

4. Thailand



Statistics

GENERAL

Population

- Total population (millions): 64.2.¹
- Population by sex (thousands): 32,333.0 (female) and 31,132.0 (male).²
- Percentage of population aged 0–14: 23.2.³
- Percentage of population aged 15–24: 17.8.⁴
- Percentage of population in rural areas: 68.⁵

Economy

- Annual percentage growth of gross domestic product (GDP): 3.7.⁶
- Gross national income per capita: USD 2,190.⁷
- Government expenditure on health: 3.1% of GDP.⁸
- Government expenditure on education: 3.6% of GDP.⁹
- Percentage of population below the poverty line: Information unavailable.

WOMEN'S STATUS

- Life expectancy: 74.3 (female) and 67.3 (male).¹⁰
- Average age at marriage: 23.5 (female) and 26.0 (male).¹¹
- Labor force participation: 65.0 (female) and 81.4 (male).¹²
- Percentage of employed women in agricultural labor force: Information unavailable.
- Percentage of women among administrative and managerial workers: 26.¹³
- Literacy rate among population aged 15 and older: 95% (female) and 98% (male).¹⁴
- Percentage of female-headed households: Information unavailable.
- Percentage of seats held by women in national government: 9.¹⁵
- Percentage of parliamentary seats occupied by women: 9.¹⁶

CONTRACEPTION

- Total fertility rate: 1.90.¹⁷
- Contraceptive prevalence rate among married women aged 15–49: 72% (any method) and 70% (modern method).¹⁸
- Prevalence of sterilization among couples: 22.6% (total); 19.8% (female); 2.8% (male).¹⁹
- Sterilization as a percentage of overall contraceptive prevalence: 30.6.²⁰

MATERNAL HEALTH

- Lifetime risk of maternal death: 1 in 1,100 women.²¹
- Maternal mortality ratio per 100,000 live births: 44.²²
- Percentage of pregnant women with anemia: 57.²³
- Percentage of births monitored by trained attendants: 99.²⁴

ABORTION

- Total number of abortions per year: Information unavailable.
- Annual number of hospitalizations for abortion-related complications: Information unavailable.

- Rate of abortion per 1,000 women aged 15–44: Information unavailable.
- Breakdown by age of women obtaining abortions: Information unavailable.
- Percentage of abortions that are obtained by married women: Information unavailable.

SEXUALLY TRANSMISSIBLE INFECTIONS (STIS) AND HIV/AIDS

- Number of people living with sexually transmissible infections: Information unavailable.
- Number of people living with HIV/AIDS: 570,000.²⁵
- Percentage of people aged 15–49 living with HIV/AIDS: 1.1 (female) and 2.0 (male).²⁶
- Estimated number of deaths due to AIDS: 58,000.²⁷

CHILDREN AND ADOLESCENTS

- Infant mortality rate per 1,000 live births: 18.²⁸
- Under five mortality rate per 1,000 live births: 19 (female) and 31 (male).²⁹
- Gross primary school enrollment ratio: 95% (female) and 99% (male).³⁰
- Primary school completion rate: Information unavailable.
- Number of births per 1,000 women aged 15–19: 48.³¹
- Contraceptive prevalence rates among married female adolescents: 40.5% (modern methods); 2.6% (traditional methods); 43.0% (any method).³²
- Percentage of abortions that are obtained by women younger than age 20: Information unavailable.
- Number of children under the age of 15 living with HIV/AIDS: 12,000.³³

ENDNOTES

1. See UNITED NATIONS POPULATION FUND (UNFPA), *THE STATE OF WORLD POPULATION 2005*, at 112 (estimates for 2005).
2. See UNITED NATIONS POPULATION FUND (UNFPA), *COUNTRY PROFILES FOR POPULATION AND REPRODUCTIVE HEALTH: POLICY DEVELOPMENTS AND INDICATORS 2003* (2003), <http://www.unfpa.org/profile/default.cfm>. [hereinafter UNFPA, *COUNTRY PROFILES*].
3. See THE WORLD BANK, *WORLD DEVELOPMENT INDICATORS 2004*, at 40 (2004), <http://www.worldbank.org/data/> (estimates for 2002). [hereinafter The World Bank].
4. See UNFPA, *COUNTRY PROFILES*, *supra* note 2.
5. See UNFPA, *THE STATE OF WORLD POPULATION 2005*, *supra* note 1, at 112 (estimates for 2003).
6. See THE WORLD BANK, *supra* note 3, at 184 (estimates for 1990–2002).
7. See THE WORLD BANK, *WORLD DEVELOPMENT INDICATORS 2004: DATA QUERY* (2004), <http://devdata.worldbank.org/data-query/> (statistical figure obtained through the Atlas method) (estimates for 2003).
8. See UNFPA, *THE STATE OF WORLD POPULATION 2005*, *supra* note 1, at 112.
9. See UNITED NATIONS CYBERSCHOOLBUS, *INFO NATION: GOVERNMENT EDUCATION EXPENDITURE* (2004), http://www.un.org/Pubs/CyberSchoolBus/infonation/e_infonation.htm (estimates for 1997).
10. See UNFPA, *THE STATE OF WORLD POPULATION 2005*, *supra* note 1, at 108.
11. See UNFPA, *COUNTRY PROFILES*, *supra* note 2.
12. See *Id.*
13. See SOCIAL AND DEMOGRAPHIC STATISTICS BRANCH, UNITED NATIONS STATISTICS DIVISION, *THE WORLD'S WOMEN 2000: TRENDS AND STATISTICS* (2000) (estimate for 2003).
14. See UNFPA, *COUNTRY PROFILES*, *supra* note 2.
15. See SAVE THE CHILDREN, *STATE OF WORLD'S MOTHERS 2004*, at 38 (2004), http://www.savethechildren.org/mothers/report_2004/images/pdf/SOWM_2004_final.pdf (estimate for 2004).
16. See UNITED NATIONS STATISTICS DIVISION, *MILLENNIUM INDICATORS DATABASE* (2005), http://unstats.un.org/unsd/mi/mi_series_results.asp?rowId=557 (last updated Mar. 16, 2005) (estimate for 2005).
17. See UNFPA, *THE STATE OF WORLD POPULATION 2005*, *supra* note 1, at 112 (estimates for 2000–2005).
18. See *Id.* at 108.
19. See ENGENDERHEALTH, *CONTRACEPTIVE STERILIZATION: GLOBAL ISSUES AND TRENDS*, tbl. 2.2, at 47 (2002) (estimates for 1993).
20. See *Id.* at tbl. Supp. 2.5, at 56. (estimate for 1993).
21. See WORLD HEALTH ORGANIZATION (WHO) ET AL., *MATERNAL MORTALITY IN 1995: ESTIMATES DEVELOPED BY WHO*, UNITED NATIONS CHILDREN'S FUND (UNICEF), UNITED NATIONS POPULATION FUND (UNFPA), 46 (2000) (estimate for 1995).
22. See UNFPA, *THE STATE OF WORLD POPULATION 2005*, *supra* note 1, at 108.
23. See SAVE THE CHILDREN, *supra* note 15, at 38 (estimate for 1989–2000).
24. See UNFPA, *THE STATE OF WORLD POPULATION 2005*, *supra* note 1, at 112.
25. See JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS) ET AL., *UNAIDS/WORLD HEALTH ORGANIZATION (WHO) EPIDEMIOLOGICAL FACT SHEETS ON HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS – 2004 UPDATE: THAILAND 3* (2004), http://www.who.int/GlobalAtlas/PDFFactory/HIV/EFS_PDFs/EF2004_TH.pdf (estimate for 2003).
26. See UNFPA, *THE STATE OF WORLD POPULATION 2005*, *supra* note 1, at 108.
27. See JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS) ET AL., *supra* note 25.
28. See UNFPA, *THE STATE OF WORLD POPULATION 2005*, *supra* note 1, at 108.
29. See UNFPA, *COUNTRY PROFILES*, *supra* note 2.
30. See UNFPA, *THE STATE OF WORLD POPULATION 2005*, *supra* note 1, at 112. The ratio may be more than 100 because the figures remain uncorrected for individuals who are older than the level-appropriate age due to late starts, interrupted schooling or grade repetition.
31. See *Id.*
32. See Saroj Pachauri & K.G. Santhya, *Reproductive Choices for Asian Adolescents: A Focus on Contraceptive Behavior*, 28 INT'L FAM. PLANNING PERSP. 186–195 (2002), <http://www.agi-usa.org/pubs/journals/2818602.html> (estimates for 1987).
33. See JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS) ET AL., *supra* note 25.

The Kingdom of Thailand is situated in Southeast Asia and borders Myanmar, Cambodia, Laos, Malaysia, the Andaman Sea, and the Gulf of Thailand.¹

The unified kingdom of Thailand, known as Siam until 1939, was established in the mid-fourteenth century. Subsequently, starting in the sixteenth century, Thailand engaged in a series of wars with its northeast neighbor, Burma (currently known as Myanmar), and in the nineteenth century, it began to fend off European powers. Though Thailand lost territory in the east to France and in the south to Britain, Thailand succeeded in maintaining its independence and is the only Southeast Asian country that was not colonized by European powers.²

Until 1932, Thailand was governed by a system of absolute monarchy, but it became a constitutional monarchy that year after a “bloodless revolution” that was organized by a group of civil servants and army officers with the support of army units in the Bangkok area.³ During World War II, Thailand was occupied by Japan after the Thai prime minister signed a mutual defense pact with Japan.⁴ However, in 1944, the prime minister was forced out of office and replaced by a civilian government.⁵

In 1992, after a series of military governments, civilian authorities replaced the military. Subsequently, there have been five national multiparty elections, which have transferred power to successive governments through peaceful, democratic processes.⁶

In 2002, the total population was 62 million,⁷ with approximately 50.8% being female.⁸ The ethnic composition of Thailand consists of 75% Thai, 14% Chinese, and 11% other.⁹ According to 1991 statistics on religious affiliation, 95% of Thais are Buddhist, 3.8% Muslim, 0.5% Christian, 0.1% Hindu, and 0.6% other.¹⁰ The official language is Thai, but English is also widely taught,¹¹ and there are numerous ethnic and regional dialects.¹²

Thailand has been a member of the United Nations since 1946.¹³ It is an active member of the Association of Southeast Asian Nations (ASEAN).¹⁴

I. Setting the Stage: The Legal and Political Framework of Thailand

Fundamental rights are rooted in a nation’s legal and political framework, as established by its constitution. The principles and goals enshrined in a constitution, along with the processes it prescribes for advancing them, determine the extent to which these basic rights are enjoyed and protected. A con-

stitution that upholds equality, liberty, and social justice can provide a sound basis for the realization of women’s human rights, including their reproductive rights. Likewise, a political system committed to democracy and the rule of law is critical to establishing an environment for advancing these rights. The following section outlines important aspects of the Thailand’s legal and political framework.

A. THE STRUCTURE OF NATIONAL GOVERNMENT

The Constitution of Thailand came into force on October 11, 1997.¹⁵ It establishes a democratically governed constitutional monarchy and declares itself to be the supreme law of the state¹⁶ from which the power of the three branches of government—executive, legislative, and judicial—is derived. Thailand is divided into 76 provinces.¹⁷ The constitution establishes sovereignty in the people.¹⁸

Executive branch

The executive branch consists of the king, the prime minister, the Council of Ministers, and the Privy Council.¹⁹ The king serves as the head of state and the head of the Thai armed forces.²⁰ The king exercises power in accordance with constitutional provisions.²¹ He exerts powerful informal influence, but has not yet used his constitutionally mandated power to veto legislation or adjourn the legislative branch.²² The king may appoint a regent in the event of his absence or incapacity to perform his functions.²³

The prime minister is the head of government and is appointed from among the members of the House of Representatives by the king.²⁴ The appointment of the prime minister must be approved by a vote of more than one-half the total membership of the House of Representatives.²⁵ The king may appoint no more than 35 ministers who constitute the Council of Ministers²⁶ and are in charge of the administration of state affairs.²⁷ Each minister reports individually to the House of Representatives²⁸ and collectively to the National Assembly.²⁹ The king has the prerogative to remove a minister from office upon the advice of the prime minister.³⁰

The constitution provides for the establishment of a Privy Council.³¹ The Privy Council submits advice to the king on matters pertaining to his functions, such as matters that require the king’s signature or sanction, including drafts of legislation, royal decrees, and appointments of high officials; petitions for clemency for convicted prisoners; and petitions regarding grievances submitted to the king by private citizens.³² The king can issue an emergency decree, which has the force of an act, to maintain national or public safety or national economic security, or avert public calamity.³³ He also has the power to issue a royal decree that is not contrary to existing laws; declare and lift martial law; declare war with

the approval of the National Assembly; enter into a treaty with another country or international organization; and grant pardons.³⁴

The king selects and appoints both the president of the Privy Council and no more than 18 of the councilors who sit on it.³⁵ The Privy Council has a duty to report to the king on all matters.³⁶

Legislative branch

Legislative power rests with a bicameral parliament, known as the National Assembly, consisting of the House of Representatives and the Senate.³⁷ The House of Representatives is composed of 500 members³⁸ who serve four-year terms.³⁹ One hundred representatives are elected on a party-list basis and 400 are elected on a constituency basis.⁴⁰ The Senate is composed of 200 members who are elected by the people⁴¹ and serve six-year terms.⁴² In 1999, only 6.6% of the seats in the National Assembly were filled by women.⁴³ The king has the prerogative to dissolve the House of Representatives for a new election of its members.⁴⁴

Bills may be proposed by the Council of Ministers, members of the House of Representatives,⁴⁵ or a petition signed by a minimum of 50,000 eligible voters,⁴⁶ but only members of the House of Representatives may introduce money bills with the endorsement of the prime minister.⁴⁷ A member of the House of Representatives may introduce a bill that his or her political party has approved and that has been endorsed by no fewer than 20 members of the House of Representatives.⁴⁸ After the National Assembly approves the bill, the prime minister presents it to the king for signature within 20 days.⁴⁹ If the king returns the bill to the National Assembly or refuses to assent within 90 days, then the National Assembly may reaffirm the bill with votes of no fewer than two-thirds the total number of members of both houses.⁵⁰ Afterwards, the prime minister may present the bill to the king for his signature and, if the king does not sign and return the bill within 30 days, the prime minister causes the bill to be promulgated as an act in the Government Gazette as if the king had signed it.⁵¹

Judicial branch

The constitution establishes a hierarchy of Courts of Justice, with the Supreme Court at the apex of the hierarchy, followed by the Court of Appeal and the Courts of First Instance.⁵²

The Sarn Dikaar (Supreme Court) is the court of last resort and the ultimate court of appeal.⁵³ It hears appeals from the Court of Appeal and from Courts of First Instance.⁵⁴ There are nine judges on the Supreme Court⁵⁵ who are appointed by the king.⁵⁶ There is also a Criminal Division for Persons Holding Political Positions under the Supreme Court, which hears cases against politicians.⁵⁷ The Court of Appeal

consists of three regional and one Bangkok appellate court. The Courts of First Instance handle both civil and criminal cases. The appointment and removal from office of a judge of a Court of Justice, including the Supreme Court, must be approved by the Judicial Commission of the Courts of Justice before being tendered to the king.⁵⁸

The constitution also establishes an independent Constitutional Court,⁵⁹ a military court,⁶⁰ and administrative courts. The Constitutional Court is headed by the president and 14 judges who are appointed by the king upon the advice of the Senate.⁶¹ The president and judges of the Constitutional Court serve nine-year terms.⁶² The Constitutional Court determines the constitutionality of bills and laws⁶³ and settles disputes on the powers of constitutional organs.⁶⁴ The constitution also provides for a maximum of three ombudspersons, who are appointed by the king with the advice of the Senate; these officials serve six-year terms and act on complaints against government officials.⁶⁵ Administrative courts hear cases between a state party (e.g., state agency or entity, local government organization, or state official) and a private individual, or between state parties.⁶⁶ Other courts include juvenile and family courts at the central and provincial levels, and fiscal tribunals.⁶⁷ The quorums in juvenile and family courts consist of two career and two associate judges, with a quota for one female judge.⁶⁸ Appeals to the judgments and orders of these courts go to the Courts of Appeal.⁶⁹

There is no law in Thailand that deals with legal aid services, but legal aid is provided in both civil and criminal cases under the Civil and Criminal Procedure Codes.⁷⁰ A range of nongovernmental organizations (NGOs) also fill some of the need for free legal work. The Women Lawyers Association of Thailand provides legal aid services to protect the rights of children and youth, and to provide assistance to low-income women.⁷¹ A Legal Aid Center, which offers legal counseling and assistance, is affiliated with Chulalongkorn University.⁷²

Customary forms of alternative dispute resolution

Thailand's long-standing tradition of conciliation under the Civil Procedure Code since 1935 was extended under the Civil Procedure Amendment Act (1999); the act expands dispute resolution procedures by allowing conciliation to be conducted behind closed doors with all or any of the parties, and by allowing the court to appoint a sole conciliator or panel of conciliators.⁷³ Conciliation is mandatory in small claims disputes.⁷⁴ The proceedings occur without a formal procedure, and may take place with or without an attorney.⁷⁵ Secrecy and confidentiality are enforced by barring the public and the press from the conciliation proceedings.⁷⁶

B. THE STRUCTURE OF LOCAL GOVERNMENTS

The local assembly constitutes an important part of local government, which is founded on the principles of self-government, autonomy, and decentralization.⁷⁷ Local assembly members are elected by local residents, who also have the right to vote for the removal of any member of a local assembly.⁷⁸ Members, who hold office for four years, may also appoint some members of the local administrative committee.⁷⁹ Women were barred from running for local office under the Local Administration Act (1914) until the act was amended in 1982.⁸⁰ Women now make up 2% of village sub-district heads.⁸¹

Local residents have the right to vote for the removal of any member of the local assembly or the local administrative committee of the local government,⁸² and also have the right to draft local ordinances and request their issuance.⁸³

Local governing bodies may adopt their own policies dealing with their governance, administration, personnel administration, and finance.⁸⁴

C. THE ROLE OF CIVIL SOCIETY AND NONGOVERNMENTAL ORGANIZATIONS

There are hundreds of active NGOs in Thailand that work in development, environmental protection, and philanthropy.⁸⁵ NGOs play an important role in the provision of social welfare services, especially to low-income women. Approximately 43% of local NGOs are dependent on foreign sources for most of their funding.⁸⁶

D. SOURCES OF LAW AND POLICY

Domestic sources

Domestic sources of law include the constitution, enactments by the National Assembly, and royal decrees.⁸⁷ Other forms of legislation, such as decrees, regulations, and administrative directives made under legislative or constitutional authority are also important sources of Thai law.⁸⁸ The legal system is based on civil law with common law influences.⁸⁹

The 1997 Thai Constitution provides protection for “the human dignity, right and liberty of the people.”⁹⁰ Under the section on the rights and liberties of the Thai people, the constitution specifies that “[a] person can invoke human dignity, or exercise his or her rights and liberties in so far as it is not in violation of rights and liberties of other persons or contrary to this Constitution or good morals. A person whose rights and liberties recognized by this Constitution are violated can invoke the provisions of this Constitution to bring a lawsuit, or to defend himself or herself in the court.”⁹¹ The constitution guarantees equal rights to men and women,⁹² and equal protection under the law.⁹³ It prohibits discrimination on the grounds of difference in origin, race, language, sex, age, physi-

cal or health condition, personal status, economic or social standing, religious belief, education, and political view.⁹⁴ The constitution also guarantees the right to life and prohibits torture, cruel or inhumane punishment,⁹⁵ and forced labor.⁹⁶ It guarantees important freedoms, including the freedoms of speech, expression,⁹⁷ and assembly;⁹⁸ and the freedoms to form an association, unionize,⁹⁹ and practice religion;¹⁰⁰ the document also guarantees family rights and the right to privacy.¹⁰¹ The constitution asserts the right of traditional communities to their customs and culture.¹⁰² It also guarantees the right to receive basic public health services, including free medical treatment for the indigent;¹⁰³ the provision of thorough and efficient public health services;¹⁰⁴ and the prevention and eradication of harmful contagious diseases, without charge.¹⁰⁵ The constitution guarantees the right of children, youth, and family members to be protected from violence and unfair treatment,¹⁰⁶ and in its Directive Principles of Fundamental State Policies, the document reinforces family integrity and the strength of communities.¹⁰⁷ The constitution promotes employment; labor protections, especially of women and children; and provides for an official system governing labor relations, social security, and fair wages.¹⁰⁸

The constitution provides for a National Human Rights Commission consisting of a president and ten other members appointed by the king with the advice of the Senate,¹⁰⁹ which has the power to examine and report on human rights violations.¹¹⁰

The domestic legal framework is also established by several codifications of law, including the penal code of 1956 and the Civil and Commercial Code.¹¹¹ The Act on the Application of Islamic Law in the Territorial Jurisdictions of Pattani, Narathiwat, Yala, and Satun (1946) applies to Muslims in these four provinces.¹¹² Successive five-year development plans provide comprehensive national policy frameworks for the country’s socioeconomic and development goals. The Ninth National Economic and Social Development Plan (2002–2006) is currently operative.¹¹³

International sources

The constitution authorizes the king to conclude a treaty or international agreement. Treaties that change the makeup of Thai territories or the jurisdiction of the state, or that require the enactment of a law, must be approved by the National Assembly.¹¹⁴ Thailand has ratified the following international legal instruments: the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (with reservations on article 16 and article 29, paragraph 1),¹¹⁵ the Optional Protocol to CEDAW,¹¹⁶ the Convention on the Rights of the Child,¹¹⁷ the International Covenant on Economic, Social and Cultural Rights,¹¹⁸ the International

Convention on the Elimination of All Forms of Racial Discrimination,¹¹⁹ and the International Covenant on Civil and Political Rights.¹²⁰ Thailand has also adopted international consensus documents including the 1993 Vienna Declaration and Programme of Action; the 1994 International Conference on Population and Development (ICPD) Programme of Action; the 1995 Beijing Declaration and Platform for Action; and the 2000 United Nations Millennium Declaration and the Millennium Development Goals.¹²¹

II. Examining Reproductive Health and Rights

In general, reproductive health matters are addressed through a variety of complementary, and sometimes contradictory, laws and policies. The scope and nature of such laws and policies reflect a government's commitment to advancing the reproductive health status and rights of its citizens. The following sections highlight key legal and policy provisions that together determine the reproductive rights and choices of women and girls in Thailand.

A. GENERAL HEALTH LAWS AND POLICIES

The constitution guarantees the equal rights of all persons to basic public health services, and the right of low-income individuals to free medical treatment from public health facilities, as provided by law.¹²² It obligates the state to provide public health services thoroughly and efficiently; promote the participation of local government and the private sector in service delivery as much as possible; and prevent and eradicate harmful contagious diseases for the public free of charge, as provided by law.¹²³ In addition, the constitution's prohibition of unjust discrimination specifically includes the grounds of physical or health conditions.¹²⁴ Secondary to these fundamental rights, the constitution's Directive Principles of Fundamental State Policies call on the state to provide and promote basic and efficient public health services.¹²⁵

Along with the constitution, the National Health Development Plan under the Ninth National Economic and Social Development Plan (2002–2006), known as the Ninth National Health Development Plan, forms the basic national legal and policy framework for the implementation of health activities and services.¹²⁶ The plan focuses on extending health-care coverage with the goal of “building healthy conditions for all Thai citizens” rather than merely treating ill health.¹²⁷

Objectives

The main objective of the Ninth National Health Devel-

opment Plan is the “Health for All” scheme, which aims to mobilize the whole society to participate in health development, inculcate health awareness in every part of society, and open opportunities for all sectors of society to play a role and use their own potential in developing a healthy society.¹²⁸ The plan's main strategies are the following:

- use an assertive approach in health development;
- establish guarantees for universal access to health services;
- reform the health management system, structures, and mechanisms;
- strengthen civil society;
- effectively manage knowledge and information on health; and
- develop and upgrade health service providers to prepare them for the reform of the health system.¹²⁹

The plan identifies 30 critical health issues; these include, among others, meeting the challenges of the guarantee of health for all, health system reform, improving nutrition and health, and conducting research on health issues.¹³⁰ Reproductive health is not specifically mentioned as one of these issues. The plan recognizes economic inequality and the resulting injustices in the present health service system.¹³¹

Specific policies introduced by the permanent secretary of the Ministry of Public Health also shape health-care priorities and services, and these are implemented through the ministry's own action plans.

A number of health-sector reforms have been set in motion in Thailand in recent years in an effort to establish universal health-care coverage.¹³² These reform measures find strong support in the constitution and subsequent laws that have stressed the decentralization of planning processes and have prompted the Ministry of Public Health to reform the public health system through decentralization, health financing reform, expansion of health insurance coverage, increased community participation, and greater transparency and accountability.¹³³ The government is now implementing these changes. By the year 2006, health system reforms will be put into action in their entirety with the enforcement of the National Health Act,¹³⁴ which is currently under the consideration by the cabinet, and will subsequently be submitted to the National Assembly for approval.¹³⁵

Infrastructure of health-care services

Government facilities

The Ministry of Public Health is the principle agency responsible for the promotion, support, control, and coordination of all physical and mental health activities; the well-being of the Thai people; and the provision of health services.¹³⁶ Other ministries that play a role in supporting

and implementing health activities include the Ministry of University Affairs, the Ministry of the Interior, the Ministry of Defense, and the Ministry of Education.¹³⁷ In addition to ministries, several discrete government bodies provide a range of support for the efficient implementation of health programs, including support in the areas of policy planning, budgetary allocations, human resources, international assistance, statistical information, and research.¹³⁸ These bodies include the National Economic and Social Development Board, the Bureau of Budgets, the Civil Service Commission, the Department of Technical and Economic Cooperation, the National Statistical Office, the Thailand Research Foundation, and the Health System Research Institute.¹³⁹ Government agencies with oversight of health services for specific groups are the Social Security Office and the Insurance Department of the Ministry of Commerce.¹⁴⁰

The Ministry of Public Health classifies health care into five groups, according to the type and level of care.¹⁴¹ The most basic group of health care is self-care at the family level, where services include the enhancement of the individual's capacity to provide self-care and make decisions about health.¹⁴²

The next group is identified as community care at the primary care level, where services are organized by the community and relate to health promotion, disease prevention, simple curative care, and rehabilitative care.¹⁴³ Service providers include village health volunteers and volunteers from NGOs.¹⁴⁴

The next group is government health facilities at the primary care level.¹⁴⁵ The services provided by health personnel and general practitioners include health promotion, disease prevention, and simple curative care. Government health facilities providing primary care include community health posts and health centers;¹⁴⁶ these facilities also provide family planning and maternal and child health services.¹⁴⁷ Community health posts are village-level health service units, established specifically in remote areas, that cover a population of 500–1,000 persons and are staffed by one community health worker, who is a Ministry of Public Health permanent employee.¹⁴⁸ Health centers are subdistrict- or village-level health service units that cover a population of about 1,000–5,000 persons, and have a health worker, a midwife, and a technical nurse on staff.¹⁴⁹ Health center staff run health programs according to standard Ministry of Public Health procedures under the technical supervision and support of the community hospital.¹⁵⁰ (Primary care is also provided by the outpatient departments of public hospitals at all levels of care.)

The fourth group is specialized care provided through government health facilities at the secondary care level; these facilities include community, general, and regional hospitals,

and other large public hospitals.¹⁵¹ These hospitals also provide extensive reproductive health services.¹⁵² A community hospital is located in a district or subdistrict and has 10–150 beds, covering a population of 10,000 or more.¹⁵³ Generally, they provide mostly curative care, compared with the mainly preventive care offered at primary care facilities.¹⁵⁴ General hospitals have 200–500 beds, while regional hospitals have over 500 beds and medical specialists in all fields.¹⁵⁵

The fifth group is tertiary level specialized care, which is provided by medical and health professionals with expertise in various specializations.¹⁵⁶ Tertiary care government facilities include regional, general, and university hospitals.¹⁵⁷

Approximately 112.4 million patients received outpatient care at government facilities in 2000; this total has increased steadily from 11.9 million in 1977.¹⁵⁸ Among these patients, the types of providers most commonly visited were health centers and community health posts (46.1%), followed by community and extended hospitals (35.7%), and, lastly, regional and general hospitals (18.2%).¹⁵⁹

According to a 2001 Ministry of Public Health survey on the health situation in the provinces only (i.e., excluding Bangkok),¹⁶⁰ when surveyed about where they sought care for severe illnesses, a solid majority (86.4%) relied on the public sector (80.2% chose to go to public hospitals, another 6.1 % went to health centers, and 0.1 % used village primary care centers).¹⁶¹ In cases of minor illness, a majority said they went to public facilities.¹⁶² Individuals living in rural areas are much more likely than those in urban areas to seek services for minor illnesses at health centers and community health posts (54% vs. 15.7%), and they are less likely than their urban counterparts to seek services at community or general hospitals (14% vs. 25%).¹⁶³

The ratio of primary health-care providers to the total population has steadily improved in every region over the past few decades; at the national level, those ratios rose from 1 to 2,421 in 1987 to 1 to 1,324 in 2000.¹⁶⁴ The overall doctor-to-population ratio in 2000 was 1 to 3,427; the ratio was 1 to 793 in the province of the metropolis Bangkok, and 1 to 5,161 in the other 75 provinces.¹⁶⁵ The overall nurse-to-population ratio in 2000 was 1 to 870; the ratio was 1 to 309 in Bangkok, and 1 to 1,066 in the rest of the country.¹⁶⁶ The number of hospital beds has also recently increased in every region across the country. However, as with the distribution of doctors and nurses, hospital beds are mostly concentrated in Bangkok and the central region, with the fewest numbers in the northeast region.¹⁶⁷

Pursuant to the Act on Operationalization of Decentralization (1999), the Ministry of Public Health must plan for the devolution of its functions, facilities, and personnel to local

administrative units, namely to *tambon* administrative organizations and municipalities by 2010.¹⁶⁸ This will result in the shifting of approximately 80% of the ministry's annual budget, and about 90% of its staff will move to local administrative units.¹⁶⁹

The draft National Health Act, which is currently under review by the cabinet, proposes broad reforms in the national health system. The draft act provides for the establishment of several new mechanisms to improve the implementation of the system, such as a National Health Committee to coordinate all government policies relating to health; a health service accreditation process to support quality improvement and accreditation of facilities at all levels; a consumers' protection mechanism; a national health manpower development committee charged with the planning and regulation of service provision by health personnel; alternative medicine provision; and a health research system.¹⁷⁰

Privately run facilities

In the private as in the public sector, health care is provided through facilities at the primary, secondary, and tertiary care levels.¹⁷¹ Private clinics, the outpatient departments of private hospitals, and drugstores all offer primary care services, while private hospitals provide secondary and tertiary medical treatment.¹⁷² Between 1987 and 1997, the country saw a period of rapid economic growth during which the private health sector also expanded.¹⁷³ In 2000, there were 13,099 drugstores, 10,875 clinics, and 461 private hospitals, with a ratio of private-to-government hospital beds of one to three.¹⁷⁴ However, as a result of the economic crisis in 2001, some private facilities have adjusted their operations, for example, by reducing the number of hospital beds and staff.¹⁷⁵

According to a 2001 Ministry of Public Health survey conducted in the provinces only (i.e., excluding Bangkok), in cases of severe illness, 13.4% of respondents relied on the private sector (i.e., 6.1% used private hospitals, 5.4% went to private clinics, 0.5% saw local traditional practitioners or monks, and 1.4% frequented other nongovernment establishments).¹⁷⁶ A minority of respondents sought relief from minor ailments in the private sector (i.e., 8.5% bought medicines from grocery stores, 10.5% bought remedies from drugstores, and 1.7% went to private hospitals).¹⁷⁷ Residents of urban areas tend to seek treatment for minor illnesses at private clinics more often than do residents outside of such areas (24.7% vs. 10.9%).¹⁷⁸

In addition to for-profit health facilities, there are about 375 nonprofit health-related organizations throughout the country, including foundations and associations.¹⁷⁹ These organizations have contributed to a number of health programs in areas such as family planning, sanitation, mater-

nal and child health, and general health services.¹⁸⁰

Financing and cost of health-care services

Government financing

Health-care financing is relatively complex in Thailand, with large resources devoted to health and relatively high administrative costs stemming from having multiple sources of funding.¹⁸¹ The total national health expenditure has increased significantly over the past few decades, from 3.8% of the country's GDP in 1980 to 6.1% of GDP in 2000, with per capita health spending rising from 545 baht (USD 13) to 4,832 baht (USD 118) during that period.¹⁸² Most of the national expenditure on health is for curative care.¹⁸³

As of 2001, government health expenditure accounted for 57% of the total national health expenditure, and 11% of the government's total budget. Although the private and public sectors spend roughly the same amount for care received in health-care facilities, the private sector total includes payments for private drug purchases.¹⁸⁴

One of the aims of the Ninth National Health Development Plan is to increase the government's budget for activities relating to health promotion and the prevention of diseases by at least 10% over the course of the plan. By its end point in 2006, an estimated 126 billion baht (approximately USD 3 billion), or about 40% of the total health budget, will be allocated for these activities.¹⁸⁵

Private and international financing

In 2000, private spending accounted for 66.7% of the national health expenditure.¹⁸⁶ Out-of-pocket expenses represented the majority of private spending on health (85% of the total) in 1998.¹⁸⁷

International financial support to Thailand in the area of health has been declining recently, from 1.44% of total expenditure on health in 1980 to 0.15% in 1990.¹⁸⁸ In 2000, international financing dropped to 0.14% of the country's total health expenditure.¹⁸⁹ Thailand is now seen as one of the donor countries providing assistance to other Southeast Asian countries.¹⁹⁰

One significant donor-funded project is the South-South Cooperation on Population, Family Planning, and Reproductive Health; this project, established in 1995, involves a network of developing countries that cooperate and exchange information and technology on related issues, including follow-up and support of the implementation of the ICPD Programme of Action.¹⁹¹ The project receives funding and technical support from the United Nations Population Fund, the Rockefeller Foundation, and the World Bank. Thailand was one of the founding countries of the project, and in 1995, it established the Center for the South-South Initiative under the Reproductive Health Division of the Department of Health to implement assigned activities, coordinate with

member organizations, and direct technical cooperation in the field of population and reproductive health for both local and international agencies.¹⁹²

Cost

Thailand has several health insurance and social security schemes covering various segments of the population.¹⁹³ Existing schemes include the following:¹⁹⁴

- medical care plans for low-income persons;
- medical care plans for civil servants and state employees;
- social security and workmen's compensation funds;
- voluntary health insurance supplied by the Ministry of Public Health;
- voluntary health insurance supplied by private health insurance institutions; and
- other types of insurance plans (e.g., compulsory and voluntary insurance for car accidents).

There are some differences between schemes in the per capita costs; for example, the health plans provided for civil servants and state employees are more heavily subsidized by the state than are the plans for low-income individuals. There are also some discrepancies in the health benefits provided under each health insurance system.¹⁹⁵

Health insurance coverage in Thailand has been expanding.¹⁹⁶ A 2001 government survey found that approximately 71% of the population is covered by at least one of the existing health insurance schemes, with greater coverage among people living in rural areas.¹⁹⁷ Overall 31.5% of Thais are covered by the plan for low-income individuals, 8.5% by the plan for civil servants and state employees, 7.2% by social security and the workmen's compensation fund, 20.8% by voluntary health insurance plans under the Ministry of Public Health, 1.3% by voluntary private health insurance plans, and 0.9% by the recently introduced 30 Baht Scheme Policy (described below).¹⁹⁸ About 29.0% have no health insurance at all. These uncovered individuals must pay for public or private health care and services out of pocket, which amounts to as much as 18.6% of the annual income of a household.¹⁹⁹

Thailand established the Social Security Fund in 1990, through the Social Security Act (1990), which requires the government, employers, and insured persons to make equal contributions to the Social Security Fund at a prescribed rate. The fund provides insurance for injury or sickness, disability, death, maternity, old age, and, as of 1999, child and unemployment benefits. As of May 2003, 7,158,068 persons were insured by the Social Security Fund.²⁰⁰ As of April 2003, 16,709 insured persons had applied for maternity benefits, the benefit type with the highest number of applicants.²⁰¹ Medical services not covered by the Social Security Act, as pre-

scribed by the Office of Social Security's Regulations (1991), are infertility treatment, tissue typing for organ transplants, artificial insemination, rehabilitation services, and any medical services that are deemed unnecessary for the treatment of individual injuries and illnesses.²⁰²

As part of the Ninth National Economic and Social Development Plan, the government calls for health-care system reform and the further development of the health insurance system to make it more efficient, more equitable, and more available to people of all disadvantaged groups. Accordingly, the government added to the previously mentioned plans by introducing universal health-care coverage in Thailand by enacting the National Health Security Act in November 2002.²⁰³ Pursuant to the act, the government announced the 30 Baht Health Plan, which is designed to provide health services for people aged 13–50 years who lack health insurance of any kind. The plan covers services necessary for the enjoyment of good health and living, including those relating to medical treatment, rehabilitation, health promotion and prevention of diseases, and a range of reproductive health-care services. The cost of uncovered services and those deemed unnecessary must be borne by the individuals. Specific reproductive health services provided free of charge under the plan include family planning services, including sterilization services, but not infertility treatment or artificial insemination; maternal health care; the provision of medication to prevent mother-to-child transmission of HIV; delivery care (for the insured's first two live births); and physical examinations for the prevention and early treatment of reproductive tract cancers, such as cervical cancer.²⁰⁴

Regulation of health-care providers

Health services rendered by health-care providers in Thailand are regulated by the Practice of the Art of Healing Act (1999).²⁰⁵ According to the act, the "practice of the art of healing" is defined as the practice of a profession that is carried out or aims to be carried out on human beings and concerns the examination, diagnosis, treatment, and prevention of disease. The Act also includes health promotion and rehabilitation and obstetric care, but excludes all other medical and public health practices governed by other laws.²⁰⁶ The act prescribes several eligibility requirements regarding the registration and licensing of individuals applying to work in their respective professions; these requirements cover the applicants' age, knowledge of the profession, professional conduct, and physical and mental health status.²⁰⁷

In addition to the Practice of the Art of Healing Act, other laws concerning the medical and health professions include the Medical Treatment Profession Act (1982),²⁰⁸ the Nursing and Midwifery Profession Act (1985, amended in 1997),²⁰⁹ the

Pharmaceutic Profession Act (1994),²¹⁰ the Dental Treatment Profession Act (1994),²¹¹ and the Protection and Promotion of Traditional Thai Medicine Act (1999).²¹²

The Medical Treatment Profession Act provides for the establishment of the Medical Council, which is a professional organization charged with the oversight of various aspects of the medical profession.²¹³ Among other functions, the council regulates physicians' conduct according to medical ethics standards, provides technical support, provides advice or recommendations to the government, and represents physicians of all fields in Thailand.²¹⁴ The council is directly responsible for registering and issuing licenses to physicians applying to work in medical professions, suspending or revoking licenses, and verifying that medical institutions meet academic standards.²¹⁵ The council also has the statutory authority to issue announcements, which are regarded as regulations, with which medical practitioners must comply.²¹⁶

Nurses and birth attendants are under the supervision of the Nursing Council, which was established by the Nursing and Midwifery Profession Act.²¹⁷ The main objectives of the council are to supervise the professional conduct of nurses and birth attendants according to prescribed ethical standards, provide technical support, issue recommendations to the government, and represent nurses and birth attendants in Thailand.²¹⁸ Important duties of the council include the registration and issuance of work licenses to persons applying to work as nurses and birth attendants, and the suspension and revocation of licenses.²¹⁹

The Pharmaceutic Profession Act²²⁰ and the Dental Treatment Profession Act also provide for the establishment of regulatory Pharmaceutical and Dental Councils, respectively.

Thai traditional medical practitioners are considered to be practitioners of the art of healing, and are supervised and controlled by the Practice of the Art of Healing Act.²²¹ According to the act, Thai traditional medicine is defined as "the practice of the art of healing according to the Thai traditional knowledge or texts, which has been transferred and developed over the years, or has been learned from the institutions which are accredited by the Executive Committee of the Medical Council."²²² Thai traditional medicine encompasses traditional medical treatments, remedies, midwifery, and other traditional practices, as determined by the minister of public health in accordance with the recommendations of the Executive Committee of the Medical Council.²²³

The Protection and Promotion of Traditional Thai Medicine Act, which was passed in 1999 and implemented in 2002, was followed by the establishment of the Department for the Development of Thai Traditional and Alternative Medicine under the Ministry of Public Health in 2002.²²⁴ The newly

established department's duties, which are prescribed by the act and will serve to implement it, include the development, support, and protection of knowledge about Thai traditional medicine, including herbal medicine.²²⁵

Patients' rights

The Medical Treatment Profession Act (1982) contains provisions that directly relate to the protection of patients' rights.²²⁶ The act provides that a person wronged by the conduct of a medical worker who violates professional codes of conduct has the right to lodge a complaint with the Medical Council.²²⁷ Complaints must be submitted in writing.²²⁸ The council then appoints a subcommittee to investigate the complaint and the accused practitioner²²⁹ before recommending that the executive committee of the council take certain actions, including dismissing the complaint or issuing a warning to the practitioner, prescribing probation, suspending the practitioner's license for up to two years, or revoking his or her license.²³⁰ The council's judgment is considered to be complete and final.²³¹ In cases where a practitioner's license has been revoked for wrongdoing, he or she may reapply for a license.²³² However, the executive committee of the council also has discretion to permanently cancel a practitioner's license.²³³

In addition to the provisions for malpractice outlined in the Medical Treatment Profession Act, persons harmed by a practitioner may also initiate legal action for medical malpractice under provisions in the penal code that recognize criminal liability for negligent or unintentional acts.²³⁴ Other code provisions that may be applied in cases of medical malpractice relate to false certification²³⁵ and the disclosure of private secrets.²³⁶

The Medical Council, the Nursing Council, the Pharmaceutical Council, the Dental Council, and the Medical Registration Committee jointly issued a Declaration on Patients' Rights in 1998; this declaration includes ten fundamental rights, such as the right to receive health services without discrimination of any kind, and the right of parents or legal guardians to exercise rights on behalf of children younger than 18, and persons with physical or mental disabilities.²³⁷ The declaration raises awareness about patients' rights, but does not include mechanisms for their protection in cases of violations.

B. REPRODUCTIVE HEALTH LAWS AND POLICIES

The Ministry of Public Health announced the National Reproductive Health Policy in 1997 stating that "[a]ll Thai citizens, at all ages, must have good reproductive life."²³⁸ The policy specifies the following objectives:

- promote an appropriate family size for the capacity of

each family;

- promote proper pre- and postnatal care;
- control, prevent, and provide treatment for HIV/AIDS;
- promote the prevention and treatment of reproductive tract infections;
- control malignancies of the reproductive organs;
- promote counseling on reproductive health issues and the dissemination of sex education;
- decrease the incidence of abortion and its complications;
- improve reproductive health-care services and their availability among youth and adolescents; and
- promote and provide services for peri- and postmenopausal women and the elderly.²³⁹

The policy's implementing strategies, which aim to achieve the policy's objectives, are as follows:

- provide fully integrated and coordinated services, so all implementing agencies concerned may jointly plan their operational plans;
- safeguard the human rights of all groups in society, especially women's human rights, and encourage men to take more responsibility;
- encourage the full participation of people, communities, and NGOs at all levels, in order to find appropriate solutions to specific problems encountered by each community;
- aim to provide higher quality services, not simply higher quantities of services; and
- disseminate information on the core elements of reproductive health to all age-groups and levels of society, in order to raise awareness of the importance of reproductive health.²⁴⁰

Reproductive health care provided through the government health delivery system includes services in the following ten areas:

- family planning (including counseling; services; and information, education, and communication activities);
- maternal and child health (including prenatal education and services, safe delivery and postnatal care, breast-feeding support, and infant care);
- HIV/AIDS (including prevention and reduction efforts);
- reproductive tract infections (including information, education, and treatment);
- malignancies of the reproductive tract (including diagnosis, treatment, and education);
- sex education, sexuality, reproductive health and

responsible parenthood;

- adolescent reproductive health (including information, education, counseling, and services);
- abortion (including prevention of unsafe abortion and management of its complications and consequences);
- infertility (including prevention and appropriate treatment); and
- sexual health issues among those who are past reproductive age and the elderly (including information, education, and care).²⁴¹

At present, reproductive health services are not integrated, and the various components of reproductive health care are carried out by different departments of the Ministry of Public Health, Ministry of Education, Department of Communicable Diseases, Department of Medical Services, and Department of Medical Sciences.²⁴² Moreover, these departments provide reproductive health services in different sectors, as demonstrated in the following table:²⁴³

Department or Ministry Responsible for Implementation	Reproductive Health Area
Department of Health	Family planning, and maternal and child health
Department of Health and Department of Disease Control	HIV/AIDS (including mother-to-child transmission and reproductive tract infections)
Department of Health and Department of Medical Services	Malignancies of the reproductive tract, abortion and abortion complications, infertility, and reproductive health care for peri- and postmenopausal women and the elderly
Department of Health, Department of Mental Health, and Ministry of Education	Sex education
Department of Health and Department of Mental Health	Adolescent reproductive health

The Reproductive Health Division of the Department of Health under the Ministry of Public Health is responsible for the overall supervision of reproductive health services. The division's specific functions include the following:

- study, research, analyze, and develop a body of knowledge and technology concerning reproductive health;
- develop and establish reproductive health standards to promote and support operational mechanisms in accordance with laws on public health and other related laws; and
- provide technical assistance on reproductive health.²⁴⁴

In 2002, the Thai National Assembly organized a national seminar on Reproductive Rights and Women's Health, in order to develop understanding and raise awareness of women's health and reproductive rights among National Assembly members, as well as to brainstorm ideas on the appropriate changes needed in laws and regulations concerning women's health and reproductive rights. After extensive discussions, seminar participants recommended a comprehensive reproductive health law to guard the reproductive health and rights of all Thais and furthermore, steps have already been taken to draft a protective bill.²⁴⁵

Regulation of reproductive health technologies

Thailand has no specific law on assisted reproductive technologies. However, in 1997, the Executive Committee of the Medical Council approved regulations affecting these technologies, which include the following prescriptions:²⁴⁶

- each center offering assisted reproductive technologies must have an ethics committee made up of at least three staff members;
- each center must provide a form for the husband and wife's written consent for all procedures; and
- the Royal Thai College of Obstetricians and Gynecologists will supervise and manage the administration of assisted reproductive technologies and produce annual reports on their use.²⁴⁷

The World Health Organization (WHO) and Chulalongkorn University in Bangkok have worked together to create the WHO Collaborating Centre for Research in Human Reproduction.²⁴⁸ Over the past five years, the center has been involved in an assisted reproductive technology project, including an in vitro fertilization and embryo exchange program using cryopreservation of embryos and sperm banks for research and treatment purposes.²⁴⁹ Research topics have included measuring reproductive hormones, monitoring short- and long-term effects of injectable contraceptive use, developing male methods of fertility regulation, studying sperm-zona pellucida interactions, and creating aging and menopausal profiles.²⁵⁰

Family planning

General policy framework

Within the Ministry of Public Health, the Family Planning and Population Division of the Department of Health is responsible for implementing the National Family Planning Program.²⁵¹

The government's objectives relating to family planning include the following:

- accelerate family planning efforts in areas where the total fertility rate is still high and the contraceptive prevalence rate is low;
- provide services for married and unmarried male and female youth, with the specific aim of reducing adolescent pregnancy;
- promote three-year birthspacing intervals;
- monitor the quality of services;
- promote male involvement in family planning; and
- better meet the needs of specific populations, including ethnic and religious minorities and underserved populations.²⁵²

Since 1976, Thailand has implemented a targeted family planning program concentrating on four groups—remote rural villages, the southern Muslim religious communities, ethnic minority hill tribe groups, and unmarried adolescents.²⁵³

Contraception

The contraceptive prevalence rate in 2001 was 79.2%. A government survey found regional disparities in prevalence among married women aged 15–44, with the highest rate in the northern region (83.8%) and the lowest in the southern region (73.0%).²⁵⁴ The southern Muslim population has an especially low rate of contraceptive use due to cultural and religious reasons.²⁵⁵

The pill was the most commonly used method (by 26.8% of married women), followed by female sterilization (22.6%) and the injectable (22.0%).²⁵⁶ The least used methods among Thai couples were vasectomy (1.2%), the implant (1.5%), and condoms (1.7%).²⁵⁷ Methods that have increased in popularity over the past few decades include the injectable, the pill, and the implant.²⁵⁸ Conversely, methods that have lost ground are the IUD, vasectomy, and female sterilization.²⁵⁹ While overall condom use has also declined slightly, its use among sex workers has risen.²⁶⁰

According to official data, 127,937 persons received sterilization services in 2000.²⁶¹ The overwhelming majority were women (95%).²⁶² The percentage of men seeking sterilization in every region was less than 1%, except in Bangkok, where it reached 3.4%.²⁶³ Such proportions remain relatively unchanged since 1997.²⁶⁴

According to community-based research in 2001 that

examined the pregnancy records of 1,180 women aged 15–59, 45% of pregnancies were unplanned.²⁶⁵

There is no available information on contraceptive prevalence rates among unmarried individuals, since they are not included in government family planning surveys.²⁶⁶

Contraception laws and policies

Generally, the government does not prohibit the use of contraception, except for methods with potentially harmful effects, such as pills containing over 50 micrograms of estrogen, which are known to raise the risk of hemorrhage.²⁶⁷ The only law dealing specifically with contraceptive methods is a law on condoms.²⁶⁸ The law defines condoms as “medical devices” and, as such, producers and importers of these products must seek approval from the secretary general of the Food and Drug Administration pursuant to the Medical Device Act (1988). Other requirements are imposed to ensure the quality and safety of condoms.²⁶⁹ The Food and Drug Administration is the main agency responsible for overseeing and making recommendations to the public health minister on matters relating to contraceptives.²⁷⁰

The government does not prohibit the use of emergency contraception, which has been widely used in Thailand for over a decade.²⁷¹ There is relatively easy access to the product, which is available in any drugstore. In 2000, the Ministry of Public Health ordered manufacturers as well as importers of emergency contraception to change its indications for use.²⁷² The new indications state that the product may be used “[t]o prevent pregnancy in case of rape, incorrect use of normal contraceptives, or emergency cases. . . .” Previously, the indications were “[t]o prevent pregnancy after sexual intercourse, in case other methods have not been used.” Pursuant to the ministry’s order, the recommended dosage and instructions for use were also modified. The instructions currently call for one tablet to be taken within 24 hours but not more than 72 hours after unprotected sexual intercourse, with a second tablet to be taken 12 hours after the first dose. The previous instructions called for one tablet to be taken immediately or within an hour of having unprotected sexual intercourse.²⁷³ The order also changes the product label from “Birth control pills after sexual intercourse” to “Emergency birth control pills.” The changes were partly attributable to advocacy by women’s health organizations for more accurate indications, since inaccurate labeling had led to improper use among some Thai women.

Regulation of information on contraception

There are no known legal restrictions in Thailand on advertising contraception. Indeed, public awareness of contraceptive options is a top government priority, in keeping with its overall population plan, as well as its efforts to combat the spread of AIDS.

All hormonal contraceptives marketed in Thailand are required to give two standard precautions on their use; one advises patients to see medical doctors in case of “irregularities,” and the other warns patients with blood vessel blockage or hepatitis not to use hormonal methods.²⁷⁴

Sterilization is legal in Thailand. However, there is no specific law on the procedure or its eligibility requirements. The only requirement is that the service provider be a nurse or midwife trained in sterilization in accordance with Ministry of Public Health regulations.²⁷⁵ In addition, persons seeking sterilization are required to give written informed consent before the procedure is performed.²⁷⁶

The Labour Protection Act (1998) includes a provision relating to employee leave for sterilization.²⁷⁷ The law entitles an employee to paid leave for such time as prescribed by an authorized medical practitioner.²⁷⁸

Although there is no specific law on the eligibility criteria for sterilization, in practice medical doctors provide the service to women with at least two children with spousal consent.²⁷⁹ Men who seek sterilization may apply for the service without spousal consent.²⁸⁰

Government delivery of family planning services

Thailand’s current family planning program aims to make family planning services available at all private and public facilities, including 9,661 public health centers nationwide.²⁸¹ Family planning services and contraceptive methods are also provided at the village level and in remote rural communities through village health volunteers and an extensive network of mobile family planning units.²⁸²

Contraceptive methods, such as the pill and the condom, are readily available at public health facilities and are provided largely free of charge.²⁸³ Contraceptive services offered in public health facilities include female sterilization, vasectomy, IUD and implant insertions, and contraceptive injections.²⁸⁴

The National Health Security Act fully covers the costs of family planning methods, including sterilization services, but it does not pay the costs of infertility treatment or artificial insemination.²⁸⁵ Holders of a social security card may also be reimbursed for the medical fees associated with sterilization, at a maximum of 500 baht for men (approximately USD 12) and 1,000 baht for women (approximately USD 25).²⁸⁶ Clients covered by the universal health coverage program, “Health for All” are also entitled to sterilization services free of cost.²⁸⁷

Family planning services provided by NGOs and the private sector

Family planning services are provided by a variety of sources outside of the government sector, including traditional healers, community-based organizations, NGOs, and private hospitals. Many of these providers partner with each other or the government to improve access to contraception.

Approximately 9% of women aged 15–44 use family planning services provided by private health institutions.²⁸⁸

The nongovernmental sector plays an important role in the provision of family planning counseling, services, and information; it also conducts related education and communication campaigns, with an emphasis on helping couples achieve their desired family size.²⁸⁹ In addition to centers run by the Planned Parenthood Association of Thailand, which target the underserved hill tribes in the northern provinces,²⁹⁰ a network of community-based village health volunteers provides family planning services in 17,000 villages in 157 districts.²⁹¹

Maternal health

Thailand's maternal mortality ratio has declined from 43.9 maternal deaths per 100,000 live births in 1996 to 23.9 deaths per 100,000 in 2002.²⁹² There are wide variations between regions, with the highest ratio in the northern region (47.95 per 100,000), followed by the southern region (23.48 per 100,000), the northeast region (16.78 per 100,000) and the central region (16.45 per 100,000).²⁹³ The very high maternal mortality ratios in the northern region reflect the negative health consequences of early marriage and limited access to health care among the several ethnic groups in that area. The two most common causes of maternal mortality overall are hemorrhaging (42.11% of maternal deaths) and toxemia in pregnancy (15.04% of maternal deaths).²⁹⁴ Poverty and lack of health insurance have been cited by experts as major obstacles to women's access to prenatal care in Thailand.²⁹⁵

Ever since malaria has become a problem of epidemic proportions in some border areas,²⁹⁶ Thai women of child-bearing age in these areas are increasingly affected by malarial infections, which can compromise maternal health.²⁹⁷

Laws and policies

Maternal health has been a stated priority of the Thai government since the National Health Development Plan of the Third National Economic and Social Development Plan (1972–1976). The current (ninth) plan again lists maternal health, including the reduction of maternal mortality, as one of its priorities.²⁹⁸ The plan has adopted the following maternal health targets:

- reduce the proportion of women having their first child before the age of 20 to under 10%;
- reduce the maternal mortality ratio to under 18 maternal deaths per 100,000 live births;
- reduce HIV prevalence among pregnant women to under 1%; and
- reduce the prevalence of iron deficiency anemia among pregnant women to under 10%.²⁹⁹

A component of Thailand's current Reproductive Health

Policy is education on maternal health and the provision of adequate pre- and postnatal care.³⁰⁰

A number of government projects and programs on maternal and child health have been initiated over the past few decades. In 1988, the Bureau of Health Promotion of the Department of Health launched the Increase of the Capability of Maternal and Child Health Project in collaboration with the WHO and the Ministry of University Affairs.³⁰¹ The project's first phase focused on increasing awareness, collecting information, analyzing problems, and strategizing. In 1998, the Safe Birth Hospital project was also initiated under the responsibility of the bureau, but with the additional participation of the Regional Public Health Division and the Office of the Permanent Secretary (Ministry of Foreign Affairs). Hospitals joining the project must meet prescribed service and quality standards. Specifically, they must have the capacity to provide basic prenatal care (i.e., at least four prenatal checkups and a voluntary HIV test); basic birth and delivery services, including having staff on hand for emergency resuscitation, cesarean sections and prompt transfers; and basic postpartum services (e.g., family planning and breast-feeding promotion in accordance with the criteria of the Child–Mother Relationships Hospital Program).³⁰² The Child–Mother Relationships Hospital Program, which is formally known as the Baby–Friendly Hospitals Initiative, was started in 1991 and promotes breast-feeding in hospitals.³⁰³ Currently, 788 public and private hospitals and 8,650 public health centers are participating in the project.³⁰⁴ In 2001, the Department of Health initiated the national Pregnant Women's Health Surveillance Project, which aims to enhance birth weight and promotes a target weight of at least 2,500 grams. This project has produced educational materials to increase knowledge and promote good health practices among pregnant women.³⁰⁵

By law, pregnant women against whom criminal proceedings have been initiated or who are incarcerated are protected in several ways. The Criminal Procedure Code gives courts discretion to defer imprisonment in cases where the defendant is over seven months' pregnant or has a newborn less than one month old.³⁰⁶ In cases where a defendant is sentenced to death while she is pregnant, the code allows the execution to be postponed until after the delivery.³⁰⁷ In addition, the Corrections Act (1936), which was amended in 1980, categorizes a pregnant inmate or an inmate with a newborn as an "ill person."³⁰⁸

Nutrition

Thailand has been largely successful in implementing policies and programs addressing problems relating to nutrition over the past several decades.³⁰⁹ The government has addressed nutrition concerns in successive National Economic and Social Development Plans, as well as in a specific national policy on nutrition.³¹⁰

Presently, moderate malnutrition is no longer a significant problem as a general matter, although it remains a problem in specific geographic areas.³¹¹ However, iron deficiency anemia remains a common problem among school children and pregnant women.³¹² The government has adopted a comprehensive strategy that includes iron supplementation offered through health clinics and schools, fortification of food products, and dietary diversification.³¹³

The Ministry of Public Health recently identified overnutrition as an emerging health problem among adults and children. The government has not yet identified specific strategies to deal with the problem, however.³¹⁴

Safe abortion

Official statistics on the incidence of abortion are limited. While maternal health in general has improved in the past few decades, unsafe abortion and its complications are still widespread, particularly in rural areas,³¹⁵ according to several discrete government studies. In 1999, for example, the Ministry of Public Health conducted a survey on abortion in Thailand by examining the records of women who were hospitalized for the treatment of complications from miscarriages and induced abortions in 787 state hospitals nationwide.³¹⁶ Of the 45,990 records examined, 28.5% were of women who sought an induced abortion.

Among women who sought an induced abortion, 48.6% were age 24 or younger, and had been pregnant, on average, for 13 weeks—a stage at which the woman is at especially high risk of infection and may suffer from a perforated uterus. More than one-quarter (28.8%) of the patients who had sought an induced abortion developed a severe infection from a perforated uterus, and 0.11% of these women died from the resulting complications.³¹⁷

According to community-based research in 2001 that examined the pregnancy records of 1,180 women aged 15–59, 8% of pregnancies resulted in abortion.³¹⁸

According to some studies, a majority of women who obtained an abortion in rural areas cited limiting family size as their main reason for seeking an abortion.³¹⁹ A significant proportion also cited the need for child spacing.³²⁰ Despite the ready availability of contraceptives, several studies have shown that a significant proportion of women who sought an abortion were not using any method prior to the procedure.³²¹

Abortion laws and policies

Abortion is generally prohibited by the penal code, and both women who seek abortions and providers who perform them are liable to penalties.³²² The law allows abortion only when the pregnancy endangers the woman's health and in cases of rape, and only if the procedure is performed by a medical practitioner.³²³ In practice, the application of the legal

health exception has often been restricted to cases where the pregnancy endangers the woman's life, rather than to a broader range of health conditions.³²⁴

The penal code stipulates the penalties for illegal abortion, which vary in severity depending on the individual performing the abortion, whether the woman consented to the procedure, and whether the woman suffered additional physical harm because of it.³²⁵ A woman who induces her own abortion or allows another person to do so is liable to imprisonment of up to three years or a fine of up to 6,000 baht (USD 146), or both;³²⁶ the penalty is more severe for the 3rd party involved in performing the abortion. If the abortion is performed with the woman's consent, whoever carries out the procedure is liable to imprisonment of up to five years or a fine of up to 10,000 baht (approximately USD 244), or both.³²⁷ If the woman did not consent, the punishment increases to imprisonment of up to seven years or a fine of 14,000 baht (USD 342) or both.³²⁸ The penalty is more severe in both instances if the abortion also results in grievous bodily harm to the woman or her death.³²⁹ An attempt to commit the offense of abortion is not considered a crime.³³⁰

Thus far, specific government regulations for requesting or providing abortion services have not been issued, and the resulting confusion serves as a major obstacle for women who seek abortions. For health service providers, the lack of clear and practical regulations has created problems in the interpretation of the law. To protect themselves from accusations of illegal activity, most physicians usually refuse to perform abortions. In cases where they agree to perform the procedure, they interpret the law as narrowly as possible to safeguard themselves as much as possible.³³¹ Currently, efforts are being made to expand the Medical Council's guidelines on abortion by expanding the health exception and drafting regulations.

Despite the general illegality of abortion, there are varying legal and religious interpretations in Thailand regarding when life begins. The criminal code does not explicitly define abortion or state when life begins. The Civil and Commercial Code, however, stipulates that a person comes into being after being born alive.³³² Buddhist conventional wisdom (Tripi-taka) contends that life starts at conception and that abortion is an act of killing and a sin.³³³ However, Buddhism tolerates given sinful acts when taking into account their social and legal context.³³⁴ Consequently, under Buddhism as practiced in Thailand, abortion is considered morally wrong but socially excusable.³³⁵ In 1979, the Council of the Catholic Bishops in Thailand issued a statement on abortion that defines human life as beginning "...at the time that the parents' seeds of life have been mixed. At such time, it is to be held that there is

already a conception, or a pregnancy has already occurred.”³³⁶ An abortion is thus “a murder allowed by the parents to happen”³³⁷ and considered “the most hideous crime.”³³⁸

The Ninth National Health Promotion Plan issued by the Ministry of Public Health includes an objective to lower the incidence of maternal mortality and morbidity resulting from unsafe abortions. Under the plan, a target for government medical facilities is to keep the maternal mortality ratio from exceeding 18 maternal deaths per 100,000 live births.³³⁹

In addition, the Medical Council has specific directives relating to abortion in its Guidelines on the Provision of Obstetric and Gynecological Services.³⁴⁰ The guidelines advise doctors to discuss all possible options with patients who present with unplanned pregnancies, including legal abortion. The guidelines also stipulate that patients should be informed of the possible health effects associated with abortion, and that they should be discouraged from seeking an illegal abortion.³⁴¹ In cases where a doctor learns that a patient has had an abortion, the doctor is bound to a strict duty of confidentiality and must not disclose the fact to any other person or the police. A breach of this duty is considered an offense under the penal code.³⁴²

There is currently no comprehensive government policy regarding postabortion care.

Regulation of information on abortion

Commercial drug advertisements are controlled by the Drug Act (1967), which restricts advertisements that “lead to an understanding that [the product] can induce miscarriages, or menstruation.”³⁴³ However, advertisements intended for medical doctors may mention that a drug could cause miscarriages.³⁴⁴

Government delivery of abortion services

Abortions, to the extent permitted by law, are available in public health facilities.³⁴⁵ Legal abortions may be performed only by a medical doctor.³⁴⁶ Only authorized government doctors can perform abortions; private doctors need to register their certificate with the Medical Council before they can offer the procedure. Although there is currently no policy on postabortion care in Thailand, the Reproductive Health Division is undertaking a three-year training project on postabortion care for interested physicians.

Abortion services are not included in the list of health-care services covered by the national health insurance system.³⁴⁷

Abortion services provided by NGOs and the private sector

Since abortion is illegal in most circumstances in Thailand, NGOs and private clinics have no data on such services.

HIV/AIDS and other sexually transmissible infections (STIs)

Between 1984 and 2003, there were 305,848 reported cases

of HIV infection, of which 223,476 had progressed to AIDS, and 69,233 resulted in death.³⁴⁸ Most people living with AIDS are of reproductive age (15–44). Although men account for most AIDS cases, the rate of HIV infection is higher among women aged 10–19 than among men aged 10–19. It is projected that an estimated 1,109,000 people, including 53,400 children, will be living with AIDS by 2006. Projections also estimate that the annual number of new cases of AIDS will be 17,000 in 2006, and that the cumulative total of AIDS-related deaths will have reached 601,000 by that year.³⁴⁹ The most common mode of HIV transmission is through sexual relations (83.80%), followed by intravenous drug use (4.72%),³⁵⁰ mother-to-child transmission (4.31%), and blood transfusions (0.03%).³⁵¹

HIV/AIDS remains a major problem among intravenous drug users and sex workers; these subgroups have especially high HIV prevalence rates of 41.7% and 12.3%, respectively.³⁵² Gaps exist in the treatment and coverage of many HIV-infected mothers in need of antiretroviral treatments to prevent vertical transmission.³⁵³

As a result of AIDS control and prevention campaigns, including efforts to promote the use of condoms, the overall STI situation has improved in Thailand over the past few decades. For example, the incidence of STIs was 7.85 infections per 1,000 persons in 2001.³⁵⁴

Laws and policies

There is no specific legislation relating to HIV/AIDS or laws that make screening of blood products mandatory.

Neither are there specific laws for the protection of the rights of infected persons, although the constitution and other laws may be invoked in cases where such persons have suffered rights violations. The constitution specifically prohibits discrimination or unfair treatment on the basis of health differences.³⁵⁵ An appeal to the Medical Council may also be made in such cases.³⁵⁶ The issue of how to balance protecting the human rights of both the general public and of people living with HIV/AIDS has been under debate and discussion, but no resolution has yet been reached.³⁵⁷

Legal discrimination based on HIV/AIDS status has been upheld in some cases. The Regulation on the Administration of Welfare Benefits for HIV-infected Workers and Families, of the Ministry of Labour and Social Welfare, requires infected persons to disclose their HIV/AIDS status in order to request financial assistance for education and occupational training and support.³⁵⁸ Specifically, such individuals must provide health certificates that include identifying personal information and that indicate their HIV-positive status.³⁵⁹

The Venereal Diseases Division of the Department of Disease Control is the main Ministry of Public Health agency

that makes policy relating to STIs. Because the incidence of STIs in Thailand has decreased over the past few decades in response to HIV/AIDS prevention policies, the division has not recently issued any special measures for STI control. However, a specific target relating to the control of STIs aims to keep the prevalence of STIs among the general population from exceeding 0.5 infections per 1,000 population.³⁶⁰

The current government policy addressing HIV/AIDS is the National Plan for the Prevention and Alleviation of HIV/AIDS, 2002–2006, which envisages a strong and healthy society where individuals, families, and communities “possess wisdom and knowledge, have a mutual sense of concern, and work together to prevent and alleviate the HIV/AIDS problem.”³⁶¹ The plan has the following broad targets:

- reduce the incidence of HIV/AIDS among the population of reproductive age (15–49) to less than 1% by the end of the plan period;
- increase to at least 80% the proportion of people living with HIV/AIDS and affected individuals who will have access to and be receiving appropriate care and support from public, private, and community providers of social, economic, educational, and primary health-care services; and
- have local administrations and community organizations throughout the country efficiently and continuously plan and carry out HIV/AIDS prevention and alleviation.³⁶²

It also has five broad strategies, which include the following:

- developing the potential of individuals, families, communities, and the broader social environment to prevent and treat HIV/AIDS and alleviate problems associated with HIV/AIDS;
- establishing health and social welfare services for the prevention and treatment of HIV/AIDS;
- expanding knowledge and developing research for the prevention and treatment of HIV/AIDS;
- fostering international cooperation for the prevention and treatment of HIV/AIDS; and
- developing a collective program management system to integrate the tasks of HIV/AIDS prevention and treatment.³⁶³

Each strategy contains its own specific objectives, target groups, and measures. Specific objectives and aims relating to the rights of people living with HIV/AIDS are to ensure that basic health-care services are provided to infected individuals without discrimination, and to establish mechanisms to protect the rights of such individuals and others affected by the disease.³⁶⁴ The plan also calls for the mandatory provision

of medical treatment for HIV/AIDS patients, in all hospital facilities, that meets the standards of the national health insurance system, as well as support for the provision of alternative health-care services at facilities both inside and outside the formal health-care system.³⁶⁵

The government also has a policy on infected persons' rights to voluntary testing.³⁶⁶ The policy respects the decisions of infected persons who cannot be forced to undergo blood tests in most situations.³⁶⁷ However, there is a significant gap between law and practice.³⁶⁸

There are several government projects focusing on HIV/AIDS prevention and treatment. One specific project aims to prevent mother-to-child transmission of HIV through the provision of AZT drugs to pregnant women. Other government prevention efforts include a successful campaign to promote the use of condoms. The government also plans to implement a special project for the treatment of infected persons using generic GPO-VIR drugs (a combination of three antiretrovirals) in certain hospitals with appropriate equipment and specially trained staff.³⁶⁹

Adolescent reproductive health

Adolescents 18 years and under comprise 27.6% (13.5% girls and 14.2% boys) of the total population of Thailand.³⁷⁰ About 22% of adolescents who are enrolled in school report having had sexual intercourse. The proportion of adolescent boys who have had sex is higher than the proportion of adolescent girls (30.5% vs. 12.8% of the adolescents who have had sexual intercourse).³⁷¹ Most adolescents are aged 15–17 when they have their first sexual experience, with boys generally starting a year earlier than girls.³⁷² The most commonly mentioned person with whom adolescents first had sex was a girlfriend or boyfriend (77%), followed by friends, and sex workers.³⁷³ In addition, 31.0% of male adolescents had their first sexual experience involuntarily, compared with 52.7% of female adolescents.³⁷⁴

Studies indicate that most Thai adolescents are aware of contraceptive methods,³⁷⁵ although knowledge does not necessarily correlate with use.³⁷⁶ Among married adolescent girls aged 15–19, for example, approximately 89% are aware of condoms, but 43% currently use contraceptives.³⁷⁷ Furthermore, a study among young people aged 15–24 from the rural areas of north and northeast Thailand found that 82% knew about different contraceptive methods, particularly the pill, with females being more knowledgeable than males about most methods (except for the condom).³⁷⁸ However, almost 30% of males and 50% of females did not use any contraceptive method during their first experience of sexual intercourse.³⁷⁹

Among unmarried adolescents, withdrawal is the most popular method of family planning, followed by periodic

abstinence, or the rhythm method.³⁸⁰ A study conducted among Thai secondary school students with a mean age of 14.9 years found that 23% of male students had had intercourse with a girlfriend or sex worker, and only 42% of them had used condoms.³⁸¹ Condom use appears to be much more frequent in sexual encounters with sex workers than with girlfriends and boyfriends.³⁸²

In 2001, the birthrate among very young adolescents was 0.2 births per 1,000 girls under the age of 15. The corresponding rates that year were 33.7 births per 1,000 girls aged 15–19, and 75.6 per 1,000 girls aged 20–24.³⁸³ Of all maternal deaths in Thailand in 2001, girls under the age of 20 accounted for 7.8% of the total.³⁸⁴ Girls younger than age 20 also accounted for 30% of the total number of women who were hospitalized due to complications resulting from miscarriage and induced abortion in 1999.³⁸⁵

Young men and women under the age of 25 constitute 29% of the total number of cases of patients who contract STIs.³⁸⁶ In 2002, this age-group accounted for 12.5% of the total number of persons with active HIV infections.³⁸⁷ Although most HIV-infected persons overall are male, among 10–19-year-olds, more women are infected than men.³⁸⁸

There are no available data concerning adolescents' access to reproductive health services. However, the Ministry of Public Health has recognized that poor accessibility to reproductive health services among adolescents is one of the main causes of unwanted pregnancy and complications due to unsafe abortion.³⁸⁹

The constitution provides that children and youth without guardians shall have the right "to receive care and education from the state, as provided by law."³⁹⁰ It also calls upon the state to "protect and develop children and the youth" in its Directive Principles of Fundamental State Policies.³⁹¹

Adolescent reproductive health is one component of the 1997 Reproductive Health Policy, which emphasizes information, education, counseling, and services.³⁹²

The Medical Council Guidelines on the Provision of Obstetric and Gynecological Services state that physicians should recognize that most adolescent pregnancies are unplanned; the guidelines recommend that physicians provide knowledge and information; recommend necessary social services agencies; and discuss in depth the best options for the pregnant adolescent, including whether to carry the pregnancy to term and raise the child or place the child for adoption.³⁹³ Physicians are also advised to discuss the resolution of an unplanned pregnancy with the patient's partner or husband or, if the patient is an unmarried minor, with her parents.³⁹⁴ Monitoring mechanisms are absent from the guidelines.

In 2001, the Family Planning and Population Division

of the Department of Health under the Ministry of Public Health launched a program called the Wai Roon Sod Sai (Vibrant Youth) Project,³⁹⁵ which is being implemented with support from the Department of Health, regional health promotion centers, and provincial public health offices. The project involves establishing "Friends Corners" to provide reproductive health services and information for adolescents. This government effort to provide adolescent-specific reproductive health services is the first of its kind in Thailand.³⁹⁶ The project was included in the Department of Health's implementation plan for 2003.³⁹⁷ It is now integrated with a project addressing adolescents' use of drugs.

Apart from the reproductive health information and services for adolescents just mentioned, the Health Promotion Office of the Department of Health has organized campaigns on general health promotion for adolescents under the program Health for School-Age Children and Youth, which covers those aged 6–21.³⁹⁸

C. POPULATION

Thailand's first national population policy was declared in March 1970.³⁹⁹ That policy established government support for voluntary family planning to address the then very high rate of population growth, which was perceived as an obstacle to the economic and social development of Thailand.⁴⁰⁰ Although the population policy advocated voluntary family planning, the National Family Planning Program under the Ministry of Public Health set operational targets annually in quantitative terms. Such targets were set beginning with the Third National Social and Economic Development Plan (1972–1976) and continued through the Seventh National Social and Economic Development Plan (1992–1996); by the end point year of that plan, Thailand's annual population growth rate had fallen to 1.2%.⁴⁰¹ The Eighth National Social and Economic Development Plan (1997–2001) marked the introduction of qualitative targets that advocated for couples' achieving their "appropriate family size" in line with a "people-centered development" approach.⁴⁰² With the announcement of its Reproductive Health Policy in 1997, the Ministry of Public Health integrated population and family planning activities into reproductive health services.⁴⁰³

Currently, Thailand has a total population of 62 million⁴⁰⁴, which is growing at a rate of 1.19% per year.⁴⁰⁵ In the near future, the total fertility rate of the Thai population is expected to decrease to a level that is lower than replacement.⁴⁰⁶

The efforts of national development plans to curb population growth, in addition to the National Family Planning Program's significant gains in increasing the accessibility and acceptability of contraceptives, have contributed to the cur-

rent low population growth rate.⁴⁰⁷ In addition, modernization has changed family structures and educational needs so that having a large number of children has become a burden rather than a benefit.⁴⁰⁸ To encourage small family norms, the government directly supports contraceptive use, and about 79% of married women were using a modern method of contraception in 2000.⁴⁰⁹

Objectives

Currently, Thailand's Ninth National Social and Economic Development Plan has maintained the "people-centered development" concept from the previous national plan.⁴¹⁰ The ninth plan's development policies on population contain the following strategies:

- enhancing the quality of life, and achieving a balanced population structure and appropriate family size norms;
- maintaining replacement level fertility;
- ensuring that Thais are in good health and capable of keeping up with the rapidly changing economy, while maintaining high ethical standards and awareness of the common good in society;
- providing no fewer than nine years of education to the school-age population and ensuring that at least 50% of Thai laborers have completed a secondary school education by 2006;
- extending equal health insurance coverage to the entire population, including social security benefits for Thais of all age-groups;
- strengthening civil society to enhance the livability of cities and communities; and
- promoting a more efficient use of natural resources and management of the environment, as well as the greater participation of the general population in such efforts.⁴¹¹

Building on the Ninth National Social and Economic Development Plan, the Bureau of Health Promotion of the Department of Health under the Ministry of Public Health has established goals for promoting the health of women of reproductive age. They are the following:

- ensuring that at least 15% of women aged 15–44 have access to basic reproductive health services;
- keeping the pregnancy rate among women less than 20 years of age to no more than 10%;
- keeping the birth control rate at at least 77%;
- increasing the proportion of the working population who have proper nutrition to at least 60%;
- raising the proportion of the working population who are physically fit by 20%; and
- ensuring that at least 15% of women aged 45–59 have

a basic knowledge of reproductive health issues.⁴¹²

The hill tribe population is a group for whom the government has designed a special development policy, which is called the Master Plan for Community Development, Environment and Control of Narcotics in Highland Areas. Currently, the Third Master Plan (2002–2006) is operational. One of the main objectives of the present master plan is to control the rate of population growth in the highland areas;⁴¹³ the plan aims to reduce the fertility rate among the highland population to 1.5% by the end of the plan period.⁴¹⁴ The birthrate of the hill tribe population was reported to be almost twice that of the lowland population in 1997.⁴¹⁵

Implementing agencies

The Ministry of Public Health is the core ministry responsible for population and family planning nationwide.⁴¹⁶ The Bureau of Social Development and Quality of Life is responsible for the formulation and coordination of population policy at the national and local levels.⁴¹⁷ The facilities responsible at the implementation level are provincial hospitals, maternal and child health hospitals, community hospitals, health centers, university hospitals, and other hospitals under the Ministry of Public Health and other ministries, as well as village health volunteers, NGO volunteers, and private hospitals and clinics.⁴¹⁸

The Center for Highlands Health Development of the Department of Health is the main Ministry of Public Health agency responsible for the implementation of reproductive health and population activities for the hill tribe population.⁴¹⁹

III. Legal Status of Women and Girls

The health and reproductive rights of women and girls cannot be fully understood without taking into account their legal and social status. Laws relating to their legal status not only reflect societal attitudes that shape the landscape of reproductive rights, they directly impact their ability to exercise these rights. A woman or adolescent girl's marital status, her ability to own property and earn an independent income, her level of education, and her vulnerability to violence affect her ability to make decisions about her reproductive and sexual health and access to appropriate services. The following section describes the legal status of women and girls in Thailand.

A. RIGHTS TO EQUALITY AND NONDISCRIMINATION

Equality and freedom from discrimination are fundamental rights under the constitution. The "supreme law of the State" provides that all persons are equal before the law and enjoy

equal protection under the law, and that men and women enjoy equal rights. The constitution prohibits discrimination on several specific grounds, which are origin, race, language, sex, age, physical or health condition, personal status, economic or social standing, religious belief, education, and political views.⁴²⁰ However, affirmative state measures intended “to eliminate obstacles to or to promote persons’ ability to exercise their rights and liberties as other persons shall not be deemed an unjust discrimination.”⁴²¹ In addition to these fundamental guarantees, the constitution’s Directive Principles of Fundamental State Policies call upon the state to promote equality between the sexes.⁴²²

In addition to being in the constitution, equality and non-discrimination provisions are included in some national legislation, including the Labour Protection Act (1998) and the National Education Act (1999).⁴²³ (See “Labor and employment” and “Education” for more information on these acts.) However, the Civil and Commercial Code, which governs secular marriage, divorce, and property rights, among other matters, does not specifically guarantee the right to gender equality or prohibit gender-based discrimination.⁴²⁴

The constitution does not prohibit discrimination on the ground of sexual orientation. Homosexuality is not a crime under the penal code.⁴²⁵

Formal institutions and policies

The National Commission on Women’s Affairs and Family Development, which was formerly known as the National Commission on Women’s Affairs and was restructured in 2003, is the central government body charged with promoting women’s status.⁴²⁶ The commission’s specific duties including the following:

- propose to the cabinet policies and master plans that promote women’s empowerment, gender equality, and the institution of the family;
- establish implementing guidelines for approved policies and master plans consistent with the current National Economic and Social Development Plan;
- coordinate, follow up, and evaluate implementation of the policies, master plans, and guidelines, and report to the cabinet at least once a year;
- advise the cabinet on the implementation of laws, regulations, policies, programs, and projects on the promotion of women’s potential, gender equality, and the institution of the family;
- recommend appropriate mechanisms and measures, and propose new laws or amendments, to the cabinet and the prime minister and advise them on the government’s positions in the national and international arenas with regard to promoting women’s potential,

- gender equality, and the institution of the family;
- promote, support, and assist related activities of government organizations and NGOs; and
- solicit necessary relevant information and materials from government officers, employees, and other relevant persons in government agencies.⁴²⁷

The prime minister or the appointed deputy prime minister is the commission’s chairperson, the minister of social development and human security is its vice-chairperson, and the director of the Office of Women’s Affairs and Family Development under the Ministry of Social Development and Human Security is its secretary.⁴²⁸ The commission’s other membership consists of high-ranking representatives from various ministries and government agencies, and up to ten experts appointed by the prime minister, at least five of whom must be directly involved in women- and family-related issues.⁴²⁹ The commission reports to the prime minister.⁴³⁰

The Office of Women’s Affairs and Family Development, which is the commission’s implementing agency, works as an integrating institution of the work of the former Office of National Commission on Women’s Affairs and is charged with certain responsibilities relating to promoting women’s status. These include the following:

- Develop and make recommendations to promote women’s potential, gender equality, and family unity for the security of lives;
- strengthen and develop measures and mechanisms to promote women’s potential, gender equality, and the institution of the family;
- provide academic support and resources to networks that work on promoting women’s potential, gender equality, and the institution of the family; and
- promote and accelerate Thailand’s implementation of international obligations and agreements.⁴³¹

In 2001, the government passed a resolution to promote the mainstreaming of gender issues in government agencies. Pursuant to the resolution, each ministry or government department must appoint a chief gender equality officer, establish a Gender Focal Point Unit, and formulate a master plan to promote gender equality principles and integrate them into plans and projects.⁴³²

In addition to government institutions that focus on women’s rights, there are other agencies that address related issues under a larger mandate to protect human rights. The Department of the Rights and Liberties Protection under the Ministry of Justice, which was established in 2002, is charged with, among other duties, promoting awareness about human rights.⁴³³ A specific division of the department is authorized to redress problems and complaints related to the violation

of individual rights and liberties.⁴³⁴ The National Human Rights Commission,⁴³⁵ an independent agency established after the promulgation of the 1997 constitution, is empowered to examine and report on acts that violate human rights or the government's obligations under international treaties.⁴³⁶ The commission has several subcommittees on specific issues, although none focus on women's rights or gender equality.⁴³⁷

B. CITIZENSHIP

Citizenship is governed by the Nationality Act (1965). Pursuant to a 1992 amendment to the Nationality Act, Thai men and women may equally confer citizenship to children born in wedlock. The amendment applies retroactively and, at the time of its passage, granted citizenship to some 2,500 children who were born to Thai women married to foreign men and were denied citizenship under the former law.⁴³⁸ Children born out of wedlock to Thai mothers are citizens, regardless of their country of birth and whether their father is stateless or if the identity of their father is unknown.⁴³⁹ While a foreign woman married to a Thai man may apply for citizenship, a foreign man married to a Thai woman does not have the same right.⁴⁴⁰

Generally speaking, citizenship is not automatically conferred upon birth within the borders of Thailand under the Nationality Act. As a result, over one million Myanmar refugees and migrants born in Thailand are stateless, as are over one-half the population of the highlands (i.e., the hill tribe population of roughly 600,000–1,000,000); their stateless status is likely to continue because of corruption and abuse in the application process for citizenship.⁴⁴¹

These groups are restricted in their movements and are subject to arrests and deportation, and they cannot own immovable property, obtain higher education, or run for public office.⁴⁴² Women in these groups face particular hardships and barriers to obtaining citizenship, including being unable to pass the language requirement for Thai citizenship because of a general lack of education. Although refugee and migrant women are frequently subject to trafficking, sexual violence, and abuse at the hands of employers and police, they lack access to legal protection or remedies because of their status as noncitizens. They often “fall into debt and into situations of deception, coercion, and/or exploitation” owing to their noncitizen status.⁴⁴³

C. MARRIAGE

Marriage is regulated in the family laws of Thailand; Muslim family law applies specifically to Muslims residing in the southern provinces of Pattani, Narathiwat, Yala, and Satun; and general family law applies to all other Thais, non-Muslims and Muslims alike. For most Thais, the relevant marriage

laws are contained in the Civil and Commercial Code (1934), which was amended in 1976.⁴⁴⁴ Muslims in the aforementioned southern provinces are governed by the Islamic Law on Family and Succession.⁴⁴⁵ The preeminence of this law in matters pertaining to marriage and other family affairs is established by the Act on the Application of Islamic Law in the Territorial Jurisdictions of Pattani, Narathiwat, Yala, and Satun Provinces (1946).⁴⁴⁶

Book Five of the Civil and Commercial Code establishes the legal requirements for a valid civil marriage. The code requires the consent of both parties to the marriage, which must be declared publicly before a registrar and legally recorded.⁴⁴⁷ Both parties must have completed their seventeenth year of age, although minors may marry with the consent of a parent or a guardian, or if the minors file an application with a court requesting permission for the marriage.⁴⁴⁸ The law forbids marriage between blood relatives, as well as between adoptive relatives.⁴⁴⁹

The code prohibits bigamy, but does not prescribe punishment for violating this prohibition.⁴⁵⁰ In practice, a person accused of bigamy may be charged with giving false information to an official under the penal code.⁴⁵¹

The code includes provisions addressing the remarriage of widows and divorced women. In general, such women may remarry only after 310 days have passed since the termination of their previous marriage, with the following exceptions:

- a child is born during those 310 days;
- the divorced woman plans to remarry her ex-husband;
- a lawful and qualified medical practitioner issues a certificate showing that the woman is not pregnant; or
- a court issues an order allowing the woman to remarry.⁴⁵²

Although the code does not prohibit marriage between persons of the same sex, it provides validation for marriage between a man and a woman only.⁴⁵³

Laws governing Muslims in four provinces

Marriages among Thai Muslims who reside in Pattani, Narathiwat, Yala, and Satun must be performed in accordance with the Islamic Law on Family and Succession.⁴⁵⁴ Although there is no clear indication of the minimum age for marriage, the law defines a person who is “of age” as someone who has reached his or her sixteenth birthday, or who will have had his or her tenth birthday within 15 days of marriage and have attained puberty.⁴⁵⁵

For persons who have not yet come of age but wish to marry, a male relative of the underage party must perform the marriage ceremony.⁴⁵⁶

The law permits a man to have up to four wives at one time.⁴⁵⁷

The law stipulates clearly that marriage may only be between a man and a woman.⁴⁵⁸

D. DIVORCE

The Civil and Commercial Code and the Islamic Law on Family and Succession govern divorce among Thais in general and among Thai Muslims residing in Pattani, Narathiwat, Yala, and Satun, respectively.

Under the Civil and Commercial Code, divorce may be effectuated only by mutual consent of the parties or court order.⁴⁵⁹ It is far easier for men to obtain a divorce than it is for women. A husband, for example, may request a divorce by demonstrating that his wife has committed adultery.⁴⁶⁰ A wife, however, must in addition prove that her husband has given maintenance to or honored another woman as his wife.⁴⁶¹ Other grounds for divorce initiated by either spouse include:

- infliction of serious harm or torture to the body or mind of the spouse, or of serious insult to the spouse or to his or her relatives;
- desertion lasting more than one year;
- imprisonment of more than one year for an offense committed without the participation, consent, or knowledge of the other spouse;
- if a spouse has been adjudged to have disappeared, or has left his or her residence for more than three years and is not known to be dead or alive;
- failure to provide maintenance and support to the other;
- insanity for more than three consecutive years;
- breaking of a bond of good behavior executed by him or her;
- the suffering by one spouse of a communicable and dangerous disease that is incurable and may cause injury to the other; and
- the physical disability of one spouse that makes permanent cohabitation impossible.⁴⁶²

Also, if the husband and wife voluntarily live separately for more than three years because of irreconcilable differences or by an order of a court, either spouse may enter a claim for divorce.⁴⁶³

In a divorce case, either party may petition the court for the amount of maintenance.⁴⁶⁴ After a divorce, if a party who is entitled to maintenance fails to receive such maintenance, or receives inadequate maintenance, the party may petition the court.⁴⁶⁵ The court will determine on a case-by-case basis whether and how much maintenance will be granted, taking into account the ability of the paying party, the receiving party's condition in life, and the circumstances of the case.⁴⁶⁶

Laws governing Muslims in four provinces

For Muslims residing in Pattani, Narathiwat, Yala, and Satun, the Islamic Law on Family and Succession specifies several ways of terminating a marriage, which are the following:

- *torla* (repudiation of the wife by the husband);⁴⁶⁷
- *pasaka* (judicial dissolution of the marriage);⁴⁶⁸
- the husband's sworn statement to the court that his wife has committed adultery;⁴⁶⁹ and
- *tadrasaka* (termination of the marriage because of gross misconduct of either party, including the renunciation of Islam by either party).⁴⁷⁰

The law obligates a husband to provide maintenance during *iddah* (the prescribed waiting period before a divorce becomes final) if the wife is pregnant. Such maintenance includes accommodation, food, and clothing.⁴⁷¹

Parental rights

For Thais who are subject to the Civil and Commercial Code in family matters, the code does not clearly specify which parent is entitled to custody of the couple's children upon divorce. Rather, divorced parents are allowed to reach a mutual agreement independently on the custody and maintenance of their children.⁴⁷² In cases where parents are unable to reach an agreement, they may petition a court for a judgment on the matter, which takes into account the financial status of both parties and the circumstances of the case.⁴⁷³

The code also contains many provisions concerning the legitimacy of children, stipulating that a child born to a woman is deemed her legitimate child, regardless of the woman's marital status.⁴⁷⁴ However, if the parents of the child are unmarried, the presumed father must apply for registration of his status as the father before he can exercise parental rights.⁴⁷⁵ Under the code, he may also repudiate his paternity by filing a court action against the mother and child jointly.⁴⁷⁶ To succeed in such a court action, the man must prove that he did not cohabit with the mother during her pregnancy during the period from the 180th day of pregnancy to the 310th day of pregnancy.⁴⁷⁷

Laws governing Muslims

Among Thai Muslims subject to Islamic law in Pattani, Narathiwat, Yala, and Satun, the father automatically receives guardianship, or legal decision-making power, over the couple's children upon divorce, while the mother is entitled to their custody and care. The father is required to pay for the maintenance of his children and has the right to take them with him in case of a change in domicile.⁴⁷⁸

In cases where a woman is pregnant with a fetus her husband is certain is not his, Islamic law permits the husband to bring an action against his wife for adultery. The husband is required to make his claim under oath, but need not provide evidence for his accusation.⁴⁷⁹ A woman who does

not repudiate the claim under oath is presumed by law to be guilty of adultery, and is required to pay compensation to her husband.⁴⁸⁰ The law also requires that the couple divorce and forbids them from ever remarrying.⁴⁸¹

E. ECONOMIC AND SOCIAL RIGHTS

Ownership of property and inheritance

The constitution protects the rights to property and succession, and provides for the scope of such rights to be determined by law.⁴⁸² It also prohibits the expropriation of immovable property except for purposes that serve the public interest, and provides for the right to fair compensation in such cases.⁴⁸³

In addition to the constitution, the property rights of most Thais are governed by the Civil and Commercial Code, which contains legal provisions relating to property, including ownership of immovable property.⁴⁸⁴ These provisions use the gender-neutral term “spouse” in discussing property rights and do not discriminate according to sex.⁴⁸⁵

The code also covers matters of succession and inheritance, prescribing the general rule that a deceased’s property passes to his or her heirs.⁴⁸⁶ The surviving spouse of a deceased person who leaves no children is entitled to the whole inheritance.⁴⁸⁷ Where there are living children, the surviving spouse and children are entitled to equal parts of the inheritance, in accordance with the code.⁴⁸⁸ The code does not discriminate against daughters or sons in their right to inheritance. In cases where a deceased husband leaves more than one surviving wife, all wives whose marriages with the deceased were registered before the enactment of Book Five of the Civil and Commercial Code are jointly entitled to inherit the deceased’s property.⁴⁸⁹ However, each secondary wife is entitled to only one-half of the share of the principal wife.⁴⁹⁰

Under the Islamic law applicable to Muslims in Pattani, Narathiwat, Yala, and Satun, the husband and wife have the right to their own property without interference from the other spouse.⁴⁹¹

Rights to agricultural land

The constitution’s Directive Principles of Fundamental State Policies call upon the state to develop and appropriate a system of landholding and land use, provide sufficient water resources for farmers, and protect and promote their interests.⁴⁹²

Labor and employment

In 2000, women comprised 46% of the Thai workforce.⁴⁹³ Almost half (48%) of the female labor force was employed in agriculture, 35% in the service sector, and 17% in industry.⁴⁹⁴ As of 2000, urban female workers were largely employed in the informal sector, and were underrepresented in professional and technical professions, as well as in administrative, mana-

gerial, and executive positions. Women continue to earn less pay than men in all categories of employment, earning on average 72% of the wages of their male counterparts in nonagricultural employment and 64% of the wages of men in manufacturing.⁴⁹⁵

The constitution’s Directive Principles of Fundamental State Policies urge the state to “promote people of working age to obtain employment, protect labor, especially child and woman labour, and provide for the system of labour relations, social security and fair wages.”⁴⁹⁶ At the level of federal legislation, the Labour Protection Act (1998) is a key labor law. In addition, the Social Security Act (1990) includes provisions addressing employment benefits for insured persons.

In general, Thai law provides for equal rights in the workplace. The Labour Protection Act guarantees gender equality in employment and payment of wages, requiring employers to “treat male and female employees equally in their employment, except where the nature or conditions of the work does or do not allow the employer to so do.”⁴⁹⁷ The law also specifically prohibits discrimination against pregnant workers, prohibiting employers from terminating a female worker because of her pregnancy.⁴⁹⁸ The law prescribes penalties for discriminating on the basis of gender in hiring and payment of wages, subjecting employers to a fine of up to 20,000 baht (approximately USD 485) for violations.⁴⁹⁹ An employer who terminates an employee on account of her pregnancy is subject to imprisonment of up to six months, a fine of up to 100,000 baht (approximately USD 2,428), or both.⁵⁰⁰

Pregnant employees are entitled to maternity benefits under the Labour Protection Act, as well as the Social Security Act. The Labour Protection Act affords pregnant employees maternity leave of up to 90 days for each pregnancy,⁵⁰¹ out of which 45 days are paid leave.⁵⁰² Under the Social Security Act, an insured pregnant employee is entitled to a lump sum payment in the amount of 50% of wages during a 90-day maternity leave in addition to what the employer pays.⁵⁰³ The Social Security Act also covers medical treatment and supplies provided during the course of prenatal care and childbirth; lodging and meals during the institution-based delivery; care and treatment for the newborn; transportation to and from the health-care institution; and other necessary services. Insured persons are entitled to maternity benefits for up to two pregnancies.⁵⁰⁴ The act also provides maternity benefits to the spouses of insured male workers who are married or in a consensual cohabiting union.⁵⁰⁵ The act also provides benefits for the children of insured workers,⁵⁰⁶ including coverage for their educational expenses, and medical care and treatment.⁵⁰⁷ Unmarried single mothers are entitled to the same benefits for their dependent children as are married female

workers with children.⁵⁰⁸ Thai labor laws do not provide for the establishment of nurseries in the workplace or nursing breaks during working hours.

The Labour Protection Act includes certain protective provisions for pregnant employees relating to working conditions. It prohibits employers from requiring that a pregnant employee work between 10 p.m. and 6 a.m., overtime, or on holidays, or that she perform certain physically demanding tasks specified in the act.⁵⁰⁹ A pregnant employee who presents a medical certificate stating that she is no longer able to perform her original duties is also entitled to request her employer to temporarily assign her to more suitable duties either before or after childbirth.⁵¹⁰ Violations of the act's protective provisions for pregnant employees are punishable with imprisonment of up to six months, a fine of up to 100,000 baht (approximately USD 2,436), or both.⁵¹¹

The act also contains provisions restricting certain types of work for all female workers, regardless of pregnancy status. These include mining, construction, erecting and dismantling scaffolding, producing and transporting explosives or inflammable materials, and any other work as prescribed by the regulations.⁵¹²

Access to credit

The Civil and Commercial Code contains provisions concerning access to credit, which do not discriminate by gender.⁵¹³ A woman may apply independently for a loan from a financial institution. If either the husband or wife wishes to use financial properties as collateral against a loan, one spouse must obtain the other's consent.⁵¹⁴ In practice, officials usually request evidence of consent from the husband of a married woman, whereas a married man is usually not requested to show evidence of consent from his wife.⁵¹⁵

The Asian Development Bank has been working in collaboration with the Thai government on projects to improve Thai women's access to credit, such as targeted credit mechanisms, projects involving training in new labor force skills and self-employment skills, and small-enterprise training.⁵¹⁶

Education

According to a recent assessment by the National Commission on Women's Affairs of the Women's Development Plan under the Ninth National Economic and Social Development Plan, 63% of illiterate persons are women, mostly aged 40 and above.⁵¹⁷ This gender gap in illiteracy among the middle-aged population reflects imbalances in educational opportunities in the past.⁵¹⁸ There is greater equality in present times, particularly at the primary and secondary school levels.⁵¹⁹ The 2000 population census indicated that the illiteracy rate was slightly higher among males aged 6–17 than among females in the same age-group, although the converse

was true among those aged 18–24.⁵²⁰

According to recent government data, there are more female than male graduates at the secondary school level, as well as more females than males who earn occupational certificates and doctorates.⁵²¹ At the secondary school and undergraduate levels, more female than male students are enrolled,⁵²² although female students tend to be concentrated in fields that are traditionally thought to be suitable for women.⁵²³ There are almost equal numbers of girls and boys enrolled at both the primary and secondary school levels.⁵²⁴

The constitution guarantees equal rights to free and quality public education for the first 12 years of schooling.⁵²⁵ In addition, the constitution's Directive Principles of Fundamental State Policies urge the state to promote education services provided by the private sector, as well as by local administrative units.⁵²⁶

In addition to the constitution, the National Education Act (1999) and the Compulsory Education Act (2002) are key laws addressing education. In accordance with the constitution, the National Education Act provides for the equal rights and opportunities of all individuals to receive basic public education for at least 12 years. The act specifies that such education, provided nationwide, shall be of quality and free of charge.⁵²⁷ The act creates mechanisms to ensure children's rights to access their education. The Compulsory Education Act (2002), which replaces the 1921 act of the same name, obligates parents and other responsible parties, including "a person...for whom the child serves in domestic service,"⁵²⁸ to send children under their care to educational institutions that provide compulsory education.⁵²⁹ The act applies to children aged 7–16,⁵³⁰ and defines compulsory education as education from the first through the ninth year, which is considered to be fundamental education.⁵³¹

Sex education

According to a study of Bangkok college students, 94% of those surveyed had knowledge about AIDS, and 92% knew about the major modes of transmission.⁵³² The majority of students also knew that HIV could not be transmitted in various casual ways or by mosquitoes, and that there were no vaccines to prevent infection.⁵³³ Secondary school students' knowledge of STIs and contraception is more limited;⁵³⁴ their main sources of information in this area are books and magazines.⁵³⁵ Research among secondary school students and their teachers shows that combined knowledge about their sexuality was only at a "moderate" level.⁵³⁶ Eighty two percent of students in the research sample agreed that sex education programs should be provided at the secondary school level, and 42.6% agreed that sex education should be provided by the family.⁵³⁷

Sex education is one component of the Thai Reproductive Health Policy.⁵³⁸ At present, the Departments of Health and Mental Health of the Ministry of Public Health have joined forces with the Ministry of Education to revise the sex education curriculum.⁵³⁹ The contents of the curriculum are to be taught according to the developmental level of the students, from the first grade through the secondary school level. The main topics of the curriculum include human sexual development; human relationships; sexual behavior; sexual hygiene; and necessary life, social, and cultural skills.⁵⁴⁰ In addition, the Department of Health and other government agencies are partnering with the private sector to prepare a handbook on life skills for adolescents, called *Modern Teenagers and the Understanding of Life*.⁵⁴¹

F. PROTECTIONS AGAINST PHYSICAL AND SEXUAL VIOLENCE

Rape

The penal code governs the crime of rape, defining the act as sexual intercourse initiated by a man with a woman who is not his wife under any of the following circumstances:

- against her will;
- by threatening by any means whatever;
- through any act of violence;
- by taking advantage of a woman who is unable to resist; or
- by causing the woman to mistake him for another person.⁵⁴²

The punishment for rape under the code is imprisonment of one to ten years and a fine of 2,000–20,000 baht (approximately USD 49–487).⁵⁴³ If the victim is seriously injured or killed, the offender may be punished by 10–20 years' imprisonment and a fine of 20,000–40,000 baht (approximately USD 487–974), or life imprisonment or death.⁵⁴⁴

There is not yet any legislation on marital rape.

Sexual intercourse with a girl under 13 years of age, regardless of whether the act was consensual, is punishable by 2–12 years' imprisonment and a fine of 4,000–20,000 baht (approximately USD 97–487).⁵⁴⁵

The code also addresses the issue of rape by a blood relative.⁵⁴⁶ The penalty is increased by one-third if the perpetrator is a relative.⁵⁴⁷

Domestic violence

Domestic violence affects Thai women across all social classes and has been given increased attention in recent years. However, the problem is still widely underreported.⁵⁴⁸ According to available information from a 2000 survey, 23% of women in the capital and 34% of women in the other provinces reported having been the victim of physical violence

by their intimate partner at least one time in their life.⁵⁴⁹ In addition, 4% of women who had ever been pregnant reported having experienced physical violence at the hands of their partner during pregnancy.⁵⁵⁰ Research also found that the majority of Thai women prefer to not press charges against their abusive partners, but would rather preserve the relationship while ending the violence.⁵⁵¹

The constitution guarantees the right of “children, youth and family members” to be protected by the state against violence and unfair treatment.⁵⁵² There is no specific national law on domestic or gender-based violence, or a law that provides protection to victims of violence through a protection order or a restraining order. However, the penal code may be invoked to charge perpetrators of domestic violence, specifically the sections of the code under the categories of Offences Relating to Sexuality and Offences against Life and Body.⁵⁵³ The Child Protection Act (2004) also protects against child abuse, as does the penal code in a provision imposing penalties for those who commit child abuse and offenses against minors.⁵⁵⁴

According to police procedures, when the police have been informed of a criminal offense, they have a duty to undertake an immediate investigation or interrogation, regardless of whether there is a complainant;⁵⁵⁵ there is also a specific police protocol in cases of domestic disputes.⁵⁵⁶ According to the protocol, in cases where a husband or wife accuses the other spouse of inflicting physical harm, the officer in charge should attempt reconciliation between the parties under certain circumstances (e.g., if a weapon was not used, if the injury was not serious, if the injury did not occur on a main road, or if the injury lacked evil intent and was “simply done as a means of admonishment”). If the attempt at reconciliation fails, the officer in charge must submit the results of the investigation for further consideration by the local police superintendent. However, if the dispute between the husband and wife involves a weapon or a serious injury, or if it is carried out on a main road, the officer in charge, if he deems it necessary, should submit the matter to his superintendent for consideration and orders for further action, “as the government has the duty to maintain peace and order, and family security as a matter of importance.”⁵⁵⁷ Perpetrators of domestic violence are subject to jail terms, but not to rehabilitation and program activities.⁵⁵⁸

To ameliorate some of the problems in enforcement and underreporting, over the past decade police units have recruited teams of female police officers in three Bangkok stations and several other parts of the country to encourage women to report domestic violence.⁵⁵⁹

In May 2002, the cabinet passed a resolution ordering

the enactment of the Policy and Plan on the Elimination of Violence against Children and Women; the National Commission on Women's Affairs had submitted this resolution to establish a national policy and plan addressing domestic violence.⁵⁶⁰ The policy serves as a guideline for the coordination of government agencies, NGOs, and community-based organizations involved in activities aimed at eliminating violence against women and children.⁵⁶¹ The designated national-level coordinating agencies are the Office of the National Commission on Women's Affairs, which is responsible for policy-level coordination on women's affairs; the National Youth Bureau, which is responsible for policy-level coordination of children's and youth's affairs; and the National Institute for Child and Family Development of Mahidol University, which is responsible for coordination of technical issues.⁵⁶² However, to date there is no report on the implementation of the policy.

Passage of domestic violence legislation is one of the main objectives of the Women's Development Plan under the Ninth National Economic and Social Development Plan.⁵⁶³

Sexual harassment

There is no specific or comprehensive law on sexual harassment. The Labour Protection Act addresses sexual harassment in the workplace and prohibits "a person who is in overall charge of staff, a supervisor, or an inspector" from sexually harassing female or child employees.⁵⁶⁴ The act prescribes a fine of up to 20,000 baht (approximately USD 487) for sexual harassment of a female employee.⁵⁶⁵ The act does not provide a definition of sexual harassment.

The penal code also prescribes penalties for a person who commits an "indecent act" with another person, although such acts are not clearly defined.⁵⁶⁶

Sexual harassment in the schools has recently received attention by the Ministry of Education. In 2000, the ministry issued a regulation on the Promotion and Protection of the Rights of Children and Youth by Educational Institutions, which provides that educational personnel who know of an act of sexual harassment against a pupil have a duty to report the matter to the responsible authorities; further, the head of the educational institution concerned has to take action to protect and give assistance to the child as soon as possible.⁵⁶⁷ The ministry also issued several subsequent policies and measures, directed at educational institutions and personnel, that attempt to respond to widespread sexual harassment, prostitution by fraud, and commercial sex acts involving pupils and students, and establishes procedures for responding to reported incidents.⁵⁶⁸ In cases of sexual harassment committed by educational personnel against a student, the staff member's employment is suspended and a committee must respond by investigating the incident or taking some other action within

15 days. Every educational institution's administrator must take concrete action against any staff member under his or her supervision who commits an offense. If the offender was assisted by others, or was exempted from discipline or other necessary action, the administrator and any other persons responsible will also be subject to punishment.⁵⁶⁹

Commercial sex work and sex-trafficking

Commercial sex work is a major industry in Thailand involving hundreds of thousands of women and fueled, in part, by widespread sex tourism.⁵⁷⁰ Anecdotal information and survey data suggest that a large number of women are trafficked as prostitutes and as forced laborers in households, factories, and farms. Thailand is both a sending and receiving country of trafficking, and it transports women to countries and regions such as Japan, South Africa, Australia, Bahrain, Taiwan, Europe, and North America.⁵⁷¹ There is also an internal flow of trafficking from the northern provinces to other regions. Comprehensive official data on the prevalence of commercial sex work and sex trafficking in the country are not readily available. The government has recently made the issue of trafficking of women and forced prostitution a national priority.

Thailand criminalized prostitution with the Suppression of Prostitution Act (1960), which penalized both prostitutes and their procurers, but not their clients.⁵⁷² While the Prevention and Suppression of Prostitution Act (1996), which repeals the 1960 act, keeps prostitution illegal and subjects prostitutes to a fine of 1,000 baht (approximately USD 24), the act's aim is to punish procurers and, for the first time, their clients, rather than prostitutes or child victims of prostitution.⁵⁷³ Whereas authorities have used this law to some degree, enforcement remains low.⁵⁷⁴ Between 1996 and 1999, 355 people were arrested for violating the act, but only 14 were convicted and sentenced.⁵⁷⁵

Thailand also has a law dealing directly with trafficking for various purposes, including prostitution. The Measures in Prevention and Suppression of Trafficking in Women and Children Act (1997) amends the Traffic in Women and Girls Act (1928) by extending coverage to girls and boys under the age of 18 who are victims of trafficking; the measures penalize conspiracy to commit a trafficking-related offense and prescribe equal punishment for principal actors as well as for abettors of trafficking.⁵⁷⁶ The act also authorizes officials to give appropriate assistance to victimized women and children by providing them with food and shelter; officials are further authorized to repatriate victims who are foreign nationals.⁵⁷⁷

Other laws that can be used to prosecute traffickers of women and children for sexual purposes include the Prevention and Suppression of Prostitution Act, the Penal Code

Amendment Act (1997), and the Amendment of the Criminal Proceedings Act (1997). The Prevention and Suppression of Prostitution Act punishes the procurement, seduction, or induction of another person for the purpose of prostitution with imprisonment of one to ten years and a fine of 20,000–200,000 baht (approximately US 487–4,870).⁵⁷⁸ The victim's consent is immaterial, and the law applies to both intra- and extraterritorial acts.⁵⁷⁹ The Penal Code Amendment Act prescribes a similar penalty for such acts; the punishment is more severe when the victim is a minor aged 15–17, and is increased even further when the child victim is under age 15.⁵⁸⁰ The Amendment of the Criminal Proceedings Act introduces more child-friendly procedures, such as allowing child victims of trafficking to offer testimony.⁵⁸¹ Under the Money Laundering Control Act (1999), the state may confiscate all property of an offender who is guilty of trafficking in women and children.⁵⁸²

The Memorandum of Understanding on Common Guidelines of Practices among Concerned Agencies for Operation in Case Women and Children Are Victims of Human Trafficking is a policy agreement signed in 1999 by government and law enforcement agencies and NGOs involved in addressing the problem of the trafficking of women and children.⁵⁸³ The memorandum expands the definition of human trafficking to include forced labor, forced begging, or any other related immoral act,⁵⁸⁴ and provides protection for female and child victims regardless of whether they are Thai citizens, foreigners, or stateless persons residing in Thailand.⁵⁸⁵ The memorandum instructs the police to interview victims immediately after they have secured their release from captivity, and to coordinate with public prosecutors to file a petition, even if the investigation of the case is not yet complete.⁵⁸⁶ In cases involving foreign victims who enter the country illegally, the police are instructed to work with immigration authorities to provide for the victims' temporary residence in Thailand in accordance with the Immigration Act (1979), after which the victims are to be transferred to shelters run by the government or by approved private organizations.⁵⁸⁷ The memorandum also prescribes various forms of assistance to be provided to victims such as food, clothing, health care, and counseling. In practice, most police officials have no knowledge of the memorandum, so many attempts to apprehend offenders are still unsuccessful and widespread trafficking violations persist.⁵⁸⁸

Although Thai laws and policies addressing trafficking increasingly have been used to arrest offenders in recent years, the number of convictions remains low and the convictions largely result in light sentences. In 2003, there were 211 trafficking arrests and 20 convictions, with most offenders receiving light sentences.⁵⁸⁹ There are also reports of complicity

and participation in trafficking violations by police officers, soldiers, and other government officials and, although a few officials have been convicted, there is no systematic plan to address this problem of corruption.⁵⁹⁰ There is also no law that provides witness protection in trafficking cases.⁵⁹¹

Government activities to address the problem of trafficking include undertaking public information campaigns, establishing a hotline for calls to report violations, and collaborating with NGOs to provide support services for victims. The government operated 97 shelters in 2003 for victims of trafficking.⁵⁹²

In July 2003, the cabinet approved a draft National Policy and Plan on the Prevention, Suppression and Resolution of the Problems of the Domestic and Transnational Traffic in Women and Children.⁵⁹³ The policy consists of seven master plans addressing discrete issues, including, among others, prevention; assistance and protection; expatriation and relocation of victims; information, follow-up, and evaluation systems; and international cooperation.⁵⁹⁴ The policy is in the process of being revised.⁵⁹⁵

Sexual offenses against minors

According to information from an NGO working in the field of child protection, the number of child rape cases it handled in 2002 increased by 39% from the previous year.⁵⁹⁶ Eighty-six of the 197 girls treated by the NGO were age nine or below, and for 93 of the girls, the perpetrator was their own father, stepfather, or other relative.⁵⁹⁷

The penal code prescribes punishment for two categories of sexual offenses against minors—rape and “indecent acts.” The severity of punishment for both offenses varies according to the minor's age; the degree of injury to the minor; the number of offenders involved in the crime; and whether weapons were used to commit the offense.⁵⁹⁸ The code does not prescribe punishment for an offender who commits rape or indecent acts with his minor wife, and exempts an offender from punishment if he marries the minor after the violation.⁵⁹⁹ An offender may file an application to the court for permission to marry the minor victim.

Statutory rape is defined in the code as sexual intercourse with a girl under the age of 15 who is not the perpetrator's wife, and is punishable with imprisonment of 10–20 years and a fine of 20,000–40,000 baht (approximately USD 487–974).⁶⁰⁰ Indecent acts with a person under the age of 13, regardless of whether there is mutual consent, is punishable with imprisonment of up to ten years or a fine of up to 20,000 baht (approximately USD 487), or both.⁶⁰¹ The punishment is more severe if the act is committed by using threats or violence, taking advantage of the victim's inability to resist, or through fraud.⁶⁰²

According to the Thai Department of Public Welfare, an estimated 12,000 to 18,000 children are currently engaged in prostitution.⁶⁰³ Some government and NGO estimates indicate that 20,000 minor girls are working as prostitutes in the country. This number includes girls aged 12–18 who have been trafficked to Thailand from Myanmar, southern China, and Laos.⁶⁰⁴ Although most commercial sex workers in the country are not imprisoned or kept under physical confinement, a large number of them work under debt bondage, a condition that affects young women in particular.⁶⁰⁵ In many such cases, parents receive a large advance from the brothel that employs their daughter against her future earnings, which creates added pressure for girls to remain in their situation.

In cases of trafficking for the purpose of prostitution, the Prevention and Suppression of Prostitution Act⁶⁰⁶ and the Penal Code Amendment Act prescribe increasingly severe punishments for younger victims, with penalties being harshest for those who traffic in the youngest victims.⁶⁰⁷ Offenders who traffic in victims younger than 15 are subject to imprisonment of 10 years and a fine of 200,000–400,000 baht (approximately USD 4,871–9,743). The punishment is still more severe if the offense is committed by means of fraud, deceit, threats, violence, or undue influence or coercion. Parents who have knowledge of and participate in the commission of an offense against a minor under their care are subject to imprisonment of 4–20 years and a fine of 80,000–400,000 baht (approximately USD 1,949–9,742).⁶⁰⁸ The punishment for owners, supervisors, and managers of establishments that engage in the sex trade is more severe if they employ minors.

The Prevention and Suppression of Prostitution Act also includes a statutory rape type penalty for sexual intercourse with a person aged 16–18 in a prostitution establishment, prescribing imprisonment of one to three years and a fine of 20,000–60,000 baht (approximately USD 487–1,461) for offenders.⁶⁰⁹ The punishment is more severe if the victim is under the age of 15.⁶¹⁰

A recent assessment of how the Prevention and Suppression of Prostitution Act was being enforced found that, in practice, police officials tended to not report cases of minors working in prostitution establishments for fear of being charged with negligence for letting minors work as prostitutes in the first place.⁶¹¹

ENDNOTES

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16. THAIL. CONST. §§ 2, 6. See BUREAU OF DEMOCRACY, *supra* note 6; see also CENTRAL INTELLIGENCE AGENCY (CIA), *supra* note 1.
17. See CENTRAL INTELLIGENCE AGENCY (CIA), *supra* note 1.
18. THAIL. CONST. § 3.
19. See CENTRAL INTELLIGENCE AGENCY (CIA), *supra* note 1.
20. THAIL. CONST. §§ 2, 10.
21. *Id.* § 3.
22. See BUREAU OF DEMOCRACY, *supra* note 6.
23. THAIL. CONST. § 18.
24. *Id.* § 201.
25. *Id.* § 202.
26. *Id.* § 201.
27. *Id.* §§ 88, 201, 211–212.
28. *Id.* § 212.
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30. *Id.* § 217.
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32. NATIONAL NEWS BUREAU, THE THAI MONARCHY, THE PRIVY COUNCIL OF THAILAND, <http://www.thaimain.org/eng/monarchy/privy.html> (last visited July 7, 2005).
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323. *Id.* § 305(1)–(2). (the exception for rape also extends to other sexual offenses); 3 POPULATION DIVISION, UNITED NATIONS, *supra* note 315, at 124. Women's health in this context is generally considered only physical health. 66 REPRODUCTIVE HEALTH DIVISION, *supra* note 239, at 66.
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533. *Id.*, “Sexual relations among young people in developing countries: Evidence from WHO case studies,” WHO/RHR/01.8.1: Demographic Characteristics. Section E: STDs/HIV/AIDS, Page 4.
534. *Id.* at 6.
535. *Id.*
536. *Id.*
537. *Id.* at 6–7.
538. THAILAND NATIONAL FAMILY PLANNING PROGRAMME, *supra* note 238, at 20.
539. Communication with WHAF, *supra* note 194, at 59.
540. *Id.*
541. *Id.*
542. Act promulgating the Penal Code, B.E. 2499, § 276 (1956) (Thail) (amended 1997).
543. *Id.* § 276.
544. *Id.* § 277 bis. (1)–(2).
545. *Id.* § 277.
546. *Id.* § 276. However, the Civil and Commercial Code prohibits the marriage between man and woman who are blood relations. Civil and Commercial Code, B.E. 2477, bk. V, § 1450 (1934) (amended 1976) (Thail).
547. Act promulgating the Penal Code, B.E. 2499, § 285 (1956) (Thail) (amended 1997).
548. BUREAU OF DEMOCRACY, *supra* note 6.
549. INSTITUTE FOR POPULATION AND SOCIAL RESEARCH, MAHIDOL UNIVERSITY & FOUNDATION FOR WOMEN, FACT SHEET ON INTIMATE PARTNER VIOLENCE IN THAILAND (2003).
550. *Id.*
551. Ava Vivian Gonzalez, *Home is Where the Hurt is*, WOMEN IN ACTION (2001), <http://www.wiswomen.org/pub/wia/wia101/hurt.html> (last visited July 1, 2005) [hereinafter Home is Where the Hurt Is].
552. THAIL. CONST. § 53.
553. Act promulgating the Penal Code, B.E. 2499, §§ 276–287 (1956) (Thail) (amended 1982).
554. Child Protection Act, B.E. 2543, § 398 (2004) (Thail); Act promulgating the Penal Code, B.E. 2499, § 398 (1956) (Thail) (amended 1982).
555. PRAMUAN RABIAB KAN TAMRUAT [COMPILATION OF THE POLICE PROCEDURES], PAAK THEE NUNG RABIAB KAN TAMRUAT KIEW KAB KHADEE [PART 1: THE POLICE PROCEDURES ON OFFENCES] tit. 1, ch. 2 art. 3(2).
556. POLICE MAJOR-GENERAL THAWEE TATAYANOND, RABIAB KAN TAMRUAT KIEW KAB KHADEE THEE PRUPPRUNG MAI [THE REVISED POLICE PROCEDURES ON OFFENCES], B.E. 2540 (1997).
557. *Id.*, at 638.
558. *Supra* note 551.
559. BUREAU OF DEMOCRACY, *supra* note 6.
560. KHANA KAMMAKAAN SONGSERM LAE PRASANNGAAN SATREE HANG CHAAT [THE NATIONAL COMMISSION ON WOMEN'S AFFAIRS], SAMNAK PALAD SAMNAK NAYOK RATHAMONTREE [OFFICE OF THE PERMANENT SECRETARY OF THE PRIME MINISTER'S OFFICE], NAYOBAI LAE PAN KHADUD KWAM ROONRANG TOR DEK LAE SATREE [POLICY AND PLAN ON THE ELIMINATION OF VIOLENCE AGAINST CHILDREN AND WOMEN] (2002); Communication with WHAF, *supra* note 194, at 59.
561. *Id.* at 18.
562. *Id.* at 18–19.
563. KHANA KAMMAKAAN SONGSERM LAE PRASANNGAAN SATREE HANG CHAAT [THE NATIONAL COMMISSION ON WOMEN'S AFFAIRS], *supra* note 517.
564. Labour Protection Act, B.E. 2541, § 16 (1998) (Thail).
565. *Id.* § 147 (1998) (Thail).
566. Act promulgating the Penal Code, B.E. 2499, §§ 278–279 (1956) (Thail).
567. RABIAB KRASUANG SUKSATHIKAAN WA DUAY KAN SONGSERM LAE KHUMKRONG SITTHI DEK LAE YAOWACHON DOI SATHANSUKSA B.E. 2543 [THE MINISTRY OF EDUCATION], *supra* note 517.

- tion's REGULATION ON THE PROMOTION AND PROTECTION OF THE RIGHTS OF CHILDREN AND YOUTH BY EDUCATIONAL INSTITUTIONS 2000] art. 16 (2000).
568. MINISTRY OF EDUCATION, ANNOUNCEMENTS ON MEASURES ON THE PREVENTION OF SEXUAL HARASSMENT AGAINST PUPILS AND STUDENTS (Sept. 10, 2001); MINISTRY OF EDUCATION, ANNOUNCEMENTS ON PROCEDURES TO BE TAKEN IN THE CASES OF SEXUAL HARASSMENT AGAINST PUPILS AND STUDENTS BY EDUCATIONAL PERSONNEL (Dec. 3, 2001); MINISTRY OF EDUCATION, ANNOUNCEMENTS ON THE POLICY, MEASURES AND GUIDELINES ON THE PREVENTION AND SOLUTIONS OF THE PROBLEMS OF SEXUAL HARASSMENT AND PROSTITUTION OF PUPILS AND CHILDREN (Oct. 15, 2002).
569. MINISTRY OF EDUCATION, *supra* note 568.
570. U.S. DEPARTMENT OF STATE, VICTIMS OF TRAFFICKING AND VIOLENCE PROTECTION ACT OF 2000: TRAFFICKING IN PERSONS REPORT 110 (2004), <http://www.state.gov/g/tip/rls/tiprpt/2004/> [hereinafter U.S. DEPARTMENT OF STATE] (last visited July 1, 2005); BUREAU OF DEMOCRACY, *supra* note 6.
571. U.S. DEPARTMENT OF STATE, *supra* note 570; See SIRIPORN SKROBANEK ET AL., *THE TRAFFIC IN WOMEN: HUMAN REALITIES OF THE INTERNATIONAL SEX TRADE* (1997).
572. See HUMAN RIGHTS WATCH, *THE HUMAN RIGHTS WATCH GLOBAL REPORT ON WOMEN'S HUMAN RIGHTS* n.29, http://www.hrw.org/about/projects/womrep/General-125.htm#P1956_541986 (last visited July 1, 2005).
573. See THE ROYAL THAI EMBASSY, WASHINGTON, DC, THAILAND'S ACTIONS FOR THE PREVENTION OF TRAFFICKING IN WOMEN AND CHILDREN, <http://www.thaiembdc.org/socials/actionwc.html> (last modified Jan. 24, 2003).
574. See BUREAU OF DEMOCRACY, *supra* note 6.
575. BUREAU OF DEMOCRACY, U.S. DEPARTMENT OF STATE, THAILAND, COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES 1999, <http://www.usemb.se/human/human1999/thailand.html> (Feb. 2000).
576. Praratchabunyat Matrakaaan Nai Kaan Pongkan Lae Prapram Kaan Kha Ying Lae Dek B.E. 2540. [The Measures in Prevention and Suppression of Trafficking in Women and Children Act, 1997] (1997) (Thail). See THE ROYAL THAI EMBASSY, WASHINGTON, *supra* note 573.
577. Praratchabunyat Matrakaaan Nai Kaan Pongkan Lae Prapram Kaan Kha Ying Lae Dek B.E. 2540. [The Measures in Prevention and Suppression of Trafficking in Women and Children Act, 1997], § 11 (1997) (Thail). In the case that the victimized person is not a Thai citizen, the repatriation of the victim shall be done in accordance with the agreement set forth in a treaty with the state party, or a convention of which Thailand is an acceding state. *Id.*
578. The Prevention and Suppression of Prostitution Act, B.E. 2539, § 9 (1996) (Thail).
579. *Id.*
580. The Penal Code Amendment Act, No. 14, B.E. 2540, §§ 282–284, 312 (1997) (Thail).
581. The Amendment of Criminal Proceedings Act, No. 20, B.E. 2542 (1997).
582. Communication with WHAF, *supra* note 194, at 53. (citing Praratchabunyat Pongkan Lae Prapram Kaan Fork-ngern B.E. 2542 [The Money Laundering Control Act 1999], § 49 (1999)).
583. SUB-COMMITTEE ON THE RESOLUTION OF THE PROBLEMS OF TRANSNATIONAL TRAFFICKING OF CHILDREN AND WOMEN, NATIONAL COMMISSION ON WOMEN'S AFFAIRS, MEMORANDUM OF UNDERSTANDING ON COMMON GUIDELINES OF PRACTICES AMONG CONCERNED AGENCIES FOR OPERATION IN CASE WOMEN AND CHILDREN ARE VICTIMS OF HUMAN TRAFFICKING, B.E. 2542 (1999).
584. *Id.* art. 2(1).
585. *Id.* art. 3.
586. *Id.* art. 4(1).
587. *Id.* art. 5(3).
588. ANTI-SLAVERY INTERNATIONAL, HUMAN TRAFFIC, HUMAN RIGHTS: REDEFINING VICTIM PROTECTION 173–185 (2002), <http://www.antislavery.org/homepage/resources/humantraff/Hum%20Traff%20Hum%20Rights,%20redef%20vic%20protec%20final%20full.pdf> (last visited July 1, 2005).
589. U.S. DEPARTMENT OF STATE, *supra* note 570.
590. *Id.*
591. ANTI-SLAVERY INTERNATIONAL, *supra* note 588, at 179. See also U.S. DEPARTMENT OF STATE, *supra* note 570.
592. U.S. DEPARTMENT OF STATE, *supra* note 570.
593. Communication with WHAF, *supra* note 194, at 54.
594. *Id.*
595. *Id.*
596. S. Ekachai, *Is this a society we can be proud of?*, BANGKOK POST, Jan. 3, 2002; ECPAT Foundation, *Editor Challenges Country to Stem Child Abuse*, UN WIRE, Apr. 1, 2002, http://www.egpat.net/preventionproject/eng/new/articles_0006.htm.
597. *Id.*
598. Act promulgating the Penal Code, B.E. 2499, §§ 277, 279 (1956) (Thail).
599. *Id.* §§ 277–281.
600. *Id.* § 277.
601. *Id.* § 278.
602. *Id.* § 279.
603. END CHILD PROSTITUTION, CHILD PORNOGRAPHY AND TRAFFICKING OF CHILDREN FOR SEXUAL PURPOSES' (ECPAT) INTERNATIONAL, COUNTRY REPORT: THAILAND, http://www.ecpat.net/eng/Ecpat_inter/projects/monitoring/online_database/countries.asp?artCountryID=173&CountryProfile=facts&CSEC=Overview,Prostitution,Pronography,trafficking&Implement=Coordination_cooperation,Coordination_cooperation,Protection,Recovery&Nationalplans=&DisplayBy=optDisplayCountry#cs1 (last visited July 1, 2005).
604. BUREAU OF DEMOCRACY, U.S. DEPARTMENT OF STATE, THAILAND, COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES 1999, <http://www.usemb.se/human/human1999/thailand.html> (Feb. 2000).
605. *Id.*
606. The Prevention and Suppression of Prostitution Act, B.E. 2539, § 9 (1996) (Thail).
607. Act promulgating the Penal Code, B.E. 2499, §§ 282–283 (1956) (Thail); The Penal Code Amendment Act, No. 14, B.E. 2540, §§ 276–287 (1997) (Thail).
608. The Prevention and Suppression of Prostitution Act, B.E. 2539, § 10 (1996) (Thail).
609. *Id.* § 8.
610. *Id.*, § 8.
611. THE DEVELOPMENT OF CHILDREN'S PROTECTION ORGANIZATION, REPORT ON THE STUDY OF THE ENFORCEMENT OF THE 1996 PREVENTION AND SUPPRESSION OF PROSTITUTION ACT, BANGKOK, DEPARTMENT OF PUBLIC WELFARE (2000).