of last resort, used temporarily while seeking to ensure placement in family-based care. [26]

Several factors contribute to this situation. The current alternative care system tends to be reactive by focusing its response on individual drivers of separation. Data collected by the Bureau of Women and Child Protection & Welfare (BWCPW) for 2015 fiscal year, [27] shows abandonment and poverty as the main drivers behind children being placed in government residential care facilities. These two main drivers appear to influence the highest proportion of children being placed in government residential care facilities (more than 30%) and two times higher than the remaining drivers which show similar proportions of about 5%. Interestingly, living with HIV/AIDS per se appears to be the lowest factor influencing placement in government residential care facilities (about 3%).

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[26] Ibid.

[27] Includes data collected from October 2014 – February 2015.

* Boarding Schools not included here as they officially are not considered providing residential care.

Table 2: Ranking of Causes for Children Being Placed in Government Residential Care

	Factors for Placement in 29 Government Residential Care Facilities*	% in 2015
1	Abandonment	16.88
2	Poverty	14.98
3	Inability of Parents to Provide Proper Care	7.36
4	Parents Imprisonment	7.21
5	Behavioural Problems of Children	6.07
6	Orphanhood	6.03
7	Divorce	5.97
8	Unwanted Pregnancy	5.79
9	Abuse from Family Members	4.62
10	Other	4.30
11	Abuse	4.27
12	Homeless/Street children	3.98
13	HIV Positive Status	3.70
14	Parental Illness/Disability	2.77
15	Affected by HIV	1.60
16	Separation from Family by Court Order	1.00
17	Separation in Accordance with The Anti-Trafficking in Persons Act 2008	0.98
18	Access as a Form of Child Welfare	0.96
19	Lost Children	0.77
20	Inappropriate Behaviour or Employment of Parents	0.41
21	Teenage Pregnancy	0.35
	Total	**100.00**

* Data from 29 Government Residential Care facilities between October 2014 – February 2015 under the Bureau of Woman and Child Protection & Welfare, March 2015

Individual drivers tend to be constructed and understood mostly in terms of an outcome or visible problem. This may preclude a nuanced understanding of complex webs of vulnerabilities to separation and institutionalisation. The risk is that the alternative care system becomes focused on a reactive response to such visible issues instead of addressing complex causes of separation and institutionalisation.

In order to develop policy and programmes better tailored to prevent or mitigate risks of separation and institutionalisation, it is important to understand how children's complex webs of vulnerabilities relate to social issues that their families, care-givers, and communities face.

Our findings show that the risk of separation is shaped and experienced because of the complex interactions of multiple drivers. Participants in our study tended to identify four main interacting and overlapping drivers of separation:

- poverty;
- inability of parents/care givers to look after a child (for a range of reasons, and particularly in the case of children with special needs, multiple special needs, and children living with HIV);
- abandonment;
- neglect and abuse, especially in the family (including physical, psychological and sexual abuse, as well as exploitation).

No single driver acts in isolation to weaken the capacity of families and communities to cope. This reality mirrors findings at international level showing that interaction of multiple social drivers affects risk of separation and institutionalisation. For example, research in Europe and Central Asia has shown:

> *"Although there are local differences, in countries across Europe and Central Asia, there are five primary drivers of institutionalisation. Many people imagine that children are in institutions because they have no parents, ie they are orphans, or 'bad' parents, ie they have been abused or neglected. In fact, research from a number of sources, including Lumos' own research, has found that the five key drivers of institutionalisation are poverty, disability, ethnicity, behavioural issues and child abuse and neglect."* [28]

When we consider webs of vulnerabilities, we discover that individual drivers hide more complex dynamics leading to separation and institutionalisation. For example, we found that abandonment or neglect intersect with public perceptions that residential care provides better care and better education opportunities – especially for children living with HIV or children with special needs when families feel unable or unwilling to care. In turn, these social drivers of separation intersect with issues that create vulnerability for care-givers (often grandparents) becoming increasingly unable to provide care because of poverty or older age. These vulnerable care-givers often feel that residential care is the only option available due to the lack of social protection for both themselves and the children, including community-based alternatives to residential care:

> *"Another problem is poverty, parents can't afford to raise them and abandoned their children with grandparents, and grandparents are quite old and poor themselves, so they leave the children at residential care." (NGO worker, North Region)*

> *"At first, I stayed at [government residential care facility] when I was 7 years old. My mother died, and my aunt took me here because she couldn't take care of me. I've never met my father; he died before I ever met him." (Former resident of residential care facility, North Region)*

> *"The reason for accepting children to stay in our foster home is not children being abandoned, but rather children being orphaned with relatives who are not able to look after them. […] Probably the*

[28] Lumos Foundation (2012). Drivers of Institutionalisation. Retrieved April 3, 2015 from: http://wearelumos.org/stories/drivers-institutionalisation

economic factor is the main issue, because they (the relatives) have their own families to care for. Actually they do want to look after the children, but these children need medication and special health care." (Social worker, Government Residential Care facility, North Region)

2.1.2 Addressing the drivers of family separation and placement into institutions requires a multi-sectoral coordinated system approach to protecting children.

These examples point to the need of refocusing child protection and alternative care on preventing and mitigating complex webs of vulnerabilities to ensure that residential care is the last resort, as recommended by the UN Guidelines. Ultimately, this means a multi-sectoral focus on policies and practices to reduce inequities. Migration – both internal and international – provides a useful example to illustrate these considerations. Migration does not appear on the data by the Bureau of Women and Child Protection & Welfare as a driver of separation however our findings suggest this is a driver of separation. This finding seems to be validated through reports from the International Organization for Migration and the Migration Policy Institute that shows that due to the significant level of internal migration, approximately 20 per cent of Thai children were not living with their parents, raising concerns over the well-being of children left behind. [29] Moreover, the population census under-reports the extent of internal migration because it only records moves of at least six months duration, thus omitting the high level of seasonal migration that occurs in Thailand. One in eight migrants had moved from another country. [30]

Although migration per se may not create vulnerability to separation, patterns of migration in their intersections with other drivers of separation may influence vulnerability of children to long-term institutionalisation. In particular, separation due to migration is becoming longer and grandparents/care-givers are now expected to fulfill their roles often for many years. Recent analyses confirm that over the last 10-15 years, one-year migrants (who live in a different community than they did one year ago) have declined while five-year migrants and life-time migrants have continued to increase. [31] The latest Multiple Indicator Cluster Survey conducted by the Thailand National Statistical Office shows the scale of migration and its impact on children: almost 24 per cent of children under 18 years of age do not live with their biological parents, mostly due to internal migration. [32]

Our findings suggest that the intersections of these patterns of migration and other social vulnerabilities may be impacting the role of long-standing culturally accepted kinship practices in Thailand to provide family-based care. For example, informants talked about how parents migrating to other areas of Thailand for work feel that they have no choice but to leave their child in residential care if there are no relatives or other people close to the family able to provide care:

[29] IOM,MPI (2011). Thailand at a Crossroads: Challenges and Opportunities in Leveraging Migration for Development. Issue in Brief N0. 6 (page 3).

[30] UNICEF (2011). Situational Analysis of Children and Women in Thailand.

[31] UN Thematic Working Group on Migration in Thailand (2011). Thailand Migration Report (page 14).

[32] UN Thematic Working Group on Migration in Thailand (2014). Thailand Migration Report (page 59).

"Another factor is work-related migration. They don't have money, so they bring the children to us to look after. Even if they are not necessarily from the area, but the situation arises while they are here, they are entitled to ask for our help." (Director, Shelter for Children and Families, BMR)

In other parts of Thailand, patterns of migration intersect with other vulnerabilities such as ageing care-givers, exposure to drug use or lack of access to reproductive health:

"In the Satingpra and Ranod district of Songkhla province, the parents have to go work in Songkhla and Hat Yai town and leave the children with the grandparents. In some cases the parents never come back. […] Many of the children from broken families like this turn to drugs, skipping class, and having sex and getting pregnant when they are not ready." (Social worker, OSCC Unit, South Region)

These webs of vulnerabilities are compounded by a social protection system for alternative care which is fragmented as many different government agencies are involved with limited coordination and information sharing, and mostly provides limited financial support for poverty alleviation without a clearly defined multi-sectoral strategy to build resilience of children and their care-givers for family-based care. As a key local informant explained:

"We need a better welfare system to fill in the gap and fully support families." (Director, Provincial Social Development and Human Security office, North Region)

From this perspective it is worth noting that while Thailand ranks high among middle-income countries, it is also the 12th most unequal country in the world [33] - over 5 million people live below the poverty line and the interconnection of poverty with other social drivers in creating vulnerabilities for children has been highlighted by previous research and reviews. For example, UNICEF Situational Analysis of Children and Women in Thailand 2011 found that, although poverty levels continued to fall between 1992 and 2009, *"Most families in Thailand have no access to family support services to help them through difficult times."* [34] The UNICEF findings also pointed to the urgency to strengthen preventive services for child protection and ensuring provision of welfare services along with development of services targeting poor families, families at risk, families with member living with HIV/AIDS or affected by AIDS, and families with elderly caregivers.

These gaps contribute not only to separation but also to other risks, for example reducing or limiting access to education, as this example shows:

"I receive 700 baht per month from the welfare money for the senior population from the government. My grandson who is in 8th grade, he goes to work in a sugarcane field. Sometimes he doesn't go to

[33] Central Intelligence Agency. (2013). The World Factbook: Distribution of Family Income – GINI Index. Updated 2009, Retrieved April 3, 2015, fromhttps://www.cia.gov/library/publications/the-world-factbook/rankorder/2172rank.html

[34] Page 46.

school because he is too tired from working so he misses the class often." (Kinship carer, Northeast Region)

Thus the findings point to the need of realizing a coordinated multi-sectoral approach to primary prevention that is currently insufficient. Table 3 illustrates the need for such an approach:

Table 3: Main Drivers of institutionalisation and illustrative multi-sectoral coordination that may be required for prevention

Top drivers of institutionalisation		Illustrative responsible actors for prevention of separation
1	Abandonment	Division of youth and children MSDHS, Local Government, MOI, MOE, Child Protection Committees, CSO
2	Poverty	MSDHS, Local Government, CSO
3	Improper care	Division of youth and children MSDHS, Local Government, Child Protection Committees, CSO
4	Parents imprisonment	MSDHS, Ministry of Justice/Interior
5	Behavioural Problems	MSDHS, MOPH, CSO

2.2 THE LEGAL AND POLICY FRAMEWORK FOR CHILD PROTECTION

Over the last 15 years, Thailand has made significant progress towards placing alternative care for children within the broader legal and policy context of child protection. However, as discussed in the previous section, there are still challenges to realize a coordinated multi-sectoral system approach. This situation is largely due to the fragmentation of the current legal and policy framework governing child protection that results in confusion of roles, responsibilities, and accountability at all levels.

Legislation pertaining to children's rights is spread throughout a number of acts, some of which are specifically targeted at children. Relevant legislation includes, but is by no means limited to: [35]

- The Child Protection Act 2003
- The Manual of Child Protection Protocols and Procedures (approved 2009)
- The National Strategy and Plan of Action for a World Fit for Children (2005 – 2015)
- The Children and Youth Development Act (2007)
- The Penal Code (amended 2007)

[35] Office of Welfare Promotion, Protection, and Empowerment of Vulnerable Groups. Ministry of Social Development and Human Security. Child Protection System in Thailand. Retrieved April 7, 2015 from: https://cpconference2012.files.wordpress.com/2012/11/7-thailand.pdf

- The Criminal Procedure Code (amended 2007)
- Civil and Commercial Code Amendment Act (amended 2008)
- The Juvenile Family Court and Juvenile and Family Procedure Act 2010
- The Child Adoption Act 2010
- The Anti-Trafficking in Persons Act 2008
- The National Child and Youth Development Promotion Act 2007
- The Domestic Violence Victim Protection Act 2007
- The Compulsory Education Act 2002
- The Promotion of Non-Formal Education and Informal Education Act 2008
- The Persons with Disabilities' Quality of Life Promotion Act 2007
- The Civil Registration Act 2008
- The Nationality Act 2008
- The Alcoholic Beverage Control Act 2008
- The Labour Protection Act (amended 2008)

In addition, Chapter III of the Thai Constitution (2007) addresses rights provisions applying to children as to other citizens. It also contains a few provisions specifically addressing children's rights. [36]

Recent studies and evaluations of Thailand's child protection apparatus have found that the fragmentation of the legal and policy framework contributes to hinder an effective system approach to child protection, monitoring, and response:

> *"The child protection system at the national level has historically been characterised by a general lack of leadership, clear mandates and interaction between key ministries with responsibilities related to children and families. As a result, there is no common framework or national strategy for child protection and the aims, objectives and overarching approach of the child protection system have yet to be defined. Different government ministries with responsibilities for children have tended to work in relative isolation."* [37]

Moreover, in its 2012 Concluding Observations, the Committee on the Rights of the Child welcomed changes made by Thailand to harmonize its national laws with the principles and provisions of the CRC. The Committee also welcomed the establishment of the Sub-Committee under the National Child and Youth Commission with the aim of revising existing laws to bring them into conformity with the Convention. However, the Committee raised concerns which are of particular relevance to the findings of our study, namely the inadequacy of measures to enforce and implement legal reform, particularly with regards to the Child Protection Act, which has not been reviewed since its implementation in 2003 and has no corresponding guidelines on the roles and responsibilities of the various agencies within its purview. [38]

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[36] Child Rights International Network. Thailand: National Laws. Retrieved March 31, 2015 from: http://www.crin.org/en/library/publications/thailand-national-laws

[37] Child Frontiers, Universalia (2013): Evaluation of the UNICEF Child Protection Monitoring and Response System (CPMRS) in Thailand Volume III –Child Protection System Context (page 19)

[38] Child Rights International Network. Thailand: National Laws. Retrieved March 31, 2015 from: http://www.crin.org/en/library/publications/thailand-national-laws

The inadequate harmonization of the current legal framework with the CRC is evident in the 2003 Child Protection Act (Article 33) which actually facilitates long-term institutionalisation – up to 24 years of age - and undermines efforts to prioritize family-based care. This runs counter to the principles of the UN Guidelines of necessity, suitability as well as the best interest of the child and substantially undermines gatekeeping practices.

At an operational level, there is a fragmentation in the efforts to support children at risk due to overlapping and uncoordinated roles and responsibilities of different government bodies, as well as poor capacity. For example, child protection committees were created under the 2003 Child Protection Act. These comprise representatives at central and provincial levels from different ministries with responsibilities for child protection, including the Ministry of Interior, Ministry of Education, Ministry of Public Health, in addition to the Ministry of Social Development and Human Security. The Child Protection Committees (Articles 7 – 21) are mandated to address issues such as stigma and discrimination which we found still play a major role in increasing vulnerability to and risk of separation from family-based care, especially for children with SN and CABA. However, most respondents felt Child Protection Committees are not working effectively to address these issues for reasons including:

- Membership is mostly by top-down appointment and often not based on sufficient experience in or understanding of child protection.
- Membership is usually rotated after two years. Respondents reported that these Committees, at least at provincial level, meet only two or three times a year. By the time most members begin to develop a more nuanced understanding of the complexity of child protection, their tenure expires and they are replaced.

Such systemic problems contribute to maintain the ground on which pathways to institutionalisation and abandonment are laid out. Table 4 illustrates how the fragmentation and lack of harmonization with good practice of the current legal and policy framework compounds vulnerabilities to separation and institutionalisation in creating pathways to institutionalisation.

Table 4: Illustrative interactions of the legal and policy framework with social drivers of family separation in creating pathways to institutionalisation

Drivers	How does it contribute to increased vulnerabilities to institutionalisation?	Sources
Legal Framework	Article 33 facilitates long term institutionalisation by allowing the institutionalisation of children up to the age of 24 Compounds social norms about the necessity of institutionalisation especially for children with special needs or children living with or affected by HIV/AIDS.	Child Protection Act 2003 Interviews with Key National Informants, FGD with Key Local Informants as well as informants working in government and private residential care facilities as well as provincial shelters.
Fragmentation of legal and policy framework and lack of a multi-sectoral implementation strategy for alternative care with clearly defined roles and responsibilities and mechanisms for coordination and accountability (everybody is responsible but nobody is ultimately accountable)	Creates a top-down approach to the issue of child protection / solving social problems, which doesn't necessarily take into account realities or the perspective of those on the ground; this is linked to a perceived disconnect between those developing and those implementing or affected by the policy framework. Precludes an integrated and systematic approach to child protection and solving social problems; this is turn maintains problems in coordination and lack of clarity over roles and responsibilities, a problem augmented by lack of clear implementation guidelines. Weakens gatekeeping mechanisms – children are allowed to be placed in residential care through multiple channels; authority for the decision can be delegated to a variety of vaguely defined "responsible officials"; placement in residential care often results from a lack of community-based options for family-based care; thus placement in residential care is seldom based on the principles of necessity, suitability as well as the best interest of the child; Lack of coordination of different government bodies prevents the effective monitoring of all children in care, and especially in boarding schools and in private facilities.	Interviews with Key National Informants, FGD with Key Local Informants as well as informants working in government and private residential care facilities as well as provincial shelters.

Drivers	How does it contribute to increased vulnerabilities to institutionalisation?	Sources
Lack of a streamlined child-sensitive social protection system that integrates financial and material support with community-based services to support family-based care.	Social protection for alternative care (kinship care and foster care) with limited financial support for poverty alleviation. Exclusion of many children from social protection. Not necessarily linked to other social protection benefits. Lack of programmes and services to prevent separation and build family resilience reinforce perception of institutionalisation as only possible option. Gatekeeping practices weakened.	FGD with Key Local Informants. Interviews with Key National Informants. Interviews with personnel in residential facilities and in provincial shelters.
Socio-cultural perceptions of benefits of institutionalisation	Norms in Thailand reinforce perception that institutional care is beneficial to children, that residential care facilities provide better care and better education opportunities and that they exist to accept children when families feel unable or unwilling to provide care, especially with children with special needs or children living with or affected by HIV/AIDS. These norms are compounded by the legal framework allowing long-term institutionalisation.	FGD with Local Key Informants; Interviews with personnel in government and private residential facilities. Interviews with former residents in government residential care.
Pervasive stigma and discrimination against children living or affected by HIV/AIDS or with disabilities and special needs especially in government schools.	Inadequate enforcement of current anti-discrimination provisions, a lack of a system approach and coordination among actors in alternative care reinforce reliance on long-term institutionalisation.	FGD with Local Key Informants; Interviews with personnel in government and private residential facilities. Interviews with former residents in government residential care.

2.3 RESIDENTIAL CARE ISSUES

2.3.1 Residential care often the only answer to children living with HIV, children with behavioural problems, and children who have experienced abuse

There are almost 50,000 children living in various residential care settings as of 2014. The majority of the children, or 67.4%, reside in the 51 government boarding schools throughout Thailand that in many cases function as residential care, followed by government residential care facilities (14.7%), registered kinship care (10.0%), private registered residential care (4.7%), non-registered private residential care (1.8%), provincial Shelters for Children and Families (0.9%), and foster care (0.5%).

Based on our self-administered questionnaire sent to all care facilities (residential care and provincial shelters for children and families), most of the children with special needs are children with neurological problems, almost 45% of the total children with special needs, followed by behavioural problem or abused children (24.6%), children with physical disability (11.5%), children who are HIV+ (11.3%), and children affected by HIV (2.3%). Almost 1% of the special need children have multiple problems.

In examining which alternative care facilities house the most number of the special need children, the results show that the majority of children with special needs reside in government residential care facilities (77.8%) with provincial Shelters for Children and Families having the least number of these children (3.4%). The composites of the children with special needs vary with types of alternative care setting. The government residential care setting composes mostly of children with neurological problems (54.8%) and they make up 42.6% of all special need children in Thailand. Both the private registered residential care and boarding school settings are dominated with children who are HIV+, 34.5% and 40.4%, respectively. About 80% of special need children in provincial shelters have behavioural problem or are children who have experienced neglect or abuse.

The data confirms that residential care if far from being used as a measure of last resort, and especially for children with special needs and children living with HIV. Although respondents recognised that institutionalisation is not in the child's best interest, they have to operate in a context where institutionalisation is often perceived as the only option available due to the lack of essential services for and capacities of families and communities.

These issues also affect the risk for separation and institutionalisation for children who are perceived to have behavioural problems in that it reinforces beliefs among parents, care-givers, community members, and even some service providers that institutionalisation is inevitable in order to provide care for these children. However, these attitudes indicate confusion in understanding the difference between behaviour control and protection of children. This sometimes results in perceiving child protection as safeguarding society from the negative behaviour of children, whether this may be drug use or addiction to electronic games and gambling. For example, several respondents working with these children blamed either parents/care-givers and/or children for these behaviours. Although some of these respondents described such problems as likely resulting from cases of abuse or neglect and require more individualised care; yet, it would appear that often the lack of qualified personnel and resources in the community for individualised care results in institutionalisation of children defined as having behavioural problems without clearly defining or diagnosing what this means. As our data show, a higher proportion of the government residential care facilities accommodate children with behavioural problems and about 80% of children with special needs in Provincial Shelters for Children and Families have behavioural problems or are children who have experienced abuse. Once in residential care, the vulnerabilities of these children are compounded by insufficient qualified personnel to provide adequate individualised care.

Moreover, due to the current geographical distribution of government residential care facilities, separation and institutionalisation is augmented by physical distance from the children's networks as children are referred where there is space to accommodate them.

Many respondents stressed the interconnection of children's behavioural problems with the changes in the traditional extended family structure. Previous reviews have also found that family disintegration is affecting child protection. [39] Our study found that vulnerability due to family disintegration, and especially of the traditional extended family structure, intersect with several factors including the changing patterns of working hours of parents/care-givers who spend longer time at work and are unable to provide role-models and guidance; the disintegration of bonds of community solidarity especially in large urban areas that is weakening the role traditionally played by the community as monitor of children's well-being in rural or smaller urban centres. Some of these factors intersect with migration, especially to the Bangkok Metropolitan Region.

Children who have experienced neglect and abuse (including physical, psychological and sexual abuse, as well as exploitation) face increased risks for separation and institutionalisation. Their risk appears to be augmented by the current problems in the system approach in child protection. Although provincial Shelters for Children and Families are mandated to care for these children for a period of up to 3 months, during the assessment process a number of actors must be involved by policy. However, in many cases some of these actors may have not received training to perform their roles and responsibilities effectively, or may not even know that they have a role to play under the Child Protection Act. For example:

> *"When we are informed about the case, we then call a multidisciplinary team, met them in that area, discuss with them on how to rescue the case, the length of time would be different from case-to- by case considering how serious it is. We needed to talk to a child's caregivers/relatives that we can trust, sometime we had to fight with caregivers and brought them to the police station. We had to undergo many procedures, for example, go to see the police, go to see a doctor, etc. Each area has a different context, the Local Administration in some areas doesn't even know the process and it was a waste of our time to explain to them about the Child Protection Act."* (Social Worker, Shelter for Children and Families, Central Region)

These findings confirm previous reviews which have shown that *"due to limited resources at the local level, including social work capacity, the protection services rarely reach children at the community level. Moreover, there is a lack of clear accountability about the work of the committees, so the delivery of services is not guaranteed for all children. Service delivery depends mainly on the capacity of individuals working in the committees and on the capacity of the existing response services."* [40]

The contradiction between the policy stated aims and its implementation are evidenced in the situation of provincial Shelters for Children and Families; their few resources create severe limitations in responding to needs, including how many cases they can actually accept and process, as these facilities have to provide help to a number of categories of vulnerable people. Additionally, because of cultural perceptions and lack of specialised care and support at community level – and especially social worker - reintegrating these children into family-based care through kinship or foster care.

[39] UNICEF (2011). Situational Analysis of Children and Women in Thailand.

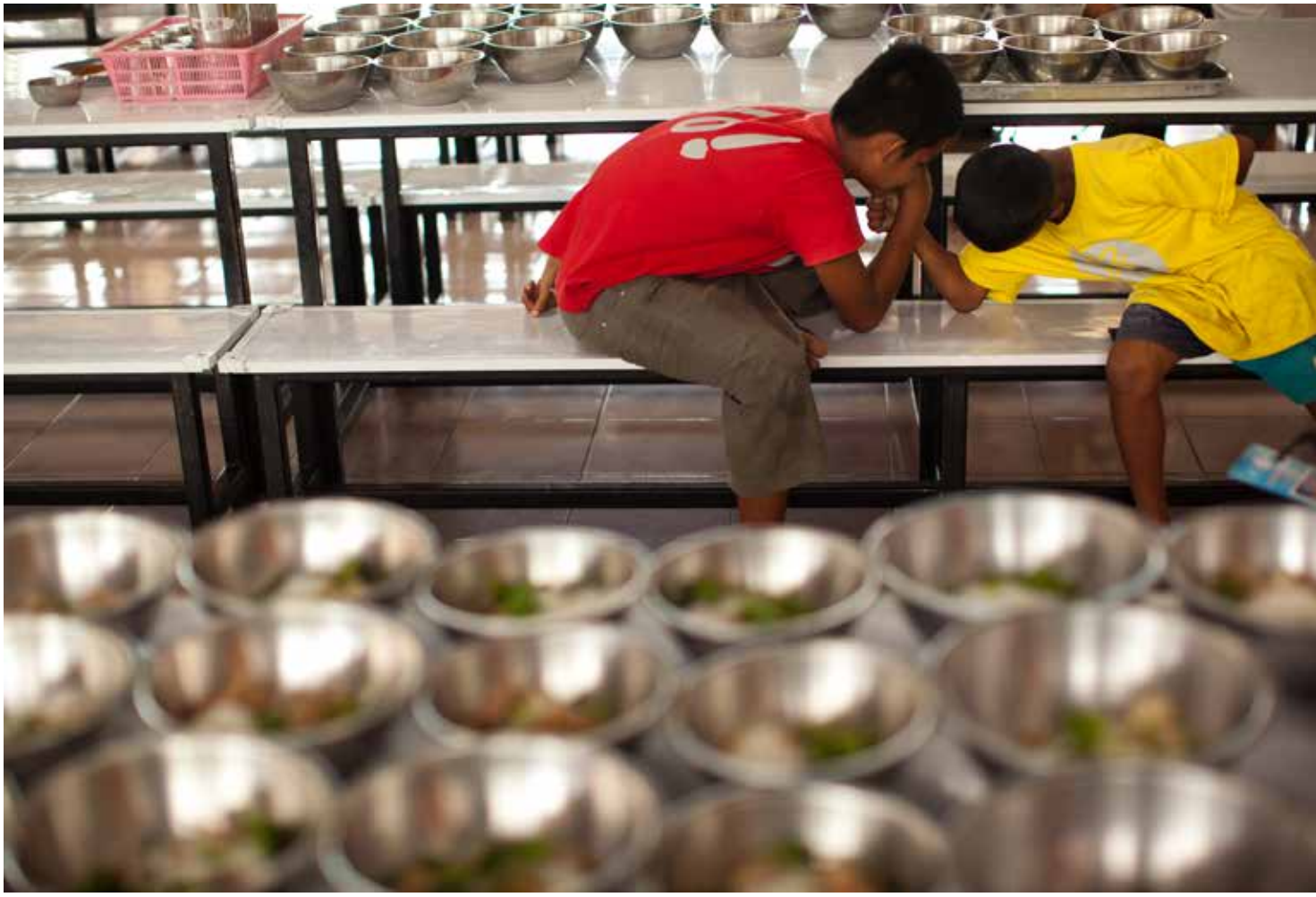
[40] UNICEF (2011). Situational Analysis of Children and Women in Thailand (page 36).

2.3.2 Evolving institutional trends in government residential care: potential for concern

Numerous challenges still exist to ensure the operationalization of government residential care realizes the principles of the UN Guidelines. These challenges are often directly related to the systemic issues discussed in previous sections.

For example, because of the evolving trends in terms of children in alternative care and the institutional practices of different facilities (with some facilities becoming self-taught specialists in the provision of care to specific types of children, such as children with special needs), facilities often end up receiving children from a wide geographical area. Facilities can then face additional challenges in terms of providing effective gatekeeping, facilitating the reintegration of the child into family-based care, as well as providing adequate care.

Transpiring from these findings is the unintended and unforeseen contribution that these evolving institutional trends in the government sector may be causing in terms of exacerbating risks of separation and institutionalisation:



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- Becoming self-taught specialist facilities: due to the pressure to accept children living with HIV or with disabilities or other special needs for which these facilities have limited capacities to provide care, these facilities find ways to learn by themselves when training is not available or does not meet their care challenges. This trend has evolved in a system based on reactive response, and reinforces this approach. In practice, this institutional trend may reinforce a focus on tertiary prevention;
- Due to its inherent focus on tertiary prevention (i.e. residential care, often long-term) and its potential negative effect on reintegration, this reactive response may reinforce risks of separation and long-term institutionalisation especially for children with SN and CABA;
- It may also divert away already limited resources to strengthening and expanding alternative programmes and services informed by good practice in providing services and support for children with SN and CABA at community level that aim to build resilience of these children and their families/ care givers for family-based care as well as reduce stigma and discrimination towards disability and HIV disease.

This situation has evolved out of a genuine concern of many facilities to do the best they can for children in their care within their constrained resources. However, at best it may provide a temporary alleviation of systemic problems, which are further discussed in the sections below. Nevertheless, in the long-term it is not sufficient to tackle these systemic problems and while the situation persists more children may experience prolonged institutionalisation.

2.3.3 Challenges in providing care: insufficient qualified personnel and limited resources

In the context of the evolving institutional trends in government-run residential care facilities, the situation of children in residential care, including for children with SN and CABA, is complex and varies from facility to facility.

Different facilities described applying different criteria for accepting children depending on sex, age, special needs, HIV status, etc. These criteria are shaped by the specific care capacities of the facility. Yet in reality, special needs and HIV have become cross-cutting issues that government-run facilities face – whether their response constitutes referring the child to another facility, or providing care despite limitations in terms of capacity.

Government facilities often described being pressured to accept children beyond their ability to provide care. This has impacts on the facility's ability to promote the wellbeing of the child, with staff and resources described as overstretched and carers sometimes required to care for children they have not been trained to provide care to, particularly CABA and children with special needs. A recurrent finding concerned insufficient numbers of specialised staff such as social workers, nurses, psychologists, and child development specialists. Staff of government residential care facilities also commonly described having insufficient caretakers.

These difficulties highlight a recurrent theme emerging from the findings: policies and regulations exist, but have become either inadequate or even counter-productive in view of the real challenges at operational

level. We found a similar situation in residential care where standards of care exist to guide the work of government facilities. Although respondents in the public sector reported following this guidance, they also commonly described difficulties in implementing the policies and meeting the standards of care, with there being gaps between policies and practices:

> *"We apply several policies from the government, the Ministry of Social Development and Human Security and the Department of Social Development and Welfare in the work we do, and it is not an easy task. […] Fortunately, there is the Child Protection Act that we can use as a tool to shape the way we work and keep us within scope of the law. To consider our children and their priorities is what keeps us on the right track. Plus, we set standards for management, environment, staff, children and services in order to achieve our goals and make working much easier."* (Director, Government Residential Care Facility, North Region)

> *"The policies are like the holistic picture, but in practice, the organisation is like a home. In a home, there are many factors; for example, in a small family with three children, it's chaotic and there and many problems to be solved, but this is a big home with many people in it, about 100 staffs […] But the policies are set for all organisations in the country. We try to adjust our organisation, so it meets the standard of the policies, the goal is to develop the life of children, to reach that goal, we face many obstacles."* (Social Worker, Government Residential Care Facility, BMR)

Levels of training that caregivers receive in providing specific care to children with special needs vary. Government facilities often described ongoing and regular trainings in how to provide care for these children; yet this is not necessarily consistent across all facilities. Additionally, respondents often described staff and capacity limitations in caring for children with 'behaviour problems'. Staff and capacity constraints in turn impact on the ability of the facility to provide individualised care for children, as well as specialised care for children with special needs and 'behaviour problems'. Respondents also described issues of frequent staff attrition and especially caretaker turnover as negatively impacting on the welfare of children. Difficulties in terms of frequent staff turn-over were described as being linked with the low salaries caretakers receive and the extremely demanding requirements of the work.

2.3.4 A blurred focus on social and emotional competencies of children and on de institutionalisation, especially for children with SN and CABA

Transpiring from the findings is an additional important systemic problem: it would appear the resourcing of the current alternative care system reflects a limited understanding of the expertise required in child development, which is critically important especially to formulate and implement Individual Development Plans (IDP):

> *"At the home [residential care facility] where I work there are 82 children, which I think is a lot, because per house there is one person taking care of children. This means there are 20-30 people caring for children in different houses. In this situation one cannot complain about the quality of care. It takes everything only to prevent children from doing harm, not to speak of emotional care. They hardly*

receive that, because the provided care is not comprehensive. This is speaking about the nature of the issue, but if you refer to overall standards, they would tell you that it is possible for one person to take care of 20 children. I would like to strongly challenge that." (Social Worker, Government Residential Care Facility, South Region)

As children often are institutionalised for years, residential care facilities face challenges to provide individualise care, and doing so from a holistic life cycle perspective.

These constraints in providing care appear to result in a regimented daily existence for many children in government facilities. Older children tend to have responsibilities in caring for younger children and in doing chores such as cleaning, washing clothes, etc. Staff of residential care facilities frequently emphasised the benefits of these daily routines and chores in teaching children to be responsible and be able to care for themselves. Former residents of residential care facilities commonly recognised such benefits; yet they also often described feeling constrained by the many rules and regulations under which they lived, as well as feeling that they did not receive enough individualised care:

"The rules made living in the facility uncomfortable, the 13 rules. Forbidding so many things, it's too much. Waking up at 5 am… But sometimes they cared for us well, there was a small number of small children and a lot of older ones. They couldn't care for the older kids properly because there were so many of them." (Former resident of government residential care facility, North Region)

The findings point to a narrow focus on care. Due the compounding effects of policy and operational challenges, the development of social and emotional competencies appears to be confined mostly to abilities for self-care and self-discipline. Although these are important and necessary skills, they contribute only partially to developing competencies for decision-making and self-determination that enables children to manage the specific issues they face to transition out of residential care and into adulthood. Moreover, the generally emphasised focus on self-care and self-discipline appears to be pursued as a strategy to create a perception that children are less of a burden for families if they can take care of themselves. This approach may be questionable from the perspective of ensuring the best interest of the child because it may be misunderstood as placing the responsibility of 'not being a burden/problem' on the child as a desirable feature for reintegration in family-based care:

"The basic in life is how they could reintegrate with the community. They need to be able to take care of themselves, putting as little burden on the people they live with as possible. We teach them how to take care of themselves; eat, going to toilet, wear clothes, shoes—all the daily routine necessary. Children who are with us are small children, so all these basic things are necessary, if they can do all that, the parents wouldn't have as much burden, they can do other things when their child get dressed for example, Other skills we teach is for children to care of the younger children once they got older, they have to also help the staff arrange the dinner table, wash dishes, arrange clothes—all the daily routines." (Social Worker, Government Residential Care Facility, BMR)

Linked to the insufficient focus on developing social and emotional competencies, we also found a general lack of capacity to develop and implement de-institutionalisation strategies and to involve children in these processes. This issue concerns all children who experience long-term institutionalisation, not only children living with or affected by HIV/AIDS. It is a problem related to the broader issue of the involvement of children. Generally, we found that service providers understand involvement of children in terms of telling children about decision that have been made on their behalf or convincing children to accept such decisions.

2.3.5 Challenges in realizing a standardised approach to care and in providing case management

The challenge to define what a 'standardised' approach to care should ideally mean and achieve is also reflected in the different ways in which different facilities understand and work on child development. Sometimes this is influenced by the types of children in residence. For example, facilities which care specifically for children with SN and CABA or include these children with general categories of children appear to focus more on IDP than facilities caring only for general children. Thus there appears to be an unofficial practice of prioritizing IDP for children categorized as having SN or being CABA. However in many cases these inconsistencies are influenced by the lack of qualified personnel developing IDP which require a multi-disciplinary team (MDT), and sufficient qualified social workers as case managers. During the scoping exercise in preparation for this study the research team found that only one government residential care facilities of those visited had access to a complete MDT. The examples below highlight the variation in these practices:

> *"Right now, we don't [do IDPs]. We only do individual plans for the cases that need it. […] We normally talk to our children in order to deal with their individual problems."* (Director, Government Residential Care Facility, BMR)

> *"For the children that have difficulty in learning, like a blind child, the teachers will determine what other activities they can do such as drawing or making door or bath mats. Then our responsibility is to do everything the teacher told us to do to help these children. After the children completed the training, we also help them find a job with different companies. If our children can work, they will be able to live with others in the society".* (Social Worker, Government Residential Care Facility, BMR)

2.4 CASE MANAGEMENT

Insufficient qualified personnel adversely impact provision of case management. Case management can include individualised development plans (IDP), collaboration with specialised care (i.e. psychiatrists), sending children to special education programmes, determining the most appropriate level of education programme for each individual child in order to provide services and support that can be most effective for his/her development. Case management is also very important for reintegration in family-based care.

We found that often case management starts with an assessment of needs for special treatment and programmes and tends to focus on medical care and education management plans. In some cases, case

management involves dividing children into specific sub-groups (i.e. disabled and level of severity of disability) as a first step to providing further services and care. Case management is particularly important for determining a child's future and can affect long-term institutionalisation or reintegration into a family setting.

It appears that the challenges to develop and implement IDP and to ensure effective case management – especially for reintegration into family-based care – are also compounded by the focus on prioritising basic standards of care over finding family-based care. Facilities place more effort on meeting basic standards, especially for the annual assessment, and this often takes priority over other important activities, such as reintegration of the child in family-based care. Although there are some assessment parameters focusing on what facilities do to promote re-integration, the assessment forms are heavily dominated by questions about basic care standards such as shelter, food, clothing, education, hygiene, health, and the facility's environment. Official data shows that so far no government facility has ever failed these assessments. As a result of all these factors, government facilities continue to focus most of their effort on adhering to these basic standards of care:

> *"When the criteria are provided, it is easy to work. We know what we should do, and what the standard assessment is because the criteria cover all positions here."* (Head of Social Work, Government Residential Care Facility, BMR)

> *"We have submitted in a report every year to the Ministry that we have met their standard. […] We are still lacking some aspects, such as the pathways and walkways for children to walk. Apart from this, we have met all of the standards set by the Ministry."* (Government Residential Care Facility, Central Region)

However, it is also important to acknowledge that some facilities do try to focus on re-integration despite the constraints within which they operate:

> *"Yes, we have standards for childcare in residential care, we have a clear goal for each target group we care for. We would prioritise children first and other standards of work are what support the primary goal. We need to see that in each year, how many children got sick, how is their well-being after they come to live with us, whether children got the opportunity to go back home. The standard of work is a step-by-step procedure. Our goal is to reintegrate them with their family, some can reach that goal, some can't, it depends — the cause may be because the parents are drug addicts, they have the problem of inappropriate parenting, repeated violence at home, if we return children into this kind of setting, then they might come back to us again."* (Social worker, Government Residential Care facility, BMR)

Access to education is one of the parameters included in the assessment of government facilities. Government facilities provide varying types of education for children — with some being in-house, and others sending children to nearby schools. Officially, government vocational education institutions should provide short-term (one year) residential care for people with physical disability. Our findings show that case management sometimes becomes problematic in relation to ensuring that this time limit is not exceeded.

In reality, institutionalisation often becomes long-term because families find ways to refuse to take children back, for example by requesting that they continue to improve their skills to have better employment opportunities. Also, when facilities send children to nearby schools the children often face stigma and discrimination, since they are often seen as 'problem' children and troublemakers. This increases the risk of long-term institutionalisation in facilities that provide in-house education or vocational training as children affected by HIV/AIDS and children with special needs face significant limitations in accessing public sector education due to on-going stigma and discrimination.

Additionally, government residential care facilities provide varying levels of support for future education and career opportunities. Yet respondents often described education, vocational and work opportunities provided for the children, as well as children's ability to take part in decisions about their future, as one of the key strengths of these facilities:

> *"We provide both general and vocational education. All the children go to different schools in the area starting from kindergarten level to university level according to their individual capacity."* (Director, Government Residential Care Facility BMR)

> *"Our strength is that we see what children want to be later on in life, we encourage them to dream and think of what they can do. We organize an event in which people from many professions come to talk to children, so they can see their options."* (Director, Government Residential Care Facility, North Region)

> *"I think I got more opportunities than other people outside. Like some children whose families are struggling, they don't get as many opportunities to go to school."* (Former resident of residential care facility, South Region)

Finally, insufficient information sharing and coordination between agencies and actors further complicates efforts for reintegration into family-based care and the effectiveness of case management to achieve this aim. Compounding difficulties in providing individualised care, conducting thorough case management, and reintegrating children into family-based care is the lack of a standardised and shared child database. Government residential care facilities (as well as some private facilities) collect data and report this to the provincial and national levels, but this information is not compiled into a shared national database of children in alternative care. As a result, facilities often face challenges when they do not receive complete information about the child or when case management information is not transferred from one agency to another.

2.5 CHILDREN IN PRIVATE REGISTERED RESIDENTIAL CARE

2.5.1 A sector largely accountable to itself

Our study primarily focused on registered private residential care facilities. In the private sector there are a total of 137 registered residential care facilities under the MSDHS [41] whose Provincial Social Development and Human Security offices are responsible for the oversight of these institutions. However, in practice registration does not equate with receiving oversight comparable to that received by government-run facilities.

Article 52 of the Child Protection Act governs licensing of non-governmental residential institutions and Article 24 gives to a wide variety of government personnel a duty to inspect. The Act confers power to impose regulations which were issued in 2006. These cover issues such as the qualifications and character of the applicant for the licence, the building, environment etc.. The Regulations do not, however, impose any conditions or process regarding the admission of children, do not regulate the staffing levels or quality of care, and do not require the implementation of any child protection policies or procedures.

Private residential care facilities often have much less clearly defined guidelines and criteria delineating the care provided and for which children they provide care. As they are often faith-based, they tend to frame the care they provide in religious beliefs and values. More generally, they often have no clear policies, guidelines and standards of care and/or tend to determine their own frameworks and standards of care:

> *"Our responsibilities set the frame for our work. We have our own "missions".* (Social worker, Private Residential Care Facility, BMR)

Some private residential care facilities do not have clear criteria defining the types of children they accept into their care, and/or do not appear to implement gatekeeping practices that would maintain residential care as a last resort. Some private facilities can also be described as acting as 'pull factors' for the institutionalisation of children – particularly those facilities that are actively promoted as providing education and other options to children from remote and disadvantaged communities. While these facilities do provide opportunities to underprivileged children, they can also be seen to go against the wider aim of maintaining children within family-based care, and their institutional practices do not encourage preventing institutionalisation.

There are several reasons contributing to the limited oversight role of the government on private residential care. These institutions are largely dependent on non-governmental funding; they typically receive no/limited amounts of financial support from the government. Some perceive that these reasons justify their limited accountability to government authorities. A number of registered private residential care facilities report information about children in their care to government agencies, while others said they do not. However the type of information shared seems to be dependent upon and limited to receiving financial or material support from government agencies and if such support stops, the flow of information also stops.

[41] Data from Bureau of Women and Child Protection and Welfare, MSDHS, October 2014.

2.5.2 Registration of private facilities

By law, private residential care facilities should be registered. Registration enables the facility to apply for government funding; however, respondents often described barriers to registration, including:

- Registration takes a long time and implies additional administrative burden such as complying with reporting to the Provincial Office of the MSDHS.
- It is easier to continue to depend on private/international funding than to apply for government funding and abide by the conditions that this comes with.
- Although private facilities should registered regardless of whether they receive government funding, many consider accessing such funding as their main reason to register and feel demotivate to do so because e government funding is typically low.

It would appear that the ways in which private institutions report information to government agencies is sometimes left to their discretion and it is done to remain registered. For example:

> *"We send the basic data. It's just the number of the children. The Sisters have to continue their license [for operating a residential care facility] every year, right? They [the PSDHS] quite trust us among other things. Other than that, what else do the Sisters write about? Our programmes and our projects."* (Manager, Private Residential Care facility, Central Region)

However, those facilities that are registered are nevertheless expected to produce reports about their work; yet there appear to be inconsistencies in the assessment of private residential care facilities, and external assessments only seem to happen once the facility has already applied for government support (in which case it has already proven that it has met certain basic standards of care).

Respondents from the private sector who were familiar with national policies and standards of care frequently described difficulties in implementing these policies and meeting standards of care. One perceived difficulty was the lack of flexibility as well as applicability of government standards and regulations as these facilities sometimes are registered with different ministries for different purposes:

> *"We use government standards as guidelines, because every house is registered respectively as care centre with the Ministry of Social Development and Human Security, but the foundation is registered with the Ministry of Interior. Therefore we adhere to the rules of the Ministry of Social Development and Human Security. Not all of it, because we are not a government facility. There are only some basic, in some issues we stay flexible in order to maintain the best interest of the child. If we are too strict the children feel limited and do not enjoy staying. Sometimes the government rules are too orderly and very limiting, which makes children sometimes want to leave and feel oppressed. The staff also feels oppressed and not natural while doing the work. This happens with (institutions of the) government sector, which have clear rules. We cannot escape the law, but we try to maintain flexibility in implementation in order to achieve the highest benefit for the child. […] The foundation has not met the legal standard set by the Ministry of Social Development and Human Security yet, which is the law for the provision of social welfare. We have the*

intention to do it, but our organisation is big and has various different houses. Therefore the introduction of standards is not easy, because there are many conditions due to our many focus groups. […]Our management is confused about how to start introducing standards. […] Therefore we would like to do it, but there is great difficulty." (Manager, Private Residential Care Facility, Central Region)

Moreover, as the example above highlights, often we found that managers and personnel in these facilities thinks the best interest of the children is to keep them in residential care.

The findings suggest a significant lack of accountability of registered private facilities to the public sector. However, this limited accountability also depends on the enforcement – or lack of- of the existing legal framework by the competent authorities. For example, during the preparatory scoping exercise we visited a private facility which has provided residential care for CABA for 14 years. When we asked if they were registered, we were told that they had submitted their registration documents that same morning. They wanted to apply for government funding support and the relevant government authorities had always assumed that they were registered.

In other cases, we found that government agencies conduct monitoring or assessments of private facilities only once every few years. In this case, for example, we asked a private facility when the relevant government agency had conducted an inspection:

"Lately no [there has been no evaluation by the Ministry of Social Development and Human Security]. […] We used to [send reports to them], but not anymore. […] Around a decade now [since the last inspection]. If they come its more for a chat, not really an inspection." (Social Worker, Private Residential Care facility, BMR)

Moreover, when private institutions are monitored and found lacking in their performance, it is unclear whether and how the public sector compels them to implement corrective measure to remedy their poor performance, except not qualifying for funding.

2.5.3 Provision of care: 'standards of care' is a relative concept and reintegration is not a priority

It should be noted that there are a number of registered private institutions providing examples of good practice in caring for children, and especially children with SN and CABA. They tend to have more holistic understanding of care and focus on reintegration.

However, as discussed above, many others determine their own model of care outside of any good practice guidance, or any guidance at all for that matter. These facilities accommodate a large proportion of the total number of children in residential care settings in Thailand. Due to issues of capacity in the government sector, as well as trends in types of children being placed into residential care, private facilities often take cases that the public sector cannot care for, particularly:

- Children living with HIV

- Children with special needs and multiple special needs

Although private registered residential care facilities are meant to act within the same overall frameworks as government residential care facilities, there is often a lack of understanding of these frameworks and of clear guidelines to implement them. While there are a number of private residential care facilities that work within policy frameworks and adherence to national health, education, protection, nutrition, and safety standards, many facilities also seem to lack even a basic understanding of key policies and basic standards of care. Some senior staff of residential care facilities seemed unfamiliar with the policy framework and with basic standards of care – seeming to not even understand what interviewers meant by 'standards of care'.

In several residential care facilities, the research team was told that reintegrating children in their family of origin or in foster or kinship care is not a primary responsibility of the facility. Staff of private residential care facilities notably described a lack of capacity to be able to reintegrate children into their families, as well as prioritising the provision of care and services while the child is in the facility. Staff in some facilities also described the role of their facility as caring for the child until he/she becomes an adult and/or has graduated from school – with reintegration into family-based care then not being part of the facility's goals.

Additionally, staff in many private residential care facilities do not have qualifications in child care, social work, psychology, or other relevant domains of expertise. These personnel are often volunteers and/or have very limited experience, skills, and qualifications in child care, as well as no clear job descriptions determining their roles within the organisation. Under such conditions, the ability of these facilities to formulate and implement individualise care and IDP is limited.

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2.5.4 Lack of accountability increases vulnerabilities for children

A number of staff members of residential care facilities recognised that staff do corporally punish children, and there seemed to be a lack of clarity around what level of corporal punishment would be considered a violation of child's rights/protection and lead to dismissal of staff. Problems in terms of knowledge of policies and standards of care were described as being compounded by a frequent lack of staff and capacity, as well as staff turnover.

The issue of corporal punishment is useful to explore how the structural problems of the legal and policy guidance contribute to inadequate operational responses. Although Thailand has made a commitment to the UN Committee against Torture to prohibiting corporal punishment of children in all settings, [42] "the policy guidance is still contradictory. Although the Regulation of the Ministry of Social Development and Human Security on Child Punishment of 2005 does not include corporal punishment among permitted disciplinary measures, the prohibition appears to apply only to corporal punishment of a certain severity: under article 61 of the Child Protection Act 2003 an owner, guardian of safety, and staff of a nursery, remand home, welfare centre, safety protection centre and development and rehabilitation centre must not mentally or physically assault or impose harsh punishment on any child under their care and guardianship, "except where such acts are reasonably applied for disciplinary purposes in accordance with the regulations specified by the Minister". Article 65 of the Act provides for punishment of children which must be "carried out reasonably for disciplinary purposes." […] Corporal punishment is lawful in early childhood centres and in day care for older children under articles 61 and 65 of the Child Protection Act 2003 (see para. 2.4) and article 1567 of the Civil and Commercial Code (see para. 2.2)." Moreover, the Committee on the Rights of the Child has three times recommended that legislation be enacted to explicitly prohibit corporal punishment of children in all settings, including the home – in its concluding observations on the state party's initial report in 1998, on the second report in 2006 and on the third/fourth report in 2012. [43]

Once again, these findings indicate that the issues of inconsistent standards of care and limited accountability to the public sector arise within a broader context of systemic problems nested in a legal and policy guidance, which is in need of urgent revision. Without a clearly defined multi-sectoral strategy for implementation, coordination, and accountability, private institutions carve out their own roles with their own models of care and their own systems.

2.6 REGISTERED BOARDING SCHOOLS: A PARALLEL UNIVERSE?

In this review we define boarding schools as institutions that provide accommodation and in-house education; and boarding houses as institutions that provide accommodation but send children to outside schools for education.

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[42] BRIEFING ON THAILAND FOR THE COMMITTEE AGAINST TORTURE, 52nd session, April/May 2014. Retrieved on April 19, 2015 from: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=5&ved=0CDcQFjAE&url=http%3A%2F%2Ftbinternet.ohchr.org%2FTreaties%2FCAT%2FShared%2520Documents%2FTHA%2FINT_CAT_NGO_THA_17055_E.docx&ei=PZw0Vb-NBoPluQSC-ICIBw&usg=AFQjCNG3LKgReMsxGk-_oYvp3nMkwnJpAA

[43] Ibid.

The Ministry of Education designated 51 schools throughout Thailand to accommodate children who may need boarding at schools and these are Rajprachanukrao and Suksasongkrao. In practice, 3 schools out of 51 don't have children who reside overnight at the schools. This research conducted a self-administered survey to all 51 boarding schools and 21 schools responded, therefore, the age specific information is based on 8,440 out of the total of 33,649 (25%) children boarding in schools. Data from the MOE indicates that most of the children who reside at schools are in the middle school and high school (74.2%). This age pattern shows similarity in the survey results where 75% are in the 10 to 18 year age group. Although conceptually children less than 6 years old may be too young to be placed in the boarding school, 46 children below the age of 6 reside in the boarding school according to the MOE data.

We visited a very small number of boarding schools and our findings are not generalizable, however they provide useful observation to understand the issues children face in these facilities.

Boarding schools are generally described as enabling access to education and other opportunities for children who cannot be cared for by their families and/or lack access to these opportunities. Some receive children who are referred by government/private residential care facilities, in order for these children to attend middle or high school. They also often receive children who are sent by their families to access education, with these children often coming from hill tribe and poor/remote communities, and/or families who have migrated for work or other reasons. Respondents also described boarding schools as receiving children who are not accepted by and/or cannot be cared for in other residential care facilities, especially government facilities, including CABA and children with special needs referred from far away provinces:

> *"We have over 800 children under care, around a hundred of them are infected [with HIV] […] During the first phase, all of our students were either those infected or those affected by the infections of their parents. Later, a variety of groups came to our care, including the homeless, the orphans, child labourers, the abused, the underprivileged, those addicted to drugs, and those from juvenile detention centre […] Most came from residential care facilities in over 30 provinces. […] We also pick up hill tribe children from remote areas in Phetchabun, Tak, and Chiang Rai. Some of them are Akha, Hmong and Karen people."* (Director, Boarding School, Central Region)

> *"Once they finish Grade 6 and want to continue their studies, the foundation then refers them to us — I mean the HIV infected children."* (Director, Boarding School, North Region)

Boarding schools typically have large numbers of children and low numbers of carers. Boarding schools described caring for between 744 and 837 children, depending on the facility; the average number of children cared for across the 3 facilities visited was 780.

In boarding schools, respondents cited a common pattern of 2 carers looking after some 40-60 or more children.

Staff of boarding schools/houses commonly emphasise that they provide a caring, 'family-like' atmosphere for children; yet there is limited ability to provide any kind of individualised care.

Key national respondents described boarding schools as guided by policy frameworks and specific standards of care, but knowledge and implementation of these standards does not seem to be consistent. Similar to what the research team found in registered private residential care, some senior staff of boarding schools and boarding houses are unfamiliar with the child protection policy framework and basic standards of care – seeming to not even understand what interviewers meant by 'standards of care'. Respondents also described challenges in meeting even basic standards of care such as hygiene, and not having clear guidelines for how to manage the cohabitation of children living with HIV with other children.

The Provincial Social Development and Human Security office is responsible for ensuring that all private residential care facilities are registered. However, not all these facilities are registered and the number of facilities currently unregistered is unknown. Staff of the PSDHS described difficulties in identifying and monitoring private residential care facilities as well as boarding houses, which in turn leads to an inability to ensure standards of care. Respondents described these difficulties as often linked with a lack of knowledge and understanding of the laws by managers of these facilities.

However, as discussed for registered private residential institutions, the problems with oversight are also compounded by the fragmentation of roles and responsibilities (in this case between the MSDHS and the MOE) in a system which is mostly working as separated components with distinct objectives devoid of a functional system strategy to make sense of how all the components create synergy toward the same strategic goal. The following examples illustrate these problems:

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"In Chiang Rai, there are 40-50 organisations, many are unregistered. […] There are more than 20 unregistered facilities, so almost half. We had meetings with them as a network in the projects and we have found many problems in [unregistered] residential care facilities." (Vice President, NGO, North Region)

"Yes, there are [unregistered facilities], but we don't know about them, it depends on our objectives, it can't be checked. The foundations are under the Ministry of Interior. We don't know about them at all. The provincial office of interior, their provincial office, we have no right to go see or check. We can only do public relations. This is not included in the law." (Social Worker, Provincial Social Development and Human Security office, North Region)

In essence, the systemic problems creating this reality are similar to those discussed for registered private residential care.

2.7 FORMAL KINSHIP CARE

2.7.1 Conceptualization and design of formal kinship care: issues of access

Informal kinship care is cited as the most common form of alternative care in Thailand, encompassing as much as 90% of all alternative care situations. [44] The definition of "kinship care" that is used in this Review is based on both the 2009 UN Guidelines for the Alternative Care of Children (hereinafter the UN Guidelines) and Thailand's National Strategy for Alternative Family-based Care – with kinship care being defined as *"family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature".* [45, 46]

Formalised kinship care in Thailand falls under the Ministry of Social Development and Human Security within the Department of Social Development and Welfare (DSDW) and is handled by the Child Adoption Centre (CAC). For the 2015 fiscal year (October 2014-September 2015), the Child Adoption Centre was allocated a budget of 120 million baht (approximately 4 million USD) with a target group of 5,000 children to support in registered kinship care families. [47, 48] This overall budget was further distributed amongst seven partner agencies within the DSDW including the Foster Care Division, [49] Bureau of Community Welfare Protection, Provincial Social Development and Human Security Offices, Social Development Centres, Family Development Centres, Provincial Shelters for Children and Families, and the Bureau of Woman and Child Protection and Welfare (BWCPW). [50]

[44] UNICEF (2014a). More than 3 million children in Thailand do not live with their parents: UNICEF. Retrieved September 14, 2014 from: http://www.unicef.org/media/media_73914.html.

[45] UN (2009). Guidelines for the Alternative Care of Children, Article 28(c:i). United Nations, Geneva.

[46] Subcommittee for Alternative Care Strategy (2011). The National Strategy on Alternative Family-based Care: Draft. Kingdom of Thailand

[47] Child Adoption Centre (2015). Details of Foster Family Budget Allocation. Ministry of Social Development and Human Security: Thailand.

[48] At the time of writing this report, the MSDHS was under restructuring but had yet to be finalized.

[49] The Foster Care Division is directly overseen by the Child Adoption Centre.

[50] Child Adoption Centre (2015). Details of Foster Family Budget Allocation. Ministry of Social Development and Human Security: Thailand.

Table 5: Kinship Care Target Group and Annual Budget:

Sector	Fiscal Year 2015		
	Target Group (No. of Children)	Amount in Baht	Total % of Budget
Provincial Social Development and Human Security Offices	2,362	56,688,000	47.2
Shelter for Children and Families	769	18,456,000	15.4
Bureau of Woman and Child Protection and Welfare	558	13,392,000	11.2
Social Development Centres	526	12,624,000	10.5
Bureau of Community Welfare Protection	385	9,240,000	7.7
Foster Care Division	240	5,760,000	4.8
Family Development Centres	160	3,840,000	3.2
Total	5,000	120,000,000	100.00

*Percentages are approximate

The CAC is responsible for distributing funding for formal kinship support to all the agencies in this structure and the Foster Care Division reports directly to the CAC. The Foster Care Division overseeing registered kinship care and its implementing partner agencies are directly guided by the Department of Public Welfare's Regulation on Foster Family Type of Child Care/Aid (2001).

As of 2014, of the almost 50,000 children living in various alternative care settings in Thailand only 5,000 were in formal kinship care. This number is the result of a budgetary ceiling decided at central government that determines the total number of children in kinship care who can be formally supported. The research found this ceiling to act as a potential barrier to promoting and sustaining kinship care as a priority alternative care option. The reasons are as follows:

1. Kinship care is the most acceptable form of non-parental care in Thailand. Intergenerational families have been a traditional form of family support in Thailand, with children caring for their ageing parents, who in turn care for their grandchildren. In recent years, this dynamic has started to shift to "skip generation" households, in which the grandparent takes virtually all responsibility for raising the grandchild during developmental years. In 2011, 13.7% of all households among persons 60 years and older were "skip generation" households. [51] As previously discussed, this trend has increased due to changing patterns of migration. Previous reviews have also shown that skip generation"

[51] Knodel, J., Prachuabmoh, V., & Chayovan, N. (2013). The changing well-being of Thai elderly: An update from the 2011 survey of older persons in Thailand. College of Population Studies, Chulalongkorn University, & HelpAge International, Thailand.

families play an important role in providing kinship care for children with special needs (SN) including children affected by HIV/AIDS (CABA). [52]

2. The National Statistical Office (NSO) conducted a national survey in 2012 and found over 3.4 million children do not live with either of their biological parents. When considering those who may need financial assistance defined as those who live below the poverty line, potentially there are over 400,000 children who may be in need of government assistance but are outside the formal system and access limited or no form of social protection. [53]

In addition to the challenges of an enforced ceiling, the actual delivery of kinship care assistance also faces:

- Insufficient allowance to meet the needs of more than one child – Kinship families meeting all criteria for registration to receive support are entitled to the welfare allowances set out in The Department of Public Welfare's Rates and Rules on Kinship Care Family and/or Child Care Assistance (2005). The rules stipulates the child receiving assistance must be between the ages of 0 to 18 in order to qualify and that monetary support for families cannot exceed 2,000 baht per month for one child. Additional assistance may be supplemented with consumer goods or schools supplies not exceeding a total worth of 500 baht per month. For families caring for more than one child financial assistance may not exceed 4,000 baht and supplemental assistance in the form of consumer goods may not exceed a total worth of 1,000 baht per month.
- Spreading the kinship care grant thin – The study found that services often have to reduce the official monetary support per child in order to enable more children to receive support. It appears that the "slicing" strategy is being applied as a form of poverty alleviation. However, it is questionable whether this strategy is sustainable in the long-term. Although in principle there is additional social protection available nationally through disability support, support for people living with HIV, support for the elderly, and scholarships for disadvantaged children, the "slicing" strategy at best appears to provide minor relief for struggling kinship families who face increased risk for separation, as many of them reported.
- Unclear how the grant amount was determined – Although the policy sets the amounts for financial support, it is unclear which criteria have been used to determine a suitable minimum level of such support to ensure a child's well-being. This raises the question of whether the criteria and the resulting minimum level of support should be the same for all children or different for children facing different vulnerabilities or special needs, or at different stages of child development. There appears to be a significant gap in the policy because it does not provide any guidance to practitioners who apply the "slicing" strategy, thus making this strategy even more unsustainable and questionable from an equity perspective.

[52] Knodel, J. &Saengtienchai, C. 2005. Older-aged parents: The final safety net for adult sons and daughters with AIDS in Thailand. Journal of Family Issues, 26 (5):665–698.

[53] UNICEF 2011. Situation Analysis of Women and Children in Thailand.

Restricting the number of families able to take in kin children through an imposed ceiling denies the majority of children in need the option of living in a family, and automatically makes residential/institutional care the only viable placement. In addition qualified kinship families are able to access assistance until the child has graduated from school, has reached 18 years of age, or has been officially adopted by the family. This greatly reduces the possibility of new children entering into the formal kinship care programme. [54,55] Kinship care is a good family-based option but its current design makes its scale extremely limited and misses an opportunity to provide family care to a greater number of children in need.

2.7.2 Insufficient social protection to support formal kinship care

The resources available for cash transfers and other types of financial and material support (for example baby milk formula, food and school supplies, etc.) are limited. Some of these services and provisions already exist within alternative care in Thailand, but the provisions through the kinship care grant are too limited and deemed inadequate for the needs of most families and children. In addition, resources and services to support children and families are often not delivered by qualified (and sufficient) personnel. Many respondents questioned how decisions were made on allocation of budget at central government as they do not seem to equate with needs at the decentralized levels.:

> *"Our province is one that is in need, but there's no evaluation to determine how much we have requested in the past. They've given other provinces 500,000 Baht, and our province 500,000 Baht as well. However, [our province] has a lot more cases than other provinces."* (Director, Provincial Social Development and Human Security office, Central Region)

This situation contributes to prevent or weaken coordinated action of the central, provincial, and local agencies and actors to focus on the strategic objective of prioritizing prevention of separation and family-based care. This emerges from responses citing gap between policy level and implementation level. In turn, these increase difficulties for coordinated action to ensure the well-being of children.

These issues affect access to kinship support and to alternative care in general because they prevent a system's approach and contribute to missed opportunities to strengthen action in the communities where children live.

2.7.3 Accessing formal kinship support: navigating complex systems and structural barriers

Informants from the agencies involved in formal kinship commonly cited a lack of awareness and understanding by potential beneficiaries of existing welfare provisions and their rights to these provisions. Practitioners (e.g. social workers, village leaders) who could theoretically enable community members to access this support also described themselves lacking knowledge and understanding about existing support systems.

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[54] Foster Care Division. Fostered Child Visiting Report Form. Ministry of Social Development and Human Security: Thailand.

[55] Child Adoption Centre (2014). ครอบครัวอุปถัมภ์ (Foster Families). Retrieved April 4, 2015 from: http://www.adoption.dsdw.go.th/about4_6.html

Compounding the lack of awareness and understanding among potential beneficiaries is a problem described by many respondents: the insufficient information sharing between different government and non-government systems and agencies involved, which creates problems in assessing, managing and following up the reintegration of children from facilities into families.

Kinship care-givers who had accessed these systems described learning about them from family and friends, local social workers, community volunteers, village leaders, as well as residential care facilities. Carers also described depending on information about the support they can receive (whether foster/kinship support or more general welfare support) from one person within a facility/government agency and facing problems if this contact is no longer there.

What appears, though, is that the overall 5,000 children ceiling decided at central level greatly affect access to support, as these examples indicate:

> *"To talk about the funding sources, whether if they are sufficient or enough, I would say it is not enough. There are a lot of families that are in need and in difficult situation here in [name of province]. Many families are facing difficulties and the difference is only that some of them have less and some of them face more difficulties. So since that budget funding that we have is not enough and we couldn't cover for all, what we can do is we have to do the selection process and help the families those are most in need."* (Social Worker, Provincial Social Development and Human Security office, BMR)

> *"Some of the underprivileged children's cases will go in to the consideration process. If there is money available in the budget then we will be able to help more cases but there are a lot of areas in [name of province] province that requested the budget to help children in their area. Therefore, we might not be able to help all the cases."* (Community Development Officer, Southern Region)

The underlying structural barriers inherent in the design of the system that we have discussed so far affect everyone involved, from service providers to children and their care-givers, because they create a context in which it is very difficult to realize the principles of the UN Guidelines and the best interest of the child that ideally would inform all the components of alternative care.

2.7.4 Factors compounding structural barriers to realize the UN Guidelines principles of good practice in the formal kinship system

The diffusion of responsibility across the agencies involved in formal kinship may not contribute per se to undermine good practice, but it results in a system focused more on meeting internal administrative purposes than principles of good practice. For example, although the CAC distributes the funding for formal kinship support to all the agencies described in Table 5 above and these agencies conduct assessments of registered kinship care families, they are not required to submit this information to the CAC; such documentation is stored internally.

This information is primarily about the age and the sex of the child and contains a notes section which each person filling in the form completes at her/his discretion. Most agencies provide additional reporting

internally but this is seldom shared, principally because there is no formalized guidance and mechanisms to do so. Although our aim here is not to suggest how lines of accountabilities should change, one of the consequences of this kind of diffusion of responsibility is the insufficient information sharing between different agencies and actors, as well as an unmet need for a standardised database and M&E system to more effectively support children and their kinship carers.

Across regions, at all levels of implementation of alternative care including the formal kinship care system, respondents cited:

- insufficient key information about vulnerable families and children, as well as the situations in which these children live
- lack of data about unregistered kinship care-givers. This is particularly significant in that these families often face challenges in continuing to care for children and can be considered a potentially vulnerable group
- data collected by actors working at the local level as not compiled into a shared database or system
- capacity, especially at local government level, to use what information exist such as through the Child Protection Monitoring System (CPMS), and especially capacity to analyse the available data

Information that could improve access to and provision of support for children in kinship care is being collected, but – like the system through which it is collected – is fragmented, not systematized, difficult to access across the components of the system, and sometimes there is an assumption that all actors at all levels have the capacity to analyse it and use it.

2.7.5 Challenges to formal kinship family-based care oversight

In principle, each kinship family applying for formal kinship care support should have a case manager (a qualified social worker).

After approval, a social worker from the respective agency of registration will regularly visit the child and the kinship care or foster family, once every two months during the first year. [56] After that, and depending on each case, house visits will be conducted no less than three visits per year. [57] The Child Adoption Centre provides guidelines for social workers which assess the development of children living in kinship care families by age group (i.e. 0-1 years, 1-2 years, 2-3 years, 4-5 years, 5-6 years, 6-7 years, and 7-18 years). [58] Items evaluated include the child's living conditions, health, education, child's behaviour, child's emotional wellbeing, and other opinions. [59] However, in many cases the agencies lack sufficient qualified social workers. The example below is representative of similar recurrent findings:

[56] Ministry of Social Development and Welfare (2001). The Department of Public Welfare's Regulation on Foster Family Type of Child Care / Aid, Section 14. Thailand.

[57] Ibid.

[58] Child Adoption Centre. Forms for Assessing the Development of Children in Kinship Care Families. Retrieved on April 7,2015 from: http://www.adoption.dsdw.go.th/Host7.html.

[59] Foster Care Division. Fostered Child Visiting Report Form. Ministry of Social Development and Human Security: Thailand.

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"At first, it seems like government agencies are distributed equally across the provinces, but the reality is it's not. Ours has the staffing of a small province, not a big one. […] We are lacking Social development workers in general. […] In reality, the policy framework set by the government mandates 14 staff, now we have 10, missing 4." (Director, Provincial Social Development and Human Security office, Central Region)

Comprehensive assessments for placement in family-based care - whether reintegration with biological parents or placement in kinship/foster families - were identified as essential in order to ensure continuity of and satisfactory placement for the child. Although all the agencies providing entry points to family-based care placement, including kinship, use the same tools to conduct assessments, there is no standardised process for how to use these tools in practice. Although most respondents cited the Child Protection Act as the general guidance they follow and some respondents described having a clear process for assessing families, many described a lack of clear guidelines and standardised processes for implementing the general guidance available.

The apparent lack of standardisation and systematization of these processes coupled with insufficient information about vulnerable children and qualified personnel contributes to further impede fully realizing the best interest of the child as set out in the UN Guidelines because these issues impact the ability of providers in all aspects of assessment, follow up, and monitoring. The fact that many respondents stressed having a lack of qualified personnel, as amply documented throughout this report, is evidence of this reality. We use 'standardised' to indicate processes that are based on documented good practice and lessons, to ensure the full realization of the core principles and best interest of the child. At a minimum, they should be based on evidence from evaluation of whether they meet these principles of good practice. The processes respondents are implementing have never been evaluated from this perspective as this response exemplifies:

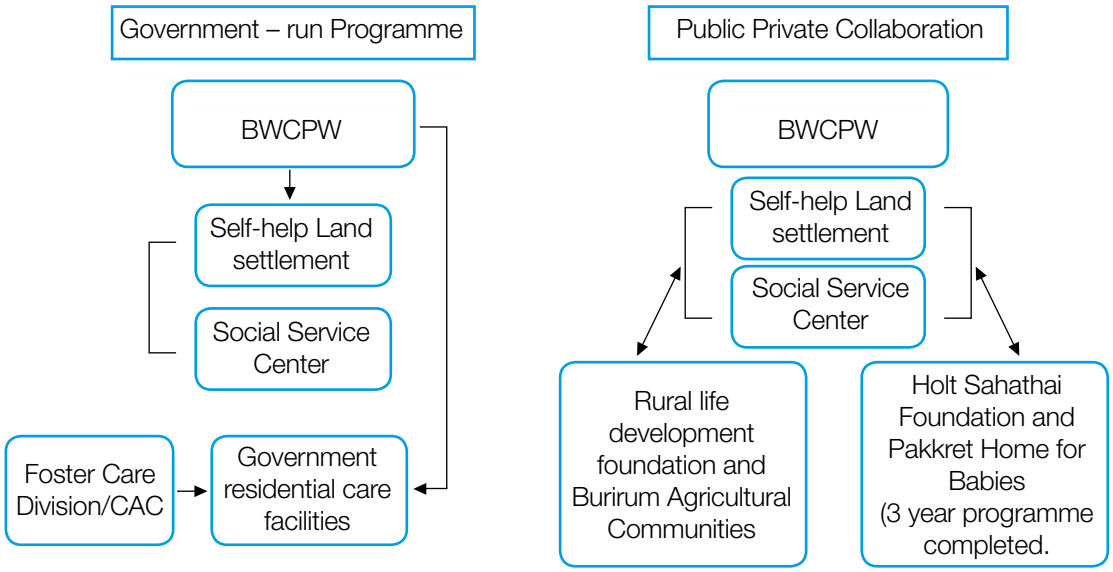
"There are many principles and policies that don't get practiced. There are no situational assessments and documentation of lessons learned from specific cases. Everybody still thinks that sending children into the care system is the way out of their problems." (Senior Social Worker, NGO, BMR)

Moreover, the type of data agencies are required to collect mostly is useful for statistical purposes, but there is no clearly defined and standardised guidance to collect information on qualitative indicators to assess the well-being of the child from a comprehensive child protection perspective.

2.8 FOSTER CARE

The Foster Care Programme began in 1999 and is overseen by the Bureau of Woman and Child Protection and Welfare (BWCPW) under the Department of Social Development and Welfare (DSDW) within the Ministry of Social Development and Human Security (MSDHS). The programme is divided into two operations: one that is completely government-run and another that is a partnership between the public and private sector:

Figure 2: Foster program in Thailand: Responsible Agencies



Overarching all collaborations, the Foster Care Programme has the following vision:

Promote temporary family-based care for children in residential care facilities so that children can develop quality standards of living through civil society's participation in their care, as well as give children the ability to successfully reintegrate into society in the future. [60]

2.8.1 Foster care remains limited to small examples of good practice

In the government-run programme, the BWCPW works in close collaboration with the Self-help Land Settlement (the latter under the jurisdiction of the MoI) which assists in selecting, consulting, preparing, and overseeing communities participating in the programme. This programme currently exists in 12 provinces including Saraburi, Lopburi, Nakorn Sawan, Gampaengpet, Songkhla, Nongbualampu, Udonthani, Khon Kaen, Chiang Mai, Nakorn Si Thammarat, Nongkhai, and Chonburi. In addition to the Self-help Land Settlement, the above mentioned sites were selected because of the presence of a government residential care facility and a Social Service Centre. Additionally, the Foster Care Programme sometimes collaborates with the Child Adoption Centre (CAC) when children in the programme are transitioned out of foster care into adoptive families. The foster programme under the BWCPW is generally considered a temporary solution while the child is waiting to be reintegrated into the original family, adopted by permanent families, or to give them 'time out' of a residential care facility and experience of living in family context.

The foster care programmes under the BWCPW coordinates with various government-run residential care facilities in order to place children in foster homes, with the vision that this experience will eventually lead

[60] Paraphrased from the Work Manual for the Foster Care Programme: Foster Care Families. Ministry of Social Development and Human Security, Thailand.

to successful reintegration into society. Foster families participating in this programme receive a monthly stipend of 2,000 Thai Baht (approximately 62 USD), in addition to necessary supplies for the child. Funding for foster care families is provided through government residential care facilities, which assess the families and provide follow-up and monitoring.

In the public-private collaboration, the foster programme of the Viengping Children's Home, in collaboration with the Holt Sahathai Foundation is one of the good practice examples of family-based care in Thailand. This programme was originally conceived as a short-term solution, yet one that was more beneficial for the child and potentially more efficient from a management and financial perspective. Trained Viengping staff make a contract with each foster family; the family receives 2,000 Thai Baht per month, as well as some essential supplies. This programme is also fairly unique in that it emphasises placing children living with HIV and affected by HIV in foster homes.

The Buriram and Rural Lives Development Programme foster care programme is another example of good practice. It began in 2002. Since then, the Buriram residential care facility and the Rural Lives Development Programme have worked together to place children in foster care. The first generation of foster children were orphans and the foster care programme was a stop-gap between the facility and more permanent placement in adoptive families. Yet over the years, foster care has often ended up being more long-term situation, with families often raising the children until they grow up. Buriram emphasises creating a network of foster families who share experiences and support each other. The carers receive 2,500 Thai Baht as well as extra support for school costs.

There are also other smaller foster care programmes run by NGOs as well as by private residential care facilities. The objectives for foster care vary between the different organisations and include, but are not limited to, preventing institutionalisation of children, providing protection from abuse, and preparing children for adoption. Among these organizations, the Centre for the Protection of Children's Rights (CPCR)'s foster care programme focuses on the placement in foster families of children who have experienced exploitation, neglect and abuse. The majority of foster parents are personnel from CPCR and therefore have the skills and capacity to care for these types of children.

2.8.2 Fragmentation of funding channels and management has prevented consolidation of foster care

Despite the BWCPW having been the primary agency responsible for foster care programmes in the government sector, government residential care facilities also sometimes received smaller amounts of funding from the Child Adoption Centre, as well as NGOs, to support foster families. In practice, the various funding sources and the absence of an integrated approach to management of foster care programmes have contributed to prevent consolidation of foster care as a significant component of alternative care.
Respondents also described a lack of standardised processes and assessment tools for monitoring and following up with kinship and foster carers. Monitoring processes varies greatly between and across programmes, with some respondents describing visiting families only once after reintegration, others describing more regular and long-term monitoring.

This situation mirrors what we discussed in relation to kinship care: there is a lack of clearly defined criteria to determine what a suitable minimum level of support should be (through financial and other means) towards ensuring the well-being of children in foster families and help build the resilience of their care-givers. As for kinship care, there is a general perception that the current level of support is inadequate.

There were also a small number of respondents at the national level who questioned the need for financial support for foster carers; in their opinion, financial support could provide the wrong incentive for families and/or be misused by families.

Also, similarly to what we discussed for kinship care, there are challenges in information sharing and coordination that sometimes affect how families can access information and support.

2.8.3 Cultural and administrative barriers to promoting foster care

As discussed previously, kinship care is widely practiced and culturally accepted in Thailand. The same level of social acceptance is not yet afforded to placing children with non-kin care-givers. Moreover, benefits of individualised family-based care and support are not always obvious to the general public, especially in terms of the long-term development of children. Many respondents cited cultural barriers to foster care systems, with Thai families reluctant to care for children who are not related to them.

Some of these barriers concern access to information and ensuring user-friendly systems and procedures for foster families. Commonly foster care-givers described difficulties such as accessing documentation required for their application process, and especially when preparing such documentation involves support or agreement from the biological parents of the child and in such cases case management becomes more complex. These difficulty sometimes prevent foster families from accessing available support.

Due to these administrative difficulties, which are also related to the lack of a systematized and efficient database in alternative care to access a child's information, sometimes it may take a long time for application and assessment processes to be completed. This situation erodes the motivation and the availability of these families to complete the process.

However, a major concern is how these administrative hurdles affect children who face increasing waiting periods to know whether they will be placed with a family, as this respondents indicated:

> *"The process of requesting adopted child previously required six months, but the process now takes over a year. It is a burden for the children, but they are a silent minority."* (Director, Private Residential Care, BMR)

These administrative hurdles are compounded by insufficient qualified human resources for case management. As a result, often it is difficult to achieve the stated aim of the programme to promote family-based care especially for children in residential care. Moreover, it appears that the fragmentation of the system and the insufficient clarity (especially at decentralized level) about the differences between the

government-run programme and the public-private collaboration at times results in unintended negative consequences for children. For example, although often conceived as a temporary measure between residential care facilities and adoption, foster care placements can become more long-term and act as a de facto adoption system / transition into formal adoption, or can become a barrier to longer-term solutions. Respondents described situations where children are placed in foster families, their files are 'forgotten', and they are not placed for adoption. Alternatively, the parents'/guardians' refusal or inability to take back the child while not allowing the child to be given up for adoption could also result in situations where the child would end up being in foster care for a long period of time, missing its chance to be adopted. In this respect, it appears that sometimes these programme have challenges to ensure the best interest of the child.

These systemic issues appear to have a detrimental effect on some children's experience of foster care. For example, informants described situations where children in foster care were withdrawn from their families once permanent adoptive families had been found, resulting in emotional difficulties for the child and sometimes behaviour problems. The fear that the child would be taken away from them was also described as resulting in reluctance on behalf of families to foster a child. Additionally, since foster care is considered a temporary solution, renewed on a regular basis and (as described above) often contingent on available funding and the family's situation, respondents described children as often being moved around from family to family, or back and forth between facilities and foster families, again upsetting the child's development and welfare.

Although recognising the need to be sensitive to the cultural context, these findings point to the need of ensuring that assessment and follow up processes become more standardised around the core principles for the implementation of the UN Guidelines and the best interest of the child. This requires recognising that "foster care is a complex and highly specialised task that deserves greater recognition." [61] The findings however show that the current policy response still relegates foster care almost within the parameters of a pilot programme disconnected from a system strategy for alternative care, and in which the only major incentive is welfare support, though this too is limited.

2.9 CHILDREN LIVING WITH AND AFFECTED BY HIV/AIDS AND CHILDREN WITH SPECIAL NEEDS

2.9.1 Challenges to realize the principles of the UN Guidelines for children living with or affected by HIV/AIDS

As previously discussed, stigma and discrimination associated to HIV/AIDS appear to still play a major role in increasing vulnerability to and risk of separation from family-based care, especially for children with children with special needs and children living with or affected by HIV/AIDS. Despite the legal and policy framework's explicit anti-discrimination provisions, stigma and discrimination were identified almost universally as drivers

[61] CELSIS (2012). MOVING FORWARD: Implementing the 'Guidelines for the Alternative Care of Children' page 90

of separation still pervasive in family and in institutional settings, especially in government schools, affecting these children.

Moreover, the way in which residential care is structured appears to reflect an approach to providing care for children living with or affected by HIV/AIDS which is not conducive to eliminating stigma and discrimination and prioritizing family-based care. Four of the 34 government-run residential care facilities in Thailand are mandated specifically to care for these children. These facilities are spread throughout the country, with one in each region (northern, north eastern, central, and southern). There are also five government facilities specifically for children with disabilities, and which are all located within the central region. In contrast, a higher proportion of registered private residential facilities as well as boarding schools care for children living with or affected by HIV/AIDS than the proportion of residential care facilities caring for these children in the government sector.

As previously discussed, the relatively large numbers of government and private facilities caring for these children suggest that institutionalisation is seen as a principal option – not a last resort – to care for these children. This is confirmed by perceptions expressed by many service providers and local key informants who, although recognise that residential care is not the best solution, ultimately see it as the only realistic option in the current context of alternative care and feel that more facilities designated to care exclusively for CABA are needed. This is evidenced by numerous respondents, including former residents, who identified the insufficient number of these types of residential care facilities as a challenge to ensure the well-being of these children:

> *"There is a bit of a problem on referral because there are few facilities that accept children with HIV, we need to contact many places, like Baan Viengping in Chiang Mai and Camillian in Rayong."* (Former Resident, BMR)

> *"There is a problem for HIV infected kids because there is no residential care facility under the charge of the government to take over the fostering of these children because we can serve just for three months."* (Psychologist, Shelter for Children and Families, Northern Region)

> *"The big issue is where to send them, because there are no appropriate facilities. Pattaya does not accept small children. They have to be sent to Ban Chang in Rayong province. For HIV children there* are hardly *any government facilities."* (Social Worker, Private Residential Care facility, Central Region)

When placed in the context of a policy framework that facilitates long-term institutionalisation, these findings point to the difficulty of realizing the principles of necessity, suitability as well as the best interest of the child for children living with or affected by HIV/AIDS. Furthermore, due to varying capacities for care within different facilities, as well as changing needs of children who enter alternative care, some government facilities have evolved over the years into being recognised by others as, for instance, facilities able to care for CABA. These facilities therefore often receive children from a wide area, which can pose challenges in terms of maintaining links with their families and reintegration. The implication is that often CABA are referred away from where they live.

Table 6a and 6b listed below give approximate numbers as to the scale of HIV+ children living in residential care:

Table 6a: Total Numbers of Children and HIV+ Children in Government Residential Care

Total No. of Children	Total No. of HIV+ Children	% of Children who are HIV+ in Residential Care
7,313	254	3.47%

*Figures based on primary data collection through survey and phone interviews with 34 Government Residential Care Facilities under the MSDHS, 2015.

Table 6b: Total Number of Children and HIV+Children in 37 Surveyed Private Residential Care

Total No. of Children	Total No. of HIV+ Children	% of Children who are HIV+ in Residential Care
2,325	178	7.66%

*Figures based on primary data collection through survey and phone interviews with 37 Private Residential Care Facilities registered under the MSDHS, 2015.

As these figures show, the percentage of children living with HIV in the private residential care is 2 times higher than the public residential care. This indicates a disproportionate number in the private residential care.

2.9.2 Challenges in providing specialised care for children with HIV

This situation affects the quality of care that these children receive and especially in terms of individualised care. Although in some cases an HIV positive child may need special services (such as medical services), this could be the case for a child facing any type of crisis or problem and it was mentioned, especially in government facilities, that the need for some special services is not unique only to HIV positive children. The official emphasis tends to be on standardising the approach to CABA to be in-line with children not infected with or affected by HIV, despite some caveats to providing specialised medical care, as needed. However, this approach is undermined by insufficient numbers of qualified personnel.

Although this approach may contribute to normalize HIV and disability and help reduce stigma and discrimination, our data shows that CABA were treated differently in terms of having specialised and more detailed IDP. However, we found insufficient focus on development of social and emotional competencies and a lack of attention to gender issues. For example, throughout the data collection we found a significant gap in helping HIV positive children cope with their HIV status as they grow, especially around skills such as:

- Managing disclosure of their HIV status
- Managing safely becoming sexually active

- Managing safely adherence to treatment as they become more independent of their care-givers
- Coping and overcoming inner stigma about their HIV status and institutionalised status
- Developing skills to manage power imbalances in inter-personal relationships as they grow and especially once they become sexually active

These findings point to the need of including the development of these competences in the IDP of these children and with a focus on making such IDP gender-sensitive. Unless children are supported to manage these issues, the current standardised approach may become a fragile shell that provides very limited protection to the complex and evolving vulnerabilities these children face as they grow.

We must emphasise, however, that our data shows that in cases where facilities also have children without HIV or disabilities, they tend to apply IDP for children with special needs as well as CABA while they just follow more standard development plans for these 'normal' children. This is explained in these two examples:

> *"Each child has a personal development plan. There's a meeting for multidisciplinary team including nurses, social workers, psychologists, teachers and nanny in each building and talk about what problems this child has. We separate it to physical problem, social problem, intelligent problem and language problem. […] But we have the same plan for all the physically and mentally fit children. We have one teacher per class and all children study the same basic material. Those that are mentally challenged such as children who start talking later than usual or cannot pronounce properly will remain with us and we will give them special education."* (Social Worker, Government Residential Care facility, BMR)

> *"We need to collaborate with child psychologist, the mental health department also does IDP. […] But if it's normal development plan, the staffs would have the form they got from the central government, we all use the same form. […] It's the child development evaluation report. If we are talking about older children, there is also a developmental plan from the school, because in the daytime, children would go to school and spending time in school for 8 hours."* (Social Worker, Government Residential Care facility, BMR)

However, we found a general lack of sufficient qualified personnel and this undermines both provision of individualised care and case management for reintegration.

2.9.3 Reintegration of children living with or affected by HIV/AIDS

These children require specialised care, such as medical care, compliance to treatment regimes, and psychological support. The material and emotional costs of providing such care were often cited as reasons that families provide to insist that children remain in residential care. The lack of community-based support for these children and their families compounds these barriers.

As previously discussed, respondents often described existing welfare support as insufficient to meet children's essential needs. For CABA, this factors intersect with other drivers of separation such as poverty and discrimination:

"We have a problem tracing the parents of HIV infected children. According to the evaluation there are 5 people left. Nobody wants them, because of the disease. They tell us directly that they do not want them. This is the original family. In foster families there are none (HIV infected children), because even for normal children there is no one prepared to receive them." (Social Worker, GRC, Southern Region)

Thus stigma and discrimination continue to reinforce the common perception that residential care facilities often are the only care option for these children.

Problems in caring for and reintegrating these children were described by respondents as very often compounded by insufficient social services and support systems such as day care services, particularly for parents who have to work as well as grandparents or other elderly carers who might face difficulties in caring for children on a daily basis.

However we also found that sometimes the attitudes of personnel in government residential care facilities may not be conducive to reintegration. For example, sometimes personnel appear to believe that institutionalisation is necessary in most cases to ensure adherence to treatment when or if preparing children and families to manage adherence is problematic:

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"Medicines make them stable. We train children daily life routine. Very few cases can be sent back to their family. We see that this kind of things can be pass on genetically. The risks make the situation dangerous. At first we consider that the temple is a suitable place as a care provider. But then, if they don't get medicine, there would be problems, families have to really be ready to care for children and children also really need to be ready, otherwise we can't send them back." (Psychologist, GRC, Central Region)

What transpires again is the need to refocus the development and management of IDP, and case management, towards building essential emotional and social competencies to contribute to facilitate reintegration.

As previously discussed, the long-term institutionalisation pattern that many children living with HIV experience is also due to how residential care is structured in Thailand with facilities (both in the government and private sectors) accepting children from other provinces. In this context, maintaining contact with the family or care-givers become very difficult. In the private sector, these issues are compounded by the fact that many facilities do not have a focus on reintegration and function as a pull factor for institutionalisation.

2.9.4 Examples of good practice to better address the needs of children living with or affected by HIV/AIDS

As this study focused on Children living with HIV disease or affected by HIV/AIDS, this report presents examples of good practice that directly relate to these children. However the practices described in these example can be adapted to all children. These examples include:

- **Support network for parents living with HIV – supported by Daughters of Charity**
  In Phayao, parents living with HIV and who are from disadvantaged socio-economic backgrounds are part of a peer support network, which is in turn supported by a Christian NGO, Daughters of Charity. [62] This network aims to provide support to parents to care for their children, as well as assistance for CABA and children from disadvantaged socio-economic situations. Although initially focusing on people living with HIV, the network has now expanded to assist other families and children affected by poverty, family problems, etc. Members of the network notably receive scholarships from the NGO for their children to continue studying through to their Bachelor's degree. They also receive other material support such as milk powder or school materials. Additionally, members help and support each other in caring for children of group members. The NGO has also provided the members of this network with training to be able to provide peer-to-peer education about life skills and reproductive health, as well as training in project proposal development and project management. Importantly, they also receive assistance from other members of the network in accessing government welfare support. The parents describe this support network as assisting them in continuing to care for their children.

[62] The NGO Daughters of Charity also supports similar peer support networks for parents living with HIV elsewhere in Thailand. However, the research team visited and met with members of one such support network in Phayao.

- **Holt Sahathai Foundation/Viengping – foster care programme, including HIV+ children**
  Respondents very often cite the Holt Sahathai Programme and Viengping Residential Care Facility collaboration as model of good practice in terms of reintegrating children into family-based care. Emphasis is placed on the reintegration of children into their original families as well as linking children in residential care into foster homes. Respondents also described the social workers who were trained through this programme as providing strong support to families, and being key to the successful reintegration of children into family-based care. The Viengping foster care programme can be considered a model of good practice in terms of reintegrating children into family-based care systems – this programme is inclusive of younger and older children, and focuses particularly on children living with HIV. Foster families receive training and ongoing support from trained social workers. Families fostering children living with HIV receive initial training in how to care for these children, including adherence to treatment programmes. They also receive ongoing support from trained social workers from the Viengping residential care facility, with whom they have established strong working relationships and who they can call on when they require advice and additional support. Additionally, the integration of children living with HIV into local communities and schools through this programme can be seen as very positive from the point of view of the welfare of the child. Respondents described the children as now being accepted by their communities, with initial stigma and discrimination having given way to a community context that is now more supportive of the welfare of the child.

- **Welfare and community support systems in the Deep South**
  There are currently examples of good practices in the South in terms of welfare and support systems for vulnerable children and families. In particular, there are currently "packages" of assistance for CABA, with the PSDHS collaborating with the Provincial Public Health Office in order to identify and provide scholarships to CABA; this support is significantly more than support provided in other areas, and can act as a strong preventative mechanism, reducing the tendency for CABA to be placed in residential care facilities. However, there are additional challenges highlighted by respondents in terms of the reluctance by potential recipients to disclose their status (if they themselves are living with HIV) or the status of their parents. Due to strong community-level systems including a community-level Committee dealing with issues affecting children and families, Songkhla in the Deep South was cited as an example of good practice in terms of welfare systems that are more accessible by community members.

  Additionally, examples from the South further illustrate the ways in which community-level support networks such as those outlined above are one way to improve access to existing welfare and social protection systems. District and sub-district level government workers, social workers, community development officers, village leaders, and other key stakeholders at the local level can also be further mobilised as important links for potential beneficiaries into welfare and social protection mechanisms. In Yala and Songkhla, for example, respondents cited many examples of how these types of local level actors as well as community-level networks can act as a 'bridge' to accessing welfare and social protection systems, as well as providing other, non-tangible support mechanisms for families. Additionally, traditional religious and community support systems were described as playing a part in filling in the gaps welfare support for vulnerable children and families.

PART 3

RECOMMENDATIONS

3.1 REVIEWING LEGAL AND POLICY FRAMEWORKS

The weaknesses identified in the legal and policy framework require urgent attention in order to ensure that any action taken at operational level will not be merely temporary fixes. For this reason it is recommended that a focus on strengthening a system approach to alternative care should balance prevention of separation and addressing the needs of children who find themselves in need of alternative care.

An improved system approach should be informed by the core principles of the UN Guidelines and aim to increase resilience and capacities of children families and communities to cope with social vulnerabilities influencing separation.

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In order to achieve these aims, the following priority overarching recommendation is suggested:

- Under the auspices of a relevant department of the Ministry of Social Development and Human Security and with expert support by UNICEF, convene a time-bound High Level Technical Working Group comprising of key stakeholders such as (but not limited to) the Ministry of Social Development and Human Security, Ministry of Public Health, Ministry of Education, and Ministry of Interior as well as relevant civil society organization with proven good practice expertise in alternative care to clarify roles and responsibilities to ensure effective coordination in implementing the current policy framework.
- In particular, this Technical Working Group would review the findings of this report and draw on the menu of recommendations provided below and making specific commitments on taking them forward.

Recommended key objectives for the work of Technical Working Group (Figure 3 and Table 7):

- Harmonizing the child protection legal and policy framework to the CRC and to the core principles of the UN Guideline, and addressing the fragmentation of the current framework.
- Developing a clearly articulated multi-sectoral opeartional strategy for alternative care around the goal of prioritizing family-based care (FBC) including clearly defined roles and responsibilities, and guidelines for coordination, oversight, and accountability.
- Ensuring child-sensitive social protection in support of family-based care with a focus on strengthening financial and material support as well as community-based services and networks.

Figure 3: A system approach to alternative care

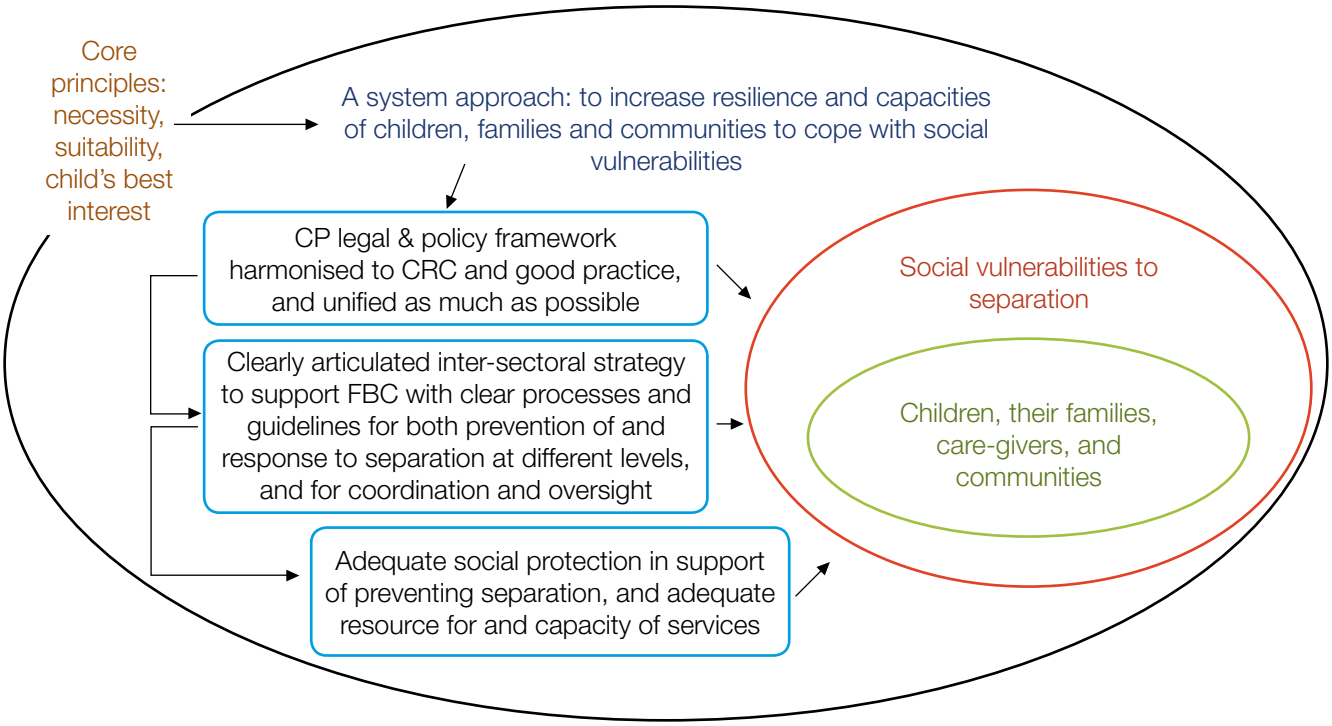

Table 7: Menu of specific and prioritised recommendations for consideration by the High Level Technical Working Group:

Type	Recommendation	Potential Time frame
Policy	As the 2003 Child Protection Act has never been reviewed since its implementation and recognising that best practice guidance has advanced since then, conduct a review of the Act in order to identify and revise provisions that facilitate long-term institutionalisation as well as impede a system approach. Ensure this review engages stakeholders at all levels (central, provincial, local) and involves civil society to represent the aspirations and needs of children, their families and communities.	1 year
	Ensure harmonization of the Child Protection Act with the CRC and with the principles of the UN Guidelines. Use the principles of the UN Guidelines as benchmarks to develop a multi-sectoral operational guidance for alternative care that identifies roles and responsibilities, mechanisms for coordination and accountability at all levels. The strategy should include steps and time lines to re-orient the alternative care system to prioritize family-based care with concrete measure to reduce reliance on residential care for all children as much as possible, including children living with or affected by HIV/AIDS. Harmonization with the CRC should also strengthen a focus on participation of children.	1 year
	Ensure the policy review build on examples of good practice to develop alternative care options for children with special needs and children living with HIV and affected by HIV/AIDS, and/or who have been abused/neglected/exploited, with the aim of preventing placement in residential care facilities and prioritizing reintegration in FBC. Ensure a focus on community-based alternatives to residential care such as group homes and foster care systems with trained, skilled care-givers.	1 year
	Review processes and mechanisms for registration of private sector organizations working in alternative care in order to strengthen integration of the private sector in the alternative care system and improve standardisation of care and accountability. In particular, identify which government authority should be primarily responsible for registration and mechanisms for coordination and accountability if more than one government authority is involved.	1 year
	Review standards of care in residential care to ensure a balanced emphasis on both meeting essential care needs as well as reintegration in family-based care. Ensure this balance is reflected in assessment processes for both government and private sectors.	1 year
	Reduce barriers to access to formal kinship care i.e. review current ceiling-based design of the system.	1 year
	Remove policy barriers/bias that currently prevent foster care from becoming an option in alternative care i.e. ensure foster care is not marginalized in alternative care.	1 year
	Review social protection for alternative care in order to provide support more holistically and in a life-cycle perspective to better respond to needs throughout the development of the child (e.g. child care services, support for care skills of parents of children with special needs and children living with HIV and affected by HIV/AIDS), as well as support for children to access education and vocational training opportunities adapted to their age, needs and capacities. Support should also mean reducing barriers to accessing services, as well as providing more intangible forms of support that would help parents/care-givers continue to care for their children (e.g. support for care-givers through counselling and peer support).	1 year

Type	Recommendation	Potential Time frame
Operational	Evaluate the effectiveness of current foster and kinships care programmes and define criteria to determine an adequate minimum level of financial and material support for children in family-based care. These criteria should take into consideration whether children have special needs for specialised care and support, and should be adjusted periodically to the cost of living.	1 year
	Identify ways to improve gatekeeping mechanisms across alterative care to become better aligned to the UN Guidelines principles. In particular, revise current practices in alternative care and develop guidance to be used by both the government and private sector to ensure that practices in residential care do not result in institutionalisation (refer to the definition of institutionalisation provided in the Glossary). Define a time line for phasing in such guidance and ensure assessment procedures include focusing on its implementation.	6 months
	Identify and address barriers to knowledge of current support for family-based care.	3 months
	Standardise processes for assessment, follow up and monitoring across actors involved in promoting existing formal family-based care.	6 months
	Standardise assessment system for registered private residential care facilities similar to the system used for government facilities and to be overseen by the MSDHS. Clearly define how oversight of private sector facilities should happen, including corrective measure if facilities have challenges in complying.	6 months
	Clarify essential competencies and roles and responsibilities for different personnel involved in different types of alternative care, ensure that such competencies and responsibilities more effectively reflect a child protection and life cycle approach to enable better understanding of children and their families. Ensure that training is standardised accordingly and updated as good practices evolve. Ensure the training is competency-based and developed according to good practices in experiential learning. For example, refer to the competencies defined in the 2014 Child protection case management: Training manual for caseworkers, supervisors and managers by the Global Protection Cluster Child Protection/European Commission/USAID.	6-12 months
	Assess the types and numbers of qualified personnel needed across alternative care to ensure quality care especially for case management, IDP, deinstitutionalisation strategies. Estimate resources necessary to recruit these personnel and develop a recruitment and training strategy (e.g. refer to the 2014 Child protection case management: Training manual for caseworkers, supervisors and managers by the Global Protection Cluster Child Protection/European Commission/USAID).	6-12 months
	Standardise training in policies, law and welfare support systems for key staff such as social workers, village health volunteers, village leaders etc. in order to ensure that these actors would work as a network, cooperating closely with communities and enabling access to services to strengthen prevention and response to abuse/neglect.	6-12 months

Type	Recommendation	Potential Time frame
Operational	Increase staff and capacity for alternative care management at all levels. Although it is important to capacitate key personnel as social workers and case managers within agencies, MSDHS, Provincial Shelters and facilities it is equally important to focus on capacitating actors at the local level to bring services to the community and mobilize the community to prevent the separation of children, support alternative care, and assist with / provide ongoing monitoring of the reintegration into family-based care. This also requires a focus on addressing cultural barriers to alternative care, especially resistance to foster care outside of the traditional Thai understanding and beliefs that residential care provides better care or better education opportunities than the family.	1 year
	Capitalize on Ministry of Interior's system of allocating ID for all new-borns. Use this ID throughout the whole system of alternative care.	3 months
	Develop an online system to record all information on each child in alternative care.	6-12 months
	Investigate unregistered private residential care facilities and assist them to register.	3 months
	Increase awareness in the community about the benefits of family-based care options and the disadvantages of institutionalisation for child development.	Ongoing
	Create a web-based directory of all existing social protection services relevant to preventing risk of separation and supporting family based care. This web based information would be managed by MSDHS but with support and cooperation from all Ministries engaged in those services. This web based information would be accessible to the public and would also be distributed in print to local actors such as Sub-District Administrators, Village Volunteers, and Community Development Volunteers with the aim of increasing awareness of and access to social protection.	6-12 months
	Design and implement a pilot at local level i.e. sub-district to develop a database of families who are willing to become foster carers. This could be a collaboration involving village heads, community leaders, and the local Sub-District Administrators would be the managers and working in close collaboration with the Sub-District Child Protection Committee. Funding for this pilot could be shared between MSDHS and MOI.	12 months

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PART 4

CONCLUSION

The study found that main challenge to ensuring the best interests of the child are met is the insufficient management, oversight and implementation in every single alternative care placement option. These problems start with a legal and policy framework that is not fully harmonized to the CRC and poorly resourced and implemented.

Most of the resources in alternative care are going into residential care, often long-term and in contrast options for family-based care are limited. Moreover, international reviews have shown that residential care tends to create institutionalisation if it focuses on practices such as:

- isolating or limiting participation of children from the mainstream community, providing little opportunity for inclusion in normal everyday life and experiences;
- housing relatively large groups of non-family members who are compelled to live together;
- resulting in prolonged periods of separation from the child's family, friends and community;
- organizing daily life according to a regimented routine that cannot respond to the individual needs and wishes of the children; and
- segregating children from the community owing to a diagnosis of disability and/or chronic illness.

Our study indicates that most residential care facilities in Thailand tend to implement these practices, both in the government and in the private sector. We recognise that the disproportionate focus on residential care partly is due to historical and contextual reasons, especially concerning children living with HIV or affected by HIV/AIDS. The early years of the epidemic were characterised by high mortality of both parents and children who had contracted the virus; treatment options were extremely limited to opportunistic infections; stigma and discrimination was a very significant barrier to overcome in most sectors of society.

Residential care provided one of the few options for care, especially for children who had lost their parents or whose parents were becoming increasingly ill and unable to fulfill their parental role. However, the situation in many ways has radically changed. HIV has become a chronic illness and treatment enables people living with the disease, including children, to lead long and productive lives. Good practice guidance has developed significantly both in the HIV field as well as in alternative care and in both arenas good practice is informed by a rights and equity perspective. Therefore it is difficult to justify the current policy framework

which does not sufficiently reflects the shift to a rights and equity perspective. As a result, the current policy framework contributes to maintain a very limited focus on prioritising prevention of separation from family-based care and mostly informs a reactive operational response. There is a need for a clearly articulated operational strategy that engages other sectors outside of the MSDHS to address the diverse set of drivers that have been found to contribute to family separation and institutionalisation. The silo that exists between the public and private sectors in providing alternative care creates duplication, inconsistent practice, and most importantly a situation where children go unmonitored and in potential harm.

Addressing these problems should include ensuring that the private sector becomes integrated in such a system approach through effective oversight modalities. Moreover, from a perspective of best use of limited resources to prevent separation and institutionalisation, it is imperative that the public and the private sectors operate as a coordinated and synergistic system. It is also necessary to address cultural barriers and social norms that reinforce institutional care. This has to start by reviewing the current legal and policy framework which currently facilitates institutional care and limits kinship and foster care. Finally, it is necessary to recognise that ensuring the best interest of children in need of alternative care – and especially the most vulnerable children - requires adequate resourcing of the system, including child-sensitive social protection that is more than financial and material support and helps building resilience at community-based level to keep children in family-based care.

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