REPRODUCTIVE HEALTH OF WOMEN IN THAILAND:
PROGRESS AND CHALLENGES TOWARDS ATTAINMENT OF INTERNATIONAL DEVELOPMENT GOALS

UNFPA Country Technical Services Team
for East and South-East Asia, Bangkok,
Thailand

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UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

FOREWORD

Greetings from UNFPA Bangkok on the occasion of World Population Day, 11 July 2005. "Equality" is the theme for this year. This means gender equality in education, economic opportunities, access to social services, participation in politics and decision-making.

The International Conference on Population and Development (1994) made a significant shift from pursuing demographic targets-driven family planning programmes to broader improvements in reproductive health of women, men and young people and to enable couples to decide freely and responsibly the number, spacing and timing of their children, free of discrimination, coercion and violence. The ICPD Programme of Action urged governments to ensure gender equality and women's empowerment which are feasible only within a human rights context. This human-rights based approach to population and development meant that reproductive health, including family planning ceased to be target driven.

Ten years after the Cairo and Beijing conferences, much progress is made in Thailand, as in many Asian countries. There is a better realisation that gender inequality compromises development in general and women's reproductive rights in particular. As young girls have to drop out of school to do household tasks, they remain uneducated, with poor access to knowledge, health care etc, and increased dependence on men for all decisions.

However, women must not be portrayed merely as victims, point out many leading thinkers in this area. Many studies show that sustainable development requires effective participation and involvement of women. In this context, the Millennium Development Goals, while not perfect and comprehensive, provide an unprecedented unifying framework for international support and national execution.

Thailand's success in achieving MDGs and their more ambitious MDG Plus targets are now well known. Yet, there are disparities within the country in education and health related indicators. Policy initiatives to address these issues include specific legal provisions, establishment of revolving funds, promoting One-Tambon, One-Product (OTOP) project, improving access to rural credit, providing health insurance through the 30-baht scheme and making reproductive health care more gender sensitive. Effective implementation of these policy initiatives requires development of managerial capacity at all levels of health system.

This report, produced in commemoration of the 2005 World Population Day in Thailand was initially drafted by Ms Theresa W. Devasahayam, UNFPA Consultant, with significant inputs from Ms Pawadee Tonguthai of the Faculty of Economics, Thammasat University, under the technical guidance of Ms Mere Kisekka, UNFPA/CST Adviser on Gender and Socio-Cultural Research. I am thankful to all of them for their contributions to this report.

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ABBREVIATIONS

AFPPD	Asian Forum of Parliamentarians on Population and Development
ARVs	Antiretrovirals
AZT	Azidothymidine
BCC	Behavioural Change Communication
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGEO	Chief Gender Equality Officers
CUP	Condom Use Programme
GDI	Gender-related Development Index
GEM	Gender Empowerment Measure
HDI	Human Development Index
HPS	Health Promoting School
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IDU	Intravenous drug user
MCH	Maternal and child health
MDGs	Millennium Development Goals
MSM	Men who have sex with men
NCWAFD	National Commission on Women's Affairs and Family Development
NESDB	National Economic and Social Development Board
NGO	Non-governmental organization
NHSO	National Health Security Office
NSO	National Statistical Office
ONCWA	Office of the National Commission on Women's Affairs
OWAFD	Office of Women's Affairs and Family Development
OTOP	One-Tambon, One-Product
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission
PoA	Programme of Action
PPAT	Planned Parenthood Association of Thailand
PPP	Purchasing power parity
STI	Sexually transmitted infection
SW	Sex worker
TAO	Tambon Administrative Organization
THB	Thai baht
TNCA	Thai NGOs Coalition on AIDS
VCT	Voluntary Counselling and Testing
ZDV	Zidovudine

1 INTRODUCTION

1.1. Aims and Structure of the Report

The report examines Thailand's progress in the area of women's reproductive health in the context of major international declarations and conventions including CEDAW (1979), ICPD in Cairo (1994), Beijing Declaration (1995), and MDGs (2001).

The report is divided into four chapters. Chapter 1 provides an overview of Thai women's status in the economic and political arenas. Chapter 2 deals with reproductive health concerns including maternal mortality STI/HIV/AIDS, adolescent reproductive health, reproductive malignancies, and older person's reproductive health. Primarily the discussion reveals a persistent gender gap in these concerns. Chapter 3 examines how larger issues concerning women's reproductive and sexual rights in the country are addressed. In addition, gender-based violence as a reproductive health and human rights issue is examined owing to the rise in the number of women who are victims of violence. The chapter 3 also details the reproductive health status of women from vulnerable groups such as the ethnic minorities and poor and rural women who engage in low-paid work, which increases their vulnerability to various health risks. The report concludes with chapter 4 that outlines a number of 'quick wins' for ensuring greater equality for women in their access to reproductive health care services in the future.

1.2. Women's Concerns in International Declarations and Conventions

International Declarations have highlighted women's concerns in human development. For example, the Beijing Declaration and Programme of Action (PoA) of 1995 specifically highlighted the need for

women's empowerment through the elimination of obstacles to women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural and political decision-making.

The 1994 International Conference on Population and Development (ICPD) also highlighted women's role in order to achieve a higher quality of life for all people by making an ambitious call to factor population issues into development strategies. Intrinsic to the ICPD is the improvement of women's access to sexual and reproductive health care services and rights through the elimination of the gender gap in access to education and the promotion of gender equality and women's empowerment.

As in the ICPD PoA, the United Nations Millennium Declaration also acknowledges the critical function of women's advancement in the entire development process. Goals 2, 3 and 5 have addressed increasing women's empowerment through the promotion of gender equality and improving maternal health. Although Goal 6 does not

Table 1: ICPD Programme of Action and MDGs and Targets

ICPD Goals and Objectives	Millennium Development Goals and Targets
...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 [para. 11.6]	Goal 2: Achieve universal primary education Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
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 [Principle 4]	Goal 3: Promote gender equality and empower women Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015
Countries should strive to effect significant reductions in maternal mortality by the year 2015: A reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015... [para. 8.21]	Goal 5: Improve maternal health Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
. . by 2005, ensure at that least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15-24 has access to information and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; that by 2005 prevalence in this age group is reduced globally, and by 25 per cent in the most-affected countries [ICPD+5 para. 70]	Goal 6: Combat HIV/AIDS, malaria and other diseases Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

explicitly specify women, it is centrally concerned with women since there continues to be gender gaps in health issues such as HIV/AIDS.

The similarities between ICPD goals and MDGs are reflected in the table 1. The ICPD also aims to raise the quality of life through population and development policies and programmes for achieving poverty eradication, sustained economic growth in the context of sustainable development.

In addition, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted in 1979 by the United Nations General Assembly, virtually functions as a bill of rights.

Thailand is a signatory to ICPD, Beijing and MDGs. It has also ratified CEDAW in 1985. In September 2004 at end of the first decade of ICPD, the Honorable Prime Minister of Thailand has reaffirmed the country's commitment to the Programme of Action, along with many other World Leaders.

Thailand's efforts to implement the various international declarations and CEDAW have been evident in its own national development plans. The Women Development Plan of the Ninth National and Social Development Plan (2002-2006) reiterates the vision that all women reach full development in every aspect and are able to live a quality and happy life. The Plan aims to improving literacy among women, protecting female labour force participation, reducing morbidity and mortality, increasing female participation at the levels of decision-making and resource allocation, and amending laws that are contradictory with the provisions of CEDAW and the Royal Thai Kingdom Constitution. Further to ratifying CEDAW, progress on the convention was made when Thailand withdrew five of its seven reservations since it first acceded to CEDAW. In addition, the present Constitution, adopted in 1997, ensures equal rights for men and women in all aspects of life.

The Implementation of CEDAW

Since the ratification of CEDAW in 1985, the Prime Minister's Office responsible for the Office of the National Commission on Women's Affairs (ONCWA) has approved the withdrawal of the following reservations:

- Article 11: Employment opportunities, following its decision to order all government agencies to review their discriminatory regulations to allow female civil servants to hold any position except those related to national security;
- Article 15: Women's legal capacity with respect to contract and other matters;
- Article 9: Change in the nationality law;
- Article 7: Equal opportunities for access for access to all government jobs;
- Article 10: Equal educational opportunities.

The two articles that continue to be subject to reservations include:

- Article 16: Equality in Family Life and Marriage;
- Article 29: Settling of Disputes by the International Court of Justice.

Source: Government of Thailand (1997).

1.3. Status of Thai Women: An Overview

Economic Participation

Women constitute 15.9 million or 45 percent of the entire labour force of 35.3 million (2005). Among the 13.0 million who are not participating in the labour force, women constitute 65 percent, while of those who reported to be 'doing household work', women constitute 96 percent. The economic activity rate of females in the age group 15 years and over was 73.1 percent in 2001, approximately 85 percent of the male rate. Although the economic activity rate of women is very high, many continue to be 'unpaid or contributing family workers'. Data for 1995-2001 indicate that on average 66 percent of women fall into this category while only 34 percent of men find themselves in this situation.

Women tend to be engaged in three major economic sectors: agriculture (47 percent), industry (17 percent) and services (36 percent). Off-farm jobs are particularly attractive to rural women who tend to be 'unpaid family workers'. The proportion of women falling into that category is more than twice that of men, both in rural and urban areas. Nonetheless, women's opportunities outside the agricultural sector have expanded along with the changing structure of the Thai economy as it has shifted more to the industrial and service sectors. Occupational segregation by gender in these sectors is evident, with women twice as likely as men to be engaged in service and sales-oriented occupations. The reverse is true for professional, legislative and managerial positions that continue to be dominated by men. Although women have begun to move gradually away from traditionally female occupations, such as clerical, nursing and teaching jobs into male occupations, the shift has been slow. Data on courses opted for by males and females at the tertiary education level demonstrate that women prefer fields considered to be female-oriented. Hence, occupational differences by gender are more likely to persist for at least the next decade.

Public Sector Employment

Within the civil service, female employees outnumber male employees, with the proportion of women rising from 55.7 percent in 1995 to 59.6 percent in 2002. There exists, however, a glaring gender gap in promotional opportunity. Thailand's civil service is characterised by a hierarchy of different levels with the lowest positions falling within the C1 level and the highest positions falling within the C11 level. Women account for 22.3 percent of the positions in the top three levels (C9 – C11) in 1999, which was up from 15.7 percent in 1994. In terms of appointment to executive positions, however, the improvement is both slow and miniscule. Women civil servants at C9 – C11 levels holding executive positions represented 15.2 percent in 1996, rising slightly to 16.5 percent in 2001.

Promotion in the civil service is theoretically based on merit along strictly defined criteria. In reality, however, the promotion trends indicate that there are certain constraints keeping women from advancing to higher-level positions. The highest position in the civil service is that of permanent secretary. Until 1998, no woman had ever been appointed to that post.

The first appointment of a woman in a high-level position was for the Prime Minister's Office, and not a full ministry. Nonetheless, the selection of a woman was widely regarded as a landmark in women's advancement in the political arena. For the first time, the civil service 'glass ceiling' was broken. Since then, four more women have been appointed to the position of permanent secretary in the following ministries: Education (2), Information, Communication and Technology (1), and Social Development and Human Security (1).

In so far as female administrators and managers are concerned, only 26.5 percent of the total number comprises women, a rise of 5.5 percent since 1980-1989 figures[1]. The professional and technical categories show more promise, as women comprise 55 percent of the total number of professional and technical workers in the country.

Labour Laws

Both the Thai Constitution and Labour Protection Law prohibit discrimination on the basis of age and sex. Yet in many private enterprises women and men have different retirement ages (that is, 55 years for women and 60 years for men). Workers without labour unions to represent them are more likely to be resigned to the situation in which they find themselves rather than attempt to negotiate for equal treatment.

The 1998 Labour Protection Act contains a number of new provisions for the protection of women workers in the areas of equality of employment, health protection, work safety and sexual harassment. Enforcement of the law, however, remains a problem. Labour inspection covers barely 10 percent of all establishments, which means employers, especially of small, unregistered firms, can continue to violate the Labour Law without being subject to prosecution.

Sexual harassment has been included in the Labour Protection Act for the first time as a result of petitions from women politicians, lawyers, academics, the Ministry of Labour and Social Welfare and the National Commission on Women's Affairs, with technical advice from The International Labour Organization. Under the Act, employers, foremen, supervisors or inspectors are subject to prosecution if found guilty of harassing women employees or co-workers. The clause on sexual harassment in the Labour Protection Act, however, does not extend to government officers.

Access to Economic Resources

Under the Family Law, men and women have equal rights to inheritance. In some areas such as the Northern region, tradition posits that daughters receive a greater share of the inheritance, particularly that of land. In the case of spousal inheritance, spouses not only are entitled to half the common property but also possess the right to inherit an equal share should they be heir.

Men and women have equal rights in landholding under The Land Act, but the rights of those married to foreign nationals are restricted as they are not entitled to buy land nor landed property. The rationale in this case is to prevent such men and women from acquiring land for the benefit of their foreign spouses.

Men's and women's access to formal and informal financial resources varies. Women are fully eligible to apply for credit from

financial institutions and there is no discrimination against women who wish to receive bank loans, mortgages and other credit sources. The Civil and Commercial Code, however, specifies that both men and women must have their spouse co-sign loan contracts. In addition, couples are responsible for the repayment unless they become divorced at a later time. In the case of collateral involving the use of common property, consent must also be obtained from spouses. Particularly in rural areas, the ways in which financial institutions operate may discriminate against women since these institutions often involve complex procedures and rigid regulations. For example, bank rules may only allow the 'head of household' to apply for a loan. As men are often regarded to be the head, women are by default discriminated against in taking up a loan in their own name.

As a result of encountering barriers in accessing formal financial resources, many women have turned to informal sources of capital such as revolving funds and village credit unions. These financial schemes, however, have interest rates between 10 to 20 percent per month, which women then struggle to pay off.

Nonetheless, there have been a number of developments in recent years that have improved rural poor women's accessibility to financial resources. In 2001, the Government introduced a number of grassroots-oriented and poverty eradication programmes, which include schemes that improve access to financial resources among poor women living in rural areas. Owing to the active participation of women in diverse productive activities in the grassroots economy, there has been considerable success in poverty reduction in the rural areas[2].

Political Participation

Among eligible voters who exercised their right to vote in 1996 – the last time that sex-disaggregated data on voters were collected – women accounted for 52 percent, their numbers being about 1 million more than men.

While women's increased political participation has occurred at both the national and local levels, they remain underrepresented both as candidates for and holders of public offices. In 2004, two women took on the positions of full Ministers in the Ministry of Culture and Ministry of Agriculture and Cooperatives respectively.

The year 2005, however, marked a watershed when in March, Thailand saw its Parliament elect a woman for the position of Deputy House Speaker. This is the first time a woman has taken on a senior parliamentary position. In the recent elections of 6 February 2005, women members of parliament accounted for 10.4 percent, an increase from 9.2 percent in the previous election and 5.2 percent increase from 1992[3].

Women's participation in 'national committees' has also increased although only minimally[4]. In 1995-96, 62 national committees covering 14 areas of national concerns were in existence; only 10 percent of the more than 1,400 members in these 62 national committees, however, were women. Even in the areas of education, culture, women, children and older persons, women comprised only 26 percent of the members. Some progress has been made since then. In 2001, among 322 national committees with 6,338 members, women's

participation increased to 16 percent. One reason for women constituting a minority in these national committees is that most members are usually assigned seats depending on their official positions, and not by personal merit. In addition, the chances of women being appointed to the national committees is less since women represent a much lower proportion of those who hold executive level positions at the C9 – C11 levels.

Women's participation in local politics has also been increasing gradually from 1.8 percent to 2.1 percent for the position of village head and from 4.9 percent to 6.9 percent for positions in the provincial council. In the 2005 general elections, 20 political parties registered candidates of whom 483 were men and only 99 were women.

As in national politics, men dominate local politics as members of councils and administrative bodies. At the provincial level, for example, of the 75 governors in 2003 none were women. The percentage of women's participation as members of the provincial councils, however, increased from 4.9 percent to 6.9 percent between 1995 and 2002. In terms of sub-district village heads, of the total of 7,245, women's participation increased from 1.8 percent to 2.1 percent.

This slight improvement of women's participation in the political arena may be attributed to the efforts of governmental and non-governmental organizations (NGOs) engaged in capacity building programmes and campaigns aimed at increasing women's political participation. Specifically these programmes and campaigns have helped

Table 2: Participation in Politics and Administration at the National Level, by Sex, 2005

Position / National Government	Total Number	Percentage	
		Female	Male
Member of Parliament (District)[1] (2005)	400	11.7	88.3
Member of Parliament (Party List)[1] (2005)	100	6.0	94.0
Senator[1] (2002)	200	10.0	90.0
Cabinet Member[1] (February 2003)	35	5.7	94.3
Judge[2] (2000-2001)	2,410	18.6	81.4
Attorney[3] (2000-2001)	1,692	11.5	88.5
Civil Service Executive:[4] (April 2001)			
Level 11	25	8.0	92.0
Level 10	198	12.1	87.9
Level 9	249	16.5	83.5

Source: Gender and Development Research Institute derived from

[1] *The Secretariat of the House of Representatives;*

[2] *The Secretariat of the House of Senate;*

[3] *Office of the Judicial Affairs;*

[4] *Office of the Attorney-General;*

[5] *Office of the Civil Service Commission.*

increase awareness and enhance the potential of women in provincial and rural areas, offering wider opportunities for them to participate in the political arena. These efforts have also had results in the Village Fund Committees, where women and men are equally represented, as a consequence of a regulation issued by the National Commission of the Village Fund and Urban Community.

There is no official affirmative action policy to promote women's participation in civil service or political office even though the National Commission on Women's Affairs requested the cabinet to consider increasing the appointment of women representatives in national committees to equal that of men. A few high profile national committees such as the Human Rights Commission began to include roughly equal number of male and female representatives (6 men and 5 women to be exact).

Education

In 1997, the new Constitution called for schooling to be mandatory for the age group 9-12 years. This step was instrumental in closing the gender gap in education as it improved children's access to education. In order to increase enrolment rates for girls in the poor rural areas, the Government has provided scholarships so as to make education available to this group. In all these efforts, it is evident that the Government increasingly views education as a right of every Thai citizen.

Yet a miniscule gender gap in access to education at the primary level in Thailand persists, suggesting that the country has slightly fallen short of achieving the MDG. This was demonstrated in the gross primary school enrolment rates. In 2000, the ratio of girls to boys in primary school was 0.93. This was a slight decline since 1990 (Table 3). Ironically, the gender gap reverses at the secondary school level where the ratio of girls to boys was 1.01. Marked differences in favour of females also show up at the tertiary level where the ratio of females to males was slightly higher at 1.15 in 2001.

Females were also found to outperform males at the university level. This is reflected in the number of males to females who graduate yearly. In 2000, the ratio of females to males who graduated was 1.3 and 1.7 for public and private universities respectively[5].

Table 3: Ratio of Girls to Boys in Primary, Secondary and Tertiary Education, 1990-2015, Thailand

Indicators	1990	1995	2000	2002	2015 MDG target
Ratio of girls to boys in primary education	0.95 (1991)	0.94 (1996)	0.93	n.a.	1
Ratio of girls to boys in secondary education	0.97 (1991)	1.02 (1996)	1.01	n.a.	1
Ratio of girls to boys in tertiary education	1 (1991)	1	1.12	1.15 (2001)	1

Source: Thailand Millennium Development Goals Report (2004).

Gender differences, however, remain pronounced in terms of chosen field of study at the university level. Women tend to opt for subjects such as health services (particularly nursing) where the female to male ratio was 2.4 in 2001, while men continue to dominate the fields of engineering, law, and computer science with the enrolment ratio standing at 0.2, 0.4 and 0.8 respectively[6]. Nonetheless, course selection according to sex is changing gradually with the female to male ratio in enrolment in mathematics and computer science increasing from 0.6 to 0.8 over the decade from 1991 to 2001 (Table 4). The gender gap in the chosen field of study is of concern because it serves to reinforce gender stereotyping in a society already marked by different perceptions of the abilities of the sexes.

Table 4: Female to male ratios in selected fields of higher education, 1991 and 2001, Thailand

Subjects	1991	2001
Mathematics and computer science	0.6	0.8
Medical and health services (including nursing)	2.2	2.4
Engineering	0.1	0.2
Architecture	0.4	0.4
Law	0.2	0.4

Source: Ministry of University Affairs, as cited in Tonguthai (2005).

Gender gaps in access to education have implications more broadly on the literacy rates of females and males. In 2002, the literacy rate of males was 99.5 percent while the literacy rate of females was 98.5 percent. A greater difference was found in the adult literacy rate in the 15 years and older age group recorded in 2001; literacy rates for females was 94.1 percent and 97.3 percent for males[7]. Specifically, the majority of the illiterates were females over 40 years old. On the positive side, illiteracy rates are gradually declining among women in Thailand. In 2000, women accounted for 56 percent of the illiterate population, a decline from 62 percent in 1990[8].

Unlike older generations, among the youth (15-24 years), literacy rates for both sexes are almost equal. Owing to the fact that younger generations of women demonstrate higher levels of literacy is indicative of the progress Thailand has made in eradicating the gender gap in education. The eradication of the gender gap in education and literacy, however, do not necessarily translate into an increase in women's empowerment. The on-going process of formulation of the UN Common Country Assessment for Thailand has identified gaps in the current curriculum among which are eradicating the unequal access to education by girls, removing gender stereotypes, and the need for integrating sex education.

1.4. From Policy to Action

Concerning the MDGs, Thailand's achievement so far has been outstanding. For example, poverty has been reduced by two thirds since 1990. Aside from poverty reduction, the proportion of underweight children has declined by nearly half. In addition, universal access to education is close to being achieved, although there remains the challenge of improving the quality of education and closing the slight gender gap in primary school education. On issues of health, malaria has been nearly eliminated while new infections of HIV/

AIDS have dropped by more than 80 percent since 1991 when the disease was at its height. As a result, Thailand has set for itself more ambitious MDG Plus targets to achieve in the next decade, placing the country well ahead of many others.

As in most countries where human development indicators improve at higher levels of economic advancement, Thailand is no exception. In 2004, Thailand was considered a middle-income country with a gross domestic product (GDP) per capita of US$ 2,467[9]. With an HDI (human development index) ranking of 76, Thailand falls into the category of countries in the 'medium human development' group[10]. In spite of the economic downturn of the late 1990s, the country was able to pick itself up and, as a result of socio-economic and domestic reforms, GDP grew by 6.7 percent in 2003, thereby improving the quality of life of its people.

Changes in the institutional structure, as captured in the Eighth National and Social Development Plan (1997-2001) and Ninth Development Plan (2002-2006), have also fostered the country's development through the principles of a "people-centred development" and "sufficiency economy". These Plans were not only instrumental in providing broad-based strategies for human development, poverty eradication and the reduction of the country's vulnerabilities to external shocks, but also facilitated the achievement of the ICPD and MDG targets. The UN in various capacities has also been instrumental in assisting in the development of the country, particularly in relation to meeting the needs of vulnerable groups.

The overall economic growth of the country has had a significant impact on women's advancement. Many poverty alleviation programmes have mainstreamed gender into their formulation and implementation, although gender budgeting has not been fully adopted into the Thai budgeting system[11]. Indicators for measuring the advancement of Thai women such as the Gender-related Development Index (GDI) are useful for tracking the progress women have made particularly in areas of gender inequality. According to the GDI, the greater the gender disparity in basic measures of human development, the lower a country's GDI in contrast with its HDI. In terms of the GDI, Thailand has been ranked 61, a significantly higher ranking than its HDI ranking of 76. Another measure of women's status is the Gender Empowerment Measure (GEM). As in the GDI, Thailand is ranked higher according to the GEM (55) than the HDI (76). In terms of women's participation in politics, evidence over the last decade, according to the HDI, affirms that Thai women are lagging behind considerably when compared to women of other countries. Even the ratio of estimated female to male earned income (PPP US$) is considerably low (0.61)[12]. On average, women's advancement in Thailand may be said to be mediocre as compared to other countries.

As in other countries, institutional mechanisms focusing on policy and planning, implementation and legislation have been instrumental in promoting gender equality in Thailand.

The major national machinery responsible for policy formulation and the coordination of its implementation is the National Commission on Women's Affairs and Family Development (NCWAFD). The Commission, chaired by the Deputy Prime Minister, is the

chief national mechanism with the mandate to formulate policies relating to the promotion of gender equality and the coordination of implementation by public and private agencies. NCWAFD consists of 34 members from government and non-government sectors, inclusive of 10 gender experts who are appointed to serve on the Commission on a two-year term. Six sub-committees have been formed to draw up detailed plans and measures dealing with the following major areas of concern: (a) family, (b) law, (c) education and economy, (d) participation in politics and administration, (e) violence against women and children, and (f) reproductive rights. The areas of responsibility of these members and experts range from gender mainstreaming, gender advocacy and women's empowerment, to research on gender and development. The implementing arm of NCWAFD is the Office of Women's Affairs and Family Development (OWAFD). An information centre has also been established to collect and integrate information on sex-disaggregated data and to coordinate the main findings of various organizations, projects/activities, articles and researches.

In the beginning of 2001, cabinet approved the appointment of Chief Gender Equality Officers (CGEO) in every government agency both at the ministerial and departmental levels. The main tasks of the CGEO are: (a) to promote gender equality in organizations, (b) to integrate gender perspectives in policy and planning policies, (c) to develop the Master Plan on Gender Equality Promotion in their respective agencies, (d) to establish network for exchanging information and knowledge on gender equality among government agencies, and (e) to manage Gender Focal Points. Under the supervision of the CGEO, a team of gender focal points coordinate gender mainstreaming in the various government agencies.

For legislative issues, various bodies have been established within the Parliament as mechanisms to deal with women's affairs. The House of Representatives and the Senate Committees on Women, Youth and Elderly Affairs monitor and promote the well being of women, youth and the elderly, and advise concerned public and private agencies on issues and problems relating to women, youth and the elderly. Members of other House and Senate Committees (such as Education, Health, Social Development and Human Security) have often called on gender experts to work closely with Members of Parliament and Senators. In addition, female Members of Parliament and Senators have established a body called the Thai Women Parliamentarian Caucus – officially and popularly recognised as a legislative mechanism for promoting gender equality. The Caucus has helped introduce gender perspectives into deliberations of the various House and Senate Committees. More importantly, it has worked closely with NGOs and parliamentarians working toward the enforcement of gender-sensitive and gender-responsive laws.

Civil society mechanisms have also been critical in promoting gender equality. NGOs and voluntary groups have consistently been involved in gender and development issues in Thailand, by forming effective partnerships with government and legislative agencies. Before the Fourth World Conference on Women in Beijing in 1995, most of the activities of NGOs were oriented towards welfare or small income-generating projects with the aim of including women

in development efforts. The Beijing preparatory process has brought new dimensions to the ways in which NGOs relate to the national machinery as well as to each other. While NGOs may have focused on meeting women's practical needs, they now have a wider, more global outlook, paying attention to impacts of socio-economic policies on women and men. International trade agreements, regional economic cooperation and human rights issues have also become the concerns of NGOs, not just for Thai women but also for women migrants from neighbouring countries. More significantly, NGOs are instrumental in lobbying for changes in keeping with international principles and commitments, in particular, the Beijing Platform for Action and CEDAW.

At the policy level, NGOs play a significant role in various national level committees and sub-committees. While legislative amendments often require broad support from the public, NGOs have been effective in the advocacy role, particularly on the issue of gender-based violence, HIV/AIDS and the elimination of discrimination against women. NGOs work closely with individual parliamentarians (many of whom were former representatives of NGOs) and the Thai Parliamentarian Caucus.

2 PROGRESS AND CHALLENGES IN WOMEN'S REPRODUCTIVE HEALTH

2.1. Meeting the Reproductive Health Needs of Thai Women

In the area of reproductive health, Thai women have experienced considerable improvement. Maternal mortality ratios declined sharply from 45 to 22 per 100,000 live births in the mid-1990s and 2004 respectively[13]. Since the MDG target of reducing by three quarters, between 1990 and 2015, is not applicable to Thailand, an MDG Plus target of 18 per 100,000 live births has been set for 2006. Nonetheless, greater attention on regional disparities is needed.

In tandem with the mortality decline, the fertility rate in Thailand has also been declining steadily over the last three decades, starting in the 1970s. The total fertility rate was at replacement level of 2.0 in 1993, further declining to 1.7 in 2004. Fertility decline may be attributed to the high prevalence rate for contraceptive use, which increased from 74.0 percent in 1993 to 79.2 percent in 2001[14]. Based on data from across the country in 2001, the contraceptive use rate of the oral pill was recorded at 27.0 percent, while female sterilisation was 22.5 percent and the use of injectables at 22 percent[15]. Clearly, women undertake the main responsibility in controlling fertility, as indicated by reports by both men and women. As such, contraceptive use rates were much higher among women than men. Contraceptives associated with males, such as condoms and male sterilisation (vasectomy) record very low rates across the country.

Despite the decline in fertility to below replacement level and an increasing contraceptive use, the National Economic and Social Development Board (NESDB) has projected that the population of Thailand will continue to rise for a few more decades owing to 'population momentum'. The rate of increase, however, is expected to decrease gradually.

Women had made progress in the area of reproductive health as a result of the Thai Government having mainstreamed population issues into all policies and programmes related to sustainable development, including those aimed at eradicating poverty. As early as in the 1960s that population issues figured prominently in Thailand's development agenda as evident in the First National Development Plan. Motivated by the concern for economic and social development, the Government shifted its stance from a pro-natalist policy. It was in the 1970s that the country's family planning programme took effect. As such, the idea of granting importance to population issues was not unknown to policy-makers and planners prior to the ICPD. At this time, Thailand had already a good health service delivery system through its primary health care (PHC) centres. Maternal and child health (MCH) services covering family planning, referral services for pregnancy and delivery complications and cancers of the reproductive system, and HIV testing were also available.

The ICPD further propelled the Thai Government to strengthen its reproductive health services. Soon after the declaration, the Government designated the National Population Board to develop the Population Action Plan, later to be incorporated into the country's Eighth National Plan. NESDB independently assigned responsibilities to the different government departments and NGOs to follow-up on the ICPD and coordinate activities related to its PoA. In conjunction with the Family Planning and Population Committee, the Department of Health took on the challenge of determining the framework and components for reproductive health.

This policy was well received by the public since there had already been a demand for smaller families. Even before the declaration of the policy, a considerable proportion of women had been practising contraception. CPR was 14.4 percent in 1970, rising to 53.4 percent in 1978 and further to 64.6 percent in 1984[16]. As such, there was a rapid receptivity to contraceptive use among Thai women from the onset of the Government's family planning campaigns. Another reason for the quick response to contraceptive use was the lack of religious-based groups opposed to the Government's family planning campaigns. Among the Thai Muslims, although abortion was explicitly prohibited, contraceptive use was permissible as long as it facilitated birth spacing and protected women's health.

Access to reproductive and sexual health services including family planning have improved in Thailand over the last decade. In July 1997, Thailand released a National Reproductive Health Policy statement reinforcing that "All Thai citizens at all ages must have good reproductive health throughout their entire lives". While a few of the services were already available prior to 1994, Thai government's commitment to the ICPD, prompted these services to be more fully integrated into the new health care infrastructure.

Over the last 10 years, additional new reproductive health services have been made available, while existing services have been strengthened. New services include: (a) pilot health care programmes for adolescents, (b) sex education[17], (c) post-abortion care, (d) premarital counselling, (e) counselling on different aspects of women's health including breastfeeding, (f) prevention of mother-to-child trans-

mission of HIV/AIDS, (g) prevention and treatment of reproductive tract infections, (h) malignancy, (i) infertility, and (j) post-reproductive and old age care.

Owing to declines in fertility, the Government does not have national targets on total fertility rates since the Eighth National and Social Development Plan (1997-2001). The Government instead has focused its current services on improving the quality of its maternal health and family planning services made available through the existing health care infrastructure. There is now greater emphasis on gender sensitive and integrated services.

Public health services are now available in all sub-districts (9,689) through a total of more than 69,331 community PHC centres[18]. Decentralised targets include: (a) reducing teenage pregnancies, (b) reducing anaemia during pregnancy as a result of iron deficiency, (c) promoting exclusive breastfeeding for at least four months, (d) establishing nutrition development corners, (e) providing care for birth asphyxia at hospitals, (f) reducing mother-to-child transmission of HIV during post-pregnancy and postpartum periods, and (g) providing formula milk for the babies of HIV infected mothers. In addition, the Ministry of Public Health has implemented the Universal Health Insurance Scheme (known as the 30-baht scheme) in 2002[19], which was aimed at providing affordable health care to the poor and vulnerable groups. NGOs and the private sector are also instrumental in the provision of health care services and the dissemination of information.

The Eighth Plan accorded greater prominence to promoting gender equality and women's empowerment, thereby integrating many of the concerns outlined in the Beijing Declaration. The Ninth Development Plan (2002-2006) emphasises strategies to promote reproductive health especially among adolescents, to facilitate gender equality in education, to empower women, and to meet the needs of a growing number of older persons in the population. The Plan also calls for improving access to basic services, including reproductive health and family planning services, among the poor and in regions recording lower health indicators compared with the national average.

Yet more needs to be done to strengthen women's reproductive rights as significant gender gaps continue to exist. For example, complications arising from pregnancy and delivery remain one of the leading causes of death among women. About half these lives lost is due to two causes, haemorrhage (34.3 percent), sepsis (16.4 percent). Causes of maternal mortality found to differ in rural and urban areas. Common causes in rural areas are postpartum haemorrhage and toxaemia. In contrast, pregnant women in urban areas face more risk of death as a result of abortion, sepsis and amniotic embolism.

In addition, access to reproductive health care services across the country is uneven. For example, maternal health in the Southernmost provinces has been found to be the poorest in the country with ratios twice as high as the national average. This is associated with maternal mortality and morbidity, lower rates of contraceptive use, unplanned and frequent pregnancies. In addition, many deliveries in the region are not assisted by birth attendants. The growing incidence of gender-based violence

is also a concern. As of now, the law has not been amended to protect women/girls against the offenders in the domestic and public contexts. Hence, more needs to be accomplished in order that the entire population across the country has access to the various new health care initiatives, as they are yet to be widely available.

2.2. The Threat of STI/HIV/AIDS

HIV/AIDS: Looking Back

Thailand attracted international recognition for its success in reducing the spread of HIV/AIDS during the 1990s. The first case of HIV was detected in 1984. The disease spread rapidly among high-risk groups reaching a peak of 143,000 infections in 1991. This was reduced to approximately 19,500 new infections in 2004.

Why was Thailand a Winner in the Battle against AIDS?

The success in the decline in new infections has been attributed to a number of factors similar to those that led to Thailand's success in its family planning programmes:

- strong leadership and the open-minded attitude of the Government in handling the situation;
- the active cooperation between the government, civil society organizations and private sector enterprises;
- the role of the media;
- the sizeable budget allocated from the national budget toward HIV/AIDS prevention programmes; and
- the generous financial support from international donors.

Source: Thailand's Response to HIV/AIDS: Progress and Challenges (2004).

Following the ICPD in 1995, the HIV/AIDS risk behaviour surveillance was initiated to boost the already existing surveillance systems. Among the females involved in this surveillance exercise were factory women, pregnant women and students. The findings of this exercise showed that the age of first sex for both factory men and women was 18-19 years old and 20-21.5 years old for pregnant women. A more important finding was that the rate of condom use remained low for both males and females, suggesting that Thailand was still at risk of an HIV/AIDS epidemic. The rates of casual sex without condoms were also found to be equally high among both males and females.

Since the beginning of the epidemic, an estimated 1,074,155 persons have been infected with HIV. Around half of them

The 100% Condom Use Programme (CUP)

In less than three years from the time the condom campaign took off in 1991, 60 million condoms had been distributed free of charge. Each sex worker including STI patients received a box containing 100 condoms on each visit to the STI clinic. Condoms were also distributed to military personnel and at workplaces and hotels. NGO involvement in the campaign promoting condom use was instrumental. The tables were turned when Thailand was hit by the financial crisis. The Government reduced its supply of condoms to the public owing to budget cuts under the assumption that condoms were in oversupply. Interestingly, research showed that the rate of condom use was consistent among sex workers. By the late 1990s, about 70 percent of condoms were purchased by individuals.

Source: Thailand's Response to HIV/AIDS: Progress and Challenges (2004).

Peer Education: A Targeted Approach to AIDS Prevention

The role of peer education cannot be underestimated, especially when the peer educators are properly trained and supervised. In a survey of 240 young factory workers in Chiangmai, it was found that education targeted at a specific group played a critical element in influencing attitudes, knowledge, beliefs and behaviour on HIV/AIDS prevention. Peer group relationships are important for young women as they are highly dependent on each other and often seek each other's help in the problems they encounter. Findings from the study showed the significance of HIV/AIDS prevention education targeted at a select number of adolescents as it proved to have a positive effect on the peer group, thereby improving young women's abilities to protect themselves. In addition, the study found that AIDS education is more effective when the materials designed facilitated participation, engaged individuals at the emotional level, utilised credible sources of information and respected individual privacy.

Source: Cash, Anansuchatkul and Busayawong (1995).

have died of the disease. In the early 1980s, HIV/AIDS was generally confined to the high-risk behaviour groups such as the sex workers (SWs) and their clients, men who have sex with men (MSM) and intravenous drug users (IDUs). Although the incidence of HIV infection in these groups has declined in recent years, rates of HIV infection are still relatively high.

Of concern, however, is that HIV/AIDS infection rates are increasing in other groups, for example, young adults among whom HIV/AIDS has become the leading cause of death, accounting for twice the number of road traffic deaths in 2003. In addition, a 2002 survey reported that only 28 percent of male secondary school students use condoms regularly with their sexual partners[20]. Since 2002, new cases of HIV were found to be higher among youth in the age group 15-24 years. Evidently Thailand's success in curbing the spread of HIV/AIDS has not had an effect on the young population as indicated by the growing incidence of HIV in this group. These trends point to a potential outbreak of HIV among the general population. The other cause of worry is the rise in incidence of HIV among pregnant women. High levels of infection have been recorded among pregnant women especially in the Southern provinces where from 2000 to 2002, prevalence rates doubled from 1 to 2 percent in the Lower South[21]. In 2002, an average rate of 2 percent was registered in eight provinces, with Nakhon Sri Thammarat and Phuket provinces registering significant rates of more than 3.5 percent[22]. Clearly current efforts to curb the spread of HIV/AIDS have not kept pace with the shifting epidemic. Public concern about HIV/AIDS has ebbed while public education campaigns lack vigour and no longer target those most at risk.

Goal 6 of the MDGs calls for bold efforts on the part of governments to halt by 2015 and reverse the spread of HIV/AIDS. Suffice it to say, Thailand's successful track record has led to the formulation of the MDG Plus targets aimed at reducing HIV prevalence among reproductive adults to 1 percent by 2006. Reducing HIV prevalence among reproductive adults and IDUs are the main indicators for the MDG Plus goal on HIV/AIDS since the incidence of this disease is growing among the first group while it continues to be exceptionally high in the second group.

Five Priority Policy Messages on HIV/AIDS for Thailand

1. **Capitalising on the success:** Thailand has been extraordinarily successful in reversing the spread of HIV/AIDS. Yearly new infections have fallen from over 143,000 in 1991 at the peak of the epidemic, to about 20,000 last year. No country in the world can rival these results. This success can be attributed to early top-level leadership that created a *supportive political environment* for strong action, broad-based mobilisation of partners well beyond the public health sector, and openness about AIDS, safe sex, and condoms so essential for an effective response. This past experience must inform today's policy-making in Thailand, as well as be disseminated effectively to other countries grappling with the complexity of the challenges posed by HIV/AIDS.

2. **Revitalizing a multi-sectoral response:** Thailand has in the last few years reverted to a narrow public health sector response to HIV/AIDS. The chairmanship of the National AIDS Committee has been delegated to the Minister of Public Health, non-health ministries are not adequately involved, and spending on AIDS has fallen by half. Non-health ministries must urgently formulate their own operational HIV/AIDS plans and allocate resources for their implementation. In addition, HIV/AIDS prevention and care, as well as management of the social and economic impact on households and communities, need to be better integrated into provincial and Tambon-level strategic development planning and programmes, especially in hardest hit areas.

3. **Shifting the focus of prevention:** While still keeping the pressure on brothel-based HIV transmission, attention must now shift towards *young people in general* who are highly vulnerable to infection. Evidence shows that young people are having more sex, starting at an earlier age, while only 20 to 30 percent are using condoms. Less than 5 percent of young people are now being reached by adequate prevention services, while public awareness campaigns have all but disappeared. Simultaneously, prevention efforts must also shift focus to effectively target *specific vulnerable groups* such as mobile populations, men having sex with men, and intravenous drug users. Evidence shows that HIV prevalence has reached 17 percent among young gay men (up from 4 percent in 1991), 50% among IDUs (up from 35 percent in 1996), and 6 percent among mobile labourers in some industrial locations.

4. **Mobilising the school system:** A major soft-spot for Thailand's current response to HIV/AIDS is the fact that the school system is not adequately mobilised. On an urgent basis, the Ministry of Education needs to include non-judgemental AIDS and sex lessons. Life skills programmes, open debate about sexual health, condom promotion, and peer education need to be introduced in a systematic manner in all schools and universities across the country as part of Thailand's national educational strategy.

5. **Achieving universal access to antiretroviral (ARV) treatment:** It is estimated that around 20,000 people have access to ARVs out of a bare minimum of 100,000 who urgently need such treatment today. As a country with a well-organized health system and the capacity of producing generic ARVs at less than US $ 300 per patient per year, Thailand should aim at becoming a leader in the global campaign for access to ARVs by going well beyond the WHO target of 50 percent coverage set for less developed countries. But for this to happen, Thailand needs to allocate more resources to treatment (but not at the expense of prevention), incorporate ARVs into its universal health coverage, and at the same time seek out alternative and multi-sourced financing to ensure sustainability.

Source: United Nations Expanded Theme Group on HIV/AIDS in Thailand.

The Situation of Women

In 2004, female patients numbered 73,883 while male patients numbered 187,113 cases[23]. The ratio of male to female cases has been changing gradually from 4.4:1 in 1995 to 2.83:1 in 1998 to 1.95:1 in 2001[24]. The rise in proportion of women indicates a feminisation of the epidemic. Sex disaggregation shows male patients outnumber female patients at all ages except those in the age group 15-24 years. HIV prevalence in this age group was 1.09 percent for males and 1.65 percent for females in 2001[25].

A growing proportion of women infected with HIV/AIDS includes widows left behind to fight the disease, after having lost their husbands to it. Infected widows tend to live longer than their husbands, as women suffering from the disease tend to take better care of themselves than men.

Although the Thai Government has not yet fully responded directly to the growing prevalence rates among adolescents, there is heightened concern over the fact that more young women are contracting HIV at a faster rate than men due to unprotected sex. Among the newly infected, women accounted for 61 percent in 2003[26]. While from 1984-1998 women represented only one quarter of the total number of AIDS patients, they constitute one third of the total number in current times. In response to the growing threat of HIV/AIDS among women, several programmes have been executed by various UN agencies and NGOs to curb the spread of the disease among this cohort.

'Powerless' Women/Girls: Sexual Double Standards

Cultural norms also weigh heavily on young women's ability to negotiate safe sex. In Thailand, the persistence of patriarchal norms has resulted in women's lack of autonomy and increased risk to HIV/AIDS infection. Women have been socialised into passivity and taking a non-initiating role, acquiescing only to male demands. Thus they lack the negotiation skills to deny their husbands or boyfriends sex and the ability to protect themselves from diseases. Clearly negotiating for safe sex on the part of women has the effect of tipping the power balance, previously in favour of men. Negotiating for safe sex has other implications. A young woman who suggests the use of a condom with her partner runs the risk of placing her own reputation at stake as it implies that she is sexually experienced. Equally, women who carry their own condoms are assumed to be sex workers or 'loose'. A further complication is that condom use implies a shift in the nature of the relationship because women associate condom use among men with commercial sex. Condom use also causes embarrassment. Women are hesitant about asking their boyfriends to have safe sex lest it implies mistrust. Hence, men not only make the decision as to whether a contraceptive is used during sex, but also secure it and provide it to their girlfriends if necessary[27]. In addition, they are often blamed for preserving their pleasure-seeking inclinations and, therefore, refusing to use condoms. Equally possible is that men may be reluctant to negotiate condom use because of the cultural values of politeness and wanting to maintain a good image.

In a 2003 study in Southern Thailand, both Buddhist and Muslim women were aware of the vulnerabilities they faced as wives since the possibility of contracting HIV/AIDS through their husbands was not unfounded[28]. Fear was heightened particularly among those whose husbands travelled for work, as the latter are more likely to engage in extramarital sexual relationships without the knowledge of their wives. Another study found that women were more tolerant of men who patronised prostitutes since the relationship was non-commercial and non-emotional. In contrast, women were more fearful if their husbands had girlfriends, as this would imply a commitment outside the marriage for which the financial stability of the family would be threatened[29]. This form of response to male sexual behaviour, however, increases women's vulnerability since sex workers are a high-risk group for HIV and STIs.

The Female Condom: How does it Rate?

Femshield® is the brand name for the female condom produced primarily for protecting women against HIV infection. This contraceptive method proved to be unpopular according to a study conducted in Siriraj Hospital in Bangkok supported by WHO. Of a small sample of 56 women, only 13 reported to have used it with little problems, while the rest had a series of complaints ranging from its size and appearance to the fact that pain was felt when it was inserted. There was a unanimous response that the product could be improved by reducing its size and making the outer ring softer and its sheath thinner.

Source: Grisurapong, Ma-un and Boonmongkon (1999).

Bonding and Transmitting

Both the ICPD and MDGs emphasise the reduction of child mortality. The MDGs makes a bold call for reductions in child mortality by two-thirds between 1990 and 2015. In the case of Thailand, the MDG Plus target was generated as a result of it already having achieved a fairly low child mortality rate. Although child mortality rate is not a pressing concern, the rising proportion of HIV/AIDS prevalence among infants is a cause for concern because of HIV transmission from mother-to-child.

Rates of HIV prevalence among pregnant women fluctuated from 1990 to 2002. Prevalence rates among pregnant women rose from 0.5 percent in 1990 to 2.4 percent in 1995, taking a dip to 1.4 percent in 2002[30]. This trend of infection, lagging behind that of sex workers and men who frequented sex workers, suggests that pregnant women were being infected by their male partners who visited sex workers. A related concern is the transmission of HIV from mother to child, which accounted for 10,796 cases (4.16 percent) of the total number of new infections as of 2004.

In understanding the severity of the problem from the start, the Thai Government established the Subcommittee on AIDS, which came under the Ministry of Public Health chaired by the Director-General of the Department of Communicable Disease Control. In 1991, the National AIDS Control Committee was set up to take over the role of the Subcommittee. It was chaired instead by the Prime Minister. The role of the National AIDS Control Committee was to manage the coordination

and cooperation of the various organizations, provide technical support and consultation, and monitor the progress of the implementation of the programme to prevent mother-to child transmission of HIV/AIDS.

Across Asia, Thailand is the first country in the developing world to embark on a national programme to prevent of mother-to-child transmission (PMTCT) of HIV/AIDS. Established in early 2000, the programme was implemented through its existing health care infrastructure in the antenatal clinics. The high incidence (2.3 percent) of HIV transmission by this route prompted the Government to implement a formula milk scheme for infants born to mothers suffering from HIV. The programme to prevent HIV transmission from mother to child was given another boost by the introduction of the antiretroviral drug for use among pregnant women in 1998. In 1999, the National Prevention of Mother-to-Child Transmission Guidelines was prepared and distributed nationwide. The Guidelines included (a) antenatal and intra-partum testing, (b) counselling to support HIV testing, (c) use of Zidovudine (AZT)[31] to reduce HIV transmission at delivery, and (d) the government provision of formula to prevent post-partum transmission of HIV. Since 2000, voluntary counselling and testing (VCT) for HIV was introduced at all antenatal care clinics.

The PMTCT programme was implemented over years with external assistance from the World Bank, the Thai Red Cross, and the United States Communicable Diseases Center. The years over which this programme was implemented was accompanied with a series of pilot research projects to test the safety and efficacy of the drugs. Another project targeted at keeping HIV-negative women healthy from HIV was spearheaded by UNFPA in 2004.

Another Chance: A Pilot Project that Worked

Pilot projects were first conducted before the national implementation of the drugs to prevent of mother-to-child transmission. In 7 provinces in Northeast Thailand, 86 percent of the 122,000 new antenatal clients had an HIV test. Of this number, 69 percent of the 900 HIV-infected women received a short-course of AZT. Over two years, the number of subjects used in the project was increased. 229 children born to women who received AZT were tested for HIV, and it was found that only 8.3 percent of them were infected.

Source: Ministry of Public Health and The World Health Organization (2003).

Intervention for HIV-negative Pregnant Women

UNFPA's most recent project on HIV/AIDS reduction among women aims at improving HIV-negative women's access to quality, gender-sensitive, integrated and age-specific reproductive health services at various reproductive health clinics. Executed by the Ministry of Public Health, this project spans from August 2004 to December 2006. The intervention strategies of this project include involving partners of HIV-negative pregnant women, IEC (Information, Education and Communication) and BCC (Behavioural Change Communication) interventions, and the creation of an enabling environment. The project was created because it was found that 90 percent of HIV-negative pregnant women and their partners under the national prevention of mother-to-child transmission of HIV programme have limited access to prevention services including VCT, BCC and prevention commodities.

Despite the economic crisis, the Government maintained its financial commitment to increasing women's access to AZT drugs. This resulted in a reduction of mother-to-child transmission from 30 percent to 8-9 percent[32]. December 2003 saw another technique to reduce mother-to-child transmission of HIV. The technique requires the administration of 300 mg. of oral zidovudine twice daily from 28 weeks of gestation (instead of 34 weeks) until labour. In addition, women in labour are required to take a single dose (200 mg.) of navirapine. Soon after birth, oral zidovudine syrup and a single dose of navirapine syrup are also administered to infants continued by replacement feeding.

The conscientious effort and determination of the Thai Government saw striking results. HIV transmission from mother-to-child started on sharp decline by about 50 percent. Without such specific actions taken at preventing mother-to-child transmission, an estimate of 5,000 children would have been born each year with HIV by 2003[33], accounting for around at least one-seventh of infections each year[34].

Human Rights and HIV/AIDS

Human rights are central to the prevention and treatment of HIV/AIDS. In Thailand, the lack of women's sexual autonomy and an understanding of women's reproductive and sexual rights not only expose women to HIV/AIDS, but also determine the quality of medical assistance that is afforded to them. Prior to 1998, there have been reports of pregnant women diagnosed with HIV being encouraged to undergo abortions and sterilisation. Although the situation reversed itself with the introduction of ARVs, it is unclear if women have the final decision as to whether to abort or keep the pregnancy. In any case, if a woman chooses to have an abortion, she is most likely going to have to seek it under unsafe conditions, thereby placing her life at risk.

Evidence reveals that the reproductive rights of women suffering from HIV/AIDS have also been violated in other instances. Evidence points to the fact that many pregnant women infected with HIV have had to pay higher fees at hospitals to receive treatment[35]. The explanation given by medical practitioners is that they have to take extra precautions when providing care to a patient diagnosed with HIV, although it is assumed that universal precaution is always taken irrespective of the HIV-status of the patients[36]. Denial of treatment and care to HIV-positive women has also been reported. Some have even struggled to find a hospital that would take up their case.

NGOs play a leading role in defending the rights of HIV/AIDS patients. Since 1995, the Government allocated funds to 371 NGOs. The Thai NGOs Coalition on AIDS (TNCA), formally established in September 1989, is one prime example of an NGO advocacy effort fighting for the rights of people with HIV/AIDS. Today, this 168-strong coalition includes capacity building, liasing with the public and business sectors to integrate the perspectives and concerns of people with HIV/AIDS in problem solving at various levels, and campaigning for a state budget for NGOs working on HIV/AIDS and issues such as health for all and the impact of AIDS on children[37].

The rising numbers of women infected with the virus is a reflection of women's subordinate status in the family and in

society at large. Campaigns against the spread of HIV/AIDS have oftentimes failed to address gender inequality and in so doing have ignored women's sexual rights. This is evident in the different phases of the Thai Government's efforts in curbing the spread of the disease. In the first phase from 1984-1990 when condom use was promoted, education campaigns were directed at high risk groups such as intravenous drug users, MSM and sex workers. While sex workers were stigmatised, male responsibility was overlooked. In the second phase from 1990-1995 when the virus took a toll on the general population, women were called to be "good wives". At this time, campaigns were directed at prevention and education in the household setting. Education campaigns also emphasised care and support for those living with HIV/AIDS. Once again, male responsibility was not addressed while the onus of curbing the spread of the virus weighed heavily on women. The third phase from 1996-2003 followed the ICPD. This phase was concerned largely with behavioural change rather than increasing women's awareness of their rights. Once growing numbers of infants had become infected with the virus, the problem was placed within the broader issues of reproductive health, sexuality and gender. Although strategies to halt and reverse the spread of HIV included life skills training for young people and peer education, little emphasis was placed on reproductive rights and women's decision-making in terms of pregnancy, abortion and family planning. In sum, the third phase failed to address gender inequality, a critical factor in perpetuating women's higher risk to the disease. The failure to address gender inequality also meant that young women were not as equipped as men to protect themselves against HIV/AIDS.

Although Thailand's efforts in curbing the HIV/AIDS spread among women are not overtly in defence of reproductive rights, a glimmer of hope awaits. In an effort to increase the rights of pregnant women infected with HIV/AIDS, the Medical Council of Thailand is calling for abortion to be legalised in cases where the foetus has physical defects or when a child may be diagnosed as HIV positive[38]. As of now, the Criminal Law Amendment Committee of the Office of Judicial Council has approved the draft of Criminal Law, Section 305 proposed by the Thai Medical Council[39]. The challenge, however, is to ensure that this law is in keeping with the objectives of CEDAW in that women are not discriminated as a result of their HIV status nor forced into having an abortion against their will.

Sexually Transmitted Infections (STIs)

In Thailand, the STIs most commonly reported are syphilis, gonorrhoea, non gonococcal genitourinary tract infection, chancroid, lymphogranuloma and granuloma inguinale. Sexual contact is the primary route of HIV transmission at 83.78 percent[40]. As STIs such as gonorrhoea, non-gonococcal infection and syphilis are closely linked to HIV transmission, the Thai Government rapidly embarked on expanding its health care services targeted at the spread of STIs. Only after the aggressive promotion of condom use in 1989-1991 did the incidence of STIs drop dramatically from 2.1 per 1,000 population in 1992 to 0.17 per 1,000 population in 2003[41]. Interestingly, while infection rates among women were higher than men at 2.3 per 1,000 and 1.8 per

1,000 respectively in 1992, women recorded lower rates of infection in 2003 at 0.14 per 1,000 while the rate of infection among men was 0.2 per 1,000 per population.

The most prevalent STI is gonorrhoea, which was found primarily among SWs. From 1987 to 1991, the rates of gonorrhoea infection dropped from 23.03 percent to 9.94 percent. The subsequent reduction in STI rates in 1989-2001 was achieved as a result of the implementation of the 100% Condom Use Programme (CUP). While infection rates were recorded at 1.09 per 1,000 population in 1992, there was a subsequent decline to 0.84 per 1,000 population in 2003. Gonorrhoea was diagnosed by the gram stain and/or isolation tests. In Northern Thailand, the incidence of gonorrhoea among pregnant women was 0.2 percent[42].

Since 1996, non gonococcal infection was the most commonly reported STI. With the 100% CUP, infection rates fell from 1.59 to 0.114 per 1,000 population in 1989-2000, while there was a slight increase to 0.122 in 2001[43]. The most common cause of non gonococcal infection is chlamydia. In a study of SWs in various parts of Thailand including Bangkok, the East, Northeast, South and North Thailand in 1996 showed that the prevalence rates were 6.1 percent, 8.9 percent, 9.7 percent, 13.0 percent and 13.7 percent respectively. In 2000, the same areas recorded declines of 5.8 percent to 8.7 percent.

Syphilis continues to be a public health issue in Thailand, although incidence rates are low. This STI, however, is most prevalent among SWs. As in the other STIs, incidence rates declined sharply after 1989 the implementation of the 100% CUP from 0.41 per 1,000 to 0.038 per 1,000 population in 2001[44]. This STI, however, has also been found among pregnant women seeking antenatal care. In the antenatal care clinic at Chulalongkorn University, syphilis was found among 3 percent of its patients in 1982, 2.1 percent in 1985 and 1.4 percent in 1992[45].

2.3. Changing Times: Youth Reproductive Health

Youth: A Neglected Group

Thailand's success in reducing fertility is linked to its effective family planning programmes. By and large, family planning services provide birth control and maternal and child health care particularly for married women. As a result, the need for contraceptive and reproductive health services among certain groups such as the young unmarried population has been neglected.

This neglected group are the sexually active youth whose numbers are growing and perhaps largest cohort ever. When compared with preceding generations, younger people tend to be more permissive in their outlook towards sex. It is not uncommon that they have more than one sexual partner either before or after marriage. There is also a clear trend towards the first sexual encounter occurring at an earlier age (approximately 14-18 years). While previously boys were ushered into manhood through sex with SWs, there is a shift to girlfriends, lovers, casual acquaintances and classmates[46]. Premarital sexual activity, gender-based violence and alcohol and drug abuse among adolescents have led to increases in unplanned pregnancies, HIV infection and abortions in this group.

There still exist, however, prejudices against women who engage in premarital sex. The common perception is that "respectable" or "good" women and girls do not engage in sex as this brings dishonour to her and the family. In contrast, premarital sex is acceptable for young males. Hence, sexual experimentation is the norm for males, while virginity is required of females.

The changing attitude to sex among youth has led to an increase in "indirect" sex work. Anecdotal evidence suggests that young school/university girls are exchanging casual sex for monetary favours so that they would be able to purchase mobile telephones and brand-name goods[47].

Patronising sex workers continues to be the norm for males. While condoms are widely available to young males, they do not regularly use them in contact with SWs. With girlfriends, condoms are rarely used because the relationship is associated with love and trust. As mentioned earlier, young women lack negotiating skills to coax their boyfriends to use condoms and, as such, are vulnerable to STIs. In addition, many lack knowledge about sex, their emerging sexuality and a perception of the risk involved in engaging in sex.

Attention towards young people in the overall HIV/AIDS prevention is one of UNFPA's main strategies, the others being pregnant women and condom programming. UNFPA is setting up a global Youth Advisory Panel to participate and advise the Fund's corporate strategy and field level implementation so that programming efforts are more youth friendly.

In Thailand, the reproductive health needs of adolescents were largely neglected in the 1990s. Since then, fertility among women 15-19 years has dropped from 72 in 1996 to 49 in 2001[48]. Much more has to be done to reach out to this group as adolescents are in the most impressionable years of their life and are easily swayed by their peers.

Sexual Violence Among Thai Adolescents: A Case Study

A survey of 1,292 male and female secondary school students on issues relating to attitudes towards and experiences of sexual violence revealed interesting results. Most sexual violence offenders were lovers, friends and acquaintances. Female students reported sexual violent acts against their will ranging from verbal abuse, touching and kissing to attempted rape and rape. The survey also found that the proportion of lower secondary female students who survived gender-based violence was greater than upper secondary school female students. It was also found that female students who were more likely to be free from parental control were more likely to be victims of attempted rape or rape. The characteristics of sexual offenders ranged from students who drank regularly to those whose friends often engaged in sexual violent acts themselves. According to the worldview of earlier generations, Thai women were perceived to be the property of men and, hence, this justified man's violent behaviour towards his wife/lover. 25 percent of male students in the survey agreed that their partners were their property, following cultural norms of preceding generations. Not surprisingly, a much fewer number of female students (12 percent) agreed with this idea.

Source: Srinual (2003).

Current programmes only reach out to a small proportion of the adolescent population. Female adolescents tend to be at risk of unplanned pregnancy and subsequently abortion as a result of not having negotiating skills and power to protect themselves. Pregnancy among young women, especially teenagers, has other social consequences. Teenage mothers have been found to face greater negative psychosocial consequences as a result of pregnancy than adult mothers. Other problems they face are interruption of education, low self-esteem, economic dependence and loss of family, peer and partner support.

The Government has tackled the issue of adolescent sexuality through targeted policies and programmes. The policies aimed at reproductive health among adolescents include: (a) the national reproductive health policy, (b) the national youth policy, (c) the national health development plan, and (d) the national AIDS prevention plan. Sex education and life skills education in schools as well as counselling services in schools, hospitals and hotline services have integrated the strategies of increasing knowledge of reproductive health, building skills in problem solving, decision making, and life planning. At the programme level, initiatives taken by the Government are counselling of adolescents and young adults on reproductive health and improving sex education in schools. In spite of the effectiveness of some projects having been questioned, current policy emphasises raising public awareness about the importance of sex education, fostering positive values in society about teaching sexuality, and promoting sex education in the context of the family, complemented by school health programmes.

Computer technology such as the internet has also become important as a conduit for conveying information, promoting health knowledge. Even health columns in the printed and electronic media have targeted health programmes for youth. Telephone hotline services in all public hospitals have similar programmes. For example, programmes reaching out to the Muslims

have been introduced with the aim of conveying culturally-sensitive information on human sexuality and reproductive health, as they have been most vehement about voicing their views on parents' role in sex education rather than having teachers impart knowledge on sex in the classroom. Yet, parents, teachers and service providers continue to feel uncomfortable and less skilled in addressing adolescent sexuality issues.

"Friend's Corner"

A notable project is the "Friend's Corner", a programme accessible to youth and at affordable costs, was established in almost all the 76 provinces in the country. This project provides a venue in which youth may engage in small informal group discussions and seek consultation on health and sexuality issues. However, evidence suggests that some provincial health departments have had to shut down this programme after finding that it had to allocate more funds toward the 30-baht scheme. In addition, the quality of the service provided is questionable.

Source: Ministry of Public Health of Thailand (2004).

Contraceptive Access and Use: Common Barriers

As society views sexually active unmarried females differently from males, obstacles in accessing health care services by adolescent females continue to persist at various levels. First, unmarried females do not have easy access to the reproductive health care services as the current services available are largely targeted at the married population. The fact that many young women are not eligible to obtain services at the Family Health Division but only the School Health Division compounds the problem. School health services, however, consisting of only general health care and vaccination programmes, tend to be inadequate because they do not provide counselling and contraceptive services. This exclusive provision of reproductive health services narrowly targeted at the married population stems from cultural injunctions that disapprove of women engaging in premarital sex.

Second, young women are afraid to seek contraception as this would reveal that they are sexually active and, hence, may be stigmatised. Even if reproductive health services were made available to unmarried women, this group is less likely to take advantage of such services because of the double standards imposed upon men and women regarding their sexual behaviour in society. In a study conducted in 2001, health personnel from public hospitals reported that young, unmarried clients comprised mostly of young males and SWs but seldom were there female adolescents even though services were made available for this group[49]. While young men freely sought treatment for STIs in public health facilities and are not condemned or stigmatised, unmarried women were less likely to access proper information and professional health care services[50]. As such, contraceptive services for adolescents and particularly unmarried women have been regarded as inappropriate and unnecessary despite the recognition of problems arising from unprotected sex among young people. While clinics for adolescents or peer counselling programmes in vocational colleges have been established in the past, the provision of such services have been short-term.

Third, lack of confidentiality, judgmental parents, teachers and service providers, lack of affordability and inconvenient clinic hours are some of the barriers that have prevented adolescents from seeking reproductive health services[51]. Moreover, girls tend to shy away from seeking advice from parents, teachers and service providers because of the sexual double standards that prohibit girls from engaging in premarital sex unlike boys. Since adolescent females are aware of the obstacles they would face when seeking health services in government hospitals, most resort to self-treatment, advice from friends or turn to drugstore proprietors, although these sources of help may not be effective. In contrast to government hospitals, reproductive health providers at NGO facilities have met with greater success possibly as these services tend to allow for confidentiality and even anonymity. Their adolescent-friendly programmes have included telephone counselling, outreach programmes and emergency services for young girls in crisis.

The 'Emergency' Contraceptive

In a 2000 study of more than 100 adolescents in a semi-urban province in Central Thailand, information on the post-coital or otherwise known as the 'emergency' contraceptive pill was received from both friends and drugstore proprietors. However, adolescents were unaware that this kind of pill was to be used in emergency situations only and not be used in lieu of the normal birth control pill because of its quality and the fact that only four pills could be used per month. In addition, adolescents had little knowledge about the side effects of the emergency pill such as bleeding, irregular menstruation, nausea and vomiting, tenderness of the breasts and liver failure. As young women often received inadequate information about this birth control method, its use has led to unwanted pregnancies.

Source: Boonmongkon, Jaranasri, Thanaisawan-yangkoon and Limsumphan (2000).

Consequences of Unsafe Sex

The increase in youth sexual activity coupled with the barriers to access to reproductive health information and services have led to a number of problems, among which are abortion and STI/HIV/AIDS.

In 1999, a hospital-based survey of 787 hospitals conducted by the Ministry of Public Health showed that among a total of 45,990 women admitted for the treatment of complications arising from both spontaneous and induced abortions, the highest proportions of women were in the age group 20-24[52], many of whom did not have or had little access to contraceptives[53]. Interestingly, the proportion of females in the age group 24 and below seeking abortions constituted at least 33 percent of the total surveyed (see Table 5). These figures were confirmed by findings from another study. A 2000 survey showed that 46 percent of women seeking assistance in public health facilities as a result of abortion complications were below 25 years[54]. For young women, the concern of interrupting education was a reason for abortion, while family problems and contraceptive failure constituted the other reasons.

Another consequence of unsafe sex is that youth are increasingly vulnerable to STI/HIV infection. The cumulative numbers of HIV infections (10-24 years) from 1984 to 2003 reached 11.1 percent in the total HIV/AIDS population. The number of infected youth reached a peak in 1996 but showed signs of decline (Table 6). While it dipped

Table 5: Percentage of Spontaneous and Induced Abortions, by Age At Time of Abortion, Select Hospitals, Thailand

Age at Spontaneous and Induced Abortion	Total (n = 45.990)	% of Spontaneous Abortion (n = 32,900)	% of Induced Abortion (n = 13,090)
<15	0.5	0.3	0.7
15-19	15.5	13.6	20.3
20-24	25.2	24.9	25.8
25-29	22.6	23.7	19.9
30-34	18.2	18.7	16.7
35-39	12.0	12.4	5.5
>40	6.2	6.4	5.5
Total	100.0	100.0	100.0
X (S.D.)	27.48 (7.15)	27.16 (7.23)	26.34 (7.36)
Min-Max	10-50	10-50	10-50
Median	27	26	25

Source: Ministry of Public Health, Thailand and The World Health Organization (2003).

Table 6: AIDS Patients According to Age and By Year, Thailand

Year/Age group in numbers and percentage	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	1984-2003
10-24	319	1,181	2,109	2,983	3,340	3,218	3,008	2,643	2,179	1,809	23,900
All ages	1,834	6,833	13,864	20,660	24,880	26,868	27,358	26,746	25,629	22,821	214,129
Percentage	17.4	17.3	15.2	14.4	13.4	11.9	10.9	9.8	8.5	7.9	11.1

Source: Department of Disease Control, 31 March 2003, as cited in Ministry of Public Health, Thailand and the World Health Organization (2003).

soon after, the epidemic continued to spread in the population at large. In spite of rigorous government programmes to curb the spread of HIV/AIDS through the use of condoms, the rate of consistent condom use among secondary school students rose only slightly from 21.7 percent in 1995 to 27.7 percent in 2002. Most alarming is the number of young women who are among the newly infected. In 2003, the Ministry of Public Health estimated that women in the age group 15-29 accounted for 61 percent of new infections[55].

Sex Education in the Classroom

In the past while open discussions about sex were taboo, it has been introduced in the school curricula in 1978, 1981 and more recently has been revised in 2001 within the broader context of reproductive health and sexuality, HIV/AIDS, safe sex, contraceptive use, pregnancy and parenthood. The Government has developed materials on sex education and educated parents on sexuality equipping them to discuss issues of sex and sexuality with their children.

Community Commitment: Strengthening Sexual and Reproductive Health and HIV/AIDS Prevention for Adolescents in the Northern and Southern Provinces

From 2002 to 2004, UNFPA supported a Planned Parenthood Association of Thailand (PPAT) project aimed at increasing access to gender-sensitive reproductive health and HIV/AIDS prevention education and services for adolescents. The project was a response to the rising incidence of HIV/AIDS and unplanned pregnancies among adolescents. In and out-of-school youth, parents, teachers, Tambon Administrative Organization (TAO) members, religious leaders and community leaders played an integral role in the project. A range of activities was carried out under this project. PPAT organised meetings for parents and youth to come together to discuss sexual and reproductive health problems and solutions. Youth centres in five districts were set up to provide information and organise income-generation and outreach activities for project participants. IEC materials as well as broadcasting programmes were heavily employed to disseminate reproductive health information. Peer educators were trained with the aid of IEC materials for advocacy work. In addition, a website (www.thaiyouths.org), serving the general youth population, was created. Among the many findings that emerged at the close of this project was that adolescents were found to prefer to receive reproductive health information and services from peer educators rather than public health providers.

Although the project did not achieve all its goals, its overall success spurred PPAT to execute another similar range of activities in the Northern provinces of Chiangrai and Lampang and the Southern provinces of Pattani, Yala and Narathiwat in the period 2004-2006. While focusing on in and out-of school youth, this project promotes reproductive health education among adolescents in both Islamic schools and regular high schools including vocational colleges and the university. Trained youth and community members are using edutainment and BCC tools to improve adolescent access to reproductive health education and services.

"Health Promoting School"

Since 1997, the flagship of the Ministry of Public Health in Thailand has been the concept of the "Health Promoting School" (HPS). The standard criteria of the HPS include: (a) school policies on health promotion, (b) school procedures and practices in change process (awareness raising, planning, implementation and evaluation), (c) school-home-community partnerships, (d) safe and healthy physical environment, (e) school health support services, (f) health education such as health and sanitation, dental health, stress management, drug education, teenage sexuality and relationships, (g) nutrition and food safety, (h) physical exercise, sports and recreation activities, (i) counselling and social support, and (j) staff health and well-being. By 2003, 84 percent of public primary and secondary schools were already participating in the HPS programme. Of these schools, about 21 percent had achieved all the standard criteria set for the programme.

Source: Ministry of Public Health, Thailand and the World Health Organization (2003).

In 2001, the National Youth Bureau, the Office of the Prime Minister formulated a national policy on youth and a long-term plan on children and youth development 2002-2011. The national policy provides directions for the Government in service provision and family and community support for the development of children and youth. The policy statement, however, did not directly address HIV/AIDS although it had

implications for the prevention of the disease. For example, the Health and Disease Prevention initiative clearly addresses issues related to HIV/AIDS such as: (a) surveillance of communicable diseases, (b) support directed at schools to become healthy, community environments in order to prevent sexually transmitted diseases, and (c) dissemination of reproductive health knowledge to youths in order to facilitate a deeper understanding of sex education and youth health[56]. Instead HIV/AIDS should have been highlighted in the policy more explicitly since the incidence of the disease is increasing among adolescents.

Currently there is a dearth of teaching materials for teachers and youth volunteers or peer educators working at the community level with the exception of the recently launched guidebook on sex. In March 2005, the Ministry of Education launched its first sex education guidebook to be used in a pilot scheme in some 20 to 30 primary and secondary schools. Essentially the Guidebook provides tips on how teachers should educate students on sexuality issues. The guidebook covers six areas – sexual development, interpersonal relationships, prevention of sexual harassment, sexual behaviour, sex-related health issues, and sex within the society and cultural context. As expressed by the Permanent Secretary of the Ministry of Education, the aim of the guidebook is to have teachers form a good grasp of sex and sexuality issues, be open-minded and to convey information on sex in a positive light. UNFPA has pledged its support to this initiative and is keen to have the other UN agencies involved in supporting and providing technical assistance to this Ministry of Education project. Should this pilot project be a success, it is planned that the use of the sex education guidebook will be expanded to schools nationwide[57].

2.4. Reproductive Cancers

The availability of further diagnosis and treatment of complications arising from reproductive tract infections, breast cancer and cancers of the reproductive system are goals of the ICPD[58]. The Department of Public Health reports that more than 6,000 new cases of cervical cancer are diagnosed each year[59]. In 2002, policy goals aimed at reducing the incidence and mortality from cervical cancer by 50 percent by 2007[60]. This goal was bolstered by another policy mandating that all women aged 35-64 years must have Pap smear tests every five years. Poorer women are not excluded under this policy, as this test has been made available under the 30-baht scheme.

The diagnosis of first stage breast cancer has also been on the Government's heath provision agenda. Its goal is to increase coverage for the diagnosis of first stage breast cancer from 20 to 40 percent within ten years. To meet this end, at least 10 percent of women aged 40 and older must undergo annual clinical breast examinations and a mammogram every once in two years. The aim is that during the ten years, mortality from breast cancer is reduced by 20 percent. Secondary screening is available in all health centres.

In the fight against cancer, the Thai Government has hosted numerous education and screening campaigns. Paradoxically, while increasing women's awareness to cervical cancer, these campaigns have also been found to cause undue anxiety. Although the rate of cervical cancer in

The Fight against Cervical Cancer in Khon Kaen Province

The Government launched a series of campaigns to encourage Pap smear screenings among Khon Kaen women. In spite of vigorous campaigning, a study in 1998 showed that out of 1,028 women, only 34.6 percent underwent the Pap smear within the last two years. It was later discovered that there were misunderstandings regarding the purpose for undergoing the Pap smear test. A sizeable proportion of women thought that the Pap smear was a routine post-natal check, while a good half did not know its purpose at all. Women were found to be quick to undergo the Pap smear, however, if they possessed abnormal symptoms. At this stage, the motivation for wanting a Pap smear was to verify for signs of cancer and receive treatment.

Source: Grisurapong, Ma-un and Boonmongkon (1999).

Thailand is 28 cases per 100,000 women, a study on women in Northeast Thailand in 1999 found that women were quick to attribute any symptoms of the uterus they may have felt to cervical cancer rather than to other medical complications[61].

Knowledge can prompt action. Findings from a 2003 survey of Thais in the Southern region showed that more than half of Buddhist women (56.4 percent) underwent cervical cancer screening as they had a greater knowledge of reproductive health and contraceptive methods. Muslim rates of cervical cancer screening were much lower (29.3 percent), following the fact that they were not as well informed about reproductive cancers[62].

The embarrassment of having to go to a public health centre also influences decisions for undertaking medical examinations. An evaluation of a health promotion programme conducted in the Southern provinces in 1999-2000 showed that although 49.1 percent of women performed breast self-exam, only 18.0 percent would visit a doctor or health personnel[63].

2.5. Reproductive Health of Older Women

Older Women: A Growing Population

The proportion of older persons in the 60 years and older age group stood at 7.3 per cent in 1994. In 2004, their proportion increased to 9.4 per cent or about 6 million people. In sum, the number of older people has doubled in the last 25 years. The number is projected to more than double again in the next 20 years. Another projection is the growth in the proportion of the oldest old, that is, those

aged 80 years and older. While the percentage of this group will be less than 1 per cent until about 2010, it is expected to increase to 1.8 per cent by 2025 and 3.8 per cent by 2040[64]. The ratio of males to females is largest in the 60 and older age group, standing at 82.3[65]. As such, there are more women in the older population than there are men.

Situation of Older Women

The profile of the present older population in Thailand is worrisome. The majority (91 percent) have only four years or less of formal education, while one third continues to be playing the breadwinner role in their families. Although nearly all have been found to possess some source of income, a staggering two million did not have sufficient funds to make ends meet. Among the poor, 400,000 older persons (16 percent) receive 300 THB per month in terms of assistance, which is only sufficient to cover a small portion of their daily living expenses. In addition, a growing number of older persons have been found to be living alone because of rural-urban migration of the younger generation. Should they not be living alone, many are saddled with the burden of having to provide care for grandchildren especially if their own children have migrated to the cities in search of employment or have lost their lives to AIDS.

It was found that older women are more likely to be most vulnerable in terms of having their health care needs met, as many are poor and are more likely to be in greater need of financial assistance. The 30-baht health care scheme purported to target the poor, however, was not designed nor implemented with older persons in mind since the scheme does not cover the chronic illnesses associated with old age. In addition, there is also the problem of increasing access to public health facilities for this group. The majority of older people lives in the rural areas and is unable to seek medical treatment in the public health facilities located mainly in towns, as they have to travel great distances.

In four independent studies conducted in the late 1990s, it was found that older women tended to experience undue stress and physiological disturbances, as they had not taken appropriate and adequate health measures to cope with menopause. Women between 40 to 59 years are also included in this group as medical problems related to menopause or other such causes tend to emerge at this age.

Responding to Reproductive Health Needs

The call to enhance the self-reliance of older persons is explicitly outlined in the ICPD[66]. The growing number of older persons raises concerns for increasing their autonomy while accommodating their needs, particularly their health needs since older persons are usually more vulnerable to various health risks. Accommodating the health needs of older persons is not synonymous with encouraging dependency. Instead promoting a healthy lifestyle through increasing older persons' access to health services reinforces their autonomy.

Currently the National Health Security Office (NHSO) is not sufficiently prepared to meet the needs of a growing older population. With a new NHSO campaign that aims at preventing disease rather than promoting medical treatment only, the Government hopes to ensure that older

persons are more likely to lead healthier lives[67].

The Thai Government adopted a series of national plans. The main concern of the National Plan for the Elderly (1982-2001) focuses on the elderly poor, the majority of whom are women. Included in this plan were efforts to provide the target group with welfare services. In 2000, a National Commission for the Elderly was established. The Commission then developed the Second National Plan (2002-2021), providing wider coverage and involving a larger number of agencies including the Ministry of Social Development and Human Security, Ministry of Public Health, Ministry of Interior and Ministry of Education in meeting the needs of a growing older population. The programmes under the more recent plan range from strengthening social security schemes, promoting life-long education to creating community awareness of the needs of the older population, and encouraging recently retired persons to be involved in community activities, such as H.M. the Queen's Brain Bank Project. In essence, the Plan, as well as the programmes that followed, reaffirmed the ICPD mandates. Since the majority of older persons are women, these policies and programmes greatly benefited this group.

The National Plan for the Elderly and the National Commission for the Elderly both were later bolstered by the Standard of Reproductive Health Services for Menopause and Andropause, as spelt out in the Eight and Ninth Health Development Plans. Aside from effective counselling services and health education on nutrition, exercise and so forth, the Standard of Reproductive Health Services emphasise Pap smear examinations at least twice a year, self-examinations for breast cancer at least once a month, visits to a health personnel for breast examinations at least once year, measurements of weight, height, Body Mass Index (BMI) and blood pressure once a year, and screening for diabetes.

Over the years, Thailand's primary and reproductive health care infrastructure has been strengthened to meet the needs of a growing older population. For example, in each community, general and regional hospitals and regional health promotion centres, "golden age clinics" have been established (Table 7). Older persons who seek the services provided at these clinics do not need to pay a fee.

Government policies and action plans directed at older persons are complemented by the work of NGOs. NGOs have become

Table 7: Percentage of "Golden Clinics" in the Various Health Care Units, Thailand

Health Care Unit	Total Number	% With Menopause Clinics
Regional Health Promotion Centre	12	100
Regional Hospital	25	92
General Hospital	67	100
Community Hospital	726	80
Health Centre	9,694	43
Total	10,524	45.9

Source: Ministry of Public Health, Thailand and The World Health Organization (2003).

involved in managing some of the Government-sponsored programmes while the Government itself takes an active lead in providing certain services.

The provision of quality reproductive health care services for older women saw a change in recent years. The Population Council seminar held in 2000 discovered that many menopausal women were 'victims' of hormone therapy because health workers would distribute hormones without adequate counselling on health matters. In response, the Ministry of Public Health adopted the stance that most women are able to deal with the adverse effects of menopause without hormone therapy. Instead the Ministry championed health promotion, lifestyle changes, good dietary habits and regular exercise. In addition, the Ministry has developed standards for menopausal care for Pap smears and breast self-examinations.

3 REPRODUCTIVE HEALTH AND RIGHTS

3.1. The Right to a Healthy Reproductive Life

Reproductive rights as articulated in the global consensus at ICPD and Beijing include the freedom to decide freely and responsibly if, when and how many children to have, the right to information and access to safe, effective, affordable and acceptable methods of fertility regulation and the right to access health care for safe pregnancy and childbirth. In Thailand, women have become increasingly aware of their reproductive health needs; however, fewer are aware of their reproductive rights. For example, many are yet to be fully empowered, especially in their choice of contraceptive method.

By and large in rural health centres, the availability of contraceptive methods tends to be limited to oral pills, injectables and condoms. The 30-baht scheme, while designed to assist the poor has instead become the determining factor for the kind of contraceptive that is made available and the quality of care provided. In rural health centres, usually only one type of pill tends to be distributed in an attempt on the part of the Government to keep costs low. Should greater choices be in demand, they would only be available at the larger district

hospitals. To this end, women's rights to choice of contraceptives are curtailed.

In addition, women tend not to be fully informed about the side effects of contraceptive use[68]. According to studies, in some cases women's choices have been found to be steered by the health personnel involved in distributing the contraceptives or determined by the method being campaigned by the Government at that time[69].

Women's rights are also curtailed in the context of abortion, which has been illegal since 1957 following Sections 301-305 of the Penal Code. Abortion is only permissible under instances of rape, assault, incest and if there is a risk of hereditary disease, mental illness or foetal abnormalities. Despite the threat of legal punishment, it is estimated that 200,000 to 300,000 abortions are carried out each year[70].

Concerning reproductive treatments for infertility, ideally women seeking such medical help should be provided as much information as possible. Instead many women have been found not to be inadequately informed about the medical process they are undergoing as well as the chances of success of the treatment[71]. Women's rights may also be compromised when they are not given adequate counselling and mental and emotional support from medical staff.

Many Thai women have little understanding of their rights at the interpersonal level. Contraceptive use, particularly among married couples, is thought to be a woman's responsibility. They undertake the primary burden of contraceptive choice, the side effects, discomforts, weight gain and other health-associated risks from the use of hormone contraception[72]. Yet they, as with many women across the world, have difficulties in negotiating condom use with men, although this form of contraceptive is the safest choice and has the fewest health risks for women[73]. Thus, although men are seen as initiators of sex, generally women are made to shoulder the responsibility of avoiding pregnancy.

To complicate matters, condom use continues to be associated with sex work. However, in circumstances in which married men do not engage in safe sex with SWs, often their wives are also vulnerable to health risks. Hence, there is a need for women to be aware of their sexual rights as individuals for their own protection.

3.2. Gender-based Violence

Gender-based violence takes many forms: wife battering, marital rape, incest and sexual exploitation. This kind of violence against women is not just a violation of fundamental human rights or a social problem, but increasingly has also come to be seen as a public health issue.

The number of women approaching crisis centres for help was relatively high. Within the first six months of 2000, the Hotline Foundation provided counselling services on domestic violence and rape to 891 and 131 women respectively. The following year, the Friends of Women Foundation provided services to 869 women on domestic and sexual violence[74]. While reports of physical abuses and rapes have been rising alarmingly in the past decade, it has also been reported that the victims are younger than previously, ranging from 4-15 years of age[75].

In Thailand, studies have found that 15-18 percent of rape victims are left pregnant[76]. Moreover, rape victims have a greater

likelihood of using painkillers and sleeping pills than the rest of the population. In addition to suffering physical health problems, victims of gender-based violence are forced to cope with the psychological trauma (both rape trauma syndrome and post-traumatic stress disorder) and emotional humiliation. It is of no surprise that medical costs for treating victims of gender-based violence are about 2.5 times higher than the costs for treating non-victims[77].

Among efforts that have been introduced to eliminate gender-based violence is the one-stop crisis centre in hospitals for victims of violence. In addition, law enforcers are expected to undergo gender-sensitive training programmes. There have also been a number of community-based activities to prevent gender-based violence. Owing to limited resources, however, crisis centres have been restricted to Bangkok and the immediate surrounding areas.

Organizations in the city helping battered women include the Emergency Shelter of the Association for the Promotion of the Status of Women, the Hotline Foundation and the Friends of Women Foundation. Aside from providing counselling on domestic and sexual violence, some of these organizations also provide shelter to victims. The efforts so far, however, have been inadequate for the reasons of lack of funds and the inability on the part of health services and policy makers to view services targeted at gender-based violence victims in a holistic manner.

In addition, the Thai Government is in the process of reviewing and drafting a bill facilitated by the advocacy work of the Standing Committee on Women Parliamentarians of the Asian Forum of Parliamentarians on Population and Development (AFPPD). Clearly, this is a reflection of the advocacy role of NGOs propelling the Government's commitment to addressing gender-based violence.

3.3. Women in Vulnerable Groups

The ICPD clearly states that: "all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed"[78]. Disparities are most evident among religious and ethnic minorities including the hill people and Muslim communities in the South, and occupational groups such as sex workers who thus constitute vulnerable groups. Generally these groups are under-served because they face discrimination and other barriers based on cultural, religious and language differences, which set themselves apart from the rest of Thai society.

Many women enter sex work as a result of poverty or trafficking, while others are forced into this sector by family members. Given the illegal nature of prostitution, many women and girls who enter the sex trade are at high risk for sexual and reproductive health problems, particularly among brothel workers as they tend to service more clients than other sex workers. Sex workers' access to reproductive health care services is complicated by the fact that they face prejudice and discrimination. In addition, their situation is worsened by the fact that most migrant women have little or no education. Often these women are ill informed about contraceptive use and lack knowledge about safe sex in order to protect

themselves from STIs. Even if many SWs may be aware of contraceptive use for protection, a study found that older sex workers were more willing to forego having their clients use condoms in the hope that this would increase their desirability. Some clients also deliberately pay higher fees to have sex without condoms; in more cruel situations, SWs may be forced to have unsafe sex. Another risk SWs may face with unprotected sex is unplanned pregnancies and unsafe abortions.

In Thailand, HIV infection rates among SWs are particularly high at about 13 percent in 2002, a grim reminder that the fight against HIV/AIDS among certain groups is far from over[79]. With the HIV/AIDS scare, young girls are the most sought after as it is assumed among clients that they are the least likely to be inflicted with diseases. Particularly young girls in sex work are at enormous risk, as condoms are never used in the "selling of virginity"[80]. Having multiple sexual partners also places SWs at a higher risk of developing cervical cancer. Others who use contraceptives such as injectables at a young age are at danger of developing reproductive cancers. Gender-based violence is another health problem faced by these workers. The risk is heightened especially since commercial sex work is illegal as well as clandestine, resulting in the vulnerability of these women and girls to the control of pimps who may be exploitative.

Enticed into Sex Work: The Ethnic Minority Story

Girls and women of the minority ethnic groups from the highland reaches of the country are often enticed into sex work. Poverty, lack of education and inadequate economic opportunities leads them into sex work. Many of these girls and women are at highest risk of becoming infected with HIV and STIs. Many do not speak Thai and have difficulties negotiating safe sex. Given the marginalised status they hold in Thailand such as not being able to claim citizenship, many are vulnerable to abuse. Such girls and women are least aware of their rights and easily fall victim to gender-based violence. As with foreign women who engage in sex work, highland girls and women have found themselves under the exploitative control of pimps.

Source: Contribution from UNESCO, as cited in Thailand's Response to HIV/AIDS: Progress and Challenges (2004).

4 CHALLENGES AHEAD

Clearly Thailand has made progress in implementing the international declarations in the area of reproductive health. Many more women now have access to reproductive health services, which were unavailable 15-20 years ago. Among the challenges that remain are: reducing the wide disparities within and between groups, expanding services for youth and older women, ensuring services for women living with HIV/AIDS and expanding services for victims of gender-based violence.

At the global level, the UN Millennium Project Report titled Investing In Development: A Practical Plan to Achieve the MDGs (2005) adopted the following Quick Wins that are relevant to Thailand as well:

- Expanding access to sexual and reproductive health information and services, including family planning services;
- Launching national campaigns to reduce violence against women; and
- Empowering women to play a central role in formulating and monitoring MDG based poverty reduction strategies and other critical policy reform processes, particularly at the level of local governments.

At the national level, the Thai Women Watch has published a report with reflections from the civil society titled The Advancement of Thai Women: 10 Years After Beijing. The report points out some of the challenges ahead in this area. They include:

- Need for sex-disaggregated MDG monitoring. There is also a need to incorporate gender dimension into macro-economic policies and trade negotiations. Engendering the budgeting process is an urgent need.
- Empowering women means creating viable alternatives for them to make choices. This involves further changing of laws, social norms and mindsets. Effective enforcement of laws is also needed.
- Roles and responsibilities of men need to be recognized and enforced.
- MDG-3 on promoting gender equality and empowerment of women currently has only one target, namely eliminating gender disparity in education. Although this is extremely important, expanding access to reproductive health and rights should also be reflected as one of the targets of MDG-3, as pointed out in the Quick Wins.
- Health care centres and services need to be more gender sensitive.

In order to effectively address the above challenges, the existing institutional mechanisms to promote gender equality and empowerment of women (policy mechanisms, implementing mechanisms and legislative mechanisms) and civil society interventions have to be further strengthened. There is a need to set up a monitoring task force to support government and civil society organizations. A clear and implementable strategy is needed to increase the participation of women in decision-making and to make such decisions gender sensitive and issue oriented. The initiative should start from women for which more enabling social and economic policies and structures and legal frameworks are needed. Lack of managerial capacity at all levels of health system can put limits to scaling up services that are user-oriented, women centred and pro-poor. Changes in sex stereotypes in education, and mass media as well as in attitudes of men are also needed.

Government and civil society organizations, with support from UN agencies in Thailand need to engage in coordinated action to meet the above future challenges to maintain and further strengthen Thailand's progress towards attainment of international development goals.

ENDNOTES

[1] UNDP, Human Development Report (1994).

[2] The current Government is spending massive amounts of money on eliminating poverty in the rural areas by promoting rural economic activities. An example is the "One-Tambon, One-Product" (OTOP) programme. A Government-community partnership, the programme aims to expand small and medium enterprises by promoting, improving and marketing the Tambon (sub-district) community's most promising products created with the use of local knowledge and skills. On the part of the Government, modern technology and management have made it possible for these village goods to be sold not only in the domestic market, but also to be made available in the international market, especially through the use of the internet. Women are the main driving force behind the tremendous success of the OTOP project. The goods produced with the support of this programme are a result of the creativity and hard work of the local people. Another initiative is the Village and Urban Community (Revolving) Funds used toward generating supplementary jobs and additional sources of income for rural groups or community enterprises, most of which are run by women. Introduced by the Government in 2001, this scheme was intended to strengthen the grassroots rural and urban economy. Each of the 71,364 villages (as well as 3,517 urban communities) received 1 million THB from the Government to be managed by the local committee for use as credit facility by members of the village. The major role of the villagers was to be responsible for managing the fund and setting the loan conditions. At the grassroots level, not only does this scheme widen economic opportunities, but it also promotes self-reliance by strengthening the fund management capacity of the local people.

[3] UNDP, Human Development Report (1994).

[4] A common practice in the administration of the Government is that major issues requiring technical advice are assigned to national committees comprising of senior ranking persons from the concerned agencies in addition to 'national experts' who may include academics and civil society representatives. The results of the discussions are then submitted to the relevant ministries or to the cabinet. The various 'national committees' are therefore extremely influential as the proposals that emerge from their deliberations are treated with greater credibility by the public than those put forth entirely by ministry officials. Women have also participated in these national committees. Their role is crucial especially in mainstreaming gender into high levels of policy making.

[5] Thailand Millennium Development Goals Report 2004, as cited in Tonguthai (2005).

[6] Thailand Millennium Development Goals Report 2004 (2004).

[7] UNDP, Human Development Report 2003, New York, Tables 22 and 24, as cited in Tonguthai (2005).

[8] National Statistical Office, Population and Housing Census, 1990 and 2000, as cited in Tonguthai (2005).

[9] One of the fastest growing economies in South-East Asia with a growth rate of 5.9 percent in 2004 in spite of the economic downturn suffered in 1997, Thailand has achieved remarkable progress in poverty reduction in recent years.

[10] Other countries in Asia falling into the same category are China, Indonesia, Malaysia, Philippines and Viet Nam.

[11] The Office of Women's Affairs and Family Development, Ministry of Social Development and Human Security (2004).

[12] Human Development Report (2004).

[13] Ministry of Public Health of Thailand (2004).

[14] Ministry of Public Health and the World Health Organization (2003).

[15] Gender and Development Research Institute (2005).

[16] Ministry of Public Health and the World Health Organization (2003).

[17] The term life skills education is most commonly used in Thailand instead of sex education, although the most recent guidebook for teachers on the subject was entitled the sex education guidebook. Sexuality education, sexual health education and family life education are the terms employed by UNFPA and other UN agencies. The term sexuality education, sexual health education or family life education refers to the acquisition of knowledge on the biological, emotional and social dimensions of human sexuality, and improvement of skills necessary for reproductive health and personal development. This term is differentiated from life skills education, which aims to encourage healthy lifestyles through the expansion of knowledge, attitudes and basic how-to-skills crucial for confronting and dealing with real life challenges.

[18] Decentralisation has transferred the task of the provision of reproductive services such as the distribution of contraceptives, for example, to the provincial health centres. The budget allocated to the provincial governments by the central Government via the Ministry of Public Health makes these purchases possible. Provincial governments also allocate money toward training, research evaluation, maintenance and administration. Presently community PHC centres distribute contraceptives. The pill, condom and injectables are heavily subsidised by the Government and produced locally in order to keep costs low, thereby ensuring their widest possible availability.

[19] The 30-baht scheme ensures the right of all, including the poorest of poor, to have access to health care services except more advanced treatment such as kidney dialysis and ARV drugs. Under this scheme, people buy gold cards on showing official identification documents. Thais including non-Thai citizens who earn below a certain wage level may participate in the scheme by paying an outright fee at the onset. Subsequently for every health visit, the cardholder is entitled to medical care and treatment with the payment of a single fee of 30 THB.

[20] Communication, Ministry of Public Health, Thailand (2004).

[21] Thailand's Response to HIV/AIDS: Progress and Challenges (2004).

[22] Thailand's Response to HIV/AIDS: Progress and Challenges (2004).

[23] Communication, Ministry of Public Health, Thailand (2004).

[24] Ministry of Public Health, Thailand and the World Health Organization (2003).

[25] Ministry of Public Health, of Thailand (2004).

[26] Thailand Millennium Development Goals Report 2004 (2004).

[27] Yoddumnern-Attig, Sethaput and Sirirassamee (2002).

[28] Report of 2003 Reproductive Health Survey in the Southern Region of Thailand (2004).

[29] VanLandingham, Knodel, Saengtienchai and Pramularatana (1995).

[30] Thailand's Response to HIV/AIDS: Progress and Challenges (2004) and Office of the National Economic and Social Development Board and United Nations Country Team in Thailand, Thailand Millennium Development Goals Report 2004 (2004).

[31] AZT (Retrovir®, zidovudine, ZDV) is the first drug to treat HIV and is always used in combination with other anti-HIV drugs. It is also used in the prevention of HIV transmission from mother to child. The side effects of the drug are nausea, vomiting, and low red or white blood cell counts.

[32] Ministry of Public Health of Thailand (2004).

[33] Thailand's Response to HIV/AIDS: Progress and Challenges (2004).

[34] Ministry of Public Health, Thailand and the World Health Organization (2003).

[35] Moving Into Action: Realizing Reproductive and Sexual Health and Rights in the Asia Pacific Region (2003).

[36] Moving Into Action: Realizing Reproductive and Sexual Health and Rights in the Asia Pacific Region (2003).

[37] 2002 Thailand Country Profile: HIV/AIDS Situation in Thailand and National Response to the Epidemic (2002).

[38] Chamsanit (1999).

[39] Ministry of Public Health, Thailand and the World Health Organization (2003).

[40] Communication, Ministry of Public Health, Thailand (2004).

[41] Chandeying (2004).

[42] Chandeying (2004).

[43] Chandeying (2004).

[44] Ministry of Public Health, Thailand and the World Health Organization (2003).

[45] Ministry of Public Health, Thailand and the World Health Organization (2003).

[46] A national survey in 1995 found that more than 25 percent of boys and less than 5 percent of girls had their first sexual experience before age 15 (Ministry of Public Health, Thailand and the World Health Organization, 2003).

[47] Government of Thailand (1997).

[48] Ministry of Public Health of Thailand (2004).

[49] In fact, the study found that the main clientele consisted of young males and female sex workers while very few adolescent girls visited medical facilities run by the Government (Tangmunkongvoraku and Bhuttarowas 2004).

[50] Yoddumnern-Attig, Sethaput and Sirirassamee (2002).

[51] Ministry of Public Health, Thailand and the World Health Organization (2003).

[52] Ministry of Public Health, Thailand and the World Health Organization (2003).

[53] Warakamin, Boonthai and Tangcharoensathien (2004).

[54] Ministry of Public Health, Thailand and the World Health Organization (2003).

[55] Thailand Millennium Development Goals Report 2004 (2004).

[56] Tantinimitkul (2004).

[57] "Teachers get sex education guidebook: Schools picked for experiments" (Bangkok Post, March 22, 2005).

[58] Para. 7.6 in Population, Reproductive Health and the Millennium Development Goals (2002).

[59] Ministry of Public Health, Thailand and the World Health Organization (2003).

[60] Ministry of Public Health, Thailand and the World Health Organization (2003).

[61] Boonmongkon, Pylypa and Nichter (1999).

[62] While 43.6 percent of Buddhist women surveyed did not take any steps toward undergoing any kind of screening for cancer, an overwhelming 70.7 percent of the Muslim women never had similar checks (Report of 2003 Reproductive Health Survey in the Southern Region of Thailand (2004).

[63] Ministry of Public Health and the World Health Organization (2003).

[64] Moriki-Durand (2005).

[65] Office of Women's Affairs and Family Development, Gender Statistics, 2004, Table 1, Bangkok, as cited in Tonguthai (2005).

[66] Chap. VI. Para. C.19 of the Programme of Action (2004).

[67] 'No health policy to target elderly' (The Bangkok Post, May 6, 2005).

[68] Chamsanit (1999).

[69] Chamsanit (1999).

[70] Chamsanit (1999) and Ministry of Public Health, Thailand and the World Health Organization (2003).

[71] Grisurapong, Ma-un and Boonmongkon (1999).

[72] Grisurapong, Ma-un and Boonmongkon (1999).

[73] See Grisurapong, Ma-un and Boonmongkon (1999) for the side-effects caused by the use of many of the commonly available contraceptives.

[74] Thailand Millennium Development Goals Report 2004 (2004).

[75] Saranya Chaiyasuta, et al. "Domestic Violence: The Hidden Menace", in *Thai Women Watch, The Advancement of Thai Women 10 years after Beijing: Reflections from the Civil Society*, Bangkok, June 2004, as cited in Tonguthai (2004).

[76] WHO (1996), as cited in "Addressing Rape: The Urgency for Action" in ARROWS For Change, (1998).

[77] WHO (1996), as cited in "Addressing Rape: The Urgency for Action" in ARROWS For Change, (1998).

[78] Chap. VIII. Para. C.21 of the Programme of Action (2004).

[79] Thailand's Response to HIV/AIDS: Progress and Challenges (2004).

[80] Boonmongkon, Guest, Marddent and Sanders (2003).

ANNEX

MAJOR INTERNATIONAL AND NATIONAL ORGANIZATIONS AND ACADEMIC INSTITUTIONS WITH INITIATIVES ON GENDER AND DEVELOPMENT

Government Organizations

Office of Women's Affairs and Family Development, Ministry of Social Development and Human Security

Address: Sun Tower, A Building, 23rd Floor, 123 Vibhavadi Rangsit Road Chatuchak, Bangkok 10900, Thailand
Tel: (02) 612-8738; Fax: (02) 612-8748
E-mail: women.family@m-society.go.th
Website: www.women-family.go.th

Quality of Life and Social Development Office, National Economic and Social Development Board

Address: 962 Krung Kasem Road, Bangkok 10100, Thailand
Tel: (02) 280-4085 ext. 2512; Fax: (02) 281-6128

Non-Governmental Organizations

Asia Pacific Forum on Women, Law and Development (APWLD)

Address: Santitham YMCA Building 3rd floor, Room 305-308
11 Sermsuk Road, Soi Mengrairasmi, Chiangmai 50300, Thailand
Tel: (53) 404 613 to 4; Fax: (53) 404 615
E-mail: apwld@apwld.org
Website: www.apwld.org

Association for the Promotion of the Status of Women (APSW)

Address: 501/1 Mu 3, Dechantungka Road, Sikan, Donmuang, Bangkok 10210, Thailand
Tel: (02) 929-2301 to 7; Fax: (02) 566-3481
E-mail: admin@apsw-thailand.org
Website: www.apsw-thailand.org

Development and Education programme for Daughters and Communities Centre

Address: P.O. Box 10 Mae Sai, Chiang Rai 57130, Thailand
Tel: (53) 733-186, 642-599; Fax: (53) 642-415
E-mail: info@depdc.org, depc@ksc.th.com
Website: www.depdc.org

Employers Confederation of Thailand

Address: 1055/3 Srichareon Square, Srinakarin Road, Bangna, Bangkok 10260, Thailand
Tel: (02) 398-4880 to 82; Fax: (02) 398-4879
E-mail: ecot@bkk.loxinfo.co.th
Website: ecot@bkk.loxinfo.co.th

EMPOWER Foundation

Address: 57/60 Tivanond Road, Nonthaburi 11000, Thailand
Tel: (02) 526-8311; Fax: (02) 526-3294
E-mail: badgirls@empowerfoundation.org; empower@asianet.co.th

Foundation for Women (FFW)

Address: 295 Charunsanichwong 62 Road, Bangplad, Bangkok 10700, Thailand
Tel: (02) 433-5149, (02) 435-1246; Fax (02) 434-6774
E-mail: ffw@mozart.inet.co.th
Website: www.womenthai.org

Friends of Women Foundation (FOW)

Address: 386/61-3 Ratchada 42, Rachadapisek Road, Kwaeng Ladyao, Chatuchak, Bangkok 10900, Thailand
Tel: (02) 513-1001; Fax: (02) 513-1929
E-mail: FOW@mozart.inet.co.th
Website: www.friendsofwomen.net

Gender and Development Research Institute (GDRI)

Address: 501/1 Mu 3, Dechatungka Road, Sikan, Donmuang, Bangkok 10210, Thailand
Tel: (02) 929-2088 to 9; Fax: (02) 929-2090
E-mail: gdri@cscoms.com
Website: www.gdrif.org

Gender and Development Working Group (GAD-WG)

Address: 386/61 Ratchadapisek Soi 42, Ladyao, Chatuchak, Bangkok 10900, Thailand
Tel: (02) 513-2276; Fax: (02) 930-6097
E-mail: gadwg@loxinfo.co.th

Girls Guide' Association of Thailand Under the Royal Patronage of Her Majesty the Queen

Address: 5/1-2 Phayathai Road, Rajathewi, Bangkok 10400, Thailand
Tel: (02) 245-0242; Fax: (02) 246-4699
E-mail: ggat@cscoms.com

Homenet Thailand

Address: 386/59 Rachadapisek 42, Rachadapisek Road, Kwaeng Ladyao Chatuchak, Bangkok 10900, Thailand
Tel: (02) 513-9242, 513-8959; Fax: (02) 513-8959
E-mail: homenet@asianet.co.th

Hotline Foundation

Address: Hotline Villa Bldg, 145/6 Vibhavadi Rangsit Soi 20, Ladyao, Chatuchak, Bangkok 10900, Thailand
Tel: 02-276-2950; Fax: 02-691-4056 to 7

International Federation of Business and Professional Women

Address: 46 Soi Sukumvit 61, Wattana, Bangkok 10110, Thailand
Tel: (02) 343-4905, (66-1) 837-6868; Fax: (02) 287-3056

Thai Women Watch (TW2)

Address: 2234 New Petchburi Road, Huay Kwang, Bangkok 10320, Thailand
Tel: (02) 314-4316, 314-5076; Fax: (02) 718-0372
E-mail: tw2a@asianet.co.th
Website: www.thaiw2.com

The Council of the Work and Environment Related Patient's Network of Thailand (WEPT)

Address: 70/53 Mu 2, Tiwanond 45, Ta Sai, Nondhaburi 11000, Thailand
Tel/fax: (02) 951-3037

The National Council on Social Welfare of Thailand

Address: Mahidol Building, Rajvithi Road, Rajthevi, Bangkok 10400, Thailand
Tel: (02) 245-8823, 246-1457 to 61 ext. 212; Fax: (02) 247-6279

The National Council of Women of Thailand (NCWT)

Address: 51 Manungkasila House, Larn Luang Road, Bangkok 10300, Thailand
Tel: (02) 281-0081; Fax: (02) 281-2189
E-mail: secretary@thaiwomen.or.th
Website: www.thaiwomen.or.th

The Pan Pacific and Southeast Asia Women's Association of Thailand

Address: 1/5 Krungthep Kreeta C2, Sapansoong, Bangkok 10250, Thailand
Tel: (02) 251-1791, 01- 910-8727; Fax: (02) 251-1792

The Planned Parenthood Association of Thailand (PPAT)

Address: 8 Vibhavadi Rangsit Soi 44, Vibhavadi Rangsit Road, Ladyao, Chatuchak, Bangkok 10900, Thailand
Tel: (02) 941-2320; Fax: (02) 941-2338
E-mail: ppat@samart.co.th, info@ppat.or.th
Website: www.ppat.or.th

Women and Constitution Network (WCN)

Address: 9th Floor, Institution Building 3, Chulalongkorn University Phyathai Road, Pathumwan, Bangkok 10330, Thailand
Tel: (02) 218-8166 to 7, (02) 264-2014; Fax: (02) 218-8164

Women's Health Advocacy Foundation (WHAF)

Address: 12/22 Tessaban Songkroh Road, Ladyao, Chatuchak, Bangkok 10900, Thailand
Tel: (02) 591-1224 to 5 ext. 14; Fax: (02) 591-1099
E-mail: contact@whaf.or.th
Website: www.whaf.or.th

Regional Organizations

Asian Development Bank (ADB)

Address: Social Development Division, 6 ADB Avenue, Mandaluyong City 1550, Philippines, P.O. Box 789, 0980 Manila, Philippines
Tel: (632) 632-4444; Fax: (632) 632-2444
E-mail: gender@adb.org
Website: www.adb.org/gender and development

CEDAW South East Asia Programme (CEDAW SEAP)

Address: 157 Thipya Court, Rajavidhee Road, Dusit District, Bangkok 10300, Thailand
Tel: (02) 244-8753, 243-4168; Fax: (02) 244-8754
E-mail: supatra@unifem-ESEASIA.org
Wbsite: www.unifem-eseasia.org

Committee for Asian Women (CAW)

Address: 386/60 Ratchadaphisek Soi 42, Ratchadaphisek Road, Ladyao, Chatuchak, Bangkok 10900, Thailand
Tel: (02) 930-5634 to 5; Fax: (02) 930-5633
E-mail: cawinfo@cawinfo.org
Website: www.cawinfo.org

Friedrich Ebert Stiftung (FES)

Address: Thanapoom Tower, 23rd Floor, 1550 New Petchburi Road, Makkasan, Ratchathewi, Bangkok 10400, Thailand
Tel: (02) 652-7178 to 9; Fax: (02) 652-7180
E-mail: info@fes-thailand.org
Website: www.FES-Thailand.org

Global Alliance Against Traffic in Women (GAATW)

Address: 191/41 Sivalai Condominium, Itsaraphap Road, Soi 33, Bangkokyai, Bangkok 10600, Thailand
Tel: (02) 864-1427 to 8; Fax: (02) 864-1637
E-mail: gaatw@gaatw.org
Website: www.gaatw.org

United Nations Organizations

Food and Agriculture Organization Regional Office for Asia and the Pacific (FAO/RAPS)

Address: 39 Phra Atit Road, Bangkok 10200, Thailand
Tel: (02) 697-4000
E-mail: fao-ro-asia-pacific@fao.org
Website: www.fao.org/world/regional/rap/

International Labour Organization (ILO), Sub-regional Office for East Asia

Address: 10th, United Nations Building, P.O. Box 2-349, Rajadamnern Nok Avenue, Bangkok 10200, Thailand
Tel: (02) 288-1731, (02) 288-2485; Fax: (02) 280-1735
E-mail: srobangkok@ilo.org
Website: www.ilo.org/public/english/region/asro/mdtbangkok/index.htm

UNAIDS Country Programme

Address: Office of the UN Resident Coordinator, c/o United Nations Development Programme, 12th Floor, United Nations Building, Rajadamnern Nok Avenue, Bangkok 10200, Thailand
Tel: (02) 288-2612; Fax: (02) 280-2701
E-mail: unaids.Thailand@un.or.th
Website: www.un.or.th/unaidsth

United Nations Children's Fund (UNICEF)

Address: 19 Phra Atit Road, P.O. Box 2-154, Bangkok 10200, Thailand
Tel: (02) 356-9499
E-mail: thailandao@unicef.org
Website: www.unicef.org

United Nations Development Fund for Women East & Southeast Asia (UNIFEM ESEARO), Bangkok

Address: c/o United Nations Development Programme, 5th floor, United Nations Building, Rajadamnern Nok Avenue, Bangkok 10200, Thailand
Tel: (02) 288-2093; Fax: (02) 280-6030
E-mail: info@unifem.un.or.th
Website: www.unifem-eseasia.org

United Nations Education, Science and Cultural Organization (UNESCO)

Address: 920 Sukhumvit Road, P.O. Box 967, Prakaknong, Bangkok 10110, Thailand
Tel: (02) 391-0577, (02) 391-0703 ext. 318; Fax: (02) 391-0866
E-mail: gender@unescobkk.org
Website: www.unescobkk.org/gender

United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP)

Address: Gender and Development Section, Emerging Social Issues Division, 6th Floor, United Nations Building, Rajdamnern Nok Avenue, Bangkok 10200, Thailand
Tel: (02) 288-1572; Fax: (02) 288-1018
E-mail: gad@un.org
Website: www.unescap.org/esid/gad

United Nations Population Fund (UNFPA)

Address: 12th Floor, United Nations Building, Rajadamnern Nok Avenue, Bangkok 10200, Thailand
Tel: (02) 288-1880; Fax: (02) 280-1871
E-mail: unfpa.fo@unfpa.un.or.th, cst_Bangkok.unescap@un.org
Website: www.cstbkk.org

Academic Institutions

Center of the Advancement of Lanna Women, Chiangmai University

Address: Faculty of Education, Huay Kaew Road, Muang District, Chiangmai 50200, Thailand
Tel: (053) 944-219; Fax: (053) 944-217

Department of Occupational Health and Safety, Faculty of Public Health, Mahidol University

Address: 420/1 Rajvidhi Road, Bangkok 10400, Thailand
Tel: (02) 245-7793, 246-1258 to 9 ext. 2604; Fax: (02) 247-9458
E-mail: phcck@mahidol.ac.th

Faculty of Social Sciences and Humanities, Mahidol University

Address: Salaya, Nakorn Pathom 73170, Thailand
Tel: (02) 441-0220 to 3 ext. 1228; Fax: (02) 441-0252
E-mail: shstc@mahidol.ac.th

Foundation for Women, Law and Rural Development, Chiangmai University

Address: P.O. Box 110, Chiangmai University 50200, Thailand
Tel: (053) 943-592 to 3; Fax: (053) 892-464
E-mail: forward_w@hotmail.com
Website: www.soc.cmu.ac.th/wsc/forward

Institute of Population and Social Research, Mahidol University

Address: 999 Buddhamonthol 4, Salaya, Nakhon Pathom 73170, Thailand
Tel: (02) 441-9666, (02) 441-0201 to 4; Fax: (02) 441-9333
E-mail: prkac@mahidol.ac.th, directpr@mahidol.ac.th
Website: www.population.mahidol.ac.th

Social Research Institute, Chulalongkorn University

Address: Phayathai Road, Bangkok 10330, Thailand
Tel: (02) 218-7380; Fax: (02) 255-2353
E-mail: cusri@chula.ac.th

Women and Youth Studies Program, Thammasat University

Address: 2 Prachan Road, 4th floor, Library Bldg., Bangkok 10200, Thailand
Tel: (02) 613-3150 to 1; Fax: (02) 224-9420
E-mail: wysp@tu.ac.th, malee_p@hotmail.com

Women Studies Center, Khon Kaen University

Address: Faculty of Humanities and Social Sciences, Bldg. 2, Muang District, Khon Kaen 40002, Thailand
Tel: (043) 241-331 to 5, (043) 242-331 to 41; Fax: (043) 241-216

Women's Studies Center

Address: Faculty of Social Sciences, Chiangmai University Muang District, Chiangmai 50002, Thailand
Tel: (053) 943-572, (053) 943-592 to 3; Fax: (053) 219-245, (053) 892-464
E-mail: wsc@chiangmai.ac.th
Website: www.soc.cmu.ac.th/wsc

Women's Studies Center, Research and Development Institute

Address: Faculty of Social Science, Payap University, Chiangmai 50002, Thailand
Tel: 053-241-255 ext. 228; Fax: 053-241-983
E-mail: soc-ant@payap.ac.th

Women's Studies Program, Naresuan University

Address: Faculty of Education, Muang District, Phitsanulok 65000, Thailand
Tel: (055) 261-028; Fax: (055) 261-028

Women Research and Development Institute

Address: Faculty of Management Sciences, Prince of Songkla University, Hadd Yai Campus, Songkla 90110, Thailand
Tel: (074) 212-826 ext. 114, (074) 212-808

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