THAILAND : National Report on Population and Development

A Report prepared by Thailand Working Committee for Preparation of the International Conference on Population and Development , 1994

Government of Thailand
September 1994

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Preface

This national report has been prepared for the International Conference on Population and Development (ICPD), 5-13 September 1994, Cairo, Egypt. It was drafted according to the suggested outline of the United Nations Population Fund (UNFPA) and the objectives of the Conference to address not only the country population situation, policies and programmes, but also information about actual population policies, programmes and services available, including maternal and child health and family planning; population information and education; population data collection; women, population and development activities; information about other important population issues, including population and the environment, youth, AIDS and ageing; and the processes that have led to the formulation of population policies and programmes in Thailand.

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Human Resource Planning Division
National Economic and Social Development Board
September 1994

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With the Compliments

of the

Human Resource Planning Division

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Part I

Thailand's Demographic Context

Past Trends

Like many other developing countries, Thailand experienced rapid population growth after the Second World War. Its population exceeded 26 million in 1961 and almost doubled within a quarter of the century, growing to more than 52 million in 1986, the end of the Fifth National Economic and Social Development Plan (1982-1986). Population growth between 1961 and 1986 was almost entirely determined by trends in mortality and fertility, since international migration played an insignificant role. Mortality decline preceded that of fertility by more than two decades, culminating in a 3.5 percent rate of population increase during the period 1961-1966. After fertility started to decline, the average annual rate of growth for consecutive five-year time intervals was almost halved from 3.5 percent in 1961-1966 to 1.8 percent during 1981-1986.

It has been estimated that the expectation of life at birth has increased from almost 54 years for males and 59 years for females in 1959-1961 to more than 60.3 years for males and 66 years for females in 1980-1985. During roughly the same time period, the crude death rate was nearly cut in half, from 13.5 (deaths per 1,000 population) in 1960 to 7.8 by 1980-1985. In part, this reflected a sharp drop in the infant mortality rate, from 84 (infant deaths per 1,000 births) in 1964-1965 to 45 in 1983. The estimates of infant mortality for the time period from the mid-1960s to the mid-1980s suggest that much greater gains in infant survivorship had been achieved in the various regions before the mid-1970s than thereafter.

The onset of fertility decline in Thailand probably occurred around the mid-1960s, even before the government launched its anti-natalist population policy. The reduction in the total fertility rate (TFR) from a level of over six children per woman was initially slow. Following the introduction of the national family planning program in the 1970s, fertility decline gained momentum, bringing the TFR down to 3.5 children in 1984. This TFR decline was to a large extent made possible by a rapid spread of family planning practices. By 1981, 60 percent of married women of reproductive age were using contraceptives, up from 15 percent in 1969. However, contraceptive use, which is higher in Bangkok and the Central region, has not yet spread evenly over all regions. Fertility in the Northeast and South, and especially among certain population groups, such as rural people in the remote area, hill tribes and Thai Muslims, remain higher than the national average. Religious values, culture and traditions of those groups have made it difficult for the government to introduce modern contraceptive methods to limit family size.

Mortality and fertility declines during the past few decades caused substantial shifts in the population age structure. Declines in infant and child mortality and continuing high fertility between 1960 and 1970 caused a small increase in the proportion of the population under age 15, making the age distribution of the population younger. After 1970, the level of fertility declined and the Thai population grew progressively older. This is indicated by a rapid drop in the proportion of the population below age 15, from about 45 percent in 1970 to about 37 percent in 1984. At the same time, the proportion within the age group 15-59 grew from 50 percent in 1970 to more than 57 percent in 1984.

Shifts in the age structure after 1970 were accompanied by differentials in rates of growth of the subpopulations within the age groups 0-14, 15-59 and 60+. Thus, the average annual rate of growth of the population below 15 during the period 1970-1984 was 1.4 percent, while that of the age group 15-59 was more than two and one-half times larger at 3.7 percent. The rate of growth of the population aged 60 and over was almost as large at 3.6 percent.

Also during the past decade, the rural-to-urban migration stream gained in importance. Whereas rural-to-urban migration constituted only 12 percent of all moves during the five-year period preceding the 1970 census, it increased to more than 15 percent in the five-year period preceding the 1980 census. Although there were no significant changes in the regional distribution of the population as a result of this, the proportion of the population which was urban increased only marginally between 1960 and 1971 (from 12.5 percent to 13.2 percent), whereas it jumped to an estimated 25 percent by 1984. During that period, the Bangkok Metropolis increased its share above 10 percent by 1984.

Current Situation

According to the preliminary 1990 Census report, the nation's population size has increased to 54.5 million. The Northeast region, which is the largest area of the country, accounted for about 35 percent of the total population; the Central region, 33 percent; the North, 19 percent; and the South, 13 percent. The country's population growth rate decreased to 1.43 percent by 1991. The present Seventh National Economic and Social Development Plan (1992-1996) targets reducing the population growth rate further to 1.2 percent by the end of the plan.

The report of the Survey of Population Change in 1991 indicates that the TFR dropped from about 2.41 in 1989 to 2.17 in 1991. However, a fertility differential clearly exists between regions. While the fertility rate of women in the Northern and Central regions as well as the Bangkok Metropolitan Area (BMA) in 1991 was below replacement level, that in the Northeast and the South and among minority groups was still high, between 2.67 and 2.98.

In addition, mortality levels are quite low due to vast improvements in public health and education. By 1991, the crude death rate was at 5.93 per 1,000 population, while the the infant mortality rate was 34.5 per 1,000 live births. A decrease in the mortality rate, discussed further in Part III, was reflected in an increase in life expectancy: 67.7 years for males and 72.4 years for females by 1991.

Due to a reduction in fertility during the last 20 years, significant changes in the population age structure have emerged. The population under 15 years of age accounted for about 32 percent in 1991, compared to 45 percent in 1970. Meanwhile, the percentage of the population over 60 years of age has increased slightly from about 5 percent in 1970 to 6 percent in 1991. It is estimated by the year 2000, young and old age groups will account for about 27 and 8 percent of total population respectively.

The urban population also grew at about 3.5 percent annually during 1975-1984. This was due mainly to internal migration from the rural areas to the BMA where residents suffer severe shortages of public utilities, facilities and housing, and increases in unemployment, crime, environmental deterioration and pollution. The urban population was estimated to be about 18 million or 32 percent of the population in 1990, and is expected to increase to about 25 million or 39 percent in 2000. One half of this population was living in the BMA. Consequently, the BMA has become the primate city of the country. In 1991, its population was 5.6 million which was about 2.3 times that of the second largest city which is Nakorn Ratchasima in the Northeast region.

Future Outlook

It is expected that the basic demographic trends displayed in the last twenty years will continue in the near future. Mortality will continue to fall and by the year 2000 will have approached the levels of developed nations. Fertility will also continue to fall although the rate of decline is less certain. Migration in or out of the country is not expected to play a major role. Total internal migration will continue at the rather high rates of the recent past, but the rural to urban movement will increase for economic reasons. By the year 2000, Thailand will be facing an urban-dominated population situation.

The official projection for Thailand during 1980-2015 based on the medium fertility assumption, which is thought to be the most likely phenomenon, is that the population, which numbers around 56 million in 1990, will increase to 64 million by the year 2000. The projection by age distribution indicates that 32.6 percent will be in the 0-14 age cohort in 1990 which will reduce to 26.7 percent in 2000. The population in the 60+ age cohort, however, will increase from 6.2 percent in 1990 to 7.8 percent by 2000. Regional fertility differentials will continue to exist with the highest fertility being in the South. The urban population is estimated to increase to about 25 million or 39 percent of total population in 2000.

The results of these projections suggest a need to become more concerned about specific groups and area-based strategies, in particular subtarget groups and a regional approach to successfully reduce the population growth rate. There is also a need to increase the availability of contraceptive devices and to analyze various socio-economic variables that can act as an incentive for population control by affecting the demand for children. Relying on family planning alone to deal with these target groups may not achieve ambitious national goals.

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Part II

Population Policy and Planning

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National Perceptions on Population Issues

Population problems have been developmental issues since the country began its First National Economic Development Plan (1961-1966). However, the problems were narrowly related to considerations of population increase as a barrier to improving people's standard of living and to increasing the nation's gross domestic product (GDP). It was argued that as a population increases rapidly, there is a need for a more rapid increase in income and national productivity. The major population and development issues boiled down to greater efforts to raise the living standard and to increase the GDP through accelerated economic growth. Since the vast majority of the people lived in rural areas, with a low density of agricultural land, a population increase could be absorbed through the expansion of farm land and increasing productivity per acre.

The labor force's rapid growth rate, which arose from high population growth, began to become a problem for the government in the Second Plan (1967-1971) as it had to raise the rate of economic growth to a level such that it could absorb the growing labor force. Furthermore, the growth of major cities and towns demanded a greater allocation of financial resources for the construction of basic infrastructures and the provision of public utilities.

During the Third Plan (1972-1976), the pressure of high population growth was again recognized as a major cause of the country's developmental problems, including rural poverty, rural-urban migration, poor housing conditions, crime, landlessness, underemployment, urban congestion and difficulties in the provision of government services. For instance, in the field of educational development, rapid growth of the school-age population at all levels made it extremely difficult for the government to increase coverage and improve the quality of education in order to accelerate the economic development rate.

Rural-urban migration and the resulting high growth rate of the Bangkok Metropolis and regional cities also caused problems of urban congestion, a poor social environment, inadequate housing and social services, the growth of slum areas, urban unemployment, crime and drug addiction. These were the most basic social problems that underlied the developmental efforts made during the Fourth and subsequent Plans.

The problems of population size, quality, and structure, as well as the pattern of human settlement and unemployment have become increasingly complicated since the Fourth Plan (1977-1981). Even though the population policy during the Third Plan successfully achieved its target of population reduction, the rapid rate of population growth before the Third Plan raised the labor force's rate of increase. It is significant to note that more than 70 percent of the labor force were unskilled, having no more than primary education. They were unable to engage in economic activities other than low-income ones. As a result, unemployment grew rapidly during the Third Plan. The agricultural sector also faced natural disasters and low productivity, causing underemployment and seasonal unemployment. Increasingly rural people headed for urban areas to seek employment thus creating a high urban unemployment rate which, in turn, resulted in many other related urban problems.

Environmental deterioration and natural resource exploitation, particularly related to forestry and water resources management, have become more aggravated since the Fourth Plan as a consequence of rapid population growth and the uncontrolled nature of human settlements. These problems have led to the environmental development commitment to conserve existing rich forest land, to conduct reforestation in watershed areas, to make optimal use of idle coastal land, and to control the use of underground water throughout the country, particularly in the Bangkok Metropolis.

At the same time, unrelenting and uncontrolled urban growth created congestion in the Bangkok Metropolis, which is the country's economic base where its industrial and other economic activities are heavily concentrated. There was no system of urban communities or cities to distribute balanced growth and development among various regions of the country, which therefore aggravated Bangkok's worsening environmental situation. Rural areas, furthermore, were no better off than urban ones. Rapid population growth increased the number of farm households and consequently reduced the size of landholdings. Simultaneously, the number of landless farmers and tenants rapidly increased. Population pressures also led to rampaging encroachment onto forested areas which yielded farms of only low productivity.

During the present Seventh Plan (1992-1996), it is recognized that the beneficiaries of economic progress in the past were those who lived in the Bangkok Metropolis and the Central region. The great majority of the rural people hardly benefitted from the fruits of development. Rapid population increase inconsistent with available resources and employment opportunities in these areas also created many social problems, including those related to migration, urban congestion and housing. Moreover, the population structure, loaded with young children, created a high dependency ratio. Poor economic conditions therefore forced children and women to participate in the labor force to an excessive extent. This, in turn, led to the problem of exploitation of children and women's labor which adversely affected the family and society as a whole.

Population Policy: Evolution and Current Status

The policy of reducing the population growth rate was first adopted in 1970 and officially announced in March of 1970. Population reduction programs were subsequently included in the Third National Economic and Social Development Plan (1972-1976). It was also stated in the country's 1974 Constitution, Article 86, that the State must formulate a population policy consistent with natural resources, economic and social conditions and technological progress, to benefit the country's economic and social development and national security, through the promotion of voluntary family planning. The goal was to reduce the rate of population growth from 3 percent per annum to 2.5 percent by the end of the Third Plan. This included reducing the demographic dependency ratio of children and working-age population and helping to accelerate the rate of economic growth. Another reason for reducing the population growth rate was to enable the government to re-allocate

the amount of money saved to other developmental activities, such as improving the educational system to better the quality of the future population.

The Fourth Plan (1977-1982) continued to set a goal of population growth rate reduction, from 2.5 percent in 1976 to 2.1 percent per annum in 1981. In addition, the continuous flow of rural people into the Bangkok Metropolis, at a persistently high rate, led the government to set up a policy to reduce and divert migration into Bangkok and other urban areas and redirect it to regional urban centers to be developed.

Since the Fifth Plan (1982-1986) to the present Seventh Plan (1992-1996), the government has continuously set a policy to further reduce the population growth rate from 2.1 percent in 1981 to 1.5 percent in 1986, 1.3 percent in 1991 and 1.2 percent in 1996. The emphasis has been on remote and underdeveloped areas, the South and the Northeast, and among population groups that pose problems and need accelerated development, namely those in slum areas, rural poor, hilltribe people, and Thai Muslims.

Furthermore, in order to stem the flow of rural migrants to the Bangkok Metropolis, a policy has been formulated to develop a system of urban areas and other specific development areas. The specific areas include the three provinces of the Eastern Seaboard, the Western Area, the Lower Eastern Seaboard, the Upper North, and the Southern Border Provinces. The system of urban areas to be developed consists of primary and secondary cities in all developmental regions of the country. One main objective of the area development is to slow down the growth of the Bangkok Metropolis.

Population and Development Planning

Since 1970, Thailand's effort to pursue social and economic development in a way that accommodates population trends has been supplemented by concerted efforts to modify those trends. The initial objective of the new population policy was to slow population growth, making it easier for the country to attain a variety of development goals. Additional objectives, such as changing the geographic distribution of the population, were subsequently added as official perceptions of population problems became sharper. By identifying population objectives and formulating policies to achieve them, a conceptual framework for population planning has gradually emerged.

The perception that rapid population growth was a major impediment to development has made the rate of population growth the key target variable of population planning in Thailand. Consequently, since the early 1970s, all development plans have specified target rates of population growth for their terminal years. Policy makers have sought to reduce fertility by a sufficient amount during each successive five-year plan period to achieve the target population growth rates, thus making the fertility the major concern of population policy. To achieve fertility reduction, Thailand has relied on a government-sponsored and implemented national family planning program.

In order to ensure the success of the family planning program, a variety of measures

were envisaged. These measures concern: (a) the delivery of family planning services ; (b) population education; (c) legal measures and incentives; (d) information, education and communication aspects of population activities; and (e) special target groups. Among the measures relating to the family planning delivery are: expansion of the service infrastructure in the public and private sectors, improved dissemination of information, development of personnel and improved research and evaluation.

More recently, the inequitable population distribution among regions and among urban and rural locations came to be seen as a problem to be addressed by the national population policy. As a result, the Population Plan advanced several objectives relating to the population distribution, which called for: (a) a pattern of population distribution and human settlement that would be consistent with existing resources, job opportunities and national security concerns; (b) a pattern of population distribution and human settlement in urban areas that would prevent environmental degradation and make energy conservation possible; and (c) a more balanced distribution of the educated population throughout the country to achieve a more equitable pattern of socio-economic development.

A series of instruments has been used to meet the objectives for population distribution and human settlements. They include, for example, measures to improve conditions for agricultural production in underpopulated, potentially productive rural areas and to enable low-income populations living in high density areas to move into targeted agricultural zones. The measures also include investment in social and economic infrastructure in low density urban areas as a precondition for industrial investment and employment generation in those areas. Other measures include investment in educational facilities in rural areas.

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Part III

Population Program Profile

Population Data Collection and Analysis

Thailand's population policies, plans and programs, as discussed in the previous sections, are based on systematic assessments of statistical changes in the population structure as reflected in numerous national surveys. In itself, Thailand's present statistical system is a partially centralized one. Although the law authorizes the National Statistical Office under the Office of the Prime Minister to be in charge of all statistical development activities, many statistical activities, and data collection in particular, are done by various statistical units under the government's respective ministries. However, statistical coordination and standardization are kept under the responsibility and control of the National Statistical Office (NSO).

To increase the quality and quantity of population data analyses undertaken within the NSO and other government agencies, many microcomputers are being used by the NSO both in the division in charge of census and surveys and also in provincial offices. In addition, training courses are offered by the NSO in the general use of microcomputers, the setting of standards for demographic and statistical data sets, improvement in timeliness for data distribution to users, and so forth. These and other efforts facilitate the government in upgrading the quality of population data and its analysis and in widening its dissemination for use by key policy makers and planners in public and private sectors.

The primary sources of population data are nationwide censuses conducted every ten years. In addition, several nationwide surveys have been conducted such as: a) three dual-record surveys of population changes conducted in 1964-1967, 1974-1976 and 1984-1986, b) two longitudinal surveys conducted in 1969-1970 and 1972-1983; c) the World Fertility Survey or "The Survey of Fertility in Thailand" in 1975; d) three contraceptive prevalence surveys undertaken in 1978-1979, 1981 and 1984; e) the Demographic and Health Survey in 1987; f) the labor force survey conducted in three rounds every year; g) a socio-economic survey conducted every two years; h) a survey of children and youth; i) a survey of health and welfare conducted every five years; j) a migration survey every two years; and k) a housing survey and survey of population change within the census period, the most recent of which was conducted in 1990. The result of these surveys is a set of population data and a series of demographic and related statistics which serve as the basis for the national planning and policy making process.

Thailand also has many research and training institutions in the fields of population studies, social science research and reproductive health research, to name only a few, who make use of these population data sets. These research units are located both in the Bangkok Metropolis and in various regions throughout the country. During the last decade especially, data obtained from surveys and ten-year censuses have been analyzed by scholars working in various research fields from Thailand and abroad. Thailand's demographic surveys, in particular, have been intensively analyzed, while its contraceptive prevalence surveys continue to provide a model for other nations.

Besides population censuses and surveys, statistics are also collected as part of the

national registration system. In Thailand, the civil registration system has long been established (1916), although it is considered to be incomplete in providing reliable measures of fertility and mortality. Nonetheless, it does provide time series data sets for certain vital statistics. The registration system will be improved to the point where it can be used to study annual changes in fertility and mortality, including relevant issues such as changes in distributions of birth orders and in causes of death.

In looking at population changes over time, it is quite evident that Thailand is now a country in transition, not only in terms of its population structure, but also with respect to other aspects of social, economic, and cultural life. Consequently, the Seventh Plan (1992-1996), which began in October 1991, calls for greater research into the interrelationships between population and economic development, human resource development, and the environment. While these research studies are important, though, presently the greatest necessity in Thailand is for behavioral research into the social and cultural underpinnings and processes influencing various population, socio-economic development and health and nutrition developmental trends. For instance, population aging continues to be an important research area, although several studies have already been conducted in Thailand. Special topics requiring further study under this area include problems of the elderly in areas of heavy out-migration, changing family dynamics in the context of rapid economic growth and urbanization, implications for the living arrangements and care of elderly, behavioral patterns relevant to family planning, and the cultural underpinnings of higher fertility among minority groups. Furthermore, AIDS has also become a paramount issue for investigation. All of these various research areas and fields of interest fall within the nation's Seventh Five-Year Development Plan and are aimed towards Thailand's many research institutions.

Population Distribution

Thailand's population is not evenly distributed. The Central region, excluding Bangkok, is the most densely populated, while the Northeast has the largest number of people, and the South has the least population. Either as a city or a province, Bangkok has the largest population number and it is the most populated area in Thailand. As a city, it is can be classified a mega-city with a population that is 22 times larger than the second largest city of Nonthaburi Municipality. As a province, Bangkok's population is more than twice that of Nakhonratchasima, the second largest province.

Government policies concerning population distribution were first mentioned in the Third National Economic and Social Development Plan (1972-1976). It dealt with the high rate of in-migration from rural to urban areas which caused problems in the receiving areas such as unemployment, housing, crime, etc. Since then, population distribution policies have been explicitly stated in the Fourth, Fifth and Sixth National Economic and Social Development Plans. These policies were designed to slow down the high population growth of Bangkok due to in-migration. The policies ranged from setting up growth poles in every region in order to absorb labor within the region, developing these growth poles as the

centers for economic and social development as well as administrative centers of the regions, promoting satellite cities around Bangkok to absorb labor from other parts of the country, developing the Eastern Seaboard and areas of the South as new development zones, accelerating rural development, discouraging industry or industrial expansion in Bangkok, and providing incentives for industries who locate outside of Bangkok. In total, these policies were successful in reducing Bangkok's population growth rate but the rate of reduction was not large enough to bridge the gap between Bangkok and other areas.

The Seventh National Economic and Social Development Plan (1992-1996) does not explicitly state any population distribution program. However, many population distribution policies are continued from the previous Sixth Plan but under the banner of economic and social development. These policies include developing linkages between the Eastern Seaboard and Bangkok including its peripheral areas, restructuring agricultural production and decentralizing industry and services, and developing growth poles as the centers for economic development and employment of the regions. Certainly even under other programs, these policies would have a direct impact on population distribution.

Recently, the Government announced a new industrial decentralization scheme of investment promotion zones: Zone 1 (Bangkok), Zone 2 (provinces surrounding Bangkok), and Zone 3 (remaining provinces). These zones encourage industrial development outside Bangkok by granting higher tax and duty privileges for promoted industrial zones. Zone 3 is given the highest tax privileges, while Zone 2 receives half of these privileges, and Zone 1 receives none. A recent increase in the number of Zone 3 industrial investment applications to the Office of Board of Investment indicates that the country's population distribution will improve in the future.

Internal and International Migration

The role that internal migration plays in undesirable patterns of population distribution is fully recognized by the government. However, no policies are applied which directly intervene in the migration decisions of individuals. There are no legal or administrative restrictions to geographical mobility. Instead, indirect policies, primarily aimed at affecting the location and development of economic activities, have been instituted with the aim of affecting internal migration. All Five-Year National Economic and Social Development Plans since the Fourth Plan (1977-1981) have included polices designed to promote economic growth outside of Bangkok, to discourage the expansion of industry within Bangkok, and to decentralize government services.

These policies, outlined in the previous section, have as a major aim the redirection of migration away from Bangkok to regional centers. By building infrastructure and providing investment incentives to industries that locate in provincial areas, new employment opportunities will be generated and this will reduce the need for the rural population to migrate to Bangkok in search of jobs. There are some indications that these policies are

having an effect, with growth rates of regional growth centers exceeding those of Bangkok, although levels of migration to Bangkok remain high.

Many of the government's social and economic policies will have an affect on levels of internal migration. In particular, one of the main objectives of the Seventh National Economic and Social Development Plan is to increase the quality of the population's human resources. Human resource development is also associated, in most contexts, with increased geographical mobility. For example, the current policy to increase the transition rate from primary to secondary school from 46 percent to at least 73 percent by the end of the Seventh Plan will create a more mobile labor force and a more highly educated one in search of more suitable work opportunities. The government recognizes the need to support regional development so that the expected higher levels of mobility of the Thai population will not be directed towards Bangkok as in the past.

Policies designed to improve the quality of life of the poor, while not in most cases targeted at migrants, often affect this group because of their geographical concentration. For example, policies aimed at improving living conditions of slum dwellers by increasing access to health and educational services cater to large groups of migrants. However, it is also recognized that many of these services do not reach the large numbers of temporary migrants who spend part of the year living in large cities. For specific services, such as the provision of family planning and AIDS information, some attempts have been made to reach these groups by targeting workplaces in which temporary migrants can be found.

One area in which government policy has a major impact on internal migration is through rural resettlement schemes. In the past, the opening up by the government of new areas for agricultural production was an important contributor to the high levels of rural to rural migration that has been observed in Thailand. While the expansion of agricultural frontiers is no longer a significant factor in migration patterns, the need to resettle persons who have encroached on land set aside as national parks, watershed areas or designated forest reserves has been recognized. In the Sixth and Seventh Plans, the adverse environmental consequences of this encroachment are recognized and policies designed to move people from these areas to other areas where they are provided with land are proposed. Several projects which are designed to provide land to the poor and landless who are currently living in these areas have been initiated. This has resulted in large numbers of the rural population being moved. The main resettlement scheme is currently being reformulated.

International migration from Thailand is not regulated and hence data concerning the international movement of Thais is difficult to obtain. Most persons who leave do so on the basis of short-term contracts for employment in foreign countries. There are also large flows of illegal migration, especially to countries in East Asia and neighboring countries. The government recognizes the benefits at macro and micro levels of the legal international employment of Thai labor and has initiated a number of policies designed to encourage the extent and direction of movement, to protect the interests of workers both before and during migration, and to assist in the reintegration of workers upon their return. The benefits from migration include foreign exchange remittances by workers, the learning of new skills by workers overseas, and reductions of pressures on the local labor market. The specific

policies adopted by the government include implementation of bilateral negotiations between Thailand and other countries in order to encourage the use of Thai labor. Since the Sixth Plan, the policy has been to diversify the markets for Thai labor from the Middle East to other regions. Recent negotiations have concentrated on improving access to East Asian labor markets. Efforts have also been made to improve monitoring systems of workers in foreign countries so that problems can be quickly responded to and information on changes in labor market demands can be communicated effectively to Thai workers. The government has also attempted to set minimum conditions for employment, including wage levels and benefits, so that Thai workers will be protected. Skilled labor is to be tested and the level of skills certified. Policies for the establishment of registrars of skilled labor have been adopted. The aim of this policy is to ensure that receiving countries are aware of the availability of skilled labor in Thailand and can be sure that the labor that is provided meets acceptable standards.

Another area of governmental concern is the protection of workers' interests before they leave Thailand. The government has an active policy of reducing the recruitment costs that workers have to pay agencies. These costs are fixed by law, and policies have been implemented to help workers obtain the money to meet the costs. Labor recruiting agencies are licensed and are regularly monitored in order to ensure that they are meeting the required standards. The government has a policy of providing information at the village level to potential job seekers about the opportunities available, costs of and procedures for recruitment.

In the Sixth Plan, the importance of providing workers with language and other work skills necessary to compete in the international labor market was recognized. In the Seventh Plan, the need to upgrade the labor skills of Thai workers seeking to work overseas was also stated. It is anticipated that some of the traditional markets for Thai labor, especially in the Middle East, would become smaller, and therefore to maintain the level of remittances, it would be necessary to provide higher quality workers.

A major concern of the government has been the large numbers of illegal immigrants residing in Thailand. Disparities in levels of economic development between Thailand and neighboring countries has resulted in increasing flows of illegal migrants into the country. Thailand is also used as a staging area for illegal immigrants moving on to other countries. An active policy of enforcement of immigration laws is followed, with illegal immigrants being apprehended and deported. Problems resulting from large numbers of refugees have been eased with the successful repatriation of Cambodian refugees during the last year, although there still exists refugee groups from Myanmar and Laos.

In summary, forces affecting internal movements within Thailand and international movements from Thailand are largely determined by market mechanisms and are not directly regulated by the government. For both types of movement, the government has preferred outcomes. For internal migration, the preferred outcome is a slowing of movement to large urban centers while encouraging international labor migration. To achieve these outcomes, however, mainly indirect policies are pursued. For internal migration, this involves attempting to influence the location of economic activities, while for international migration the government primarily plays a facilitating and protective role.

Mortality and Health

Among the components of population change, mortality has historically played an important role in determining population growth. The rapid decline in mortality in Thailand over the past 30 years has led to a high population growth rate with serious consequences. An examination of mortality trends estimated from various sources indicates that the mortality transition in Thailand began around 1950, with a decline in crude death rates from 27 in 1948 to 18 in 1955.

During the first phase of the transition (1947 to 1960), an 11 year gain in life expectancy at birth was noted. Mortality continued to fall steadily after 1960 although, in more recent years, this decline has started to level off. During the same periods, infant mortality, one of the most revealing health indicators, declined substantially. Based on direct and indirect measures of infant mortality, the estimated rate in 1992 was 35.5 per thousand live births. The current crude death rate is 5.9 per 1,000 population and the life expectancy at birth for males and females in 1992 and 66 years and 71 years respectively. From 1980 to 1990 male and female life expectancy increased by about 3 years. Socio-economic, regional and rural/urban differentials in mortality remain, however. Important differentials can also be found for education, occupation, housing characteristics, and environmental factors.

Results from several studies which have investigated sources of death reveal changes in the leading causes of deaths in Thailand since the 1970s. During the present decade, non-infectious diseases and accidents are increasingly important causes of death, and they have become one of the nation's most unsolved health problems. Infectious diseases, namely, pneumonia, diarrhea, diseases of the digestive system and viral diseases, remain as major health problems among the underone and underfive year old population groups. Regional differences in causes of death among the general population are correlated with the degree of social and health development of each region. A new factor in mortality patterns is the growth in the AIDS epidemic. It is estimated that if current sexual behaviors do not change by 1993, two to four million Thais will become infected by the year 2000. During that period, 650,000 AIDS cases and 560,000 AIDS-related deaths are projected to occur.

To solve such public health problems and improve the health status of the Thai population, health development policies have been included in all of the National Five-Year Development Plans. The first national health development plan, which was part of the First Five-Year National Economic Development Plan (1961-1966), came into operation in 1961 and emphasized the construction and expansion of health facilities. During the Second (1967-1971) and the Third Plans (1972-1976), health itself was recognized as an important part of the social sector together with education and social welfare. These plans accelerated the growth of rural health and medical care and stressed the improvement of existing services, especially for low income groups. Public health activities were expanded, medical care services improved, and research in the medical and public health fields was expanded. Coordination between planners at national, regional and provincial levels improved, resulting in an increase in resources available for health activities. Emphasis was also placed on maternal and child care and family planning, communicable disease control and eradication,

improvement and expansion of medical care, development of environmental health, integrated health services and health manpower development, public participation, and community psychology and mental health.

Even though planning targets were achieved in the Third Plan, health service coverage was still only 15 percent. A substantial difference in coverage between urban and rural areas was observed and targeted for improvement. Accordingly, the Fourth Development Plan (1977-1981) committed itself to provide health services, including health prevention, curative care and health promotion to all of the population, especially to those living in rural areas. It also aimed at improving the health service system both in government and private sectors.

The major effort in the Fourth Plan was the Primary Health Care program. It aimed to recruit villagers and train them as village health volunteers (VHV) and village health communicators (VHC). The government, through the Ministry of Public Health and other health-related ministries and agencies, began a series of steps to develop national commitment, strategies and action plans in order to reach the goal "Health for All by the Year 2000" (HFA/2000).

The Fifth Plan aimed at rural development and undertook a commitment to attain the target of HFA/2000. This Plan included a national drug policy and a traditional medicine and self-reliance policy. The health service network, which includes community hospitals (formerly district hospital), health centers, VHCs and VHVs where seen as the basis of primary health care. The Fifth Plan also used an interdisciplinary strategy as the approach to rural development. Targets were set to construct community hospitals and health centers in all districts and tambons (subdistricts) in the country. Recruitment and training of health volunteers in every village and community participation in health development were claimed as new policies in the Plan. Community members were to be taught to be aware of their problems and realize how to solve them in coordination with government support.

The government also took on a target-specific approach where specific poverty-stricken districts were identified, and then needed services and resources were funneled to them. Social programs were introduced into these areas such as primary health care, nutrition development, clean water supplies, and community hospital construction. A special government budget was allocated to this program of rural development, with coordinating efforts among the four main ministries (Health, Education, Agriculture and Interior). During the Plan, the Ministry of Public Health included two more programs into this development plan: a program on immunization, and one on maternal and child health. For the Sixth Plan (1987-1992) no new policy was established, however emphasis was placed on continuing the former policies, especially those from the Fifth Plan.

To ensure that the Thai population's quality of life and health (both physical and mental) is continually developed in order to attain the global goal of HFA/2000, the Seventh National Health Development Plan (1992-1996), or the latest plan, is based on coverage and quality, integrated development, relevancy to local needs, and self-reliance. Policies of the Seventh Plan center on the following.

1) Support the continuity of primary health care in rural areas, develop and enhance its diversification and expansion to the urban area.

2) Improve the quality and efficiency of health services at all levels by developing the lower tier of health services to cope with endemic diseases and emergency care in order to reduce the heavy utilization of hospitals in major cities. This includes development of provincial hospitals and improvement in the efficiency of the referral system.

3) Provide services to all of the Thai population especially the poor, laborers (inside and outside the country), the elderly, children, the disabled and the underprivileged to ensure that they receive health services in preventive, promotive, rehabilitative and curative areas.

4) Improve the efficiency of the health administration and regulations related to health administration development. This entails improving the organization and structure of the health service system to enable it to solve the more severe problems which occur during the Seventh Health Development Plan, such as problems related to consumer protection, occupational health, environmental health, mental health and AIDS.

5) Mobilize and develop resources to support the development of an adequate and high quality health care system in order to solve problems efficiently.

6) Improve and develop the efficient dissemination of health information to the general public in order to change their behaviors to assure good health.

7) Develop and promote the use of science and technology. This encompasses supporting research for health development which is based on gradually increasing self-reliance in the long-run.

8) Improve laws and regulations to facilitate health development.

The main targets of the Seventh Five-Year Health Development Plan (1992-1996) are: 1) reduce the infant mortality rate to 23 per 1,000 live birth; 2) reduce the maternal mortality rate to 0.3 per 1,000 live births; and 3) reduce the mortality rate of children aged below 5 years to 35 per 1,000 live births

In conclusion, the national health policy of the country is based on ensuring the quality of life of the population, with both physical and mental health policies directed towards the attainment of the long term goal of HFA/2000. These targets are to be achieved through a basic minimum needs approach and under the principle of social justice and self-reliance of the individual, family and community.

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Part IV

Multi-Sectoral Components

Introduction

A key part of Thailand's success in population and development is the multi-sectoral component approach it has taken in planning and implementing policies, plans and programs aimed at rectifying the nation's most urgent problems. This part of the report discusses six of the most immediate target areas that the government is now embracing using this multi-sectoral component approach.

Population Research

In the Seventh National Economic and Development Plan (1992-1996), three main aspects are focused upon: to maintain the economic growth rate at an optimum level, to distribute income and development to regions and rural areas, and to develop human resources, quality of life and environment. The Plan also provides specific objectives and strategies on human resources, education, public health, mental health, culture, and social development. Quality of life and the environment are being developed along with socio-economic development. Along these lines, population research concentrates on finding ways to improve the quality of life in accordance with the nation's current situation and the national plan. The focus of current population research can be summarized into five main areas.

Sexuality and AIDS. This has become an urgent problem affecting individuals, families and society as a whole. Strategies to prevent and solve this problem are in great demand.

Demographic Transition and the Family. Thailand has been very successful in reducing the population growth rate within a short period of time. The next step is to improve quality of life, especially within the family, which is the basic social unit. Research in this area includes studies on family planning and fertility, nuptuality and family maintenance, adolescent studies, and ageing of the population.

Population and Health. It is well-accepted that a physically and mentally healthy population is essential for development. Research in this field works to support and improve the health of rural and urban populations.

Migration and Urbanization. With industrialization, Thailand has experienced a massive influx of rural migrants to urban areas. This has affected employment, income, and living conditions of the population of both at rural points of origin and urban destinations. Understanding the mobility process is therefore critical.

Population and the Environment. The environment has become an important issue because of interrelationships, both direct and indirect, between environmental change and the quality of life of the population. Population processes are themselves one of the major causes of environment problems. Research studies into these areas are required to reduce the negative impacts.

Population and the Environment

During Thailand's recent years of rapid economic growth, the economic structure has become increasingly oriented towards the modern industrial and service sectors. At the same time, traditional rural agricultural society has steadily been moving towards an urban industrial orientation. As a result of these and other forces, environmental quality has deteriorated, with increasingly serious pollution problems.

Rapid economic growth associated with urbanization and industrialization has had serious implications for natural resource and urban environmental situations. In rural areas, rapid forest depletion and related soil degradation, mainly because of unsustainable agricultural practices and commercial logging, are placing these natural resources in jeopardy. Forest cover has declined substantially. Flooding and other natural disasters also pose a major challenge. Water supply and distribution for rural and urban use is becoming a major problem, in part as a result of climatic vagaries but also due to ineffective management of water supplies.

In the Seventh Plan, broad measures are envisaged to protect the environment and manage the use of natural resources. Although several environmental laws and regulations have been enacted, they have not been strictly observed nor enforced. The Seventh Plan, however, proposes to adjust and enforce standards. Community and local organizations will be mobilized and young people trained to participate in environmental protection and conservation of the natural heritage. High priority will be given to prevention of air pollution and water pollution caused by factories and toxic waste.

Ageing

As of 1980, Thailand's age structure resembled fairly closely that of the world's less developed regions taken as a whole where 6 percent of the total population was aged 60 and over. Thailand is now experiencing unusually fast growth of the elderly population, however, in comparison to other less developed countries. During the 1970-80 decade, the 3.9 percent annual growth rate of the population aged 60 and over in Thailand exceeded considerably the 2.7 percent rate for the elderly population of the world's less developed regions as a whole.

Given the disproportionately large increases projected for the elderly, their share of the total population will increase. The population aged 60 and over will grow from 5 percent of the population in 1980 to 9 percent by 2010 and to 13 percent by 2020. Thus the Thai population will become noticeably older in the next few decades provided fertility remains low and mortality continues to improve. The elderly population itself is projected to age somewhat with the population aged 75 and over representing a slightly larger percentage of the total elderly aged 60 and over in the future. The sex ratio of the elderly (males per 100 females) is not projected to change very much with the deficit of men relative to women

persisting at about the same relative level throughout the period covered by the projections.

In Thailand the main institution responsible for care of the elderly is the family. Most elderly (over three-fourths) live with their children. Government services for the elderly are quite limited although effort is being made to expand free medical care. Only a few token institutional residences have been established for elderly who are unable or unwilling to live with their families or on their own. These government homes house less than 2,000 residents, only a fraction of one percent of the total elderly population. Given the rapid increase in the absolute size of the elderly population that is certain to occur in the coming decades, any meaningful shift of responsibility for their welfare from the family to the state will require massive outlays of government funds. Undoubtedly in recognition of this, the current Seventh Five-Year Plan (1992-1996) of the Thai government and the latest official declaration on Long-Term Policies and Plans for the Elderly (covering 1992-2011) appear to rely on and emphasize the responsibility of the family for providing welfare for elderly members. While social security schemes to provide old age financial assistance are scheduled to be implemented by the end of the decade, details of such schemes are still under discussion.

Adolescents and Youth

Adolescents and youth in Thailand are people aged between 13-25 years. According to the 1990 Population and Housing Census, the number of youth (age 15-25 years) was 11,459.8 thousand people. An adolescent and youth development plan for Thailand was first integrated into the Fourth National Economic and Social Development Plan (1977-1981) as a manpower planning effort. After that, a long-term Policy and Plan (1982-2001) and the Five-Year Plans on Children and Youth Development were formulated and became parts of the Fifth, Sixth and Seventh National Economic and Social Development Plans (1982-1996). These plans addressed six developmental areas: 1) youth and health; 2) youth and education; 3) youth and employment; 4) youth and morals; 5) youth, government and politics; and 6) youth and resources.

Population changes and the nation's social and economic situation impact greatly upon adolescent and youth development. The decline in youth segments of the population, an increase in urban youth numbers, the country's transitioning from an agricultural to an industrial society, and the rapid economic growth rate have significantly influenced the youth situation in terms of illness and death associated with industrialization and urbanization, increasing demands for a specialized and well-educated work force, people's values and lifestyles tend to move towards greater individualism, materialism, consumerism and self-interest. Five major problem and need dimensions now exist with respect to adolescents and youth.

Physical, mental, health and nutritional well-being. Morbidity and mortality rates are still high especially in terms of communicable diseases, AIDS, mental illness, accidents

and injuries from poisonous chemicals, occupational hazards, and pollution. At the same time, the physical fitness of adolescents and youth is still lower than the standard, and they continue to face nutritional problems such as micronutrient deficiencies and over-nutrition.

Intellectual capacities. Inadequate levels of educational services and support for out-of-school youth, limited knowledge levels regarding science and technology, and little support for talented youth exist as major problems in this dimension.

Occupational preparation. Several deficiencies persist in this area including insufficient training in the knowledge and skills needed for work and occupational advancement, unemployment among out-of-school youth, and poor working environments.

Social, cultural, moral and political problems. This wide-ranging dimension includes a lack of proper personality and awareness such as in the areas of constructive initiatives, innovation, analytic, synthetic and scientific mindedness, systematic problem solving and discipline, constructive use of time, lack of awareness on environmental and natural resources conservation, cultural preservation, a declining faith in morality, ethics and values, lack of a proper understanding of political affairs, leadership, self-confidence and nationalistic sentiment.

Children in especially difficult circumstances (CEDC). Children in especially difficult circumstances include those children and youth who are encountering extreme hardships and are in need of societal assistance. These individuals can be categorized into four main groups which, to a certain extent, overlap: abused children and the exploited, abandoned children, children participating in criminal or other socially unacceptable behaviors such as drug abuse and prostitution, and disabled children.

Four main approaches are being used to address the problems of adolescents and youth in Thai society: 1) social mobilization to motivate people, institutions and organizations responsible for adolescents and youth to be well aware of the current situation as described above and then take an active role in youth development activities; 2) pooling of resources from GOs and NGOs for adolescent and youth development; 3) creating among adolescents and youth an increased awareness of their rights, duties and obligations towards self-development and society; and 4) implementing policies and measures for the benefit of adolescent and youth development.

These four approaches are in line with seven main objectives: 1) accelerate pre-school education for children aged 0-5 years; 2) extend basic education from 6 to 9 years for children age 6-14 years; 3) expedite the number and quality of vocational training opportunities for out-of-school youth (14-25 years); 4) develop to the utmost young people's attitudes, values, ethics, culture and democratic ways of life; 5) increase rapid prevention and control measures for AIDS/HIV among adolescents and youth; 6) increase rapid protection, prevention, cure, rehabilitation and development for CEDCs in such areas as child labor, child prostitution, drug abuse, etc.; and 7) promote, in close cooperation with business and industrial sectors, intelligent and gifted adolescents and youth to achieve their fullest potential.

Working to fulfill these approaches and objectives are not less than 46 governmental departments and more than 20 NGOs who are working in over 400 child and youth development programs and projects. These include the following.

Physical, mental, health and nutritional development. At least 19 organizations (departmental level) are involved in 75 projects/programs in the area of physical and mental health with a budget of over 30.952 billion baht for 5 years (1992-1996). Eleven organizations are focusing on nutritional improvement in 25 projects/programs using 2,042 billion baht. These projects/programs address information, education and communication on nutrition and correct food and drug use. The projects/programs on health concern the subjects of family planning, mother and child health care, EPI, prevention and control of AIDS/HIV and accidents.

Intellectual capacity development. Over 10 organizations with 113 projects or programs using over 342,058 billion baht for 5 years are working on expanding educational opportunities for in- and out-of-school youth. These include promoting local youth centers, providing education for gifted and talented children and youth, and improving access to the education for local communities.

Vocational and occupational development. Twenty-six departmental organizations with 74 projects/programs and over 34,868 billion baht for 5 years are working on preparing adolescents and youth for the labor market, providing occupational training and job placement, and improving occupational health conditions.

Social; cultural, moral and political development. Thirty-three departmental organizations with 96 projects/programs using over 3,070 billion baht for 5 years are placing their efforts on promoting society's principle institutions like family and religious institutions, improvement of learning and teaching methods on religion and ethics in educational institutes, and instilling moral and values for young people.

Special adolescent and youth group. Over 18 organizations with 87 projects/programs and over 5,188 billion baht are working to provide protection, prevention, rehabilitation and development services for children in especially difficult circumstances. This includes improving their access to social services such as family guidance and suppressing children and youth exploitation practices.

Women in Development

Women are key leaders in Thai society, and the nation cannot achieve its development goals without the true participation and cooperation of women who assume many of society's most important roles: wives, mothers, labor force participants, and citizens. About half of the Thai population is comprised of women, and their human resources should be developed to their fullest potential. Moreover, women should not only become the targets or beneficiaries of development, but also significant contributors. The development of women's quality of life and their livelihood potentials, therefore, will benefit their families and Thai society as a whole.

Thailand is committed to achieving several policy objectives related to developing women's fullest potential in terms of physical, mental, intellectual, aptitude, talent, emotional

and ethical dimensions. These will be accomplished through the provision of economic and social services, offered by both government and non-government agencies, and which are accessible to all women. In addition, greater efforts will be directed towards promoting a better quality of life for women, and encouraging them to participate in formulating social directions, as well as community and national development. Also crucial is promoting equality between men and women and to eliminate discrimination against women, both *de jure* and *de facto*, especially for those who are employed and those in the disadvantaged groups. This will entail especially offering women protection in various circumstances and enhancing social thoughts and values related to the acceptance of the worth of women, their ability to think as well as to work. In Thailand's fast paced society, it also is becoming ever more important to also protect women from various abuses, since as human beings they have dignity. Such protection also covers women in the work places as well as women as mothers. One final objective is to promote the participation of women in all aspects of life: economic, social, political, family, community, at national and international levels. In particular, they must participate in the tasks of carrying out responsibilities and in the decision-making processes of political development, environmental protection, religious and cultural development, family development and mass media development.

Several basic strategies to promote women need to be developed or strengthened to achieve the above objectives. First, governmental central organizations or other mechanisms responsible for women in development should be further developed and promoted. In particular, to develop human resources will also require conducting training in various subjects so that women can have the knowledge and skills to determine societal changes. Government agencies also need to be persuaded to include women in their projects and activities, and formal and informal groups should promote the protection of women. Also important is promoting policies related to women as a part of political platforms belonging to all political parties.

Networking among governmental as well as non-governmental agencies should be established. Coordinating and networking should be on horizontal and vertical levels, all the way to the village level. One particular aim should be to establish a systematic exchange of information on innovations used for women in development. This distribution and dissemination of information will help change the image of Thai women especially in the international community.

The initiation of programs and projects with special reference to women are of high priority as is integrating women in all programs and projects, both as beneficiaries as well as agents of development. Campaigns for values and attitudinal changes related to women are paramount, especially those aimed at changing negative connotations or stereotypes. Pressure groups should be formed to encourage and open ways for women to participate more fully in economic and social development.

Furthermore, the family should be seen as a common social unit for promoting developmental equality, and elimination of gender-based biases especially for children and youth. This will call upon revising laws and regulations to facilitate equality.

Recognition of the importance of information is crucial as is the use of mass media with special emphasis on women's issues and the status of women in order to create a

common understanding and common needs so that goals can be achieved. To better understand the position of women in society and their needs, efforts need to be directed towards collecting and analyzing information on women in development as well as the promotion of research related to women.

In all of these undertakings, men should also be encouraged to equally participate along with women in order to break the gender-specific barriers and close the inequality gap.

HIV/AIDS

In Thailand, the first AIDS cases were reported in 1984 amongst homosexuals, and the disease then spread rapidly among intravenous drug users (IVDUs), commercial sex workers (CSWs), male customers of CSWs, and eventually to the wives of these men. Presently, the virus has spread rapidly among different population groups including adolescents in every province. The Ministry of Public Health has reported at least 200 cases of full-blown AIDS. The Thai Working Group on HIV/AIDS Projection estimated for 1991 that the total number of HIV infected persons was between 200,000 and 400,000. By the year 2000, it is estimated that two to four million persons will have become infected. If these projections are accurate, by the year 2000 one in three deaths will be caused by AIDS.

In 1989, Thailand began a medium-term plan on AIDS. At that time, AIDS was viewed as a medical problem. However, as AIDS has spread to wider and wider circles, it has become clear that its impact will have far-reaching social ramifications. A greater understanding emerged that AIDS was spread by individual behavior and reflected the larger social problems of the country. It was acknowledged that AIDS can be prevented and controlled given an appropriate set of guidelines for educating the general population and certain target groups.

The Thai government gives high priority to solving the AIDS problem according to the first policy proclamation. The National AIDS Prevention and Control Committee chaired by the Prime Minister emphasizes the need for total cooperation among all sectors of society including public and private sectors. The Committee has formulated a National AIDS Prevention and Control Master Plan under the framework of the Seventh Five-Year National Social and Economic Development Plan. The purpose of this plan is to promote a unified and coordinated approach to implementation by government and private sectors.

The National AIDS Prevention and Control Plan (1992-1996) has three main objectives: 1) to reduce HIV transmission as much as possible, down to a manageable level; 2) to promote understanding among the population and to provide assistance to HIV infected persons in living normally in society without societal stigmatization and discrimination; and 3) to mobilize resources and personnel from governmental, non-governmental, and international agencies to cooperate in the prevention and control of AIDS in Thailand.

The main strategies being used to achieve these objectives include: 1) emphasizing

disease prevention through public information campaigns that yield correct knowledge and understanding of AIDS, and encouraging modification of relevant behaviors and attitudes, including non-discrimination against those infected; 2) supporting diagnosis, treatment and care services that are appropriate and impartial in their continuous application; 3) supporting the protection of human rights and providing appropriate social support; and 4) supporting research, monitoring and evaluation activities.

These strategies are incorporated into four main programs. First, regarding *public information and education*, there are guidelines and measures for providing knowledge and in promoting a correct understanding of AIDS in the areas of prevention, non-discrimination against infected persons, and changes in behaviors, norms and attitudes as well as awareness of individual responsibility and human rights.

For *medical treatment and care*, guidelines and measures have been formulated for the non-discriminatory provision of diagnosis, treatment and care. There will also be preparatory and supportive services for families of infected persons, communities and the private sector in providing for the HIV infected and AIDS persons.

Within the *human rights and social support* program, there are guidelines and measures to ensure that the rights of individuals are protected whether or not they are HIV infected. The patient and family are entitled to an appropriate level of social support.

Lastly, for *research and evaluation*, guidelines and measures also exist in providing support for research into interventions and solutions to the AIDS epidemic. Also, there must be active monitoring and evaluation of all aspects of these programs and activities.

The National AIDS Prevention and Control Plan also provides guidance for public and private sectors to formulate their own activity plans at the ministerial, provincial and district levels. This is to ensure a coordinated and unidirectional effort that is consistent in goal and strategy, with clear principles and continuity of effort. If properly implemented, these plans should slow the spread of HIV/AIDS in the society and reduce the eventual social and economic impacts of AIDS on the nation.

Several areas of progress show that the Plan is having a positive effect. In terms of *structural enhancement*, the establishment of the National AIDS Prevention and Control Committee has facilitated leadership from the top-level of the government and widespread participation, including active involvement from all ministries, in AIDS prevention efforts in Thailand. Decentralized participation in planning AIDS activities through Ministerial and Provincial AIDS Committees also improves the effectiveness of AIDS prevention efforts. In 1993, this has also included the district level.

For *institutionalization*, this decentralized structure facilitates both top-level leadership and widespread participation, and it has been institutionalized to maintain specific planning and coordination functions over the long-term. Recent Cabinet resolutions have also institutionalized the National AIDS Prevention and Control Plan as the national policy guidance instrument. The AIDS Policy and Planning Coordination Bureau was established in 1992 to implement AIDS related activities in the Office of the Permanent Secretary under the Office of the Prime Minister.

Condom use increase/STD incidence decrease. The MOPH has reported drastic increases in condom use over the past few years. Condom distribution by the MOPH itself

has increased from 5-10 million pieces annually in the past several years to 60 million pieces last year and another 50-60 million condoms sold through commercial channels. Simultaneously, the incidence of sexually-transmitted diseases has decreased. HIV prevalence among IVDUs and female CSWs has stabilized or even declined in some provinces. With 100% condom use programs implemented in all provinces, the government expects that these trends will continue to increase this year reinforcing a belief that condom use behavior among Thai males may be changing.

Knowledge of AIDS has increased on a wide scale. A large majority of the Thai population has a basic knowledge about AIDS due to wide-spread information dissemination through multiple channels. Efforts must continue in order to improve attitudes and motivation to change behaviors in ways that will significantly slow the epidemic and facilitate a comfortable life for those people infected with HIV.

In-depth training programs have been implemented by many government agencies in order to improve staff knowledge and skills in AIDS prevention and control.

Living with AIDS. Over 30 NGOs are active in promoting understanding and societal sympathy for those infected with HIV. Through this and other efforts, the government hopes to encourage the Thai people to adopt attitudes which will enable society to live with AIDS. Special emphasis will be placed on employment practices and workplace settings.

Blood screening. All units of donated blood are screened using antibody/antigen tests and cost-recovery through service charges for those who can afford them.

Behavior change interventions. The country has adopted new directions in program interventions believed to have an impact upon long-term behavior change including changing sexual norms and culture and early STD/AIDS education in primary schools.

Summary: Component Integration

Thailand has long recognized the importance of population issues, which are closely interrelated with almost every aspect of national development. In a very real sense, Thailand is already attempting to improve its population program in line with the recommendations of the World Population Plan of Action (WPPA) and many of the points called for in the Bali Declaration.

Presently, Thailand is implementing the Seventh Five-Year National Economic and Development Plan (1992-1996). The Plan's objectives are sustainable development, equitable distribution of development and improvement of quality of life, and conservation of natural resources and the environment. Population policies in the Seventh Development Plan are focused on reducing population growth, population distribution and population quality developments. The population growth rate of 1.2 percent is targeted at the end of the Seventh Plan. Strategies to achieve the target are the promotion of family planning, population education and IE&C programs. Despite a low national fertility level, Thailand still faces a regional fertility differential. Thus, the family planning program will be concentrated

in the Northeast and Southern regions where fertility levels are still higher than those of the national average. The program will focus on special population target groups such as ethnic groups and urban slum women. The Seventh Plan also attempts to preserve environmental quality along with economic development.

The broad definition of population policies includes improvements in quality of life, education, health and environment. A reduction in the infant mortality rate from 34.5 to 23 per 1,000 live births and a decline in second and third degree malnutrition for children aged 0-5 years to less than 1 percent are major targets for health development in the Seventh Development Plan. In order to improve family planning and maternal and child health services for the population, regular monitoring of program performance at local and national level through improved FP/MCH program management information systems and periodic demographic surveys are required. To increase the percentage of secondary education to 73 percent of primary education graduates is an important policy objective for educational development.

Policies on population distribution are aimed at promoting population distribution and settlement patterns according to socio-economic development and the employment situation. The population distribution strategies are urban-oriented ones, including development of regional cities, special area developments such as the Eastern and Southern Seaboards, and promotion of industrial estates in the provinces.

Due to a rapid reduction in fertility during the last 20 years, the age structure of the population is changing to one with a higher proportion of older people. The government must prepare for problems related to aging such as social security, the involvement of families in caregiving, morbidity, chronic diseases, and well-being for the aged. In addition, fertility reduction has brought about changes in the family pattern. The proportion of single-child families is becoming larger and will exacerbate the seriousness of ageing problems.

Growing urbanization, mainly caused by an influx of migrants from rural areas, is another problem to be faced by the country's policy makers and planners. The integration of population and urban planning has not been achieved in the planning process, either at the national or the sub-national level. It seems that local government officials have an insufficient understanding of this issue in the city planning context. Their awareness of urban problems and commitment to seeking solutions needs to be enhanced.

Hilltribe internal migration and immigration which greatly affects the country's forests are to be managed through a regulation and arrangement of permanent settlements for them. A policy of the Seventh Development Plan is to increase FP activities and help with socio-economic development.

At present, women account for approximately a half of the Thai population as well as nearly half of the economically active population. In some situations, exploitation is apparent, and the problems faced by disadvantaged women need to be addressed. Since the Thai Government adopted the UN proclamation of 1975 as part of the International Year of Women and the period 1976-1985 as the Decade for Women, the role and status of Thai women has gained increasing prominence. Many programs and projects have been initiated to ensure that women's concerns are integrated into all sectors of development. Long- and medium-term women's development plans have been drawn up as policy guidelines for

women's development. The women development plan is also an integral part of the current Five-Year National Development Plan. In addition, the National a Commission on Women's Affairs, whose members are from government and non-government agencies involved in policy decisions and program implementation, has been established to coordinate and monitor efforts of public and voluntary agencies to integrate women's concerns into the development process.

Thailand's youth population aged 15-24 years old, which numbers about 12 million, accounts for 22 percent of the total population. Most live in rural areas and have completed only primary compulsory education. There are serious problems in this group include drug addiction, unemployment, migration, adolescent fertility, juvenile crime, AIDS, and also exploitation. To deal with these problems, activities have been promoted such as formal and non-formal education, vocational training, on-the-job-training and other development activities.

Recognizing the considerable progress that has been made in the development of national population information systems, Thailand will continue to strengthen and extend these national programs within its framework. Technical cooperation programs among developing countries will be strengthened.

Environmental deterioration is also a very serious issues and may cause major delay in development efforts. This has been partly due to mismanagement of natural resources and the environment. There seems to be a general lack of proper understanding about the dangers posed by environmental deterioration, and thus there is a pressing need to raise national awareness of these issues.

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Part V

Population, MCH and Family Planning Program Operations

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Political and National Support

As a result of the Declaration of the National Population Policy in 1970, a National Family Planning Committee was established in that same year. The committee was composed of twenty-two representatives from various ministries/organizations which would be involved in national family planning (FP) activities and the Minister of the Ministry of Public Health (MOPH) was appointed as the chairman. The committee was responsible for proposing FP policy programs and evaluating program achievement. The composition of the committee was periodically adjusted and the recent committee consists of 24 members. Under the National FP Committee, two subcommittees were established: 1) the Technical Committee composed of 17 members primarily responsible for providing technical support to involved organizations, and 2) the Coordinating Committee composed of 18 members, the main function of which is to strengthen coordination among related government and private agencies.

The National Family Planning Program (NFPP) is the responsibility of the MOPH. Three major units are concerned with family planning activities. First, the Office of the Permanent Secretary for Public Health is responsible for all provincial public health offices (PPHOs), provincial and district hospitals, and health centers. This office is responsible for virtually all FP/maternal and child health (MCH) service delivery activities. Second, the Department of Health is directly responsible for managing the NFPP. The Director General of the Department of Health is also the Director of the NFPP. Lastly, the actual planning and management of MCH/FP services are the responsibility of the Family Health Division, a constituent part of the Department of Health. Its main functions are planning, logistic support, training, public information and motivation, research and evaluation, and delivery of services through four regional MCH Centers, district hospitals, and village health centers.

National Implementation Strategy

Since 1970, the Thai Government has declared a population policy that "The Thai Government has the policy to support voluntary family planning in order to solve the problems of rapid population growth which cause adverse effects to the economic and social development of the nation." The policy stated clearly that family planning was the main strategy to reduce rapid population growth, and the Ministry of Public Health was given the responsibility for establishing the National Family Planning Program (NFPP). Ever since the Third Five-Year Development Plan (1972-76), the NFPP has been designated as the principal organization for implementing the population policy. After the declaration of the policy, specific goals to lower population growth rate have been set in each National Five-Year Social and Economic Development Plan. In line with the national goal, the NFPP converted the demographic goal into FP targets to provide contraceptive services.

Throughout the next two decades, the NFPP has achieved the targets set. The success of the NFPP in recruiting family planning acceptors was due to two main activities implemented by the MOPH: 1) increasing the availability and accessibility of contraceptive supplies and services; and 2) increasing demand for contraceptive methods by supplying information, education and communication (IE&C).

To meet the ultimate goal of reducing the growth rate and increasing contraceptive acceptors, the two strategies were launched in a series of activities in each Five-Year National Development Plan. The NFPP was highly centralized; all plans and targets were set by NFPP central personnel. IE&C, training and research activities were planned, programmed and budgeted. The main role of the NFPP central office has been in supporting technical assistance services and budgeting for programs, equipment and transportation to every provincial outlet. During the last two decades, all bilateral and multilateral funding for population activities has been allocated to these activities and it continues to mount. The NFPP has become the largest financial resource of the provincial public health office compared to other health activities. The result has been an emphasis at the provincial level on family planning services.

MCH, FP and IE&C Service Delivery

Maternal and Child Health and Family Planning Services

Maternal and child health and family planning services in Thailand are a part of the nation's primary health care system. These services, moreover, are provided by both public and private sectors.

Public Sector

The first five year national health plan came into operation in 1961 with an emphasis on expanding health facilities, particularly in rural areas. Maternal and child health (MCH) and preventable disease control were the two major programs initiated to solve high maternal and child morbidity and mortality. Since the MCH program was introduced, surveys and analyses of various available records have been made to estimate changes in infant and maternal mortality. Results show that the infant mortality rate (IMR) has declined from about 84 per 1,000 live births in 1965 to 34.5 per 1,000 live births in 1991. The difference in infant mortality levels between urban and rural areas is dramatic, however, with the former showing a rate of 21 per 1,000 live births while in rural areas it is 37 per 1,000 live births. Data obtained from various sources reveals that conditions originating during the perinatal period, especially respiratory system infections and diarrheal diseases, are the major causes of death. Child mortality has likewise tended to decrease gradually.

A declining trend in maternal deaths can also be observed even though the number

of maternal deaths is believed to be under-reported and miscategorized. It is estimated that the maternal mortality rate (MMR) was less than 30 per 100,000 live births in 1989. Most deaths occurred among women of low social and economic status. The most common causes of death were hemorrhage, infection and eclampsia all of which can be preventable.

Today, the MCH program aims to reduce IMR and MMR by half the current rate at least by the year 2000. This will be accomplished by improving MCH service quality, promoting breast feeding, and strengthening nutrition programs. One of the foremost achievements of the MCH program is in the area of immunization coverage. At present, vaccination coverage in Thailand is above 90 percent for BCG, diphtheria, whooping cough, tetanus and poliomyelitis. In addition, development and strengthening of the well child care program is under way. Special programs have also been introduced including premarital counseling on family planning and heredity diseases, promoting an MCH guide book for mothers, introducing high risk factor approaches, monitoring weight increase, providing tetanus vaccinations for pregnant mothers, strengthening the referral system and encouraging community participation in MCH programs. Discussions are widely held with hospital staff and records are analyzed to identify causes of maternal and infant deaths. The vitamin K supplementation program for newborns will be strengthened. The baby friendly hospital program is being expanded to encourage exclusive breast feeding. Finally, a priority MCH program for HIV/AIDS is being launched to cope with this increasing problem.

For family planning services, the Thai government announced a policy of supporting voluntary family planning in 1970. The mandate was given to the Ministry of Public Health to be responsible for a National Family Planning Program (NFPP). As a result of this program, there has been a dramatic decline in the rate of population growth. Contraceptive prevalence surveys and reports, moreover, have shown that the rate of contraceptive use has risen sharply from 15 percent to 75 percent of married women of reproductive age (MWRA) from 1970 to 1992. The decrease in fertility through an increasingly higher contraceptive acceptance rate has reduced the burden of child raising and provided families with the opportunity to maximize their abilities to support children development. With the infant mortality rate dropping from 80 to 35 per 1,000 live births during the same period, the quality of life and health of the Thai people has clearly improved.

Operationally, the family planning (FP) and maternal and child health (MCH) programs are totally integrated into the existing health infrastructure. Information and FP/MCH services are offered through 8,000 government facilities. By 1992, 80 percent of contraceptive users (or approximately 5.2 million) and 90 percent of pregnancy cases (around 0.9 million annually) obtained services at government facilities. FP has thus been made widely known and available. All seven modern contraceptive methods such as male and female sterilization, oral pill, IUDs, injectables, Norplant and condom are accessible in both rural and urban areas throughout the country. Volunteers, who are able to provide pills and condoms, are also present in most villages. Paramedics, particularly auxiliary midwives and nurses, have been trained to deliver FP services. A program for using trained nurses to handle IUD insertion, postpartum sterilizations and Norplant insertions is being tested. The delivery of FP services has mainly been a women-to-women effort, and the array of methods ensures that women's needs are met throughout their reproductive years.

To overcome disparities in contraceptive prevalence between regions, the NFPP has redoubled its efforts and given special attention to rural low-performance areas. For example, outreach strategies have been extensively introduced. Information and services not available such as IUDs, male and female sterilization and Norplant have been delivered by mobile units in districts and villages throughout the country. The NFPP made a concerted effort to reach underserved groups with innovative programs for minorities, emphasizing an extension of MCH and family planning services, outreach factory programs, and expanded FP counseling and services for adolescents. The NFPP has also encouraged non-governmental agencies, private hospitals/clinics and pharmacies to participate in the program. The NFPP also supported non-governmental agencies with financial help and contraceptive supplies. As a result, FP services and distribution channels have expanded and contraceptives have become more available to the public.

Private Sector

Private sector primary health care and family planning services usually cover people which government services are not able to reach effectively such as rural people in remote areas, hilltribe peoples and Thai Muslims. Their scope of work mainly covers family planning, family life education, maternal and child health, and quality of life development as well as the other population-related issues like environmental conservation, AIDs prevention and so forth. Their work is conducted consistently and progressively with special attention given to keeping the public informed about FP as well as service provisioning to respond to increasing needs. Target groups cover a wide of people in all regions of the country such as children and youth, women, vocational group, special minority groups, urban/rural low-income persons, and general public.

The private sector has also provided contraceptive services through community-based volunteers which are composed of private doctors, nurses, pharmacists and rural housewives. Several projects use a community-based distribution system comprising coordinators throughout the project areas who supervise and provide contraceptives to family planning volunteer residents in each village. These volunteers are trained in family planning education and awareness and in turn educate and provide contraceptive pills to village women. Through this private community-based distribution system, family planning services are now available in 17,000 villages in 157 districts and 48 provinces throughout Thailand. This distribution system also embraces family planning and community development activities for the northern hilltribes of Thailand. Finally, a Community-Based Voluntary Sterilization Project has also been implemented to get men involved in taking responsibility in their family's reproductive health.

In addition to the above activities, the private sector has established mobile health clinics to provide primary health care services to schools, factories and slum dwellers in the Bangkok Metropolitan Area which includes Bangkok and the surrounding provinces. Within each institution, a volunteer is stationed, and he/she provides basic health care advice and services with support from visits from the mobile health van.

Family Planning Program Service Delivery

As noted above, the government sector is the major provider of contraceptives in Thailand. The two main sources of services are the 7,000 health centers and 1,000 hospitals which can be reached within half an hour.

Health Centers

Auxiliary midwives who work at the 7,000 rural health centers throughout the country are the major source of oral pill delivery particularly to rural MWRA. Surveys show that approximately 54% of current pill users have received service from health centers, 9% from hospitals and 20% from pharmacies. Rural health centers are also the major source of service for injectable contraceptives; 60% of injectable current users received the service from this source, 21% from government hospitals, and 11% from private clinics/hospitals. Health centers also provided condoms; 31% of condom current users received their supply from health centers, 12% from government hospitals and 40% from pharmacies. By 1992 half of auxiliary midwives were trained to provide IUD insertion, covering around 25% of IUD current users; 66% received IUD services from the government hospitals.

Evaluation results show that auxiliary midwives after completing grade 12 and with two years training in obstetrics and health promotion play a very important role in making temporary contraceptives available and accessible in rural areas. Over the past two decades, the NFPP has been successful in covering the country with FP services. For future tasks, a major emphasis will center on improving FP service quality at health centers.

Urban and Rural Hospitals

Government hospitals play the major role in providing sterilization services since 86% of sterilization cases have been performed by 800 government hospitals. These hospitals conducted 160,000 sterilization cases in 1986 and 130,000 in 1990. This means on average each hospital performed 170 cases per year or about one case every other day. Data analyzed from surveys reveal that only 40 percent of MWRA aged 30-34 and 35-39 years were sterilized. As the population of eligible couples aged 30-39 years is around 4 million, potential clients for sterilization total more than 2 million couples. Hospital facilities are able to cope with 3-10 operable sterilization cases per day. The main constraint of the program, however, is a shortage of physicians particularly in rural hospitals. Waiting time for sterilizations is also quite long and inconvenient to the rural acceptor. In 1983, the NFPP developed an innovative strategy which used trained nurses, who had 5 years of operating room experience, to perform sterilizations. In this way approximately 250 nurses were trained by 1992.

Insertion and removal of the Norplant implant was also initially carried out by

physicians. The NFPP conducted a pilot study on Norplant insertion using trained nurses in 1991 with positive results. Thereafter in 1992, the NFPP requested the Ministry of Public Health to authorize these trained nurses to insert Norplant. Studies showed that acceptability of the Norplant implant among clients is very high. Studies also illustrated that there was a close relationship between accessibility and prevalence. Hence, there is a need to train additional nurses in Norplant insertion to increase the method's availability and reduce the negative factors affecting Norplant acceptance, especially in terms of waiting time, supplies, and client dissatisfaction regarding choice of contraceptive methods.

IUDs were available in all hospitals before the Declaration of the Population Policy in 1970 and physicians provided the service. In 1972 the NFPP began a training program for nurses to insert IUDs. This programs still continues and by 1992 over 2,000 nurses in rural hospitals were trained. Training of auxiliary midwives stationed in rural health centers was initiated in 1976. A total of 2,000 auxiliary midwives had been trained by 1992. After training, an IUD kit was provided to each health center where the trained midwives were working. All hospitals in the province provided back up services to auxiliary midwives who provided IUD services at health centers.

Population Information, Education and Communication

As with its MCH and FP services, Thailand's population information, education and communication (IE&C) activities are also carried out by public and private sectors.

Public Sector

Thailand's FP communication program is characterized by a fortuitous combination of several factors which has contributed significantly towards its success.

1) A clear population policy was formed from the beginning and voluntary family planning was chosen as the main strategy to reduce the population growth rate in each national five year plan.

2) Specific new acceptor and continued user targets for each method were set for each five year plan, and IE&C programs were designed to recruit FP acceptors as planned in the target.

3) The FP program design contained two principle elements: a) FP services aimed not only to increase availability and accessibility but also to improve quality as well as quantity; and b) the FP communication program aimed to stimulate contraceptive acceptance and to support FP services.

4) The reproductive age groups, both single and married, were the primary targets for the communication strategy.

5) Messages to reinforce the use of different contraceptive methods were continuously transmitted through various media.

6) The vigorous communication program was first established to cover the entire country during the first decade. Specific strategies were developed to reach hard core groups and areas of low prevalence in the second decade of the program.

7) Most components of the communication program aimed at a large-scale approach to recruit contraceptive acceptors.

8) The planning and implementation of all national FP activities such as training, IE&C, evaluation were well coordinated.

All training was carried out by the NFPP training section. This section organizes training for the purposes of increasing availability and accessibility of contraceptive services. Motivation, health education, and communication subjects have been added to the curriculum of every training program in a building block fashion.

The information section has mainly been responsible for IE&C planning, project formulation, procuring vehicles, IE&C equipment and software materials, sponsoring IE&C support in the field, campaigns, mass meetings, special events, seminars, and radio programs. It also established and maintained IE&C cooperation with population related agencies and organizations. The central IE&C personnel organize orientation seminars at PPHOs before launching programs in the field, and then the PPHOs serve as field managers. All health personnel at district and village levels have been field implementators. Most of IE&C materials have been centrally produced and distributed to PPHOs for use in different IE&C programs. All central IE&C staff have backgrounds in health education and communication, and they work full time for the IE&C program. All provincial personnel are medical and paramedical personnel except volunteers.

The NFPP gives high priority to communication programs aimed at stimulating contraceptive use among the population. Information on the seven contraceptives has been standardized for repeated use in every medium. The promotion of family planning methods in every village has been carried out using auxiliary midwives in combination with a mobile film show and printed materials advertizing contraceptives. Popular radio programs with inserted contraceptive messages are broadcasted every day throughout the Kingdom. Meetings and campaigns have been regularly launched in each village. Entertainment programs which convey contraceptive messages have also been very popular. All communication programs and campaigns launched in rural villages have had a specific target number of FP acceptors for services. This strategy helps to direct health personnel in the field to identify the magnitude of the task and the goal to achieve in FP program.

The FP communication program is very intensive and covers a very large population.

All reproductive groups are aware of the different contraceptive methods and the two-child family norm. Spacing as appropriate is the way of life for the population. The rapid increase in the accessibility of contraceptive services and motivation activities at the village level has helped to accelerate FP acceptance. IE&C activities in all villages must be implemented continuously. From early 1970, vigorous village campaigns followed by immediate services have helped to increase the number of current users dramatically. In Thailand, every health centre was assigned targets in terms of new contraceptive acceptors or current users. They were supported by the NFPP to organize group meetings of eligible couples at least twice a year to motivate and recommend the trial use of contraceptives. Inventories were made of users and non-users to identify target groups. A mobile outreach strategy for contraceptive services and information from districts and provinces also joined health centers in giving services during campaigns, especially in providing contraceptive information and services which were not available at health centers. They also helped to refer cases to hospitals for sterilization service. Health centers which are staffed by a junior midwife require to be supported continuously by district and provincial teams for both IE&C and service activities.

FP service delivery and IE&C activities depend on MOPH facilities. The use of the existing infrastructure of hospitals and health centers has been very cost-effective for the FP program. From 1970-1990, there was over a three-fold increase in the number of health facilities from around 3,000 outlets to nearly 10,000 outlets. Health personnel were also increased and are very credible sources of FP information and services. FP clients feel confident of these quality services as they can consult with them as needed.

Private Sector

The private sector has been in the forefront of IE&C materials design and development for FP and AIDS education. IE&C materials in the form of videos, tape cassettes, stickers, pamphlets, posters, etc. have been produced and distributed nationally through a variety of channels. Moreover, they also produce and distribute IE&C materials on family planning and STDs through their various clinics and mobile health van. Private sector programs also provide family life education and AIDS information through training for student leaders, slum youth, students and teachers in vocational colleges as well as university lecturers. The information reaches approximately 200,000 youth each year. The television programs are televised through 13 TV channels and radio programs broadcast through 42 radio stations. These programs receive very high attention from the people.

Assessment of Successful Efforts

The NFPP achieved the targets set for new contraceptive acceptors and current users in each national five-year plan during the first two decades. The main strategy to achieve the target was not only the extensive use of paramedical personnel in remote rural

areas but also the provision of a wide-range of modern contraceptives through different health outlet levels.

Thailand has experienced a reproductive revolution. The contraceptive prevalence has reached a high level similar to that seen in developed countries. From several national surveys, the contraceptive prevalence rate rose sharply from approximately 15 percent in 1970 to nearly 70 percent in 1987. The NFPP estimated that contraceptive prevalence rate was around 75 percent in 1991 for both government and private sectors. Female sterilization is used by 26 percent of currently married women aged 15-44 years, which is equivalent to one-third of current users and is the most common method currently practiced. Male sterilization was less common with a prevalence level of only 4 percent. The contraceptive oral pill is used by 22% of currently married women aged 15-44 and is the second most common method, while injectables are used by 12 percent and the IUDs 7 percent to make them a more distant third and fourth. The condom is rarely used as the current method of birth control, while Norplant is becoming more popular. Both are used by 4 percent of married women of reproductive age.

There is no difference in prevalence rates between rural and urban women, and only minor differences among users practicing different methods. Regional differences in contraceptive prevalence rates are apparent especially in the North where it is extremely high at 84 percent of married women of reproductive age currently practicing contraception. The Central and the Northeast levels are the same at 77 percent followed by Bangkok at 75 percent which is equivalent to an average 75% contraceptive prevalence rate at the national level. The South is clearly characterized by the lowest prevalence rate at 60 percent.

The government sector is the major supplier of contraceptives in Thailand. Over four-fifths of current users use government outlets to provide them with the current methods. Government outlets are also very important as a source of sterilization, IUDs insertion and injection. The private sector, particularly drugstores, are another important supply source for the contraceptive pill, providing it to one-fourth of married women. Other private sector institutions play a substantial role in providing several methods. The level of contraceptive prevalence served by drugstores and clinics is around 15 percent of married woman of reproductive age.

Monitoring and Evaluation

Mechanisms for Monitoring and Evaluation

Since 1972, the NFPP has set a five-year target for each contraceptive method. According to the target set, achievements in delivering family planning services are shown by each province using the total population as a criteria. The reporting system of FP acceptors was introduced in 1967. Each district collects the number of FP new acceptors and current users which are then reported to the NFPP central office. The data are then

tabulated and analyzed to produce a monthly report showing the number and percentage of acceptors and current users classified by method, district, month and service outlet.

The monthly reports of new acceptors and the contraceptive prevalence rate (CPR) are then fed back to each province to evaluate their progress. Each year this report is summarized to compare with the targets set. Ranking information on each province is also sent to the provinces. The report of acceptors is also used for projecting the need for contraceptive supplies.

Personnel from the three main sections - Training, IE&C, Research and Evaluation - of the central NFPP regularly visit every province to monitor the program. Visits are also made to the lowest outlets, health posts and volunteers to evaluate the outcome of their activities. Discussions are held with the provincial personnel in order to strengthen the program.

Lessons Learnt

Thailand's NFPP has developed into a well-run program. It is a single-purpose structure with good management and well-trained staff. NFPP managers are able to focus their energies on family planning because the programs operate independently from other health programs. The managers use data from a variety of sources such as censuses, surveys, vital registration and FP service reports to implement a programmatic goal-oriented approach. They focus on budgeting, logistics, expansion of services, motivation and evaluation. From its inception, the NFPP has given priority to the regular upgrading of skills to personnel involved in the program.

Since the government of Thailand declared an explicit policy with special emphasis on voluntary family planning as a major strategy to reduce the high rate of population growth, this has helped to marshall the government resources, funds, personnel and facilities and enable the NFPP to function separately and efficiently. The NFPP, administered by the MOPH, is a vertical program. It is responsible for training to increase contraceptive availability and accessibility, logistics to maintain FP supplies, communication/motivation to recruit FP acceptors as set in the target, and FP research and reports to evaluate and monitor the program. The planning and implementation of the four essential elements are well-coordinated under the MOPH. Funding from external and internal sources for population activities is through the MOPH. The MOPH has become the focal point for all family planning activities in the country.

FP activities and programs were launched under the MOPH, and with an increase in service outlets, FP activities likewise expanded. As discussed above, the NFPP has a policy to allow paramedical personnel to provide FP services which increases access to family planning. It is essential to have trained personnel in place to ensure the success of the NFPP. Highly integrated FP services and communication activities at grass-roots level also helps to strengthen the program.

Impact, Cost-Effectiveness and Cost-Benefit Analyses

The impact of the NFPP in reducing fertility in Thailand is significant. The striking increase in the number of new acceptors, as derived from statistical analyses, is consistent with the result of surveys conducted periodically. Calculation of the NFPP's impact has varied depending on different assumptions. The method of multivariate regression analysis was also employed for estimating the impact of the NFPP. According to the study, 50% of the decline in the total fertility rate during 1962-80 and 68% of the decline during 1972-1980 were attributed to program activities.

The NFPP supported a working group to estimate the impact of the program towards the economic development of the nation in 1989. The result revealed that without the family planning program, the Thai population would have reached 67 million instead of 54 million in 1989. At present, the program is able to prevent more than 0.4 million births annually. Considering the NFPP as an investment project for human resource development, it is estimated that one baht spent on family planning in Thailand yields a return of almost 40 baht in savings. The rate of return from investment in family planning is therefore very high relative to the rate obtained from investment in other activities.

Financial Aspects

Resource Allocation and Utilization to Population Programs

During the initial period, funds from external donors played an essential role. Before the NFPP was established, the Population Council, USAID, UNICEF and IPPF provided financial and technical assistance to the Family Health Division (FHD) to study FP, provide contraceptive supplies, training and support a resident advisor. After the establishment of the NFPP, USAID became the largest donor followed by UNFPA and JICA. The World Bank also played an important role in encouraging the Thai Budget Bureau to increase support to the NFPP. During the first decade, international funds represented more than a half of the NFPP's total budget.

The Thai government allocated financial support directly to the NFPP in 1975 in the amount 10 million baht (Baht 25 = US$1). The fund increased to 200 million baht in 1985, 350 million baht in 1989, 500 million baht in 1990, and 560 million baht in 1993. NFPP managers were very effective advocates in increasing domestic support to the NFPP. The government budget for the NFPP increased when the major donors began to phase out. This rapid transition is truly exceptional in view of financial regulations, which limited budget increases to not more than 15 percent for any public agency. The increased budget allowed the purchase of additional commodities. The entire MCH and FP budget increased over 200 percent in 1982 compared to 1981. The MCH budget increased from 30 million baht in 1972 to almost 170 million baht in 1993.

The NFPP's 1992 expenditure was allocated mainly for contraceptive supplies, or

approximately 80 percent. Expenditure for FP promotion (IE&C) and administration were 10 percent each and less than two percent for research and training. The 1992 contraceptive supplies included 100,000 IUDs, 25 million cycles of pills, 6 million three-month injectables, 60,000 Norplant sets and 1 million condoms. The NFPP also provided a subsidy of 35 million baht for sterilization for approximately 140,000 cases. In 1993, the NFPP receives approximately 40 million baht from JICA and UNFPA. All JICA assistance is in kind while UNFPA funds are in cash. The Thai government also ensures its full support to the NFPP as long as it is needed.

Thailand's total budget for 1993 is 550,000 million baht. The MOPH share is 5.7 percent of the national budget. Amounts of 560 and 167 million baht is allocated for direct FP and MCH funding respectively. There is no local budget allocation for the family planning program. The FP national budget, which is allocated for the NFPP central office, does not merge with other health programs. However, the MOPH provides two-third of total MOPH expenditure for provincial health outlets which serve all health services including FP and MCH.

Cost-Recovery in Population Programs

The NFPP continues to provide at great expense contraceptive supplies for the whole country and this policy is not likely to change in the near future. Sample surveys, however, show that some couples are paying for contraceptive services. The NFPP, therefore, sets a maximum charge for each contraceptive service. The funds collected from the fees are used by health centers for improving health services. No fee is used for the purchase of contraceptives as new contraceptive supplies can be requested from the NFPP. The NFPP is now designing and testing an alternative cost-recovery program which hopefully will not effect contraceptive use and can be replicated on a larger scale in the near future.

Part VI

National Plan of Action for the Future

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Outlining a Policy Framework

For more than 20 years now, Thailand's population policy has emphasized reducing fertility and mortality rates as essential ingredients for national development. As a result, Thailand stands at a significant turning point with respect to its population development situation, a turning point that many other developing countries are also likely to reach before long. The basis of Thailand's newer demographic policy framework is that the fertility rate has now reached the point where the earlier overriding objective of lowering fertility, suitable as that objective was in an earlier context, is no longer appropriate. The policy framework must now turn to other aspects of population and development, including regional-specific concerns in MCH/FP, improving family planning services, combating the HIV/AIDS threat with its implications for both mortality and fertility, planning for rapid urbanization, and seriously addressing women's and environmental issues. Within MCH/FP, for example, the prior emphasis on reducing fertility rates is no longer needed except for groups exhibiting low prevalence rates. Rather, attention needs to be placed on improving the quality of FP services, advancing management information systems, strengthening IE&C and social marketing strategies for key population issues, promoting the role of NGOs, and advancing efforts to deal with such crucial issues as HIV/AIDS, women's roles in development and environmental awareness.

Designing Programmatic Activities

The strategy for MCH/FP in the next five years should maintain the momentum of the program, both in order to raise contraceptive prevalence rates in terms of a 10 percent rise in the number of reproductive-age women, and to provide effective follow-up for couples who are already contraceptive acceptors. Regional programs are to be launched to more effectively meet the special needs of adolescents, ethnic minorities, and to improve management, training and information systems. Strong collaboration is needed among government and non-government organizations and the private sector which play an important role in supplementing government activities. Specific short-term objectives of the NFPP during 1992-1996 include: 1) increasing contraceptive prevalence rate (CPR) from 70.5% to 77% (1987-1996); 2) increasing CPR of sterilization from 29.2% to 34% (1987-1996); and 3) reducing the rate of age at first birth below 20 years from 14.8% to less than 10% (1987-1996). To achieve these three objectives, six main strategies will be employed.

Increasing Coverage and Improving the Quality of FP Services. Emphasis will be placed on providing highly effective, economical and acceptable contraceptives for birth spacing, and using permanent methods after completing family size. Counseling and reproductive health check-up activities will be strengthened to cover most clients. Free services will be made available to selective poor income groups. An increased subsidy for

FP services will be supported by the NFPP to every service outlet in addition to contraceptive supplies and equipment. Appropriate services to adolescents, ethnic groups, factory workers and slum areas will be expanded.

Improving Management Systems. Management of planning, targeting, program monitoring and evaluation will be decentralized to regional health promotion centers and provincial public health offices. Standard index and evaluation indicators will be set to evaluate different programs. Management information systems from the village to provincial levels will be strengthened. Research to improve management information systems (MIS) will be conducted and results will be used for improvement.

Increase Potential Service Providers. Programs to improve village personnel in identifying problems, targets and determine appropriate strategies to solve community problems will be supported. Volunteers and regular health personnel will be trained to raise accessibility to contraceptive services. Research to identify training needs will be made.

Improve Attitudes and Behaviors Towards Contraceptive Use. The NFPP will organize mass media programs to regulate the fertility pattern of couples bearing their first child at age 20 or over, birth spacing of not less than three years between children, and limiting the number of children in each family to two only. Messages will be adjusted according to the cultures and norms of local ethnic groups in addition to standard messages. All messages will be disseminated through appropriate channels to influence behavioral change as per fertility control. In addition, efforts will be made to promote a correct understanding of contraceptive use, it advantages and disadvantages, and indications for use. The public will then be able to choose the right contraceptive for each period of life.

Coordination and Collaboration. The NFPP will promote the use of volunteers both in rural and urban areas to provide information and services. In addition, youth volunteer programs will be expanded in urban and rural areas. The NFPP will maintain the support of FP private organizations, while expanding support to private hospitals and clinics in providing sterilization services. It will also strengthen marketing systems through drug stores to improve the quality of services and lower the price of contraceptive goods. The NFPP will also support companies to produce good quality contraceptives in Thailand to reduce the cost of importation. Strengthening of population information systems will be made to exchange experiences and learn new technologies. The NFPP will evaluate the use of private organizations in FP activities and strengthen cooperation with them.

Social Measures and Population Development. Investigations into and change in different regulations related to FP practices to support a two child family norm will be made. Positive measures will be introduced particularly in terms of support for agricultural activities for families that meet the FP criteria.

Resource Mobilization

The Thai Government will continue its policy to further reduce the population growth rate even though the decline will be very slow as a result of a high concentration in the

young age group. In line with the NFPP target of increasing the contraceptive prevalence rate, new acceptors and active user targets are also set for each method for each year during 1992-1996. Nine million new acceptors and 6.28 million active users are estimated for FP services by the end of 1996. In 1996, users of contraceptive methods will include 1.6 million pill users, 1 million injectable users, 0.8 million IUD users, 2.8 million sterilization users, and 0.2 million Norplant users. The NFPP has also prepared in advance the financial support needed from the Thai government to meet the five-year planned target during 1992-1996. It is estimated that approximately 3.5 billion baht will be required to maintain the FP program. The distribution of FP budget will center around 80% for contraceptive supplies and the rest for promotional activities including training, research evaluation, maintenance and administration. Thailand's NFPP will continuously inform the government of the important role the FP program plays. The more successful the program is, however, the more budget required. Private outlets for FP services are available in urban areas only and not in the rural area, where the majority of Thai people with low income live.

Summary and Conclusion

Thailand has been very successful in the last two decades in curbing its population growth rate with the latter expecting to fall further to 1.2 percent by the end of the Seventh Plan (1996). Fertility decline has largely been the result of socioeconomic development and of an effective National Family Planning Program, particularly in terms of the provision of subsidized contraceptive services. Thailand's population will inevitably continue to grow for some time even if fertility falls below replacement level. This is because of the momentum built into the population structure as a result of earlier, high levels of fertility. About the lowest level at which the population is likely to level off is 70 million, or about 25 percent larger than at present, and it could well reach 80 million or higher. According to population projections officially used in the Seventh Plan, the number of women of reproductive age will peak in 2010, after having already peaked as a proportion of the total population in the late 1990s. But the proportion of these women who are married will probably fall throughout the period, as a result of a growing tendency for women to delay marriage into their late 20s and 30s or not to marry at all, as well as a likely increase in divorce and desertion. In the future, therefore, although a family size norm of two children will be held by most people, many will not marry until it is too late to have children and this will tend to lower actual fertility levels below the replacement level. The earlier policy thrust to reduce birth rates, though still appropriate for the Seventh Plan period, will no longer be needed, and emphasis should rather be placed on quality of family planning services.

Other aspects of Thailand's longer-term population strategy also need to be considered. One is the migration of population from areas of lesser to greater economic opportunity. This has long been occurring, for example in frontier settlements and in the seasonal migration of Northeasterners to Bangkok. If regional income disparities continue

to widen, such migration is likely to increase, as indeed is international migration (mainly illegal) from neighboring Myanmar, the Lao People's Democratic Republic and Cambodia as they fall further behind Thailand economically and in some cases suffer from repressive regimes. One particular locus of economic opportunity is the cities, and migration will contribute to their rising share of the nation's population. Another important element of the population strategy is the aim of raising the quality of human resources, and here improvements in education and health levels are crucial. As the population urbanizes and urban environmental issues become more acute, new health problems could very well arise, in addition to AIDS which is already causing great concern.

Thailand: Key Demographic and Development Indicators

	1980	1984	1991
1. Demographic and Family Planning			
1.1 Total Population (million)	47.0	50.6	57.0
1.2 Age Structure (%)			
0-14 years	40.0	37.0	32.0
15-59 years	55.0	58.0	62.0
60+ years	5.0	6.0	6.0
1.3 Urban Population (million)	8.3	8.9	10.0
1.4 TFR	3.7[1]	3.5	2.2
1.5 CBR	27.3	24.8	20.2
1.6 CDR	7.6	7.4	5.9
1.7 GR (%)	2.0	1.7	1.4
1.8 IMR (per 1,000 live births)	47.7	40.7[3]	34.5
1.9 Life Expectancy at Birth (year)			
Male	62.0	63.0	68.0
Female	66.0	67.0	72.0
1.10 Literacy Rate	88.8	87.2	93.0[6]
1.11 Proportion of Married Women Aged 15-49 (%)	59.0	-	71.0[5]
1.12 Contraceptive Prevalence Rate (MWRA of 15-49 years)	56.5[1]	64.6	67.4[4]
Urban	-	-	67.8
Bangkok	64.3	71.8	68.1
Provincial	63.8	64.7	-
Rural	55.0	63.7	69.4
1.13 Percent of MWRA (15-44 years) Practicing Contraception			
Pill	20.0	19.8	24.0
Female sterilization	18.7	23.5	23.5
IUD	4.2	4.9	4.7
Injectables	7.1	7.6	12.3
Male sterilization	4.2	4.4	2.8
Condom	1.9	1.8	-
Other	2.7	1.3	1.9
1.14 FP New Acceptors (million)	1.12	1.18[2]	1.7

[1] / 1981 [2] / 1983 [3] / 1985-1986 [4] / 1987 [5] / 1989 [6] / 1990

Thailand: Key Demographic and Development Indicators (cont.)

		1980	1984	1991
2.	**Economic and Employment**			
2.1	GDP (million baht)	622,482	988,070	2,509,427
2.2	GNP per Capita (baht)	14,065	19,287	43,405
2.3	Share of Agriculture in GDP (%)	23.2	17.5	12.8
2.4	Labor Force (million)	23.9	26.7	32.1
2.5	Employed (million)	23.6	26.0	31.1
2.6	Unemployed (million)	0.3	0.6	0.9

[1] / 1981 [2] / 1983 [3] / 1985-1986 [4] / 1987 [5] / 1989 [6] / 1990

Thailand Working Committee for Preparation of the International Conference on Population and Development, 1994

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