

ICPD at 15 Progress and Challenges in Implementing the Programme of Action in Thailand



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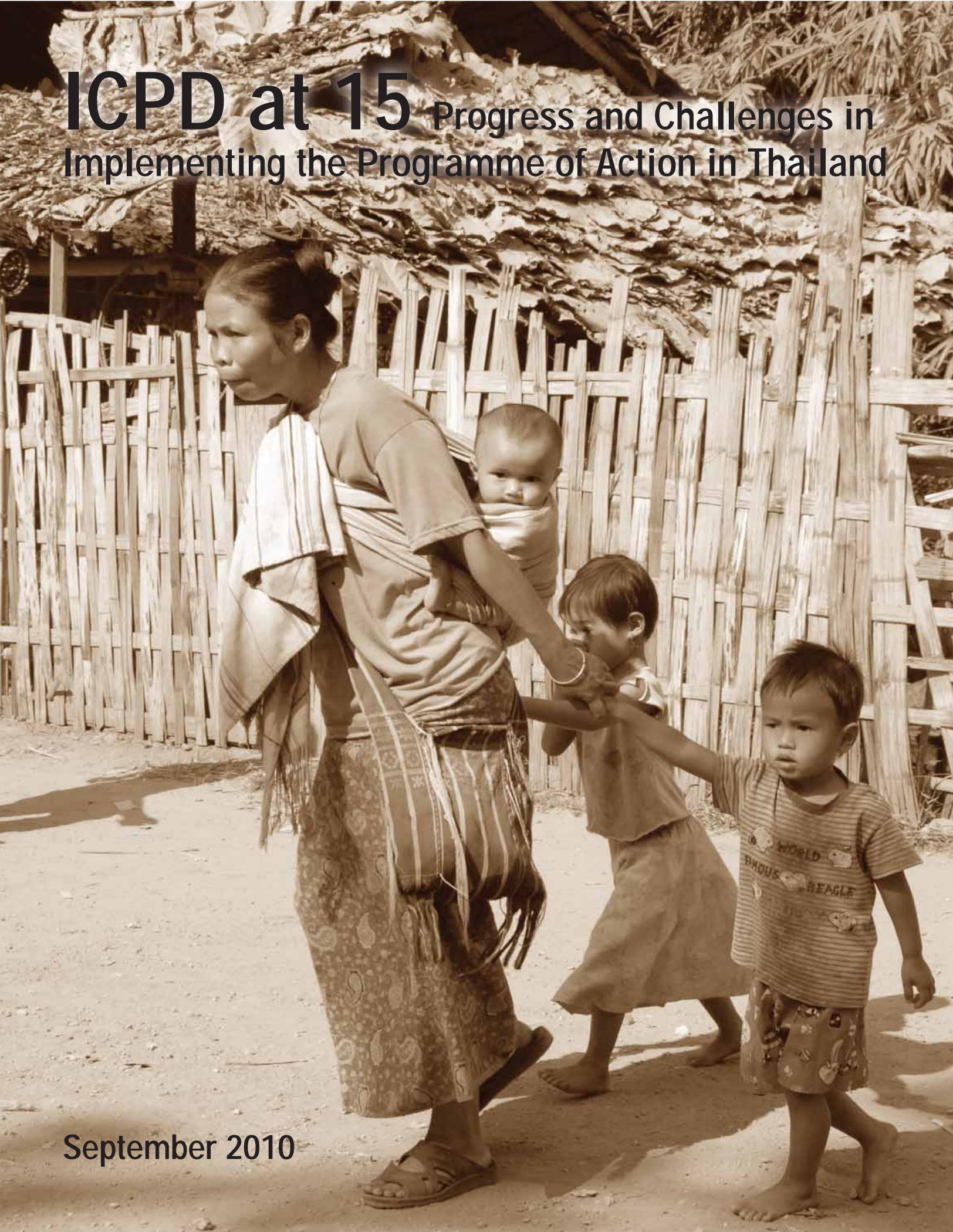
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September 2010

Foreword

The year 2009 marked the 15th anniversary of the International Conference on Population and Development (ICPD) and the last 5-year review of the implementation of the Programme of Action (PoA) before its final evaluation in 2015.

The Ministry of Public Health is pleased to issue this report on the progress that has been achieved and the challenges that remain in implementing the ICPD PoA. This report is based primarily on the findings of a review of the current status of the implementation of the ICPD PoA vis-à-vis the Millennium Development Goals (MDGs) through desk reviews of national statistics and reports, including other reliable data sources as well as the proceedings of consultative meetings with key stakeholders and experts. This report draws on Thailand's experience in implementing the ICPD PoA and highlights the good practices, lessons learned, emerging challenges and obstacles faced by the country, and recommends priority actions to be taken to move the ICPD agenda forward.

Despite the considerable success that Thailand has achieved for most of the ICPD targets and the MDGs, there are some areas that require further attention and concerted action to ensure that Thailand will fully achieve these goals and targets by 2015 and beyond. These challenges include working toward universal access to social services and social protection and reducing inequality, gaps and disparities, particularly among vulnerable populations.

The Ministry of Public Health would like to acknowledge and extend its appreciation to the United Nations Population Fund (UNFPA) for its continued support for Thailand in the implementation of the ICPD PoA, as well as the assistance provided for the periodic reviews of progress of the ICPD+5, ICPD+10 and the ICPD+15.



Jurin Laksanawisit
Minister of Public Health
Thailand

Message from UNFPA Representative

On the occasion of the fifteenth anniversary of the historic International Conference on Population and Development (ICPD) held in Cairo in 1994, UNFPA, the United Nations Population Fund, in collaboration with the Department of Health (DoH), Ministry of Public Health (MoPH) along with key stakeholders, has reviewed and appraised the implementation of the ICPD Programme of Action (PoA) in Thailand. The review and appraisal process took place throughout 2009 to mid-2010 with participation and involvement of a wide range of the line ministries and the civil society organizations. The review focused on the progress, gaps, and the commitment for a concrete action agenda to achieve the goals of ICPD Programme of Action (PoA), the Millennium Development Goals (MDGs) and other internationally agreed development initiatives.

The report reveals that Thailand has accomplished most of the indicators of ICPD PoA and the MDGs. However, disparities persist in some areas particularly among the vulnerable populations such as the people living in remote areas including ethnic groups and migrants. In addition, as an emerging Middle Income Country (MIC) Thailand faces major challenges from the consequences of its rapid demographic transition which includes rapid population ageing with a rising dependency ratio and declining working age population. This will dramatically impact the country's development which requires greater attention and action to adapt to these consequences and sustain the momentum of development progress.

I wish to acknowledge the valuable inputs and contributions of the DoH/MoPH and other partners in the development of this assessment report. Special thanks are also due to the hard working staff of the UNFPA Thailand Country Office for their substantive inputs and for organizing comprehensive consultations with the government, civil society and other partners to ensure completeness and accuracy of this report. Last but not least, special thanks to UNFPA consultant, Ms Parichart Siwaraksa, for her hard work and completing the report in a timely manner.

It is our hope that the findings of this report will further accelerate the implementation of the ICPD PoA with special attention to reducing disparities in accessing services. The full achievement of the ICPD PoA will indeed contribute directly to the achievement of the MDGs aimed at reducing poverty, hunger, poor health, HIV/AIDS and gender inequality by 2015.



Najib Assifi
UNFPA Representative in Thailand and
Deputy Regional Director of Asia and the Pacific Regional Office

Acronyms

ARH	Adolescent Reproductive Health
ARV	Antiretroviral
AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DDC	Department of Disease Control, Ministry of Public Health
DoH	Department of Health, Ministry of Public Health
FP	Family Planning
GDP	Gross Domestic Product
GMS	Greater Mekong Sub-region
GO	Governmental Organization
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology
ILO	International Labour Organisation
IMR	Infant Mortality Rate
IOM	International Organization for Migration
IUD	Intrauterine Device
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MoPH	Ministry of Public Health, Thailand
MSDHS	Ministry of Social Development and Human Security
NESDB	National Economic and Social Development Board
NGO	Non-governmental Organization
NHSO	National Health Security Office
NSO	National Statistical Office
PHC	Primary Health Care
OECD	Organization of Economic Cooperation and Development
OSCC	One-stop Service Crisis Centre
PoA	Programme of Action
PATH	Program for Appropriate Technology in Health
PPAT	The Planned Parenthood Association of Thailand
RAMOS	Reproductive Age Mortality Study
RH	Reproductive Health
RTCOCG	Royal Thai College of Obstetricians and Gynaecologists
RTI	Reproductive Tract Infection
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TAO	Tambon Administration Organization
TCDC	Technical Co-operation among Developing Countries
TFR	Total Fertility Rate
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNPAF	United Nations Partnership Framework
WHO	World Health Organization

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1.1 The ICPD and MDGs

At the 1994 International Conference on Population and Development (ICPD) in Cairo, 179 countries agreed that population and development are inextricably linked and adopted a 20-year Programme of Action (PoA) on meeting women’s needs for education and health, promoting gender equality, eliminating violence against women, and ensuring women’s ability to control their own fertility.

Six years later, at the 2000 UN Summit, 189 countries endorsed the Millennium Development Goals (MDGs) to halve poverty between 1990-2015. The MDGs represent a range of development issues, including population and development that are crucial to achieve this global commitment. The MDGs are driven by time-bound targets and specific indicators. It is the

most significant global campaign in the past decade endorsed by the UN system and all heads of states.

For both ICPD and MDGs, countries gather every five years to report on implementation progress and assess the likelihood of achieving the targets. At these follow-up gatherings, countries and the UN system exchange ideas, share lessons and best practices, make adjustments on the strategies and plans, as well as set additional targets. At the 2005 World Summit, the largest-ever gathering of world leaders reaffirmed the need to keep gender equality, HIV and AIDS and reproductive health at the top of the development agenda. Subsequently, additional targets, including universal access to reproductive health by 2015, and related indicators were added to the MDGs.

ICPD and MDGs are closely linked. ICPD goals and objectives constitute an important part of the MDGs.

Table 1.1 Linkage of ICPD and MDGs

ICPD Programme of Action	Millennium Development Goals and Targets
Chapter 3, Objective 3.16:raise the quality of life through population and development policies and programmes aimed at achieving poverty eradication, sustained economic growth in context of sustainable development.....	Goal 1: Eradicate Extreme Poverty and Hunger Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day Target 1.B: Achieve full and productive employment and decent work for all, including women and young people Target 1.C: Halve, between 1990-2015, the proportion of people who suffer from hunger
Chapter 11, Action 11.6:All countries should further strive to ensure complete access to primary school or equivalent level of education by girls and boys as quickly as possible, and in any case before 2015.....	Goal 2: Achieve Universal Primary Education Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
Principle 4: Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women’s ability to control their own fertility, are cornerstones of population and development-related programmes.....	Goal 3: Promote Gender Equality and Empower Women Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015

ICPD Programme of Action	Millennium Development Goals and Targets
<p>Chapter 8, Action 8.16:By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000.....</p>	<p>Goal 4: Reduce Child Mortality Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</p>
<p>Chapter 8, Action 8.21: Countries should strive to effect significant reductions in maternal mortality by 2015; reductions by one-half of 1990 levels by 2000 and a further one half by 2015.....</p>	<p>Goal 5: Improve Maternal Health Target 5.A: Reduce by three quarters, between 1990-2015, the maternal mortality ratio Target 5.B: Achieve by 2015, universal access to reproductive health</p>
<p>ICPD+5 Report:by 2005, ensure at least 90 percent, and by 2010 at least 95 percent, of 15-24 age group has access to information, education, communication and services to develop life skills required to reduce their vulnerability to HIV infection; that by 2025 prevalence is reduced globally, and by 25 percent in the most affected(Para 70)</p>	<p>Goal 6: Combat HIV/AIDS, malaria and other diseases Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS Target 6.B: Achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases</p>
<p>Chapter 3, Action 3.5:population issues should be integrated into formulation, implementation, monitoring and evaluation of all policies and programmes relating to sustainable development.....</p>	<p>Goal 7: Ensure Environmental Sustainability Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources Target 7.B: Reduce biodiversity loss, achieving by 2010, a significant reduction in the rate of loss Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum-dwellers.</p>
<p>Chapter 15, Objective 15.15a: To strengthen the partnership between governments, international organizations and the private sector in identifying new areas of cooperation.....</p>	<p>Goal 8: Develop A Global Partnership for development Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Target 8.B: Address the special needs of the least-developed countries Target 8.C: Address the special needs of landlocked countries and small island developing states Target 8.D: Deal comprehensively with the debt problems of developing countries Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications</p>

1.2 Thailand and the ICPD and MDG Challenges

Following the ICPD in 1994, Thailand declared the Reproductive Health Policy in 1997 which stated that “All Thai citizens, at all ages, must have good reproductive health throughout their entire lives”. The 1997 Constitution and subsequently the 2007 Constitution also stipulated that all persons are equal and shall enjoy equal protection under the law. This means that men and women shall enjoy equal rights including reproductive rights.

In March 1999, the Royal Thai Governments issued the Thailand Progress Report on the ICPD Plan of Action for the review of the ICPD at 5.

Thailand’s first MDG Report was prepared in 2004, and the ICPD+10 Report came out in the same year. Both reports suggested that Thailand had achieved most of the ICPD and MDG goals. But disparities persisted among vulnerable groups and in some remote areas. In addition, achievement in terms of quality was not assured. Some key strategies to move beyond ICPD Goals and MDGs addressed in the ICPD+10 Report include the following:

- Reducing disparities in poverty among the provinces and in access to basic health and

social services, particularly in the southernmost provinces of Thailand;

- Improving community and youth participation, and empowering women by developing policies and programmes at all levels;
- Enhancing the provision of information, counselling and reproductive services for adolescents and youth;
- Involving men in promoting the reproductive health of women;
- Sustaining STI and HIV/AIDS prevention and care for those infected;
- Improving the population, social, and gender data to provide the knowledge base to strengthen evidence-based.

The country embraced the MDG challenges by introducing an ambitious MDG Plus (MDG+) concept. The MDG+ targets represent Thailand’s ambition to achieve MDG targets well before the MDG timeframe. Some MDG+ targets and MDG+ indicators also represent an attempt to broaden or deepen the MDG progress, or to focus on areas or population groups that have lagged behind the national average. Table 1.2 gives examples of MDG targets, MDG+ targets and MDG+ indicators related to maternal and child health.

Table 1.2 Examples of Thailand’s MDG Targets, MDG+ Targets and MDG+ Indicators on Maternal and Child Health

MDG targets	MDG+ targets	MDG+ indicators
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Reduce IMR to 15 per 1,000 live births by 2006. Reduce by half, between 2005-2015, the under-five mortality rate in highland areas, selected northern provinces, and the three southernmost provinces	Infant mortality rate in highland areas, selected northern provinces, and the three southernmost provinces Under-five mortality rate in highland areas, selected northern provinces, and the three southernmost provinces
Target 5.A: Reduce by three quarters, between 1990-2015, the maternal mortality ratio	Reduce by half, between 2005-2015, the maternal mortality ratio in highland areas, selected northern provinces, and the three southernmost provinces	Maternal mortality ratio in highland areas, selected northern provinces, and the three southernmost provinces
Target 5.B: Achieve by 2015, universal access to reproductive health	This target was introduced in the year 2007. Thailand has not specified any MDG+ target for this indicator.	Not specified

The Thailand Millennium Development Goals Report 2004 is the first National MDG Report suggesting situations, achievements, and challenges in achieving the MDGs. In addition to this report, there are several MDG-related reports and projects that contribute to raising the awareness and advocating for changes toward MDG goals.

- Every two years, in compliance with the Declaration of Commitment on HIV/AIDS signed by UN member states in June 2001, Thailand reports to UNAIDS on the progress made in response to the AIDS epidemic. The latest United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Thailand Country Report was released in 2010.
- Another report “Women’s Right to a Political Voice in Thailand” was prepared by Women for Democratic Development Foundation and UNDP Thailand in 2006 to highlight an area in which Thailand still lags behind - women empowerment.
- MDG was piloted as a tool for development planning and monitoring at the provincial level with the support of the Office of National Economic and Social Development Board and UNDP Thailand.
- The Ministry of Public Health (MoPH) published several documents and manuals about health-related MDG targets, indicators and data.
- The National Statistical Office integrated MDG indicators into the Thailand Development Information template developed for the Provincial Statistical Offices.

Thailand has prepared the second MDG report which was released in late 2010, which showed some impressive achievements as well as unmet targets, renewed and fresh commitments, as well as plans to move forward.





about 40% and 70% of GDP, respectively. Prolonged political instability and the global financial crisis put the Thai economy in slow gear again in 2008 when the economy contracted to 2.6%. Negative growth was forecasted for 2009.³ Despite the political instability and frequent changes of the government leadership in the recent past, the Thai economy continually expanded in 2010, supported by domestic spending which helped cushion the impact from slower growth in exports as a result of the global economic slowdown.⁴

One of the most important challenges for both MDGs and ICPD is the process which should be participatory, engaging, and integrative, not only during the preparation of the reports, but also throughout the programme cycle. The most successful MDG and ICPD experiences are those that have been fully integrated into the national development plans and programmes with active involvement from multi-sectoral partners, and have contributed to the overall improvement of the national development analysis, planning, programming, targeting, and monitoring and evaluation system.

1.3 National Development Context

At the time of the ICPD in 1994, Thailand was one of the fastest-growing Asian economies. During 1990-1994, annual GDP growth was between 8-11%. Since then, Thailand has gone through a period of economic and political turbulence. The first shock was the 1997 crisis that culminated in the devaluation of the Thai baht and resulted in a negative growth rate of -10.5% in 1998. About 40% of all households were estimated to suffer a reduction in income, ranging from 25 to 50%.¹ Poverty incidence jumped from 14.8% in 1996 to 17.5% in 1998 and 21.0% in 2000.²

Economic recovery took place during 2002-2007 when the economy grew at least 5% per annum. But this recovery was brief, and came with a price tag. The Thai economy grew more dependent on the world economy with imports and exports representing

In addition, the country was affected by global and regional threats such as emerging infectious diseases. Severe Acute Respiratory Syndrome (SARS) and bird flu caused public health scares in Thailand and several Asian countries during 2003-2006, followed by H1N1 flu in 2009 which has infected an estimated three million Thais. Thailand also encountered an unprecedented natural calamity, i.e. the tsunami in 2004. More common natural disasters (e.g. droughts and floods) have also become more severe. In 2007, 2.3 million and 12.8 million Thais were affected by floods and drought respectively.⁵

The rise of oil and commodity prices in later part of the 2000s was a direct hit on both urban and rural households. Instability of prices of agricultural products in the past few years led farmers to put pressure for longer-term support by the government including a call to increase accessibility to farm land for the poor. Moreover, there was a likelihood of declining number of farmers and a potential farming labour shortage in the near future. For the first time in many decades, the issue of food security was seriously debated in this major food-exporting country.

The unrest that flared up in Thailand's southernmost provinces since early 2004 has resulted in heavy casualties and has severely impacted the livelihoods of the people and the endeavour to improve the quality of life and the access to social services in this Muslim majority area.

Moreover, the on-going fluid political turmoil which started in 2005, was further aggravated by the disturbances in 2009 and 2010 which illustrates the various political standpoints among the political groups in the country. In response to the political events, the government has introduced the mechanism to develop the Thailand Reform Plan to advance a reform agenda in which one of the aims is to minimize disparities between the rich and the poor. The development process of the 11th National Economic and Social Development Plan (2012-2016) gives high priority to integrating core content of the national reform agenda into the national plan development process. The core mandate of the national reform process is to generate a driving force for reform within society, promote public participation and strengthen the various civil society networks and get them involved in contributing ideas for reform. For example, the committee of local administrative bodies should be able to mobilize all villages to take part in the reform process, while universities would be involved in the process through the committee working on higher education, and cooperation of the media in promoting public awareness and participation would be enlisted through the committee on communications.⁶

In brief, the past 15 years represent a very difficult environment when compared with the pre-ICPD period during which the country enjoyed steady economic growth fuelled by cheap labour, abundant natural resources, foreign capital investment, and a less competitive world market. To date, the rapid growth of country development is partly attributed to the 'population dividend' period during which there is a large proportion of working age population. This window of opportunity will disappear after the proportion of working age population peaks in 2009 at 67% and then drops to 62% in 2025.⁷ A parallel development is a drop in the share of children and youth, and the rapid expansion of the aged population, which indicates that Thailand is rapidly becoming an ageing society.

On the bright side, lessons learned from decades of development, coupled with exposure to various kinds of present and future risks, have stimulated policy makers' and the public's interests in human security and well-being issues. There have been significant developments in this area. Most important was the promulgation of the 1997 Constitution and

subsequently the 2007 Constitution that explicitly espouse the principles of human dignity, gender equality, rights to education and health care.

The paradigm shift is also noticeable in the 8th National Economic and Social Development Plan (1997-2001) that endorsed the "People-Centered Development" approach, followed by the 9th Plan (2002-2006) following the philosophy of "Sufficiency Economy" by H.M. the King that also stated "*Thai people in the next twenty years would have good quality of life and living with appropriate population growth, structure, and distribution, good reproductive health,...*". But it was the 10th Plan (2007-2011) that placed population issues at the heart of development planning; the plan aims to prepare Thailand for an ageing society.

The 1997 and 2007 Constitutions constituted fertile ground for the development of important pieces of legislation, for example:

- The Children Protection Act 2003
- The Older Persons Act 2003
- The Promotion of the Development of Children and the Youth Act 2007
- The Protection of Victims of Domestic Violence Act 2007
- The Prevention and Suppression of Human Trafficking 2008
- The Reproductive Health Act (on-going draft)

Significant developments are also observed in the areas of health. Thailand has been outstanding for its success in reducing health risks by expanding primary health care. The health system has a nation-wide network, comprised of high-quality professionals, provincial and district hospitals, community health centers, plus almost one million village health volunteers. In the past decade, there have been major undertakings and investments in health promotion as another way to combat non-communicable diseases that have become the number one health threat in the nation.

Another landmark development is the Universal Health Coverage (UHC) programme. The UHC was introduced in late 2001 and expanded to the entire nation in 2002 under the National Health Insurance Act 2002. It is now the cornerstone of Thailand's health insurance



system in addition to the social security scheme and civil servant medical benefit scheme. The proportion of the population having some kind of health insurance rose from 45.5% in 1996 to 71.0% in 2001 and 96.3% in 2007.⁸ Under the UHC, all kinds of medical care are provided free of charge for both out-patients and in-patients. The UHC also provides anti-retroviral drugs for AIDS patients.

There has also been excellent progress in the social security system since its introduction in 1990. At present, the scheme covers 8.8 million private employees in the formal sector. In addition to basic benefits, e.g. sickness and injuries, disability, death and child delivery, child support and retirement benefits were added in 2002, and unemployment benefits in 2004. In preparation for the ageing population, the Government is planning to extend the pension system to cover 25 million workers in the informal sector.

Another milestone is the enactment of the National Health Act 2007, which is outstanding for its extensive

participatory drafting process and the rights-based approach. Reproductive health and reproductive rights figure prominently in this very important legislation.

In brief, since the ICPD in 1994, the global, regional and national landscape has undergone substantial changes. Volatility in the world economy has had immense impact on the livelihoods of the people in this very open economy. It has therefore become more difficult for Thailand to protect the progress made to-date and to make further advancements to meet the MDG and ICPD challenges. Yet, because of these risks, the Government and the people have become more concerned and have made better preparations for the future. Fundamental institutional developments in support of human and social development goals are now in place. The government has made sizable investment in health and social services by expanding the coverage and upgrading the quality of health care services.



Population and Development

2.1 Changing Population Profile

Three major trends characterize Thailand's population profile in the past two decades: population ageing, urbanization and internal migration, and international migration.

2.1.1 Population Ageing

Thailand is rapidly heading toward an ageing society, which has far reaching long-term implications on all aspects of the economy and the society.

Progress/gaps:

During the last quarter of the 20th century, Thailand's 3.7% annual growth rate in the older population was

among the highest in the East and South-East Asia. At the turn of the century, with 9.6% older persons, the country had the largest aged population in South-East Asia. In 2010, older persons accounted for 11.5% of the population. It is projected that this age group will expand to 19.1% in 2025 and 26.4% in 2050.⁹ This pace of population ageing is many times faster than the experience in the West in the past.

The exceptionally high growth of the aged population is due to the rapid decline of the total fertility rate from above six children per woman in the 1960s to below replacement level in early 1990s, and the expansion of life expectancy. In 2007, the share of the population 60 years and over was about half of the population under 15 years old. By the year 2030, the elderly will outnumber those under 15 years for the first time.

Consequently, the potential support ratio (persons 15-59/persons 60+) is projected to fall from over 6.8 in 2000 to under three by the year 2025. Due to extended longevity, the older population itself is also ageing; the oldest old (persons 80 and over) are projected to increase by almost six-fold among between 2000-2050 (0.9% and 5.3%). There is also a pronounced sex imbalance: Women outlive and outnumber men especially among the oldest old.¹⁰

There are several other demographic trends associated with population ageing. The flow of young adults from rural to urban areas, combined with their common practice of leaving their young children under the care of rural grandparents, has resulted in a higher concentration of both children and the elderly in the rural areas. The provision and care for older persons will take on quite a different dimension than has been or currently is the case.



Institutional Framework for Ageing Population

Following the First World Assembly on Ageing in Vienna 1982, Thailand established the National Committee for the Elderly and developed the National Long-term Plan of Action for the Elderly (1986-2001), and subsequently the Framework for Long-term Policies and Measures for the Elderly (1992-2011).

After the promulgation of the 1997 Constitution, this institutional structure was strengthened when transformed into the National Commission on the Elderly in 1999 to provide policy guidance to a newly established Bureau of Empowerment for Older Persons, now under the Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups, Ministry of Social Development and Human Security (MSDHS).

The Commission formulated the Second National Plan for Older Persons (2002-2021) with an emphasis on quality ageing, well-being of older persons, social security for older persons, and research and development in support of policy and programme formulation. All of these pave the way for the Older Persons Act 2003, which provides the fundamental policy framework for welfare promotion, protection and empowerment of older persons.

Source: Mujahid. G. 2006. Population Ageing in East and South-East Asia: Current Situation and Emerging Challenges. Papers in Population Ageing No.1. Bangkok: UNFPA Country Technical Services Team for East and South-East Asia.

Likewise, the high rate of chronic and multiple health problems among older persons compared to the rest of the population also means that pressures on health facilities and services will increase enormously. In brief, these demographic developments will have important consequences for families, communities, and Thai society as a whole.

At present, traditions and family ties are still strong; children and grandchildren see it as their duty to take care of their elderly relatives. With smaller family size, migration, and urbanized life style, many families will have difficulty caring for the elderly. A high proportion of the elderly support themselves as over a third were working for their own living. But they still needed extra support from their younger family members. Those that were not working relied on their children for almost three-quarters of their income.¹¹

Priority policy/action:

Compared with other countries, Thailand's response to population ageing is relatively recent, but has become increasingly vigorous during the past decade. Many governmental and other organizations have shown keen interest in this issue. For example, older persons are included among the "vulnerable groups" in the United Nations Partnership Framework (2007-2011), a five-year development plan between all UN Agencies in Thailand and the Government.

Policy and Measures in Support of Older Persons

To date, the most significant measure is the old-age allowance. In 1993, the Government initiated a 200 baht monthly subsistence allowance for indigent persons aged 60 and over. This measure was somewhat institutionalized by the 1997 Constitution that stipulated that the elderly (60 years and over) with insufficient income have the right to receive assistance from the State, and that the State shall provide assistance to the elderly and other vulnerable groups. The old-age allowance was later increased to 500 baht. In 2006, about 1 million elderly benefited from this scheme. In April 2009, in the wake of the economic crisis, the Government turned this welfare assistance scheme into an entitlement by extending it to all older persons except those receiving a government pension. As of August 2009, 5,958,767 or about 85% of total number of older persons received this welfare. Another round of registration was launched in Fiscal Year 2010 to reach the remainder.

Other measures in support of the elderly include discounts on transport fares, tax rebates for taxpayers who take care of their older parents, and the Older Persons' Fund to support the elderly's income-generating activities. With regard to health care, the UHC scheme has already played an important role in reducing health-related expenses on the part of the elderly and their families. All government hospitals with more than 120 beds now have clinics to provide health services for older persons. The MoPH also encourages community hospitals to run elderly clinics and to conduct house visits to the elderly.

Other measures to upgrade the quality of life of the elderly are lifelong education, day centers for health care and support, family assistance, counseling, and other social activities. A pilot project on Volunteers' Home Care for the Elderly by the Ministry of Social Development and Human Security (MSDHS) has been adopted as a national policy for implementation by local administrative organizations nationwide.

With the recognition that the older persons will become a significant share of the population and that they can make a considerable contribution to the economy and the society, the Government is striving to induce a paradigm shift so that the society adopts a positive outlook toward "ageing" and "ageism".

Source: Mujahid. G. 2006. Population Ageing in East and South-East Asia: Current Situation and Emerging Challenges. Papers in Population Ageing No.1. Bangkok: UNFPA Country Technical Services Team for East and South-East Asia.

Of utmost concern is the financial security of the older persons especially for two-thirds of the workforce who are in the informal sector without any retirement provision. The old-age allowance has not been legislated for them, and is by no means sufficient to support a livelihood. The government, academics, and civil society groups are developing the alternative pension systems especially for this group.

Urgent attention is also needed for other kinds of support. Government facilities for the elderly health care are crowded and inadequate. Despite the increasing demand, the government's system of long-term care for the elderly is not in place. Private nursing homes have become popular, but they are viable options only among those who can afford the prices. Systematic data on the quality of the service are not available as many facilities are not registered as such.¹²

Ensuring affordable and quality health care for the elderly is another important challenge as older persons have higher risk of sickness and impairment. The UHC will undoubtedly play the most important role, but its capacity to shoulder the steep and rising health expenses for a large number of the aged has become a major concern.

The National Savings Fund

At present, Thailand has no national retirement fund. The 2007 National Survey of Older Persons indicates that 4.4% of the elderly relied on a pension as the main source of income. As for the current workforce, only two million private sector employees are members of the Provident Fund, while about 8.8 million are covered by the social security scheme. The Government's and state enterprise's retirement schemes cover approximately 3.5 million.

Initially, the National Savings Fund would provide coverage for 24 million in the informal sector who are uncovered by another pension. Subscription would be voluntary and the Government would also contribute.

Sources:

NSO. 2007. Survey of Older Persons in Thailand 2007.
Securities and Exchange Commission, 2008. Annual Report 2008.
Social Security Office. 2008. Annual Report 2008.

In terms of research and development, the Institute of Geriatric Medicine (established in 1992) is tasked with the development and transfer of new knowledge and technologies on gerontology as well as new effective models of health care for older persons. In any case, a large part of the care for older persons will be provided by the family, community, and local administrative organizations. Enhancing their capacity to take care of the elderly is therefore the most effective way to ensure a long and healthy life for Thailand's older persons.

2.1.2 Urbanization and Internal Migration

About one-third of the population now lives in urban areas. Internal migration has become more diverse and multidirectional as a result of rapid proliferation of provincial urban centers and the economic crises in the late 1990s and 2000s.

Progress/gaps:

About one-third of Thai people now live in urban areas.¹³ Internal migration is part of the transformation of the Thai economy from agricultural-based to manufacturing-led. The first major migratory wave took place in early 1980s when young adults from the poorest regions migrated to the central part of the country to work in the industrial, service, and informal sectors.¹⁴

During 2005-2008, the migration rate dropped from 4.3% to 2.8%. The rate was higher among men. In



2008, about half of the migrants, or 980,000, were in the 25-59 working age group, 650,000 were youth (15-24 years old), 210,000 were children, and 33,970 were older persons. Migration flows have become more diverse and multi-directional. Urban-rural flows are largely dictated by a person's economic situation. Migrants return to their villages in times of a slump and leave for better paid jobs in the cities when the economy picks up. It is interesting to note that, out of a total of 1.8 million migrants in 2008, 49.9% were intra-regional flows (16.9% between provinces, 33.0% within the same province).¹⁵

Table 2.2 Urbanization and Internal Migration Indicators

Indicators	1990	1995	2000	2005	2009
1 Population in urban areas (%)	18.7	20.2	31.1	30.1	n.a.
2 Population in rural areas (%)	81.3	79.8	68.9	69.9	n.a.
3 Migration rate (%)	6.2 (1992)	4.9 (1994)	5.2 (1997)	4.3	2.8 (2008)
Data sources					
1-2 NSO. Population and Housing Census, 1990, 2000; Survey of Population Change, 1995/96, 2005/06.					
3 NSO. Migration Survey, 1992, 1994, 1997, 2005, 2008.					
Remarks: Since 2005, the survey defines internal migration as a change of residence during the past 1 year instead of 2 years defined by previous surveys.					

Contrary to alarmist views, migration has not led to widespread desertion of rural elderly. Very few rural elderly have lost contact with all their children and been left to fend for themselves. Rather, most aged parents still live with or very nearby an adult child, and the large majority of migrant children maintain contact with parents and provide at least some financial support. Remittances, especially from Bangkok are quite substantial and significantly contribute to parent's material well-being. Mobile phone technology also plays an important role in maintaining contact between migrant children and their parents.¹⁶

An important impact is the problem of "hidden populations" or people who do not reside in the administrative areas where they record their residency in the household registration. This has led to difficulty in city planning and imbalanced allocation of resources

because per capita resource allocation is usually based on the household registration database. Another kind of hidden population is related to daytime commuters. Due to expensive housing costs in Bangkok and the expansion of transport network between the Bangkok metropolis and its suburbs, the number of daytime commuters from neighbouring provinces to Bangkok has risen sharply. Accurate data is the first step in tackling this problem. The upcoming Population and Census to be undertaken in September 2010 will include, for the first time, a question to distinguish between resident and non-resident populations.

Priority policy/action:

Migration is part of the economic and social dynamics of every society. Migrant workers add much needed flexibility to the labour market. It is therefore

important that the social service delivery systems accommodate rapid changes associated with seasonal, short-term and long-term migration. The delivery of social services, especially education and health, must be flexible enough to accommodate mobile population groups. The UHC system, for example, represents a notable endeavour to achieve this. While censuses and regular surveys are effective at projecting a bird eye's view of the situation, administrative data systems often fail to capture this dynamic despite their nearly universal coverage, as in the case of civil registration system. Hence, linkages between register-based databases and other data systems including surveys, censuses, and services records should be strengthened to minimize the discrepancies.

It should also be noted that most migrant populations are vulnerable to several kinds of social maladies. For example, HIV infection is relatively high in provinces where there is a high concentration of migrant workers. Prevention and care should therefore be strenuous and specially designed and adequately funded to meet this challenge.

2.1.3 International Migration

While many Thais look for better opportunities overseas, Thailand has become a safe haven for hundreds of thousands of asylum seekers and millions of migrant workers from neighbouring countries.

Progress/gaps:

Since late 1970s, rural residents with little education and, thus, poor prospects in the industrializing labour market, have explored the option to work abroad as contract or independent labourers.¹⁷ Though, in the initial period, labour emigrants were predominantly male, the proportion of women has expanded, especially among irregular migrants.

For male workers, the principal migration route between late 1970s to mid 1980s was the oil-rich Arab states of the Gulf. Later, it shifted to newly-industrializing countries in East and Southeast Asia. The first wave of female migrants went to Europe, Australia and other Western countries to establish families and work in manufacturing and service sectors. In recent years, a noticeable trend is the large number of European men migrating to retire in Thailand alone or with families to take advantage of



Recent Development on GMS Migrants in Thailand

In early 2009, the Thai Government decided to proceed with the 7th and final round of registration (the first was introduced in 2001) to allow irregular GMS migrants who work in six specified sectors to register and apply for temporary work permits until February 2010 (the deadline has been extended to 31 March 2010 following the Cabinet Resolution of 19 January 2010), after which all migrants from neighbouring countries will be regulated according to the MoUs that Thailand signed with Lao PDR, Cambodia and Myanmar.*

The process of nationality verification (NV) of Myanmar/Burmese migrants started in July 2009 and ended in March 2010. Under the bilateral MoU in June 2003, migrants from Myanmar are entitled to legally stay and work in Thailand upon verification of their nationality. A temporary passport or certificate of identity will be issued by the Myanmar authorities, and a visa by the Thai Government. But there is a concern that some ethnic minorities may not be recognized for verification by the Myanmar Government. Further, the progress is criticized for being complicated and costly. Some migrant workers have become victims of bogus brokers. With no certain benefits and fear of persecution, many have chosen to adopt a wait-and-see approach, despite the threat of deportation.**

Sources: *IOM. 2010. Migrant Information Note, Issue#7; ** Bangkok Post, 16 October 2009.

the low cost of living and first-rate medical care. Their number increased seven-fold during 2003-2007.¹⁸

While the official record shows that over 100,000 Thais are working overseas, more than two million migrants from the Greater Mekong Sub-region (GMS), namely Myanmar, Lao PDR, and Cambodia, are living and working in Thailand.

Most are employed in fishery, agricultural, manufacturing, construction and service sectors. To a certain extent, this involves human trafficking and smuggling.¹⁹

As of 27 April 2010, there were 1,315,932 registered GMS migrants comprising 124,902 from Cambodia, 111,039 from Lao PDR and 1,079,991 from Myanmar/Burma. Migrant workers from Cambodia and the Lao PDR worked under bilateral agreements since 2007, while the MoU with Myanmar/Burma has only come into effect in 2009. An addition of more than one million foreign migrants were estimated to be living and working in Thailand irregularly, most for more than three years. About 70-80% were from Myanmar. There were more male than female migrant workers from Cambodia and Myanmar, but more females from the Lao PDR. The total of about 1.9 million of these migrants is equivalent to 5% of the Thai workforce. Over the past three decades, Thailand had provided de facto asylum to some 1.2 million refugees from the GMS and beyond, and still hosts hundreds of thousands of these mobile populations.²⁰

These efforts are highly commendable, and essential for Thailand to capitalize on international migration. Still, the response remains inadequate to address the magnitude and diversity of the situation.

Priority policy/action:

The priority should be on the reduction of mobility-related risks among migrants, e.g. malnutrition, unsanitary living environment, poverty, illiteracy, vulnerability to sexual abuse and exploitation, and



occupational hazard.²¹ In recent years, the Thai Government has been very active in introducing measures to enhance migrants' access to health and education. At present, migrant workers and their families are entitled to the same social security benefits as Thai workers. Registered migrant workers who

are not covered by the social security scheme, i.e., those working in the informal sector, also benefit from the UHC, but the individual-based UHC scheme is not extended to family members. It is important to continue to expand the access to ensure that migrants and their families have adequate health and education services irrespective of their legal status.

At the moment, financing healthcare for unregistered migrants is a daunting task for the MoPH. The country still lacks a clear, comprehensive and long-term national policy on migration management which affects all other relevant policies including migrant health policy. Both interim and long-term policies are needed.

Strengthening labour protection for foreign migrants in Thailand and Thai migrants overseas requires better information, documentation, and management system at all stages of the migration process. At present, the dearth of data makes it very difficult to formulate proper policies, legislation, institutions and intervention programmes. It is necessary to improve the availability, comparability and quality of data. A database inclusive of all categories of foreign immigrants and Thai emigrants should be jointly established by the Ministry of Interior, Ministry of Foreign Affairs, Ministry of Labour, and MoPH.

It is also necessary to strengthen transnational collaboration and promote cross-country and in-country dialogues that are inclusive of all stakeholders. Joint efforts to regularly assess the situation and the impact of international migration will provide better understanding on the character, regional and global determinants of migratory flows which will support policy dialogue and interventions.



2.2 Population and Development

This section will focus on three issues: Poverty, education, and gender equality and women empowerment.

2.2.1 Poverty

By 2007, poverty incidence had dropped to one-fourth of the 1990 level, which far exceeded the MDG target. Poverty is largely a rural phenomenon, and children, youth, and the elderly are the poorest of the poor.

Progress/gaps:

Thailand has made impressive progress on poverty reduction. Measured by the national poverty line at 1,443 baht/month/person or approximately US\$ 1.4/day/person (at 34 baht exchange rate), the proportion of population having expenditures below the poverty line was 8.4% in 2007, or only one-fourth of the 1990 level. The number of the poor dropped from 18.4 million to 5.4 million during 1990-2007. Progress has been steady, except for a brief period after the economic crisis in 1997.

Poverty has declined in all regions. The reduction was most impressive in the Northeast where the number and proportion of the poor had been largest. By 2007, the Northeast, the driest region, still housed the largest number of the poor, but its poverty incidence was 13%, the same level as the North's. It should also be noted that pockets of poverty also remain in remote areas especially along the borders, and the three provinces in the far South.

Poverty is still very much a rural phenomenon. The urban-rural gap is exacerbated by the fact that poverty reduction was faster in the urban areas. In the past two decades, urban poverty dropped from 20.5% to 3.3%, while rural poverty dropped from 39.2% to 10.6%. Women are better off than men. In 2007, poverty incidence was 8.2% among women and 8.8% among men. This gender pattern prevailed in both urban and rural areas, and in all regions. Women-headed households also fared better than male-headed households: 7.1% of women-headed households were poor, compared with 8.2% men-headed households. But it should be noted that women outnumbered men by a large margin among the elderly, which is the poorest of the poor.²²

Priority policy/action:

Poverty reduction has always been a top policy agenda. The 10th National Economic and Social Development Plan (2007-2011) aims to reduce poverty incidence to 4.0%. This represents a great challenge given the impact of the global economic crisis and domestic political instability.

In the past decade, the government's notable initiatives to curb poverty include the village revolving funds to support income-generating investments at the grassroots level, the Sufficiency Economy Programme to support communities' self-sufficient and sustainable economic and social activities, and the refinancing of non-institutional debts. The economic crises also forced the government to focus on mitigating the impact of the economic downturn by protecting jobs and income and reducing household expenditures.

The plan to establish the National Savings Fund is the most direct and ambitious endeavour to protect future generations of elderly from falling into the poverty trap. But dividends in the distant future will elude

today's vulnerable groups, namely, the elderly poor who are relying on family support and the 500 baht/month old-age allowance.

In any case, these policies are likely to be more effective at protecting vulnerable groups from falling into poverty than lifting those already in the poverty trap. The most important challenge is therefore to target and

reach out to the poorest of the poor, and to prepare to respond to different types of poverty in a flexible manner.

Poverty Profile 2007: Who are the poor?

- 4.8 million or 88% of the poor lived in rural areas
- Three-fifths of the poor resided in the Northeast.
- 53% of the poor were members of farm households, hired farm labour, and general labour.
- 88% of the poor had primary education or less.
- 47% of the poor were from families with five members or more.
- 30% of the poor were children (under 15 years old), 22% were the elderly (60 years and over).

Source: NESDB, 2008. Poverty Assessment 2007.

Poverty Incidence among Children and Older Persons

In recent years, poverty has also taken on age-specific characteristics. Children and the elderly constituted over half of the poor. The elderly became the most vulnerable group, with 13.2% poverty incidence in 2007. Next were children, with 10.9% poverty incidence.

Poverty incidence was 11.4% for households consisting of children alone, 19.4% for elderly living alone. The rate was highest at 21.1% for households consisting of children and the elderly.¹ This is an important issue as Thailand is becoming an ageing society.

Source: NESDB, 2008. Poverty Assessment 2007.

2.2.2 EDUCATION

A notable achievement is the expansion of access and coverage. Educational opportunities are further expanded by a recent policy to reduce the educational expenses of parents. But the quality of education remains an important issue that needs to be addressed.



Progress/gaps:

It is likely that, by 2015, Thailand will be able to complete a full course of primary schooling. Gross enrolment has exceeded 100% since 1995 due to over-aged students. The retention rate for primary education has gradually increased and reached 90.4% since 2005. Due to the extension of compulsory education to the lower secondary level, secondary education also expanded rapidly. In 2008 gross enrolment reached 95.6% for lower secondary and 68.1% for upper secondary levels, respectively. However, a major challenge remains how to raise the retention rate of students until completion of their secondary education.

Despite rapid expansion of educational opportunity, access is still a challenge among some population groups. In 2008, 2.7 million received education under the Ministry of Education's programmes. These included 2.5 million poor students, 41,596 poor students in remote areas, 190 forced child workers, 58 children in the sex industry, 88,295 abandoned children, 299 children in probation centres, 1,840 street children, 8,775 children affected by AIDS, 42,858 highland children, 1,750 children who were victims of violence and torture, 775 children with drug problems, 35,421 children with other problems, and 45,392 persons with disability.²³

Table 2.5 Education Indicators

Indicators	1992	1995	2000	2005	2008
1 Net enrolment in primary education (%)	70.1	77.1 (1996)	80.4 (1998)	n.a	n.a
2 Gross enrolment rate in primary education (%)	99.2	103.4	103.2	104.2	104.8
4 Gross enrolment rate in secondary education (%)	38.8	55.8	69.7	78.6	81.9
5 Gross enrolment rate in lower secondary education (%)	50.6	73.1	82.8	95.5	95.6
6 Gross enrolment rate in upper secondary education (%)	26.9	39.2	57.3	63.8	68.1

Data sources

1-4 ICT Center, Office of the Permanent Secretary, MoE.

Remarks: Gross enrolment is calculated from the total number of students regardless of age, and the total number of children in specific age groups.

Table 2.6 Retention Rate 1997-2008

Education level	Academic year	Retention rate (%)
Grade 1	1997	100
Grade 6 (completed primary level)	1995	85.9
	2000	87.1
	2002	88.4
	2005	90.4
Grade 9 (completed lower secondary level)	2004	74.6
	2005	74.4
Grade 12 (completed upper secondary level)	2002	42.3
	2007	51.1
	2008	52.8

Source: ICT Center, Office of the Permanent Secretary, Ministry of Education

For Thai children, although the government has introduced the policy to provide 15 years of free education, the most significant issue is the quality of education. The education system is criticized not only for students' poor academic performance, but also for their weakness in critical thinking and life skills. In 2000, the Organization of Economic Cooperation and Development (OECD) survey found that three out of four Thai students aged 15 could read, but had limited comprehension of the content and poor analytical skills. Another survey in 2006 produced a similar finding.

The Ordinary National Education Test (O-NET) in 2007 also indicated that students at Grade 12 or equivalent tested poorly in major subjects, especially mathematics, science, and English.²⁴ According to OECD's 2007 study on students' reading and mathematics skills in high and medium-income countries, Thai students ranked well below the group average.²⁵ This raises a question not only about long-term national competitiveness, but also about poverty reduction, since education has always played a very important role in poverty reduction.

Education for Stateless Children

One of the most deprived groups is stateless children, estimated to be around one million, two-thirds of whom were born to Burmese migrant workers. The Thai Government, having ratified the 1989 Convention on the Rights of the Child, instructed all public hospitals to issue a birth registration document to any baby born to any parents, regardless of their background. But unregistered migrants, for fear of arrest and deportation, often choose to deliver at home using traditional birth attendants. Hence, these children do not have a birth certificate or essential immunizations.*

The Ministry of Education is drafting a Prime Minister's Office Regulation that would be applied to some 100,000 stateless children at the learning centres run by private organizations and 40,000 others at refugee holding centers to ensure that they are provided with the same basic education as that given to Thai children. About 60,000 children of unregistered migrant workers have been given the same right to education as Thai children since 2005 when the Government adopted the Education for All policy. Still, most stateless children are unable to take advantage of this policy. Some face language a barrier while others have to work to support their families.**

Sources: *The Irrawaddy, July 2009; ** Bangkok Post, 1 September 2009.

15 Years of Free Education

The right to 12 years of free basic education was mandated by the Constitution since 1997. Students were enrolled on a tuition-free basis. Nonetheless, it was estimated that three million students were in shortage of school uniforms, textbooks, and lunches in 2008. Starting in 2009, the Government introduced a 15-year free education policy (from kindergarten to upper secondary level) for students in formal and non-formal education. In addition to free tuition, text books are available at every school. School uniforms, education materials and student development activities are also provided free of charge. Budget for school lunch and school milk for primary school students was also increased.

Priority policy/action:

Enhancing vulnerable groups' access to education is still an important agenda item. It requires close collaboration and concerted efforts at the national and local levels to reach out to these groups, and to arrange appropriate learning modules, taking into account their special needs and constraints.

Investment in quality improvement through curriculum and teacher development, and interactive e-learning are crucial for enhancing the quality of education. The "education reform" following the enactment of the National Education Act 1999 was largely bureaucratic restructuring. The Government and all societal groups are now calling for a more comprehensive reform. The role of the private sector, local administrative organizations and the communities in providing educational services also needs to be reviewed.

2.2.3 Gender Equality and Women's Empowerment

Women have equal opportunities and excel in education, are almost equal in the workplace, but are left far behind in policy and high-level decision-making

Progress/gaps:

Girls and boys have equal opportunity in primary and secondary education. At the tertiary level, the 2007 data show that women outnumbered men in most

fields including science (1.08:1), but there are predominantly more men in some disciplines, e.g. engineering (0.28:1).

More women than men pursue higher education. According to the Office of Higher Education Commission, a total of 23,081 women or 60.9% of all graduates completed postgraduate degrees in 2007. This includes 694 PhD graduates (58.2% of all PhD graduates), and 22,387 masters degree graduates (56.8 % of all masters degree graduates).²⁶

Women who are not enrolled in the school system are encouraged to participate in the non-formal education system. In 2005, 1,320,959 women accounted for 60.1% of total enrolment.²⁷

The literacy rate is high for both sexes, especially among youth. But a gender gap remains among people in old age. Despite the Women Development Plan (2002-2006)'s target to reduce illiteracy among women aged 40 years and over, their illiteracy rate remained unchanged at 17.6% during 2000-2005, compared with 8.8% for men.²⁸



Thai women participate actively in the labour market. In 2007, they accounted for 45% of waged employment in non-agricultural sector. Their income was 92% of male workers, a slight improvement from 90% in 2005. It should be noted that since 2001, income data are available for only government, state enterprise, and private sector employees. Excluded are employers, own-account workers, and others in the informal sector. An analysis of pre-2001 data shows that the gender gap in this group was slightly larger than in the formal sector.²⁹

It is in the area of policy making that Thai women lag far behind. Although there has been noticeable improvement in the past two decades, women still account for only 15.8% of the Senate and 11.7% of the House of Representatives. Election results show that women are equally successful as men. The small representation is due to the small number of female candidates. Most women still have reservations about running for elected office.

Notable Progress in Gender Equality

The amendment of the Name Act in 2002 represents a landmark. Now the law allows married women to use Ms. or Mrs. It also allows married men and women to make their own decision to use their family name or their spouse's family name.

Another notable progress is the amendment of the Penal Code to broaden the definition of rape to protect people of all sexes from rape, to cover all kinds of sexual penetration, and to penalize marital rape. The Civil Code was also amended to provide equal rights to claim compensation from whomever was raped by their fiancé, and to ensure equal grounds for divorce. Earlier, the law favored men over women with regard to infidelity and extramarital affairs.

It should be noted that the share of female senators and MPs are higher from an election than from selection/appointment. The fact that women account for only 8.8% of party list MPs also indicates a strong gender bias among major political parties. In the executive branch, women held no more than 8% or three positions in the three cabinets during 2005-2008. Women also take a back seat to men in local administration. Only 10-11% of Chief Executive Officers (CEOs) and councilors at provincial, municipal and sub-district levels are women, with the exception of Bangkok where women's share of district and local councilors is about 17-18%.³⁰ This, however, does not mean that women are entirely left out of local development affairs. In 2008, women comprised 47.4% of community organization leaders.³¹ Nearly 52% of the central administration personnel were women. But a very small number made it to the executive level during 2004-2007.

Women at Work

The Labour Protection Act 1998 guarantees gender equality in employment and wages unless the nature or conditions of the work do not allow. The law also prohibits discrimination against pregnant employees; employers cannot terminate a female worker because of her pregnancy. Moreover, a pregnant employee will receive 90 days of maternity leave for each pregnancy, out of which 45 days are paid leave. In addition, under the Social Security Act, the pregnant employee is entitled to 50% of wages during a 90-day maternity leave, plus other benefits such as medical treatment for prenatal care and childbirth, and care and treatment for the newborn.

Source: Saejeng, Kittipong. 2009. Thailand Country Report, presented at the Expert Group Meeting to Assess the Progress in the Implementation of the Plan of Action on Population and Poverty Adopted at the Fifth Asian and Pacific Conference. Bangkok: 3-5 February.

Table 2.8 Share of Women in an Executive Position in the Central Administration

Executive positions (%)	2004	2005	2006	2007
Permanent Secretary, C11	10.5	12.9	10.5	5.3
Secretary-General/Director, C11	8.3	16.7	18.2	15.4
Deputy Permanent Secretary, C10	7.6	14.3	21.4	10.5
Deputy Secretary-General/Deputy Director, C10	31.8	40.5	34.9	36.4
Director-General/Director/Secretary-General, C10	14.6	17.9	17.1	20.5
Deputy Director-General/Deputy Secretary-General/Deputy Director, C9	24.4	23.2	25.3	24.5

Source: Office of Civil Service Commission

Priority policy/action:

Enhancing women’s opportunities to participate in politics and administration is a principal objective of the Women’s Development Plan (during the 10th Plan period). The aim is to increase female representation in political positions and policy making including the decision makers at the highest level that shape the national agenda and development directions.

At present, the Office of Women’s Affairs and Family Development (OWAFD) under the Ministry of Social Development and Human Security is the national focal point for gender equality and women’s empowerment. A chief gender equality officer and gender focal point are appointed at every departmental-level government agency to serve as the champions for gender equality. The OWAFD plans to introduce this mechanism at the provincial and local levels, and expand it to state enterprises, public organizations and independent organizations.

Networking and collaboration among the OWAFD and local administrative organizations, NGOs, civil society, women’s and family groups are essential especially for policy advocacy. Major policy proposals are submitted by the OWAFD for the consideration of the National Commission on the Promotion and Coordination of Women’s Affairs, chaired by the Prime Minister, which are then forwarded to the Cabinet.

**The Women’s Development Plan
(2007-2011)**

Five strategies to promote women’s advancement and gender equality:

- 1) Promote gender-equality attitudes,
- 2) Increase women’s participation in political and public decision making,
- 3) Improve women’s health including reproductive rights,
- 4) Strengthen women’s personal security,
- 5) Promote women’s participation in the economy.





Reproductive Health and Reproductive Rights

3.1 Maternal and Child Health

Maternal health service has improved significantly. The infant mortality rate and under-five mortality rate are well below the ICPD's 2015 targets. Yet, more

remains to be done to expand universal access to reproductive health, to promote exclusive breast feeding and iodized salt consumption, and to reduce disparities in maternal and child health in marginalized populations and vulnerable areas.

Progress/gaps:

There is more controversy concerning maternal mortality ratios (MMR) than other indicators due to the fact that there are many sources of data, all of which have limitations. The MMR from the RAMOS survey during 1995-1996 by the Bureau of Health Promotion, Department of Health (DoH) was 44.1 per 100,000 live births, and 36.4 per 100,000 live births in 1998. Data from the Safe Motherhood Project, DoH also show progress: the MMR dropped from 26.9 to 20.6 per 100,000 live births during 2000-2007.

The Thailand MDG Report 2004 concluded that the MDG target to reduce MMR by three quarters between 1990-2015 was not applicable (as the MMR in 1990 was already very low at 36.2 per 100,000 live births). The MDG+ target specified at that time was to reduce MMR to 18 per 100,000 live births by 2006. However, recent estimates suggest that the level of maternal death in Thailand may have been higher than previously specified in the MDG+5 target. A special study using a multi-data matching method

yields an MMR in the range of 37.4-44.5 per 100,000 live births during 2004-2006.³² Yet, some adjustment is still needed to cover incompleteness of birth and death registration, incompleteness of health coverage, and maternal death due to induced abortions. Moreover, some concerns were raised that the future estimates of maternal death should include data for cross-border migrants. In 2010, two working groups introduced MMR estimates using a mathematical model to suggest MMR estimates which are internationally comparable across timelines (see Table 3.2).

All data sources confirm that maternal mortality remains exceptionally high in some sub-populations and in some areas, e.g. ethnic highland people in the mountainous North, and predominantly Muslim population in the three provinces in the deep South, where traditional customs and distance from health services pose barriers to better maternal health. However, due to small population sizes, the maternal mortality ratios reported at the provincial level could fluctuate widely due to small number of births given in a year. Adjustments will be needed to give a more robust estimate at the provincial level.

Table 3.3 Maternal Mortality Ratios in Mae Hong Son and The Southernmost Provinces (per 100,000 live births)

Province	2003	2004	2005	2006	2007	2008
Mae Hong Son*	33.2	79.0	n.a.	27.2	113.4	29.7
Yala/Pattani/Narathiwat (average MMR)**	44.0	40.5	42.0	40.2	52.6	39.6

Sources: * Bureau of Policy and Strategy, MoPH; ** DoH

The instability and violence that has flared up in the deep South since 2004 have drawn attention to deficiencies and deprivations, including access to quality maternal health services in this area. In addition to the intensification of prevention and care, a special data system was set up to monitor progress, which has been slow to date. Language barriers, cultural differences, and safety concerns have made it difficult for health personnel to work effectively, especially in remote rural areas.

There are debates, though to a lesser extent, about child mortality data. The problem with infant mortality data is the failure to report births and deaths promptly in remote areas. The best estimates show that the infant mortality rate (IMR) dropped by more than half during the past two decades to 12 per 1,000 live births by 2009. The mortality rate of children under five years old also dropped from 12.8 to 9.9 per 1,000 live births during 1990-2008.

The 2007 Multiple Indicators Cluster Survey by NSO supported by UNICEF³³ is the largest survey on children and women in Thailand. The survey was conducted among 43,000 households providing in-depth data on nutrition, health, education and other important development issues. The survey highlights the remaining challenges to children's health that require urgent attention as follows:

- Exclusive breast feeding. Only 5.4% of infants were exclusively breastfed during the first six months. This is one of the lowest exclusive breastfeeding rates in the world, and lower than the DoH's 30% target during the 9th Plan (2002-2006).
- Iodized salt consumption. Only 58% of households consumed iodized salt. The rate was lowest - at 35% — in the Northeast. Severe

deficiencies of iodine can result in mental retardation, while even mild deficiencies can restrict children's mental capacity and negatively affect their school performance.

The MIC Survey also reveals that women and children had different levels of access to basic knowledge, services and commodities. The gaps were between urban and rural, among provinces, ethnicities, speaking languages (Thai and non-Thai), socio-economic status and education backgrounds. For example:

- 15% and 16% of children from the poorest households were underweight (measured by weight for age) and were stunted (shorter than average for their age), compared with 4% and 7%, respectively among children from the richest households.
- 13% of children of uneducated mothers were underweight, compared with 6% among those of mothers who received secondary education.
- 42% of very poor households consumed iodized salt, compared with 75% for very rich households.





Priority policy/action:

Several causes of maternal death can be prevented through improvements in early detection during prenatal care and emergency obstetric care. Since 2005, more than 90% of pregnant women had four antenatal visits and 99.4% of births were delivered with the assistance from trained health personnel.

However, it should be noted that the Social Security Office has a policy to support child delivery on a lump sum basis which may have undermined the effort to improve the quality of child birth. Since 2007, the mother can choose to obtain the service from any health outlet. The mothers can then receive a lump sum support of baht 12,000 to cover the cost of ante and post-natal care, delivery, and care for the newborn upon presenting the birth certificate.³⁴

Capacity development, both on the part of health personnel at primary health centres and on women and their family and community, are key factors to quality improvement. The most important part of family and community involvement is men's participation in maternal health care and maternal and child

The Family Love Bonding Project

Under the auspices of Her Royal Highness Princess Srirasmi, Royal Consort to the HRH Crown Prince, the DoH launched the Family Love Bonding Project in 2006 to pilot an integrated model of child development. The number of pilot public and private hospitals expanded from 49 to over 200 in the following two years.

The project aims to enhance mother's and child's health through quality process and quality services in ante-natal care, childbirth, post-natal care, and child-rearing. The "process" and the "care-givers" extend beyond the hospital to the family and the community. The model includes ante-natal care, parental school, mother's nutritional care, mother's dental care, safe motherhood hospitals, breastfeeding clinics, child's development check-up, child nutrition, child dental care, child edutainment, and community-based breastfeeding, volunteer mother, and Family Love Bonding groups.

The project aims to reduce the birth asphyxia rate to 30%, reduce the rate of low birth weight by 0.5% per year, and increase the rate of exclusive breast feeding for at least 6 months by 2.5% per year. Another target is to achieve 90% standard development among children 0-5 years of age. The DoH plans to expand this project to 90% of public and private hospitals.

Source: DoH. 2008. Family Love Bonding Hospital, August.

rearing counseling, including HIV-blood checks. The expansion of health services to the community level also contributes to sustainable progress. About one million village health volunteers across the country have played an important role in disseminating and collecting necessary information, including basic health surveillance data.

Area-specific policies and measures are critical success factors to reduce disparities in the MMR. To expand the access to and increase the usage of reproductive health services in the deep South and the highland areas, it is necessary to upgrade the capacity of local personnel and strengthen the linkages with provincial and national networks, and to adopt a culturally sensitive approach. For example, the reproductive health service sites in the far South have been modified to facilitate Muslim fathers to conduct the blessing of the new born - an Islamic cultural practice, to increase the rates of ante-natal visit and institutional delivery.

The principal strategy for child development focuses on family development and holistic child development. Many child health and development projects were initiated to promote not only physical but mental and emotional health of the children including, for example, the Family Love Bonding Project, the 3-Generaion Family Ties Project, the Child Development Caravan Project, the Book Start Project, and the Parental School Project. Moreover, sustained public campaigns and supportive environment need to be promoted to encourage women to breastfeed for a longer period.

An Example of the Culturally Sensitive Approach: Pre-Marriage Training for Young People in the Southernmost Provinces

Training on preparations for marriage life according to Islamic teachings and reproductive health issues has enhanced knowledge and life skills of young people in the Islamic communities in the three southernmost provinces.

The Planned Parenthood Association of Thailand (PPAT), with support from UNFPA, piloted a project in collaboration with the Islamic Committees of Pattani, Yala and Narathiwat provinces during 2004-2006. The Islamic Committees in these provinces as well as in Songkhla and Satun, have adopted this initiative as their policy and organise the training on a regular basis, with support from the MoPH.

Source: Planned Parenthood Association of Thailand

Parental School

The Parental School Project, initiated by the DoH in 2003/2004, provides opportunities for parents and couples to obtain knowledge and skills, and to exchange ideas and attitudes with health professionals regarding marital living, parenthood and child-rearing practices. The programme consists of ten courses; six courses to introduce parents to good child-rearing practices to facilitate all aspects of child development according to their age and social conditions, and four courses for parents of children with special needs.

Source: <http://www.jvkk.go.th/researchnew/details.asp?code=103420701022>

3.2 Adolescent Reproductive Health

Adolescent birth has been increasing. To improve adolescent reproductive health, Thailand should be moving toward an integrated approach with strong linkages to other development issues including health, education and social services.

Progress/gaps:

Due to the rapid fertility decline in Thailand that began in the 1970s, the share of the population aged 10-24 years old has gradually dropped since the early 1990s but still accounts for one-fourth of the total. Adolescents and youth today are prone to high risk behaviours such as smoking cigarettes, excess alcohol drinking, use of illicit drugs, careless driving, and having unsafe sex.

Children and youth begin their sexual activities at younger ages than previous generations, and this includes the risks of unsafe sex, STIs, HIV/AIDS, teen pregnancy, induced abortion, and related socio-economic problems. Although condom use is being promoted for its dual functions in preventing pregnancy and in protecting against STIs, many studies have shown low condom use among adolescents. For instance, only 20-30% of sexually-active young people are using condoms regularly.³⁵ This is partly due to the perception of the low risk of contracting the incurable diseases and ignoring the possibility that the women could become pregnant.³⁶

Table 3.4 Adolescent Reproductive Health Indicators

Indicators	1990	1995	2000	2005	2008
1 Births by women 15-19 years old (per 1,000 women 15-19 years old)	42.2	41.2	31.1	49.3	50.1
2 Births by women under 15 years old (per 1,000 women under 15 years old)	0.2	0.3	0.2	0.4	0.4
Data sources					
1,2 Bureau of Policy and Strategy, MoPH, Annual Health Statistics					

An important consequence of unsafe sex among adolescent is unplanned pregnancy. Adolescent pregnancy is a medical risk, irrespective of marital status; the younger the mother, the higher the risk. The increasing trend of births in adolescents compared with the downward trend of births in all women has highlighted the importance of a comprehensive approach to adolescent reproductive health.

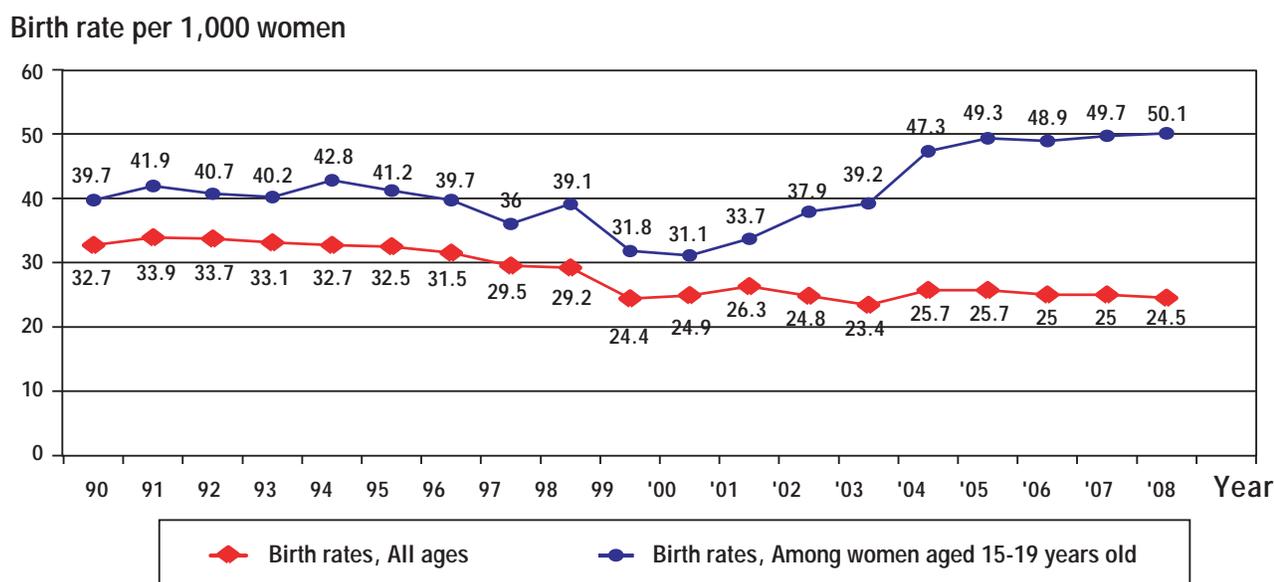
There was an increase in STI cases among youth from 23.4 to 34.8 per 100,000 population between 2002-2007.³⁷ Hospital-based data also indicate that almost two-thirds of induced abortion cases were among women below 25 years of age.³⁸

The Government has adopted a “Positive Youth Development” approach and outlined a strategy

that focuses on 1) increasing knowledge of sexual and reproductive health and problem-solving, decision-making, and life skills development; (2) promoting a safe and supportive environment; (3) offering adolescent-friendly health services; and (4) enhancing youth participation and empowerment.³⁹

Sexuality and HIV/AIDS education has been integrated into the school curriculum. Counseling services are available in every secondary school. The school-based support system is established and linked to the health service system. This has led to significant progress on information and service coverage. Integration of reproductive education in the college and university system has also been scaled up. But it is doubtful whether the quality of the education, e.g. teacher’s skills, is consistently up to standard.

Figure 3.1 Birth rates per 1,000 women from 1990-2008



Source: Annual Health Statistics, Bureau of Policy and Strategy, MoPH.

Lovecare Station Public and private partnership in extending youth friendly sexual health service

Established in 2007 as a pilot project to provide “Adolescent sexual reproductive friendly services”, the Lovecare Station was initiated by the Program for Appropriate Technology in Health (PATH) with support from the National Health Security Office (NHSO), Health Promotion Fund, Bangkok Metropolitan Administration (BMA), and UNFPA to provide VCT/STI/HIV and contraceptives at three health centres and eleven private clinics in Bangkok. The clinics were conveniently located for the youth, had friendly staff, flexible hours, and were free of charge (subsidized by the NHSO).

The project was successful due to its multi-modality and strong effort to reach the youth in schools, communities and social gathering places, including through the Internet. A Lovecare Call Center offered risk screening and referral services. After 13 months of implementation, over 16,000 young people received risk screening and counselling, 5,544 decided to take HIV testing, 3.0% were HIV positive (five times higher than the national average), and 17% received STI treatment. The model has been expanded to 43 provinces with support from the Global Fund to Fight AIDS, TB and Malaria.

Solution Exchange

In December 2007, UNFPA launched the Solution Exchange as a joint UN web-based programme to advocate policy development on youth and HIV in Thailand. The e-platform <http://www.solutionexchange-un.net.in/Thailand/AIDS/index-en.htm> encourages professionals and interest groups to share their knowledge and experience. It proved to be very effective and efficient in soliciting and managing tacit knowledge from relevant sources in the field.

By September 2009, there were nine queries from underprivileged youth groups identified by subscribers. The replies were synthesized and consolidated. These include critical issues such as Parent’s and Guardian’s Role in Sex Education; Youth-friendly Sexual Reproductive Health Services; Healthy and Happy Positive Young People; Family Planning for Young People; E-consultation on Standards of Health and Reproductive Health Services for Young People; and Sexuality Education in Thailand.

With the support of UNFPA and participation from many agencies concerned, the National Standard on Youth Friendly Health Services (YFHS), and the Quality Assurance system were developed by the Bureau of Reproductive Health to make hospitals a youth-friendly place. The MoPH aims to have 80% of government hospitals become youth-friendly by 2013. The YFHS model was also pioneered in other settings such as private clinics, shopping malls, and communities. Nonetheless, it should be noted that most hospitals still find it challenging to achieve “Quality Comprehensive Friendly Services”, due to several constraints. For example, adolescents may not receive family planning services in the hospitals where health care providers still have negative attitudes toward youth sexuality.

Participation by the youth is a critical success factor. Youth Councils introduced by the MSDHS were set up in every province with the network extending to the sub-district level. The councils’ capacity and youth peers are tapped to help develop adolescent and youth reproductive health. But in practice, the youth often find that they cannot participate in a meaningful manner. Without genuine youth participation, the programmes and projects often fail.

Priority policy/action:

Government agencies should adopt an integrated approach with a focus on strengthening the linkages among health, education and social services, as well as the networking among multi-partite partners at every level. A partnership of government and NGOs, such as in the case of the Ministry of Education and the Program for Appropriate Technology in Health (PATH) in promoting comprehensive sexuality education as a school-based curriculum is an indicator



that a more progressive approach is evolving. Rapid-scaling up of these initiatives should receive high priority.

The most important challenge is to cultivate a social attitude that accepts youth sexuality and youth empowerment. Youth service providers in health, education, and social services need to be more sensitive to the needs and the rights of young people.

Availability and accessibility of adolescent friendly health services including contraceptives, STI/HIV and safe abortion are the key components that contribute to the betterment of adolescent health. Based on studies and several YFHS pilot models, the MoPH is preparing for scaling up the services to all levels of health facilities. It is important that the experiences and lessons are shared with the network partners.

Finally, the mass media has a major role to play in communicating health information to adolescents. It is important that positive-message media (print, broadcast and electronic) reach the adolescents.



3.3 Family Planning

Successful family planning contributed to high contraceptive prevalence among married women. But contraceptive services for unmarried women and adolescents remain a challenge.

Progress/gaps:

Thailand is internationally renowned for its success in family planning. In 2009, the contraceptive prevalence rate (CPR) among married women 15-49 years old was 79.6% with small differences between urban and rural areas.

The oral pill was the most popular method, followed by female sterilization, injection, IUD and condom, vasectomy, implant, and other methods. In 2001 the unmet need for family planning was only 1.2%, compared with 5.9% in 1996.⁴⁰ However, there is a data gap about unmet need for family planning, because data collection often misses information from sexually-active women who self-report as being single.

The high prevalence of teenage pregnancy, unsafe abortion and a rising demand for emergency pills suggest a need to revitalize the family planning programme targeting young people.

Family planning is covered by the UHC. According to a study on the satisfaction of contraceptive acceptors by the Bureau of Reproductive Health, DoH in 2005, 80.8% of acceptors were very satisfied with the services from both government and private health facilities.⁴¹ Nevertheless, it is noted that the supply of contraceptives is limited to inexpensive methods such as combined oral pills, condoms, and the injectable contraceptive. Semi-permanent methods such as the sub-dermal implant and IUD are generally not available. This has forced those who used semi-permanent methods to switch to temporary methods, thus creating an unmet need. This change in method mix is shown by a drop in acceptance of the IUD and contraceptive implants reported in the 2006 and 2009 Reproductive Health Survey.⁴²



Despite the high national average, the CPR was only 69.7% in the South where there is a large proportion of Muslim population. The CPR was also lower among marginalized groups such as hill tribes, refugees and migrants. At present, the MoPH, is implementing programmes, with collaboration from NGOs and UNFPA, to improve the situation.

Another significant gap is on the gender issue, as evident in the very low use of male contraceptive methods. More effort should be made to meet the needs of unmarried women and young people. CPR data are scarce and unsystematic for unmarried but sexually-active population sub-groups, especially adolescents. Moreover, there was a sharp increase in the annual statistics on production and import of emergency pills from 3-4 million units to about 11 million units since 2005.⁴³

Priority policy/action:

Quality improvement is an important challenge, especially during this transitional period in which a large part of the family planning budget was shifted to the UHC programme. Capacity development of service providers should focus on technical aspects as well as a rights-based counselling.

The gender gap is expected to be addressed by the new reproductive health and maternal and child development approach that focuses on the responsibility and participation of men in the family. Through various programmes and activities, men are expected to gain more knowledge and take a more active and supportive role in family planning and reproductive health, maternal health, and child development.

The MoPH also recognizes the urgent need to reduce the unmet need for contraception among adolescents and has adopted the Adolescent-Friendly Health Services strategy. Information campaigns targeting youth which report the negative effects associated with using emergency contraception are disseminated to the public on a regular basis. The on-going development of the Reproductive Health Act gives high priority to strengthening the rights-based approach to improve universal access to reproductive health, particularly among in-school and out-of-school youth, including protecting the rights of female students to continue education during pregnancy.



3.4 Abortion and Related Complications

Despite the high contraceptive use rate, increased use of emergency pills, and increased access to safe abortion due to recent legal developments, unsafe abortion still represents an important reproductive health problem.

The exact magnitude of abortion and related problems is unknown. The Second and Third National Health Examination Survey conducted in 1996-97 and 2003-4 respectively found that the prevalence of abortion among women aged 15-59 years was 19.3% and 19.8% respectively. About 13.5-14.4 % were spontaneous abortions and 3.6-5.4% were induced abortions.⁴⁴ The Second National Health Examination Survey also showed that 8.4% of women had experienced an abortion in the past year; 1.8% was induced abortion.

A study conducted in 1999 in 787 government hospitals using data collected prospectively through case records found that 71.5% of women turning up for treatment had a spontaneous abortion and 28.5% had an induced abortion.⁴⁵ Of the 13,090 induced abortions, 29.2% included serious complications namely septicemia, uterine complications and death. Almost half of the induced abortions were in young women under 25 years (0.7%, 20%, and 26% in women age below 15, 15-19, and 20-24 years, respectively).

Abortion is illegal unless it is performed by a physician only for the sake of the woman's health or for termination of pregnancy due to a sexual crime.⁴⁶ "Health" was interpreted narrowly to refer only to "physical" aspects. Access to safe abortion is therefore restricted, resulting in high morbidity and mortality.

Since 1957 attempts to amend the law have been unsuccessful. In 1999, to increase access to safe abortion, the DoH, the Thai Medical Council, the Royal Thai College of Obstetricians and Gynaecologists and the Women's Health and Reproductive Rights Foundation of Thailand advocated to expand the definition of "health" to include mental health. In 2005, a more liberal medical regulation for termination of pregnancy was approved and published in the Thai Royal Gazette.

More work needs to be done to reduce unsafe abortion. The women who seek abortion and all concerned parties are stigmatized. Further, there are only about 2,000 physicians trained in obstetrics and gynaecology. Their attitude is generally that abortion is illegal and religiously sinful. The unwillingness to perform the procedure constitutes a formidable barrier to women's reproductive health. Consequently, women often have to resort to unsafe abortions late in their pregnancy.



Priority policy/action:

The MoPH and other organizations are collaborating to promote reproductive health and prevent unplanned pregnancies through comprehensive sexuality and reproductive health education⁴⁷, women's empowerment, men's responsibility and expanded access and utilization of family planning services.

A sustained public health communication campaign is needed to raise the awareness of the risks and losses involved in unsafe abortions, and to enhance understanding of women's reproductive rights and reproductive health. Information and knowledge about abortion should also be included in comprehensive sexuality and reproductive health education. Counselling and shelters can also play an important role in reducing unsafe abortions.

Another important measure is to improve the capacity of health providers in the management of post-abortion complications.

It is also necessary to fill the data gap. Without adequate, continuous and reliable data, it is difficult to estimate the magnitude, the trends, as well as the major factors involved in unwanted pregnancies. Periodic national surveys and research combined with systematic analysis of administrative data are needed to monitor the situation and to formulate appropriate intervention measures.

3.5 STIs and HIV/AIDS

Sustained HIV prevention efforts with an emphasis on coverage and quality of comprehensive interventions among the population engaging high-risk behaviour is needed to prevent the resurgence of the spread the HIV.

Progress/gaps:

Thailand is among a few countries that have demonstrated effective efforts at controlling the spread of HIV and most of the HIV/AIDS-related ICPD goals have been achieved. The first AIDS case in Thailand was reported in 1984. To date, it is estimated that 1,115,000 people have been infected with HIV since the start of the epidemic.⁴⁸ The epidemic was explosive during late 1980s and early 1990's, first among injecting drug users, then low-fee female sex workers and their clients. The epidemic subsequently spread to the general population including youth.

The current estimate puts the number of people living with HIV in Thailand at 585,800 in 2008, including around 12,800 cases of new infection during that year⁴⁹, compared with 140,000 cases of new infection in 1991. HIV prevalence among military recruits and women attending antenatal clinics continued to drop from a peak of 4.0% and 2.3% in 1993 and 1995 to 0.5% and 0.7% respectively in 2008.

Table 3.6 STI and HIV/AIDS Indicators

Indicators		1990	1995	2000	2005	2008
1	HIV prevalence among conscripts (%)	2.1	2.4	0.8	0.5	0.5
2	HIV prevalence among pregnant women (%)	0	2.3	1.5	1.0	0.7
3	HIV prevalence among pregnant women aged 20-24 years old (%)	n.a.	2.5	1.8	1.2	0.3
4	HIV prevalence among pregnant women under 20 years old (%)	n.a.	2.4	1.0	0.7	0.2
5	Coverage of antiretroviral treatment (%)	n.a	n.a	<10	41.0 (2006)	67.2
(note: data are rounded to nearest tenth of a percent)						
Data sources						
1	Armed Forces Research Institute of Medical Science, HIV Surveillance System (2nd recruits)					
2-4	Bureau of Epidemiology, DDC, HIV Sentinel Surveillance.					
5	National HIV/AIDS Committee, National Progress Report as per the United Nations General Assembly Special Session on HIV/AIDS; Thailand 2008-2009, 2010.					

Key factors contributing to the success of the HIV/AIDS programmes include high-level political and financial commitment, multi-sectoral partnership especially active participation of civil society groups, a system of comprehensive surveillance and strategic information, and nationwide evidence-based interventions. Since 2005, comprehensive care including antiretroviral treatment has been provided under the UHC.

The expansion of the antiretroviral treatment programme started in 2002. The MoPH introduced the use of local generic combination antiretroviral drugs. In addition, the Government included AIDS treatment as part of benefits package in the universal health coverage scheme in 2007. Compulsory licensing of certain imported drugs has significantly improved the coverage of antiretroviral treatment. The proportion of ART coverage in 2008 was 67.2% (66.5% for adults; 86.1% for children).⁵⁴

Since 2002, there has been much concern about the prospect of re-emerging STIs and HIV/AIDS epidemic. The following are some of the disturbing signals:

- HIV prevalence among men who have sex with men in Bangkok was high at 17% in 2003, and increased to 30.7% in 2007.⁵⁰
- HIV prevalence among injecting drug users has always stayed high at around 40%,

reflecting slow progress in the harm-reduction strategy.⁵¹

- HIV prevalence among non-venue-based sex workers is also high at 20%, compared with 2.5% among venue-based sex workers in Bangkok.⁵²
- Less than half of sexually experienced young people had accurate HIV/AIDS information.⁵³
- 40-45% of new infections in 2005 was the result of spousal transmission⁵³.

Another HIV-AIDS related issue that has not received adequate attention is children living with HIV/AIDS. According to one projection, in 2009 approximately 15,000 Thai children under 15 years of age were living with HIV and 470,000 were adversely affected by HIV.⁵⁵ At present, most children living with HIV have access to government-sponsored antiretroviral drugs (ARV). Comprehensive care and services for children living with HIV have been piloted in some provinces. But adolescents living with HIV are growing in number. Counselling, reproductive health services and other social support for children and young people living with HIV should therefore be considered for national programme planning.

With regard to STIs, several surveys show a recent increase, particularly for gonorrhoea (GC) and Chlamydia. The Integrated Biological and Behavioural Surveillance found a prevalence of 1-2% GC and 10% Chlamydia infection among sex workers.⁵⁶

Of more concerns are the repercussions from the recent decentralization and health care service reform, which has led to less STI vigilance and less concerted prevention efforts. Under the health care reform

From “Prevention of Mother to Child Transmission of HIV (PMTCT)” to “Comprehensive Four-prong PMTCT”

Thailand was the first developing country that launched PMTCT (Prong 3) as a national programme in 2000. PMTCT consists of voluntary counselling and testing (VCT) for HIV, and a long course of anti-retroviral (ARV) drugs for HIV-positive pregnant women during pregnancy starting from the 28th week of gestation until delivery. Within 48 hours of delivery, the baby receives ARV drugs for one week or six weeks depending on the duration of ARV administered to the mother. The HIV-positive mother is advised to substitute breastfeeding with formula milk provided free of charge until the child is two years old. The programme has been successfully implemented and able to reduce the peri-natal transmission rate from 25% to 4%. Starting in 2003 the MoPH has also provided antiretroviral treatment to HIV-positive mothers, husbands, and children who meet the criteria (Prong 4). PMTCT Prongs 3 and 4 are available at all public health facilities and some private hospitals. In 2007, prevention of unintended pregnancy in HIV-positive mothers (Prong 2) has been strengthened using the involvement of people living with HIV. The model has been applied in selected hospitals with a plan to expand nationwide in a few years.

Risk of contracting HIV among women in Thailand can come from marital sex. In addition, extramarital sex by male partners is not rare, particularly during pregnancy. The target programme to prevent HIV among women is still limited (Prong 1). In 2004, the DoH and UNFPA have developed a service system as part of the maternal and child health programme that helps HIV-negative pregnant women stay negative using couple participation (even if their partner is already infected or practicing high-risk behaviours). An enrolment-based programme during ANC was developed, and became known as the Men as Partners in Maternal Health (MPM) Project. Service protocols were designed to guide health providers to better involve male partners in the different stages of pregnancy - including antenatal care, delivery, family planning and well-baby services. The couple-service model is well-accepted by both service providers and clients, and is being integrated with the national programme. Thailand should serve as a good example of implementing the four-prong model of PMTCT in the maternal and child programme nationwide.

in 2002, the authority and responsibility for STI prevention and services was transferred to local hospitals. The devolution was marred by inadequate planning and lack of coordination among the parties concerned. As a result, the STI service has become less accessible, with noticeable lower quality of service for sex workers. Outreach services are very limited. Reporting of information and data with regard to the STI situation and trends has been limited. The MoPH has recently reviewed the impact of decentralization on health services, and has taken remedial actions to thwart and control the re-emergence of STI and HIV/AIDS.

From “100% Condom Use Programme (CUP)” to “Comprehensive Condom Programming (CCP)”

Thailand's 100% CUP has been recognized worldwide as one of the most effective HIV prevention programmes. CUP is based on a broad-based collaboration that involves government authorities, provincial governors and provincial officials, health personnel and business enterprises. The programme was initiated in Ratchaburi in 1991 and expanded nationwide in 1993 with support from the National AIDS Committee. The key strategy was to empower sex workers to refuse sex service when customers did not agree to use a condom. No condom, no sex. This reduced HIV infection among sex workers and played a crucial role in controlling the spread of HIV infection among the general public, resulting in a decline of new HIV cases from 150,000 in 1991 to less than 14,000 in 2008. The programme was adopted in Cambodia, China, Lao PDR, Myanmar, Mongolia, the Philippines, and Vietnam.

Since 2007, to maximize the impact and sustainability of the 100% CUP, UNFPA has provided support to the Government to establish the national working group and develop the comprehensive condom programming (CCP) strategic approach to expand the CUP strategy beyond sex-work settings. Gaps in the national programme were identified. Efforts of government, civil society, and private organizations were harmonized. This initiative has led to a comprehensive and more strategic approach of condom policy and programming. The CCP strategic plan links supply, demand and supportive mechanisms to expand access to and increase the use of quality, affordable male and female condoms. The condom has been “rebranded” to present a new image as a tool for sexual health. The female condom has been included and introduced for woman as an empowerment tool.

Priority policy/action:

Thailand is committed to universal access to HIV prevention, treatment, care and support by 2010. In 2009, having recognized the renewed threat of HIV/AIDS, the National AIDS Commission chaired by the Prime Minister set targets and developed an acceleration plan to halve new HIV infection by 2011, in addition to the implementation of the National Strategic Plan of AIDS prevention and alleviation 2007-2011.

The National Strategic Plan for HIV Prevention and Alleviation (2007-2011)

The Plan aims to reduce new infections at least half, provide universal access to antiretroviral treatment to HIV infected persons in need, and ensure that at least 80% of HIV-affected persons and families have access to social services and support. The key strategies include:

- mainstreaming and integration of HIV prevention, treatment, care and support into all relevant sectors;
- integration of HIV prevention, treatment, care and support initiatives into comprehensive continuum for HIV and AIDS;
- ensuring human rights protection in all aspects of HIV and AIDS programming;
- enhancing monitoring, evaluation, research and knowledge development.

This represents a renewed interest in HIV/AIDS at the highest policy level. Strong leadership with good coordination and adequate resources is vital for successful implementation. It is highly appropriate to revitalize the prevention efforts with an emphasis on vulnerable populations, namely sex workers, men who have sex with men, intravenous drug users, young people, and other marginalized population including inmates and migrants.⁵⁷ Certain groups, e.g. registered migrants and ethnic minorities still find it difficult to realize the full benefit of the prevention and care under the UHC programme due to language barriers and distance to services. Others, e.g. irregular migrants, do not have any coverage at all. For the prevention efforts to be successful, these vulnerable groups should also have access to and utilize the HIV/AIDS and STI services.

In the long run, sustainable HIV/AIDS and STI prevention and care is not achievable without mainstreaming this issue into the plans and programmes of governmental and non-governmental organizations in all sectors and at all levels, particularly the local administrative organizations.

3.6 Other Reproductive Health Issues

Cervical cancer and breast cancer are the leading causes of death in Thai women. But a large number of women have not taken early detection measures.

Progress/gaps:

According to the Health Intervention and Technology Assessment Programme, the Visual Inspection with Acetic Acid (VIA) screening among women aged 30-45 and Pap smear among women aged 45-60 are highly cost effective. But the Reproductive Health Survey 2006 indicated that only 50% of Thai women aged 35-59 had received this screening in the past 5 years.⁵⁸ The Risk Behavioural Surveys 2007 also showed that only 52.7% of Thai women aged 35-75 had had the screening in the prior three years, an increase from 43.7% in 2005.⁵⁹ As for breast cancer, the Reproductive Health Survey 2006 reported that 24% of women aged 35-49 had checked their breasts, 24% had their breasts examined by health personnel, and 13% did both.⁶⁰

The national cervical screening programme was launched in 2005, with a target to serve 800,000 women per year. The cytology programme aims to have women aged 35-60 undergoing screenings every five years. In 2009, the DoH piloted a cervical cancer screening programme through a combination of VIA and Pap Smear in two provinces: Nakhon Si Thammarat in the South, and Chiang Mai in the North. The outcomes and determinants of the dual-technique screening programme is being evaluated.

An important obstacle in expanding the screening for cervical cancer and breast cancer is Thai women's shyness. For positive cases, the challenge lies in the limitation of services. First of all, the referral and follow-up system is not well-developed, which results in the loss of contact for a large number of cases. Further, due to expensive facilities and equipment, services are available only in large hospitals.

Priority policy/action:

The most effective measure is to raise the awareness to create demand for regular cervical and breast cancer screening through culturally sensitive approaches. Health communication should be strengthened to overcome existing barriers. The referral and follow-up system can be strengthened by expanding the networks at all levels. Enhancing technical skills and the discretion of service providers is also an important part of quality improvement.

Now that scientific research has revealed that the major cause of cervical cancer is HPV, and the HPV vaccine is available (but costly), the relevant agencies should seriously assess the cost-effectiveness and long-term costs and benefits of promoting HPV vaccine as a national programme.



3.7 Post-reproductive and Elderly Health

Thai women accept menopause as part of the ageing process. Hence, balanced information and advice need to be given to enable them to make their own health and behavioural choices.

Progress/gaps:

The average age of Thai woman going through menopause is 47.7 years old, plus or minus 5.5 years. Their knowledge about the permanent cessation of menstruation is at medium level. Most are not paying adequate attention to post-reproductive health because they view menopause as part of the natural ageing process, and see the positive aspects of menopause as entering a part of the lifecycle that is free from menstrual cycles and unwanted pregnancy. As for men, 79% experience the discomforts of andropause such as fatigue, anxiety, and depression. But most do not acknowledge the condition since it is regarded as an unacceptable threat to one's masculinity.⁶¹

Quite a number of menopausal women are tempted to use hormone replacement therapy and nutritional supplements believed to help lessen the physical and emotional problems at menopause such as osteoporosis. Some health personnel also treat menopause as an illness, thus focusing on treatments rather than giving women other options such as a change of life style or health promotion.

Due to increased awareness of population ageing, post-reproductive and elderly health has gained more recognition from policy makers and the public. The "Golden Age Clinics" have been set up at all public and private hospitals. But more appropriate interventions remain to be done.

Priority policy/action:

Effective communication and client-centred counselling is key to the promotion and provision of post-reproductive and elderly health. The MoPH has established the standards of services and trained health personnel to understand clients' needs and to help them consider their options. It is also important to empower the women to protect them from the commercialization of menopausal therapies and health-related products and to encourage them to make their own lifestyle decisions.

3.8 Gender-based Violence

The Thai society has shown increased sensitivity to gender-based violence (GBV). Expanded access, care and services have encouraged the victims to seek help for themselves and to combat this long-standing and hidden problem.

Progress/gaps:

In the past decade, Thai society has become more aware of various kinds of violence against women, including physical, sexual, mental and emotional dimensions, largely manifested by domestic violence, sexual harassment and abuse, and forced prostitution.

Annual totals of sex-related crimes reported to the police increased from 3,741 to 5,269 cases during 1997-2007. Less than half of the perpetrators were arrested. The number of closed-court cases on sex-related offenses at the Criminal Court and the Juvenile and Family Court also increased from 6,056 to 10,094 cases per year during 2003-2007.⁶² These statistics constitute only the tip of the iceberg as a large number of women decline to file complaints.

Another set of data are from the One-stop Service Crisis Centre (OSCC), established by the Cabinet decision in 1999. The MoPH piloted this project in 20 hospitals and expanded it to all provincial hospitals in 2004. Today the OSCC is the largest network of counselling and assistance facilities. Women facing violence seeking assistance increased annually from 6,951 cases in 2004 to 26,631 cases in 2008. Most women suffered from physical abuse while most children were victims of sexual abuse. Alcohol, drug, and jealousy featured prominently in these cases.

Women and children including those who are cross-border migrants who have been exploited in prostitution and human trafficking need physical and emotional rehabilitation, as well as other support. Between 2004-2006, the number of women and children seeking assistance from women's shelters and other support centres under the MSDHS rose from 15,750 to 18,617.⁶³

To some women, "home is where the hurt is". Domestic violence runs deep and transcends socio-economic status. The full extent of this problem is multi-factorial. Due to cultural norms that value family cohesion over women's rights, women are reluctant to disclose their "private" misfortune, while others prefer to stay out of this "internal matter".

Based on the analysis of the WHO Multi-country Study on Women's Health and Intimate Partner Violence conducted by the Institute for Population and Social Research, Mahidol University in 2001, it was found that one in five women were forced or unwilling to have their first sexual experience, with the highest percentage (46%) among girls aged 10-14. Most perpetrators were husbands, boyfriends or friends, and most of these first-time sexual experiences occurred without condom use.⁶⁴ The same survey found that 44% of ever-married women aged 15-49 years old had ever been either physically abused or sexually abused by their intimate partner.⁶⁵

Table 3.7 Numbers of women and child victims of violence at the One-stop Service Crisis Centres, 2004 - 2008

Year	Number of hospitals	Total number of clients	Clients		
			Women	Boys	Girls
2004	70	6,951	3,585	690	2,676
2005	109	11,542	5,656	792	5,094
2006	110	15,882	7,901	1,601	6,380
2007	297	19,067	9,469	1,826	7,772
2008	582	26,631	13,595	1,632	11,404

Source: One-stop Service Crisis Centre. DoH Service Support. MoPH.

Priority policy/action:

The fight against GBV has been strengthened by the Protection of Victims of Domestic Violence Act 2007 and the Prevention and Suppression of Human Trafficking Act 2008 that replaced the Protection and Suppression of Women and Children Trafficking Act 1997. In addition, the amendment of the Criminal Act in 2007 made spousal rape punishable by law. These legislations provide a comprehensive legal framework for the prevention, protection and rehabilitation for the battered women, and punishment of the offenders.



The extensive network of OSCCs adds the structure and strength to the endeavour to curb GBV. The fight against GBV has now been extended to the local level: 75% of community health hospitals have set up GBV services, while the Family Development Centres established by the MSDHS focus on prevention. NGOs are active in policy advocacy and outreach. In 2007, 2,716 women sought assistance from the Association for the Promotion of the Status of Women, the Friends of Women Foundation, and the Foundation for Women.⁶⁶

Like most gender-related issues, the root cause of the GBV problem is the social norms and attitudes. Hence, the “Women Development Plan” (during the 10th Plan) highlights the cultivation of the society’s attitude on gender equality and respect for human dignity as one of five strategic issues.

It is important to strengthen gender and human rights education in various sectors of the society. Better understanding and appreciation of gender-sensitive and human rights issues among policy leaders and the public, especially opinion leaders, role models and the media, are essential for effective implementation of the newly-introduced legislation to combat gender-based violence.

Another important priority is to enhance the capacity and sensitivity of the justice system and procedures to cope with an increase in GBV, especially when it involves youth.



Health Service System Development and Partnership

By and large, Thailand is well-equipped to handle upcoming challenges and opportunities on health. The institutional structure has been well-developed over the past decades.

4.1 National Policies and Laws

Thailand's first population policy dated back to March 1970 when the Government stated that "The Government has a policy to promote voluntary family planning in order to solve the problems related to a high population growth rate". Following the ICPD, Thailand declared the Reproductive Health Policy in 1997 which stated that "All Thai citizens, at all ages, must have good reproductive health throughout their entire lives". Owing to the successful family planning programme, the 9th National Economic and Social Development Plan (2002-2006) aimed to maintain the total fertility rate at no less than 1.8. The 10th Plan (2007-2011) places an emphasis on enhancing human potential and upgrading the quality of population. In 2009, Thailand has a new reproductive health policy to promote planned, safe, and quality births by encouraging all Thai people to maintain good reproductive health, based on principles of volition, equality, and accessibility.

Quality reproductive health is clearly stated by the "Population and Development Policy Orientation Framework". The National Health Act 2007 mentions the special needs for reproductive health of women. The National Health System Constitution endorsed by the Cabinet on 30 June 2009 also reiterates the role of the State in promoting sexual and reproductive health.

Section 4, Article 31:

"The State shall formulate, based on participatory approach, the Sexual Reproductive Health Strategic Plan, and support the implementation of the Plan.

The State shall also support legislative developments related to sexual and reproductive health."

National Policy Committee

In order to utilize reproductive health as a tool for human development throughout the span of the life cycle, the Cabinet approved the establishment of the National Reproductive Health Development Committee on 27 November 2008. The Committee, established on 3 March 2009, chaired by the Minister of Public Health, consists of high level officials from ministries and departments concerned, experts, and representatives from the DoH and NGOs. At the first meeting, the Committee approved the new National Reproductive Health Policy. The Bureau of Reproductive Health, DoH, MoPH is the national focal point on reproductive rights and reproductive health. It is responsible for policy development, research and development, and has a mission to support health centres and health promotion networks to promote reproductive health and upgrade the standard of services.

New National Reproductive Health Policy and Strategies (2010-2014)

The development of the new National Reproductive Health Strategy (2010-2014), endorsed by the Cabinet on 14 September 2010, aims "to ensure that all births are desired, safe, and attended with quality services, and to bring good reproductive health to all Thai people of both sexes and all ages, with an emphasis on adolescent sexual health, with a voluntary, equitable, and inclusive basis". The six strategies include:

- (1) Enhance the strength and quality of new families and new generations of youth.
- (2) Promote proper reproductive behaviour and sexual health among Thai people of all sexes and ages.
- (3) Develop quality and efficiency of reproductive health and sexual health services.
- (4) Develop an integrated management system of reproductive health and sexual health.

(5) Develop legislation, measures, and regulations for reproductive health and sexual health.

(6) Develop and manage the body of knowledge and technologies on reproductive health and sexual health.

4.2 Resources

Since 2000, the social budget (including education, health, social welfare, religious, culture and recreation) has been approximately 40% of the total Government budget.⁶⁷

As for health, Thailand has invested heavily to expand health facilities and services. The share of the health budget of the national budget grew from 5.4% in 1990 to 9.0% in 2009.⁶⁸ As a consequence, the population having some kind of health insurance, with the UHC being the largest system, increased from 33.5% in 1990 to 96.3% in 2007.⁶⁹ Reproductive health and sexual health services are included.

4.3 Reproductive Health Services

Since 1995, as part of the MoPH's service standard, all primary health centres at the sub-district level offer 3+ integrated reproductive health services, including maternal and child health, family planning, and preliminary screening for reproductive organ cancer. These centers provide a one-stop reproductive health service as clients can get all types of services in one visit. More sophisticated services are available at secondary and tertiary health facilities through referral under the UHC programme. At present, the MoPH is making another substantial investment to upgrade all primary health centres to become health promotion hospitals.

Another area that needs improvement is data. Data on accessibility and usage at the reproductive health service centres all over the country should be collected and disaggregated by gender, age and population group. Such a database is very important for monitoring



the situation as well as for improving the services, and formulating policy.

4.4 Partnership and Networking

Multi-partite collaboration is a cornerstone of Thailand's population and development and reproductive health system. Active collaboration from development partners from every social sector, particularly community organizations, the civil society, and local organizations is instrumental for the success of all programmes. Besides field work, representatives of these groups are appointed to various policy committees. They play a major role in planning and implementing population development and reproductive health programmes and projects.

Partnership with NGOs⁷⁰

Strengthening the partnership and networking is crucial at all levels. In the area of population and reproductive health, government agencies collaborate closely with NGOs. Five NGOs have participated actively in the National Family Planning Programme from the very beginning in 1970. They are the Planned Parenthood Association of Thailand (PPAT), the Population and Community Development Association (PDA), the Thai Association for Voluntary Sterilization, the Association for Strengthening Information on National Family Planning Programme,

and the Thai Fertility Research Association. At present, both PPAT and PDA are very active in promoting reproductive rights and reproductive health. Their activities focus particularly on creating awareness and providing counselling and services for family planning and HIV/AIDS, especially among adolescents and young people.

Many other NGOs are active in women's development and related fields. They are very active in advocating for legislative amendments and have broad-based support from the public. To name only a few, they are the National Council of Women of Thailand, the Association for the Promotion of the Status of Women under the Royal Patronage of HRH Princess Soamsawali, the Gender and Development Research Institute, the Thai Women's Watch, the Pavena Foundation for Children and Women, the Empower Foundation, the Foundation for Women, and the Friends of Women Foundation.



International Cooperation

Thailand has benefited from its partnership with several international organizations, such as UNFPA, UNDP, WHO, UNICEF, UNAIDS, JICA, and CIDA, among others. These organizations have played an important role in supporting Thailand in both technical and financial aspects.

As a founding member of the Partners in Population and Development: A South-South Initiative launched at the ICPD in 1994, Thailand has hosted several training courses and organized international workshops. Thailand also shares its successful experience with policy makers and programme managers from other countries regarding family planning and reproductive health services.

Since 2000, Thailand has also contributed to support other less developed countries in tackling poverty to achieve their MDGs through its ODA programme that started in 1992. Development partnership programmes are implemented through various activities, ranging from training courses, study tours, and study programmes, to the secondment of experts and volunteers.⁷¹

South-to-South Collaboration

The Thailand International Collaboration Agency (TICA), Ministry of Foreign Affairs has spearheaded the development of the strategy "Thailand's centres of excellence on reproductive health and population & development". Selected leading academic and educational institutes in Thailand received technical and financial assistance to enhance their academic excellence and training capacity. A regional International ICPD forum hosted by UNFPA was held in Bangkok in September 2009 providing an opportunity for member countries to exchange their experiences on progress of ICPD related issues.



5.1 Thailand's Achievements

Thailand has achieved almost all ICPD and MDG goals and targets as summarized in the table below.

5.2 Challenges and Opportunities

Thailand has achieved most of ICPD goals and objectives, but will have to strive strenuously to sustain the momentum of progress in some areas, e.g., reduction of gender-based violence, teenage pregnancy, unsafe abortion, and HIV/AIDS infection. Certain population groups require special

attention and care such as youth, people in remote areas on highlands, and in the deep South, and marginalized populations such as migrants, ethnic minorities, sex workers, transgender populations, drug addicts, and prison inmates.

Considerable challenges lie in the future. The momentous demographic changes will have far-

reaching economic, social, and health impacts. Thailand needs to take a very good care of its children, and support their development to the fullest potential. As there will be fewer than before, every child is an important asset to the society. Thailand also has to take better care of the elderly, as there will be proportionately more than ever before. While they

should be protected and cared for, it is important that the elderly remain physically, mentally, economically and socially active.

This two-pronged task will fall upon the working-age population who need quality education to prepare themselves to cope with the globalized, competitive,

and an increasingly volatile world. One of the most difficult and urgent tasks is to develop social protection and health care systems that accommodate all population sub-groups, especially the most vulnerable. The UHC is a step in the right direction. Still, the question remains as to how to maintain the quality of services and the public financing of the large and expanding systems of health insurance in the long run. These are very important policy issues that require serious consideration by the Government and all the parties concerned.

On top of this, the impact of climate change will be more fully revealed in the next few decades. The first wave of impacts is likely to be on food-security and health. The Government and all development partners must keep abreast of these rapidly changing situations.

Thailand has made some preparation to meet these challenges. But the real challenge lies in the balancing act of addressing priorities appropriately. It is also critically important that emerging issues are addressed and tackled in a timely fashion. It is equally important that persistent issues that are fundamental to people's

well-being are not neglected, and that no one is left behind.

5.3 Priority Agenda

The National Reproductive Health Policy and Strategies (2010-2014) is based on the strengths as well as gaps of the existing system. The situation reviewed in Chapter 3 also reflects these issues and suggests the following priority areas/issues for immediate action.

1. Enhance the strength and quality of new families and new generations of youth

As more Thais stay unmarried, and married couples bear fewer children, the new generation of Thai families will be very different from today. Every child is an important asset to the family as well as the society. Each birth should involve proper preparation on the part of the mother, the family, and the society. The focus on the family is congruent with Thai values and traditions, and is in line with the national social development policy. The focus on new generations of youth also addresses the society's growing concerns.



Chapters 2 and 3 show that while most children and youth enjoy better access to education, the type and quality of education provided is still inadequate to help them develop physically, mentally and socially to their optimum potential. They also need protection from preventable diseases, and other old and new risks. But the most important issue is how best to accommodate many different groups of disadvantaged children in many parts of the country.

2. Promote proper reproductive behaviour and sexual health among Thai people of both sexes at all ages

People of both sexes and all ages are entitled to good reproductive and sexual health. To achieve this, they need access to life-long learning about gender issues, reproductive rights, reproductive health, and sexual health, that is safe, based on mutual respect and free from violence.

An emphasis should be placed on adolescent and the youth as they feature prominently in unsafe sex, unmet need for contraception, unplanned pregnancy, abortion, HIV, and gender-based violence. At present, Thai society is facing several challenges in tackling this issue. Youth problems are escalating rapidly. But traditions and cultural norms often make it difficult to acknowledge the magnitude of the problem. A good communication and advocacy strategy is needed for both adolescents, youth, and the rest of society. An important tool is behaviour change communication (BCC). BCC has played an important role in many health programmes and projects by promoting positive health outcomes and behaviour change. An example is the programmes/projects regarding HIV/AIDS.

It is also important that the society is well-informed about reproductive rights and other rights-based issues, especially those concerning women's rights, gender equality, sexuality, adolescents and youth, and transgenders. Broad-based collaboration and sustained advocacy and public communication, evidence-based studies, smart social marketing and media strategies are needed to steer the Thai society toward the rights-based development approach.

3. Develop quality and efficiency of reproductive health and sexual health services

Thailand offers integrated reproductive health counselling and services at all primary health centers. This extensive coverage is exemplary. Nevertheless, there is room for improving the quality of services. Such improvement should not be restricted to

technical aspects, but also extend to other areas such as overcoming language and traditional/cultural barriers, especially with regard to promoting reproductive health and sexual health among ethnic minorities in highland areas in the North and the Muslim population in the deep South. In these and other areas, reproductive and sexual health services should be based on cultural sensitivity and local participation.

Moreover, data on clients' usage are needed to improve the services. There is a need for age-specific usage data to develop an effective surveillance and service system for specific population groups, e.g. adolescents and youth.

4. Develop integrated management system of reproductive health and sexual health

During the past decade, decentralization has had a profound impact on social service delivery systems including reproductive health and sexual health. At present, public health personnel are concerned that the reproductive health management system is becoming fragmented and ineffective. The Reproductive Health Plan also envisions the establishment of the Reproductive Health Provincial Committee to coordinate the planning and implementation of reproductive health issues and resources among provincial and local organizations concerned. This structure may help improve coordination. Nevertheless, a review of decentralization experiences, best practices and lessons learned to reflect on this very important issue will be useful for the Government and all the parties concerned.

5. Develop legislation, measures, and regulations for reproductive health and sexual health

Thailand is in the process of drafting the Protection of Reproductive Health Act to strengthen the linkage between reproductive health management and socio-economic, cultural policies and implementation, and to facilitate multi-sectoral collaboration. The draft bill highlights the role of reproductive health and sexual health information and education, counselling and services by both public and private sectors. It also guarantees the rights of pregnant women to services from the ante-natal to post-natal stage. Further, the draft bill will promote breast feeding, protect working pregnant women, HIV-infected pregnant women, women with unplanned pregnancy, pregnant women in detention, mothers who are unable to care for their children, and provide opportunities for pregnant teens to continue their education, etc.

6. Develop and manage the body of knowledge and technologies on reproductive health and sexual health

Thailand has relatively good quality data. Data collected on a regular interval and continuous basis have been used for planning, monitoring and evaluation of the implementation of policies, programmes and projects. The National Statistical Office (NSO) is the main source of data on population and development. Various departments under the MoPH also conduct surveys and collect administrative data through provincial offices and health centres.

In many cases, different sets of data serve different purposes. But they do create a great deal of confusion and debate. The MoPH's attempt to consolidate data management has had some success. Nevertheless, strengthening health, especially reproductive health, data capacity remains an important agenda.

In the area of research, Thailand has several research institutes to produce quality research and surveys on population and development, e.g., the College of Population Studies (CPS), Chulalongkorn University, and the Institute for Population and Social Research

(IPSR), Mahidol University. They collaborate closely with the MoPH, the NSO, and international organizations, and their outputs feed into the policy and planning process. Both institutes also provide training for degree and non-degree courses. The Thailand Development Research Institute (TDRI), Thailand's most influential research institute, also produces policy research on a wide range of topics, e.g. poverty, labour, social protection, health economics. The International Health Policy and Programme (IHPP) of the MoPH has produced several key reviews and studies to suggest appropriate health policy development.

Importantly, the Bureau of Reproductive Health of the DoH, MOPH also conducts reproductive health research on such topics as reproductive health behaviours, assessment and enhancement of the capacity of local administrative organizations in the provision of reproductive health services, development of quality and standards of reproductive health services, assessment of family planning demand and capacity development of health providers, behaviour change communication for reproductive health, and reproductive health service systems for vulnerable groups, migrants, slum dwellers, people in remote areas, elderly and neglected people.



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