Chapter 1. Women and Human Development

A. Population and Geography

Thailand is divided into six regions, Northeast, Northern, West, Central Plains, South, and East. The Bangkok Metropolitan Administration is in Central Plains. The regions vary considerably in population, wealth, and resources. The Northeast is the most populous region, and contains large plains that have been deforested over the last century. This region is regarded as the poorest in Thailand, it has poor soils and is subject to periodic droughts. Its economic potential may lie in its proximity to the neighboring countries of the greater Mekong subregion. The people of the Northeast region are predominantly Lao Thai, with close cultural and language affinities to the neighboring Lao People's Democratic Republic (PDR). The Northern region is underdeveloped but rich in mountain forests, minerals, and areas suitable for cultivating temperate crops. It includes a number of successful tourism centers, particularly Chiangmai, and is home to most of Thailand's ethnic minorities. The West is a small mountainous region bordering Myanmar. Gem mining, logging, and illegal opium cultivation are its principal industries, but its scenic attractions make it suitable for tourism development. The Central plains are the "rice bowl" of Thailand, characterized by fertile, irrigated farmlands and general prosperity. This region contains the smallest proportion of the population, if metropolitan Bangkok is excluded. The South and East regions contain important tourism centers. The East region contains major oil palm and rubber plantation industries. The South, bordering Malaysia, is more mountainous and under-developed, and is home to Thailand's Muslim minority.

The national population growth rate in 1992 was 1.44 percent and population density was 113 per square kilometer. People of working age were the largest cohort at 63.4 percent, and 58 percent of the population was married.

B. Human Development Indicators

The UNDP Sixth Human Development Report (1998) contains two gender-aware measurements. The first is the Gender-related Development Index (GDI), which disaggregates the three variables of the Human Development Index (HDI) (life expectancy, educational attainment, and adjusted real income) by gender. The second is the Gender Empowerment Measure (GEM), which looks at women's representation in Parliament, women's share of managerial and professional jobs, and women's share of national income.

Thailand ranks 59th among 174 Countries, and 29th among 124 developing countries, on the UNDP Human Development Index. Within East Asia, it is outranked only by Hong Kong, South Korea, Malaysia, and Singapore. Regional comparisons show that peace and the prosperity of the growing market economy have produced, overall, higher levels of human development in Thailand compared with neighboring countries (Table 1).

Thai women have benefited from the trends toward longer life, increased child survival rates, and decreased fertility rates. Economic development has greatly improved women's access to social infrastructure, especially health and education. Mortality rates declined from 13.5 per 1,000 in 1961 to 4.9 per 1,000 in 1991. Declining population growth rates have contributed to an improvement in living standards. Key demographic trends include declining dependency ratios and school-age population, resulting in an increased number of people of working age, and decreasing pressure on primary education spending.

Table 1: Comparative Human and Gender Development Indicators, Greater Mekong Region

Indicator	Cambodia	Lao PDR	Myanmar	Thailand	Vietnam
HDI Rank	140	136	131	59	122
GDI Rank	129	125	120	40	108
Life Expectancy at birth	52.9	52.2	58.9	69.5	66.4
Adult literacy	65.0	56.6	83.1	93.8	93.7
Real GDP per capita ($,PPP)	1,110	2,571	1,130	7,742	1,236
Population below poverty line	NA	46	NA	13	51
Gross enrollment at all levels	NA	50	48	53	55
No safe water	64	56	40	11	57
No health services	47	33	40	10	10
No sanitation	86	82	57	4	79
Infant mortality (per 1,000 live births)	108	102	105	31	33

Source: UNDP Human Development Report, 1998

There has also been a greater commitment to improving the nation's "human capital", with social sector expenditure (education, health, and welfare) rising from 29.7 percent of the total expenditure in FY1993 to 33.8 percent in FY1997. An important objective for Thailand's long-term development will be to continue to increase investment in human development and the quality and coverage of basic social services, while making them more efficient and cost-effective. A further critical strategic goal will be to design and implement effective measures that give girls and women more opportunities and equal access in education and training.

C. Women and Education

1. Formal Education

Thailand has not placed sufficient emphasis on policies and investment aimed at building a skilled workforce to meet the economic and technological challenges and international competition that now prevail. Thailand's education profile does not compare favorably with its competitors in East Asia, with only 9 percent of enrollment in science and technology compared with, for example, PRC at 36 percent, or the Philippines at 20 percent.

The Eighth Plan explicitly recognizes a number of deficiencies in Thailand's education system, especially its highly centralized nature and the focus on formal over vocational education. Opportunities for vocational education are limited, especially in rural areas, and it is recognized that the existing curricula are often not relevant to rural needs or sufficiently oriented toward skill development.[1] The educational disadvantage of women is reflected in their position in the Thai workforce. The proportion of women with low education in the workforce (Table 2), along with their concentration in low-skilled, low-wage occupations and sectors, has remained fairly consistent since 1960. However, during the same period, the illiteracy rate has declined from 29 to 7 percent.

Table 2: Labor Force Participation Rates by Level of Education, Sex, and Location

Level	Urban	Rural

[1] Juajan Jongsathityu. 1996. *A Report on the Status of Women in Education, Employment and Culture*. Paper presented at the Second Women's Congress, National Commission on Women's Affairs, Bangkok.

	Female	*Male*	*Total*	*Female*	*Male*	*Total*
<4 years or none	36.3	57.4	42.9	51.0	71.0	58.5
Lower Elementary	61.6	87.3	73.3	75.7	91.6	83.6
Upper Elementary	56.9	66.6	61.8	68.8	80.4	74.6
Lower Secondary	53.6	72.8	64.7	50.5	74.8	65.6
Upper Secondary	47.9	66.0	58.2	72.4	91.5	84.3
Vocational	59.2	64.3	61.9	54.2	66.1	61.5
University	90.6	93.7	92.2	95.9	99.2	97.7
Higher Technical	82.3	96.2	86.8	79.7	93.8	87.1
Teacher training	81.6	86.9	83.8	88.5	95.0	91.7
Short-term training	88.9	58.3	83.3	43.5	0	43.5
Other	20.4	46.9	40.4	63.0	43.8	49.6

Source: Labor Force Survey (1992). National Statistics Office.

In 1992, the male-female disparity in enrollment ratio almost disappeared, being 48.9 and 48.4 for males and females, respectively.[2] However, 1990 census figures revealed that six out of ten of the illiterate population (3.1 million) above six years of age were female. Most of these women were in the older age groups, reflecting past discrimination found among poor families where sons, rather than daughters, were sent to school. This practice has not disappeared completely. In poorer regions, the opportunity cost of educating girls beyond primary level is higher than that for boys because of the demand for female labor in industries.

In 1995, female rates of participation were lower than male rates in pre-primary (49:51), primary (48:52), and vocational upper secondary (46:54) (Table 3). However, the proportion of female students was higher than that of males in general upper secondary (54:46) and higher education (52:48).

Table 3: Proportion of Male and Female Students by Level of Education, 1995

Level of Education	**Female**	**Male**
Pre-primary	49.0	51.0
Primary	48.4	51.6
Lower secondary	49.9	50.1
Upper secondary: general	54.0	46.0
Upper secondary: vocational	46.1	53.9
Higher education	51.6	48.4

Source: Education in Thailand, 1997

Although female students have approximately equal participation rates in education, male students predominate in pre-employment certificate and diploma courses (Table 4), and are more likely to study subjects for which there is higher market demand. Boys are more likely to be better prepared for entering courses such as engineering, mathematics, and science, while girls continue to enter more traditional female service occupations. Studies of girls' career preferences at the secondary level show that there are four times more females than males aspiring to careers in nursing and teaching, and a much

[2] Office of the National Education Commission. 1997. *Education in Thailand*.

smaller proportion aspiring to technical and vocational studies. Female preference for careers in nursing and teaching rises further at college level, resulting in six-and-a-half times more female nursing graduates than males, and 10 percent more graduates in teaching.[3]

Table 4: Tertiary Graduates by Qualification and Sex, 1991

Qualification	Percent Female	Percent Male	Total
Certificate	25	74	3,485
Diploma	35	65	1,231
Bachelor Degree	57	43	66,487
Graduate Diploma	43	57	928
Master Degree	50	50	5,168
Doctoral Degree	47	53	68
Total Number	41,943	35,420	77,363
Total Percent	54	46	100

Source: Ministry of Higher Education

Gross enrollments in higher education have grown from around 50,000 in 1965 to over one million in the mid-1990s. They currently comprise approximately 15-16 percent of the 20-24 age group, with a 70 percent transition rate from upper secondary levels. This is relatively high by developing country standards. Much of the growth has been in open admission universities, which attract around 50 percent of annual enrollments. In the short-term, expansion of higher education will be constrained by the comparatively low enrollment rates in secondary schooling.

Choices made by women for both professional and vocational education are narrow, mainly confined to a few subjects such as home economics, commerce, and business administration, while men prefer industrial and agricultural training. At university level, women are found mostly in the social sciences, education, and nursing. There is increasing female enrollment in medicine, but women are under-represented in law and science, and few women study engineering. At university level, the gender difference in the choice of fields of study clearly indicates that women graduates will work in business, social sciences, humanities, and health sciences.

These patterns of subject choice, however, are not related to different abilities among boys and girls. The International Education Association gave a test in science and mathematics to half a million 13-year old students in 41 countries in 1996. The results demonstrated that Thailand was one of only 11 countries that showed no gender gap in these subjects. Hopefully, this result indicates a reduction of gendered career aspirations among the younger generation, and that girls who perform well in these subjects will be encouraged to pursue them at a higher level. Traditional attitudes to gender and occupation tend to be deeply rooted, so the long-term opportunities and benefits of technical and scientific training need to be actively promoted among girls at junior secondary levels, where subject choices are made.

Principles of equal opportunity in education are not applied by all institutions of higher education. In some disciplines, the education administrators have set quotas determined by sex. For example,

3 Juajan Jongsathityu, op.cit.

veterinary sciences, agricultural economics, economics of cooperatives, industrial agriculture, marine sciences, archeology, marketing, and production management all specify a higher proportion of male students. The only discipline that has a higher quota for female students is nursing. One explanation given for these quotas relates to the demands of the labor market, the demand for women veterinarians, for example, is said to be very limited.

Despite the fact that the ratio of male to female doctors was almost 3:1 in 1996 (15,572 male doctors and 5,535 female doctors), women have been restricted to 50 percent of entrants to medical degrees for many years. It is argued that this quota system is needed to address the continuing scarcity of doctors in rural and remote areas, since women doctors are believed to prefer working for hospitals in urban areas. In fact, there are pressing reasons why women should be given incentives to serve in rural areas. Thai women tend to have strong objections to being examined by male doctors or discussing with them matters of reproductive health, including HIV/AIDS and other sexually transmitted diseases, contraception, and cervical or breast cancer screening.

2. Vocational Training and Nonformal Education

Vocational training operates predominantly at two levels: pre-vocational training in secondary schools, and institution-based pre-employment skills and workforce training programs. In the secondary education system, approximately 55 percent of students follow a general education stream, while 45 percent follow vocational streams, with trends to increasing enrollments in the general stream. A key issue in secondary education is the quality and relevance of curricula.

Government and nongovernment providers offer nonformal education to people who wish to acquire skills and obtain credentials for further education and training. In 1996, the proportion of females participating in nonformal education courses offered by the Department of Nonformal Education, Ministry of Education, was 53.5 percent, compared with 46.5 percent for males. The gender difference is obvious in many courses, with enrollment rates being higher for females in adult functional literacy, vocational certificate programs, and vocational short courses. Male enrollment rates were slightly higher in adult general educational programs (Table 5). Participation rates were higher for males in classroom-based teaching programs and distance education, and for females in courses based on self-instruction (Table 6). The latter difference may reflect the greater demands on women's time.

Table 5: Proportion of Males and Females Participating in Nonformal Education Activities, 1996

Nonformal Education Activity	Female	Male
Adult general education	48.3	51.7
Adult functional literacy	58.8	41.2
Vocational certificate	51.0	49.0
Vocational short courses	66.7	33.3

Source: Education in Thailand, 1997.

Table 6: Proportion of Males and Females Receiving Adult General Education by Type of Education, 1996

Type of education	Female	Male
Classroom learning	45.0	55.0
Distance education	47.6	52.4
Self-instruction	55.8	44.2

Source: Education in Thailand, 1997.

The Government has recognized the need to increase the supply of skilled workers—a shortfall of 1.2 million over the next five years has been estimated—and has expanded pre-employment training in regional and provincial centers and retraining programs through a Skills Development Fund. Fewer than 10 percent of those attending full-time courses in training centers run by the Department of Skill Development, Ministry of Labor and Social Welfare, are women, and women represent less than two percent of instructors.[4] The courses offered include basic skills, skills upgrading, and on-the-job training. Employers, who pay a large part of the expenses, are often unwilling to invest in training for women workers, and courses tend to be oriented toward metal work, auto-mechanics, and plumbing, which are considered to be masculine skills.

Technological improvements in both agricultural and industrial sectors have generally been of less benefit to women than to men. At present, women workers are the first group to be replaced when technology is upgraded, and they are routinely excluded from training programs on new methods of production. It is commonly argued that, as women have less technical knowledge than men, they are therefore likely to be more difficult to train. Similarly, in agriculture, men are often assumed to be better informed than women, and are invariably selected to take part in training for new agricultural techniques and technology. Agricultural trainees are usually selected by male-dominated village committees, who tend to exclude women from the selection process. On-the-job training is a key strategic area for the continued improvement of women's status in the workforce. Initiatives to strengthen small- and medium-scale enterprises through training in provincial areas have not reached equal numbers of men and women. For example, of 1,443 entrepreneurs trained by the Department of Industrial Promotion, Ministry of Industry in 1995, only 307 (21.2 percent) were women.

The Thai Government has been reviewing nonformal education curricula with a view to placing greater emphasis on relevant vocational training. However, making such programs more accessible to women must also be taken into account. Women's participation is often limited by the schedule and location of training programs, which may make attendance difficult due to competing domestic demands. Facilities at training sites are often not "women-friendly", and most classes start inconveniently early in the morning or finish too late in the evening, when it is more risky for women to travel. Women's participation may also be deterred by training programs that require an overnight stay.

The higher rate of illiteracy among women (two-thirds) is a further source of their disadvantage in adjusting to new technology and gaining access to training. In all types of employment, applicants are commonly required to demonstrate their ability to understand simple written instructions. Using literacy tests to screen applicants almost always results in women losing out to men. With the increasing use of new technology, quick response or "just-in-time" production, and intense global competition, workers are required not only to be able to understand written instructions in Thai, but often in English as well, posing further barriers to women in upgrading their skills and position in the workforce. Audiovisual methods are given low priority or ignored, despite the benefits of this medium for illiterate workers, among whom the majority are women.

[4] Report of a Workshop on Participation in Training for Thai Women, Department of Skills Development and the Asian Development Bank, Ministry of Labour and Social Welfare, Thailand, October 1996.

3. Women's Training Issues

The demand for higher skills levels in the industrial sector has relegated the majority of women in the workforce to unskilled and semi-skilled work. Current programs for skills training urgently need rethinking to bring skills training closer to the workplace. Affirmative action policies will be required. Funding for short nonformal education courses may be better spent as an incentive to approved manufacturers to offer training for women, along with special programs in literacy education. Nonformal and vocational training programs for women offered by both Government and nongovernment providers currently emphasize "feminine" pursuits. Such courses are popular with students who believe skills such as hairdressing, dressmaking, food preparation and preservation, and handicrafts, are in demand. These courses often represent an extension of women's traditional domestic roles. Most of them are short and the skills learned usually can only be applied to supplementary occupations rather than full-time wage- or self-employment. Many women are unable to use their training for self-employment because of non-existent or heavily oversupplied markets, or because they lack the initial capital to start a business.

Rural women are more interested in receiving training that provides them with an independent occupation and income to support a family, rather than training that aims to enhance their domestic role or help them earn a little income on the side. The task of matching skills to markets is particularly important for training programs aimed at reducing female labor migration. If graduates fail to find work near home, they will move to larger cities in search of opportunities to use their new skills.

Training programs should be based on research into local labor markets and small business opportunities, and should be designed to offer students more realistic courses linked to market demand. Skills training programs lack follow-up such as improved access to capital, and support in building management skills and marketing techniques. The items produced, particularly handicrafts, may be left unsold for a long time due to lack of quality control expertise and because the designs are repetitive, old-fashioned or do not suit consumer tastes, particularly local consumers who can afford to pay higher prices, or those of export markets.

D. Women and Health

Economic development has greatly improved women's access to social infrastructure, especially health and education. The infant mortality rate fell from 47.7 per 1,000 live births in 1961 to 34.5 in 1991, while the maternal mortality rate dropped from 4.2 to 0.2 per 1,000 during the same period. Thailand's health indicators indicate a transition from infectious diseases as the major cause of morbidity and mortality, toward the noncommunicable diseases associated with increased life expectancy. This transition is characteristic among modern industrialized societies around the world. However, while basic life-threatening infectious diseases are considered to be under control, new causes of death and disability are emerging, such as occupational diseases, drug abuse, accidents, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). Mental disorders are more frequently reported.

1. Women and HIV/AIDS

The spread of HIV infection has been rapid since the first reported cases in 1984. In 1984-1988, there were 18 known cases. In the following four years, the number of known cases of HIV infection grew to 8,173, of whom the great majority were male (7,083) (Table 7). The rate of HIV infection among

women aged 15-25 is greater than among all other women combined (ESCAP, 1994; UN, 1995). Human immunodeficiency virus is known to have been transmitted to 1,182 children under 10 years of age by their mothers. It is believed that between six and ten percent of pregnant women in poorer provinces carry the disease.

Between September 1994 and December 1996, 52,997 cases of AIDS were reported, with a male to female ratio of 5:1. Seventy-five percent of AIDS patients (9,916) were in the 20-39 age-group, 11 percent (1,112) were female. Of the total number of patients in all age groups, 14 percent were female. It is predicted that, by the year 2000, there will be between 700,000-900,000 people infected with HIV, and 250,000-500,000 with AIDS. However, Thailand has one of the most successful AIDS control programs, and the growth rate of AIDS cases is declining.

The transmission rate of AIDS reveals several aspects of the social subordination of Thai women, both culturally and economically. In 80 percent of the reported AIDS cases, the disease was transmitted from commercial sex workers to their clients and then to their clients' wives or other sexual partners (ESCAP, 1995). Wives are expected to tolerate their husband's infidelity and married men commonly patronize commercial sex workers. Few married women have sufficient economic independence to exert bargaining power in marital relations, and thus have a high risk of being infected by their husbands.

Table 7: Number of AIDS Patients by Age group and Sex, 1984-1994

	September 1984-88			**1989-1993**			**January-October 1994**			**September 1994-October 1994**		
Age Group	M	F	Total	M	F	Total	M	F	Total	M	F	Total
0-9	0	2	2	349	296	645	168	144	312	517	442	959
10-19	0	0	0	86	78	168	24	35	59	110	113	223
20-29	9	0	9	2,890	419	3,309	1,801	326	2,127	4,700	745	5,445
30-39	5	0	5	2,521	200	2,721	1,578	167	1,745	4,104	367	4,471
40-49	0	1	1	737	62	799	471	48	519	1,208	111	1,319
50-59	0	0	0	288	21	309	173	12	185	461	33	494
60+	0	0	0	184	8	192	95	3	98	279	11	219
ank*	1	0	1	28	6	34	8	2	10	37	8	45
	15	3	18	7,083	1,090	8,173	4,318	737	5,055	11,146	1,830	13,346

*Age not known

Source: Bureau of Health Policy and Planning, Office of the Permanent Secretary, Ministry of Health

The number of commercial sex workers with HIV is difficult to determine. A commercial sex worker may average five clients a day, so the risk of transmission is very high. Although considerable efforts have been devoted to promoting safe sexual practices among female sex workers, many continue to be vulnerable to HIV/AIDS because clients refuse to use condoms, commercial sex workers typically lack negotiating power, and competition within the sex industry is intense.[5] As male awareness of the danger of AIDS transmission grows, demand for younger girls who may not yet be infected increases.

[5] Sobha Spielmann. 1996. *Traditional, Present and Future Role of Women in Thai Society*. Background notes to a panel on Development of Rights of Women and Youths at a Symposium on Democracy, Quality of Life and Human Rights within 20 years, Bangkok.

While Thai sex workers are becoming more informed and assertive about sexual protection, increasing numbers of less-informed and more economically desperate young women from the poorer regions of Thailand and neighboring countries are being recruited into the Thai sex industry.

Approaches to prevention and control have tended to perceive women as both the cause and the problem in the AIDS epidemic, rather than as victims. There has been little effort to address the behavior of men and their responsibilities in preventing the spread of the disease. Programs for both family planning and the control of sexually transmitted diseases (STDs) are still based on the notion that reproductive health is essentially a female concern.

The AIDS prevention and control program has been more successful in Thailand than elsewhere. However, the threat of HIV/AIDS to the continued economic development of Thailand and the well-being of the Thai people is sufficiently serious to warrant a more broadly based approach to prevention and control measures that recognizes the dynamics of gender relations, the need to target male attitudes and practices, and the need to empower women. The spread of HIV/AIDS has both social and economic dimensions. Recognition of the economic causes has encouraged some minor, but important and effective, initiatives for small industry development in the North and Northeast, to provide young women with an alternative to migration in search of work. Such iniatives for regional development must be expanded. The social causes of the epidemic, which are related to patterns of gender inequality, have not been adequately addressed so far.

2. Occupational Health and Safety

The concentration of women workers in many low-technology manufacturing enterprises, and the significant proportion of women employed in the construction industry, mean that women are increasingly exposed to hazardous working conditions.

The regulation of occupational safety is weak in Thailand, and employers are often reluctant to add to their production costs by providing improved facilities and procedures. However, occupational health and safety was recently put on top of the agenda of women workers' demands to the Government.[6] The issue has received wide public support, especially since a fire at a toy factory in May 1993 which killed 188 people, most of whom were women.

Another problem of women's occupational safety is that of chronic illnesses that result from years of exposure to health hazards. This is shown in the textile and electronics industries, where it is now known that women who have worked in these industries for more than three decades are likely to suffer chronic respiratory illnesses from the cumulative effects of dust inhalation. One study shows that 30 percent of female workers in textile factories and 36 percent in electronics firms suffer a significant illness.[7] Pay in these industries is low, and the majority of workers are women migrants from rural areas. Women in low-paid positions change jobs more frequently than men and there is no law requiring employers to keep records of workers' health. Hence it is extremely difficult to claim compensation for such cumulative illnesses. Plans are underway to establish an institute for a safe, healthy environment at the workplace.

Occupational safety is also an issue in the rapidly modernizing agricultural sector. Women are increasingly exposed to daily contact with hazardous chemical substances, such as pesticides and

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[6] Sally Theobald. 1996. *Walking on a Tightrope: Women workers' perceptions and reactions to industrial environmental hazard in Northern Thailand*. Paper presented at the Sixth International Conference on Thai Studies, Chiengmai.

[7] National Commission on Women's Affairs. July 1996. *Thailand's Combined Second and Third Report to the Committee on the Elimination of Discrimination against Women.*

herbicides, typically with little or no education on the toxic levels of these chemicals and how to protect themselves.[8]

3. Maternal and Child Health

Women's health has improved markedly over the past 30 years, and women's life expectancy is now five years longer than that of men. Infant mortality and maternal deaths have approximately halved since the 1960s (Table 8). However, significant urban-rural access gaps are prevalent. Around 20 percent of the rural population do not have access to safe water and sanitation. Access to piped water is about 50 percent of villages in the central and northern regions, compared with 45 percent and 38 percent in Northeastern and Southern regions, respectively. Access to curative health services is concentrated in Bangkok, where doctors and hospital beds per capita are two to three times the national average.

Table 8: Infant and maternal mortality per 100,000 live births

	1962	**1975**	**1992**
Infant mortality by age			
Perinatal (stillbirths & <7 days)	19	14	8
Neonatal (<28 days)	31	20	9
Infant (<1 year)	119	81	20
Maternal deaths by cause	**1989**	**1991**	**1993**
Abortion	42	40	24
Obstetrical causes	160	144	94

Source: Adapted from Ministry of Public Health. Health in Thailand 1992-1993, Bureau of Health Policy and Planning.

Nutrition surveillance by the Ministry of Public Health reports that the proportion of malnourished children declined in 1990-1991, and there was a slight decline in the proportion of low birth-weight babies during this period. Pre-school and school-age child malnutrition rates are 15 and 7 percent, respectively, and malnourished children are concentrated in rural areas.

A medical anthropologist who researched women's reproductive health in Northeast Thailand in 1994-97 states that abortion—although illegal—was prevalent in the region, with most abortions being performed by traditional practitioners using traditional methods.[9] This may have a greater impact on female deaths than recorded officially, and reflects lack of knowledge of, or access to, effective methods of contraception.

National figures do not reflect regional variations, so it is difficult to demonstrate regional disparities in the standards of women's health and their access to services. Ministry of Public Health data from 1993 demonstrated that contraceptive acceptance rose from 59 percent of married women of reproductive age in 1981, to 72.8 percent in 1992. Table 9 shows the contraceptive methods accepted by women and men in 1993. Over 90 percent of those taking responsibility for contraception were women.

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[8] Supachit Manophimoke. 1996. *Thai Women and Environment Problem: a gender perspective on impact and participation.* Paper presented at the Sixth International Conference on Thai Studies, Chiengmai.

[9] Dr Andrea Whittaker, personal communication, August, 1997.

Greater focus is needed on primary health care, and on providing services that are accessible to rural women. This will require more women doctors to be posted to rural areas to direct programs, and will necessitate the abolition of male-preferential quotas in training medical practitioners, and curriculum reform in the training of both nurses and doctors. More effective local clinics are needed to overcome inefficient referral systems that result in large numbers of people bypassing clinics to attend hospitals. This pattern disadvantages poorer rural families with larger transportation distances and costs.

Table 9: Contraceptive Use by Method, 1993

Method	Active Acceptors
Contraceptive pill	1,373,180
Contraceptive injections	954,974
Intrauterine device (IUD)	544,321
Tubal ligation (female sterilization)	1,979,485
Vasectomy (male sterilization)	396,222
Contraceptive implant (NOR)	118,843
Total	5,367,025

Source: Family Health Division, Ministry of Public Health