UK/THAI COLLABORATIVE RESEARCH DEVELOPMENT IN REPRODUCTIVE AND SEXUAL HEALTH: PROCEEDINGS OF THE SYMPOSIUM ON THE MAHIDOL-EXETER BRITISH COUNCIL LINK

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Foreword

The British Council has been trying to develop links between University departments and Institutes in Thailand and Britain for many years. They have taken the form of mutual staff training, or curriculum development, or joint research. We have some 20 running at the moment, and are hoping for that number to increase.

This particular link between Mahidol and Exeter has been one of the most successful and my favourite one, and I think that has been largely due to the quality of staff in both institutions, and to the fact that it has concentrated on collaborative research, which has been valuable for both Institutes. For us the importance has been also the direction that research has taken - towards ways of preventing the transmission of HIV. It is one of the most serious problems facing every country at the moment.

I have only worked in Thailand for three years, and have been impressed by the amount of sex education that I have seen. I think that some of the papers read this afternoon will reveal that a lot still remains to be done. It is many years since I studied anthropology at University, but even then we were very much aware of the crucial problems that women faced within the family. As the structure of family life changes and environmental and economic pressures increase, those strains are accentuated. I very much look forward to hearing some of the papers produced at this seminar and wish it every success.

Mr. Peter Moss
Director
The British Council
Thailand

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The editors would like to express their grateful thanks to the British Council for its generous and extended support for the Mahidol-Exeter Link. In particular we would like to thank Mr.Peter Moss, Ms.Morna Nance, Mr.Andrew Spells and Mr.Bruce Brown for their encouragement and assistance. We would also like to acknowledge the assistance from Ms.Yupin Vorasiri-amorn, Ms.Panee Vong-Ek, in helping to compile this volume of papers and Dr.Tony Pramualaratana for assisting simultaneous translation during parts of the symposium.

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President 's Foreword

Mahidol University has developed out of Siriraj Hospital which was originally founded by His Majesty King Chulalongkorn in 1887 to fulfill his wish of providing appropriate medical services for his people. In 1969 His Majesty King Bhumibol Adulyadej gave the University the name "Mahidol" to honour his father, His Royal highness Prince Mahidol of Songkhla, who had played a very important role in the development of medical education and public health in Thailand. The Institute for Population and Social Research(IPSR) was founded in 1971 in order to develop applied research and training in population social and health issues. During its period of existence I am pleased to note that IPSR has attained national and international recognition for the quality of its research. Educational connections between Thailand and U.K. go back a long way, indeed many of the senior figures in Siriraj and Mahidol obtained their original medical training in the U.K. In more recent years educational contacts have been made with many other countries as well, but links with the U.K. are still very important and I am delighted with the continuing success of the collaboration between IPSR and the internationally renowned Institute of Population Studies(IPS), University of Exeter.

The social aspects of population and health are crucial to all countries' well being and of vital importance in the process of development. Key themes of the IPSR/IPS link such as reproductive health and HIV/AIDS prevention are of immense important to Thailand. The research findings generated through this collaboration are channelled to government and non-government organisations responsible for improving the quality of life. Furthermore IPSR/IPS have undertaken a number of collaborative research and health programme training workshops which have played an important role in strengthening contacts and capabilities in several other Asian countries.

I hope and trust that both of these very active institutions will continue to work together to contribute towards these national, regional and international concerns. Mahidol University has been pleased to support this link and I wish to express my thanks to the British Council for its wise and generous assistance and support.

Professor Dr. Pradit Charoenthaitawee
President
Mahidol University

Chapter 1

U.K./Thai Collaborative Research Development in Reproductive and Sexual Health : the Mahidol-Exeter British Council Link

Nicholas Ford
and Aphichat Chamratrithirong (Editors)

Introduction

Demographic change and reproductive and sexual behaviour have crucial multi-faceted ramifications for social developments spanning societal, community and personal levels. Possibly no other area of human behavior so thoroughly interweaves public and private concerns, linking national policies and personal propensities, values and feelings. Reproductive behaviour comprises one of the most rapidly changing facets of the lifeworlds in developing societies, with the pace of such change being especially accelerated in Thailand. With passage through the demographic transition the objectives, rationales and emphases of population and reproductive-related policies necessarily change. These shifting, but often complementary, rationales include demographic-developmental, health and human rights imperatives. These wide ranging themes underlie the research and research training focii of the Institute for Population and Social Research (IPSR), Mahidol University and the Institute of Population Studies (IPS), University of Exeter.

Perhaps it was inevitable, given the two Institutes' shared and distinctive focus upon the psycho-social, cultural and programme-related aspects of population, that they should have developed collaboration in research. The early and ad hoc connections between the Institutes were strengthened and given clear direction by the establishment (under the Committee for International Co-operation in Higher Education CICHE) of a British Council Link commencing April 1st 1991. The link revolves around three objectives:

Chapter 2

Epidemiological Transition: Health Change with Development and Modernization

Dr.David R Phillips

Introduction

It is widely appreciated that ill-health and causes of mortality assume different forms as development and modernization progress. One framework for discussing this and for examining whether there is any recognizable pattern to such changes and their implications has been the concept of epidemiologcal or health transition. This can help to focus on the fact that many so-called Third World or developing countries have today epidemiological profiles that reflect all types of medical and social needs: infectious and parasitic conditions; chronic and degenerative diseases; psychological and psychiatric morbidity; and the social care needs of very young and very old people. In the context of epidemiological change, it is no longer suitable to classify countries or their cities simply as developed or developing, or as north-south or east-west. Neither is it easy to say whether, say, urban areas that have grown rapidly have 'better' health than less urbanized areas. It is perhaps more accurate to say that there will be various sub-groups in most populations in terms of health and that variations within specific countries are likely to be as large as those between countries.

A number of authors have begun to point out the necessity of looking closely at the epidemiological conditions **within** specific countries and, particularly, within their growing urban populations and specifically their impacts on the urban poor (Harpham et al, 1988; Hardoy and Satterthwaite, 1989; Tabibzadeh et al, 1989; Hardoy et al, 1990). It is increasingly evident that not only are there differences over time in the nature of diseases in countries but that their internal distributions can be quite variable. This can reflect differences amongst economic social or occupational groups, between regions or districts or between

research priorities and links to the later paper with Nittaya Piriyathamwong on ageing, and the Social Epidemiology curriculum development of Buppha Sirirassamee. Chapters Three and Four derive from the Institutes long-standing concern with family planning programmes. In Chapter Three Amara Soonthrondada presents findings and discussion from a study of community participation in family planning programmes in Thailand, assessing the underlying theory and rationale, implementation and practice, relevance and demand. In Chapter Four Panee Vong-EK reports upon some recent analysis of survey findings on breastfeeding and contraceptive practice. Chapter Five by Nittaya Piriyathamwong and David Phillips reviews the implications of the advancing demographic transition for social support of the growing proportion of elderly, concluding with an outline of a research proposal.

Section two reflects the Institutes' major interest in developing a fuller understanding of sexual culture and its implication for reproductive and sexual health and HIV prevention. The papers are structured developmentally from childhood, adolescence to aspects of married relationships. In Chapter Six Umaporn Pattaravanich discusses the broad differences in the socialisation of boys and girls in Thai society which provides a basis for sexual lifestyles in later adolescence and adulthood. In Chapter Seven Chanya Sethaput and Umaporn Pattaravanich outline some preliminary analysis of findings from a survey which investigates the communication from mothers to daughters of information and values concerning reproductive and sexual issues. The essential question is how far are mothers cognitively and emotionally able to help prepare their daughters in these crucial aspects of their lives? In Chapter Eight Nicholas Ford and Sirinan Kittisuksathit present qualitative (focus group discussion) findings from the first phase of a large scale study of the sexual awareness and lifestyles of young, single factory workers. This chapter delineates the gender structuring of the sexuality of Thai youth and links it to sexual health concerns. The HIV/AIDS epidemic is highlighting important social questions in Thai society which were perhaps not previously addressed so openly and systematically. One such issue concerns the sexual interaction of husbands with prostitutes. Chapter Nine by Kanchana

Tangchonlatip and Nicholas Ford presents some preliminary (focus group discussion and in-depth interview) findings from an ongoing investigation into husbands and wives perception of husbands' frequenting of prostitutes.

Section Three briefly presents some information on curriculum developments. In Chapter Ten Buppha Sirirassamee describes the newly developed M.A. Curriculum on Social Epidemiology and Medical Health Demography and in Chapter Eleven Orapin Pituckmahaket discuss curriculum development on Data Analysis.

The Contributions selected for this volume reflect some of the collaborative research undertake by IPSR Mahidol and IPS Exeter. It is important to acknowledge the contribution made by all staff of both Institutes to the vitality of the Link.

1) the development of collaborative research;
2) strengthening training capacities;
3) assistance with post graduate students.

The visits made by personnel from/to Exeter/Mahidol in the link are given in Appendix One. During the first phase of the link both Institutes received the designation of Collaborating Centre in the World Health Organization, Human Reproduction Programme. The Institutes each undertake extensive research training of postgraduate students, mostly, but not exclusively, from Asia, Africa and Latin America. Their respective M.A. programmes in Population Research have now evolved to a position of some maturity and doctoral research programmes have also recently been established. Numerous population researchers from Thailand have attended the training programmes at Exeter (Appendix Two) which facilitated the development of the IPSR/IPS link. The Institutes have also collaborated in undertaking a series of research training workshops (held at IPSR, Mahidol) in family planning, sexual and reproductive health research methodology since 1986.

Since their inceptions, (IPSR Mahidol 1971, IPS Exeter, 1978), both Institutes have strived to develop transdisciplinary research which is not only of academic interest and quality, but also of practical value in addressing major population and reproductive health related problems. Combining the theoretical and applied in a way conducive to solving problems is an elusive goal, but one towards whic both Institutes are moving, hopefully with some measure of progress. This practical approach has involved both Institutes in working closely with government commissions, health ministries and authorities and pertinent non-government organizations (NGOs). It was gratifying that the Seminar on U.K/Thai Collaborative Research held in Bangkok (November 9th, 1993) was attended by over sixty participants from the Ministry of Public Health, international agencies, NGOs and University departments, many of whom have worked with IPSR, Mahidol in translating research objectives into relevant reproductive health related

policies and programmes. The feedback provided by the participants at the seminar has been taken into account in the revision of papers for collation in this volume.

Whilst macro level demographic and developmental trends provide a context to the Exeter/Mahidol research, the main emphasis is upon generating understanding of more micro-level behaviors in ways such that appropriate policies and programmes may be formulated, evaluated and modified. The research agenda unfolds in relation to current and anticipated major population and reproductive health-related problems. As Thailand has moved towards concluding its fertility transition and shifted towards the later phases of the epidemiological transition so concern has shifted away from demographic objectives more towards such issues as the reproductive health problems facing adolescents, and the social support of the elderly in a mobile and ageing population. The greatest new challenge confronting researchers in Thailand is contributing to the prevention of HIV transmission and coping with the concomitant deepening AIDS epidemic. The Institutes have built upon their experience in research into fertility-regulating behavior to develop research concerned with HIV prevention. Much of this work has revolved around forming a stronger understanding and analysis of the sexual culture in order to inform policies and programmes which seek to promote 'safer sexual' practices.

The papers collected in this volume represent a major part of the work undertaken within the Mahidol/Exeter link. Research is here presented at different stages of development:-fully completed and disseminated, preliminary analysis or data collection being undertaken, or proposal submitted for funding. The contributions are arranged in three sections the first section comprises a diverse range of papers concerning health, family planning and ageing issues. The second section comprises a fairly coherent series of papers concerned with different aspects of the sexual culture, involving an elaboration of the gender structuring of sexuality in Thailand. The third section outlines some developments in curriculum design. The first section commences in Chapter Two with David Phillips review discussion of the epidemiological transition with particular reference to East and South East Asia. This provides broad contextual overview for the assessment of health

town and country (Harpham et al, 1988; Frenk et al, 1989; Phillips, 1990, 1991; Phillips and Verhasselt, 1994). The implications of epidemiological change, and particularly of differential epidemiological change, are far-reaching for services, economies and families.

The general concept of epidemiologic(al) transition

The basic principles of epidemiological transition and its relationships with demographic transition are well known and have been outlined by authors such as Omran (1971, 1977) and Caldwell (1982). The idea of epidemiological transition is quite straightforward and the `theory', as Omran (1971) calls it, "focuses on the shifting web of health and disease patterns in population groups and their links with several demographic, social, economic, ecologic and biologic changes". The `theory' addresses the nature of the relative balance between various causes of mortality in particular (and morbidity implicitly) and the ways in which changes occur whilst societies modernize. Today, the term **health transition** is preferred by some, and was used in an exploratory Rockefeller Foundation programme. Health transition is said to involve the cultural, social and behavioural determinants of health and implies a concern with health and survival rather than death; it also suggests continuing, socially-influenced, change (Caldwell and Santow, 1989; Caldwell et al, 1990; Chen et al, 1992; Hill and Cleland, 1991; Caldwell, 1993). The concept of 'risk transition' may also be helpful which emphasizes the evolution of environmental and occupational health hazards (Smith, 1990).

It is certainly not new to suggest that behaviour and lifestyle can play a major role in determining health and risks death. The precise balance of the contributions of lifestyles, public health measures, medical care and general improvements with development to health, however, is quite fiercely debated. It is increasingly evident that, in areas such as sexual health, HIV transmission, substance abuse and the like, lifestyles and behaviour are critical influences on health.

Epidemiological transition as originally envisaged involves a one-way movement through a series of stages beginning with a preponderance in the Old World of epidemics of infections and famine, through an era of receding pandemics, to a pre-eminence of degenerative or sometimes `man-made' (human-made) diseases. Some authors are implicitly and explicitly discussing a fourth stage of epidemiological transition, in which length of life expectancy increases (as major killer diseases are being better treated or detected) but in which health may deteriorate, as the causes of chronic but non-fatal morbidity are yet to be defeated (Verbrugge, 1984; Riley, 1989; Riley and Alter, 1989; Phillips, 1991). Epidemics or increasing incidence of mental disorders seem also to be characteristic of this fourth stage. Olshansky and Ault (1986) have called this the `age of delayed degenerative diseases' and see it as a stage that will propel life expectancy into and perhaps beyond the eighth decade. This is already evident in a number of developed countries and in some middle and upper income newly industrializing countries, particularly in South-east and East Asia (Leete, 1985; Chen and Jones, 1989; Phillips, 1992; Leete and Alam, 1993). It is clear that population ageing and differential demands on health and welfare services, as well as on the family care systems in many countries, have far-reaching implications for very many economies (Tout, 1989; Phillips, 1992; Ben, 1993).

The rate at which the transition occurs and the factors influencing it, however, appear to have varied from one group of countries to another. In the West, transition began before many modern medical discoveries such as antibiotics and was clearly associated with improved standards of living and public health (McKeown, 1965, 1988). The transition in the West is now probably almost, if not quite, complete. It took 100 to 200 years and is the Classical or Western variant of the theory. In its first stage, the `Age of pestilence and famine' gradually merged into a period of `receding pandemics', to be followed in the mid-twentieth century by an `age of degenerative and man-made diseases'. This transition tended to be fairly gradual. As it was associated with the industrial and social revolution in the West, it is generally felt that it cannot be exactly repeated elsewhere in the world.

The accelerated transition, the second variant of the model, has been seen in countries such as Japan and the USSR and probably also in certain others in Eastern Europe and South-east Asia. Mortality and fertility declined rapidly and a rapid change took place to a modern epidemiological profile. By contrast, some countries, principally in the poorer Third World, appear to be in a `delayed' model. The transition started late, but was effected to an extent by Western technology. Insofar as fertility has not always declined rapidly and living conditions have not always improved substantially for all people in these countries, their transitions have not been complete. Many aspects of degenerative and man-made diseases have become evident but many infectious ailments remain. These countries (or, at least, certain of their citizens) in effect may suffer from the worst elements of both major groups of ailments Omran (1971) singled out Sri Lanka as an example of the delayed transition but, today, certain countries in Africa are likely to be cited, as well as some in South Asia.

It is perhaps the middle income countries today that are experiencing the most rapid changes in health in some areas and for some sectors of their populations. This implies to Phillips (1988), Frenk et al (1989) and others a modification of the theory, or at least the third stage, in which there is not a simple sequence of the eras but a period in which two or more may overlap. Changes in patterns of morbidity and mortality may also be reversible, and a type of counter-transition may occur. It would seem that this is the case in countries which still suffer from outbreaks of infectious diseases and famines (which are often human-influenced). Peru in the early 1990s provides an example of a country with relatively high morbidity and mortality from cholera, spreading to other parts of Latin America. Many parts of Africa are experiencing food shortages and morbidity and mortality patterns reminiscent of the early eras of epidemiological transition.

A see-saw effect of health improvements can occur within specific countries or in parts of countries. Sometimes, only certain sectors of the population, such as the very young, mothers, the poor, or infirm people, may be affected. When there is an incomplete change, or where different types of diseases coexist has been

called a protracted epidemiological transition (Frenk et al, 1989). In some instances, there is growing evidence of epidemiological polarization. Richer sectors of populations may develop more or less `modern' health and disease profiles whilst some poorer sections may experience infectious and nutritional disorders on top of, or instead of, more degenerative and chronic ailments. The inhabitants of many cities in developing countries in particular industrializing ones will often be exposed to 'traditional' infectious and environmental health risks as well as to chronic ailments and the spin-offs of industrialization. The social factor as a determinant of health status is in many ways gaining enormous influence in these cities in a way that it has ceased to do, or that is much muted, in Western cities. Who you are and which part of the city you live in become major factors influencing the health and life chances of you and your family. This obviously has very important implications for public health policy and for the planning of health and social care services.

Epidemiological change and the middle-income countries

In the rather heterogeneous group of middle-income countries, many appear to have passed relatively rapidly through some elements of epidemiological transition. This is especially true in South-east Asia although, in the majority, by the mid-1980s, Hansluwka (1986) considered that the synergistic interaction of malnutrition with infectious and parasitic diseases was still paramount, with malaria, tuberculosis, leprosy and acute diarrhroeal diseases maintaining considerable importance (the last-named, particularly for infants and children). This has changed somewhat over the past decade and three or four countries in South-east Asia do stand out as having experienced fairly rapid, and in cases, spectacular, transitions. These are Hong Kong, Singapore, Malaysia and Thailand. In these countries, modern epidemiological profiles have been emerging, over the period after the mid-1960s to early 1970s in particular. Elsewhere, Jamaica, Turkey and Mexico typify middle-income countries. Thailand and, to an extent, Malaysia, Mexico and Jamaica retain important elements of mortality from infectious conditions and accidents. Figure 1 shows the distinct trend towards a

modern epidemiological profile for Hong Kong during the last half of this century and particularly since the 1960s. Figure 2 shows the increasing relative importance of heart disease and cancers in particular, and decrease of most infectious ailments as causes of mortality in Thailand over the past few decades. Mexico has seen very marked falls in mortality from malaria, whooping cough and dysentery in the period since 1950, and also steep rises in mortality from ischaemic heart disease, diabetes and motor vehicle accidents (Frenk et al, 1989).

In many of the countries, whilst there may be a steady epidemiological change on average but some, such as Mexico, Thailand and Malaysia, continue to have groups or pockets of population with high infant mortality and relatively high incidence of infectious disease mortality or morbidity. The under-5 mortality rates in Table 1 show considerable variety both in their 1990 levels, ranging from 7 per 1,000 live births in Hong Kong to 80 in Turkey, and in the rate of decline over the past 30 years or so. Infant mortality today also shows a considerable range as do proportions of one-year old children minimized. There has been a general increase in the life expectancy at birth, but this has reached higher levels in Hong Kong and Singapore (mid to upper 70s), than in Thailand and Turkey (mid- 60s). There is not a simple, one-way correlation between life expectancy and its rate of increase and (say) GNP per capita. The WHO (1992) and Caldwell (1993) cite examples such as Sri Lanka, China and Vietnam, with very low per capita incomes yet life expectancies of around 70 years, which contrast with high income countries such as Saudi Arabia, Libya and Oman, where life expectancy may be 5-10 years lower. Success in extending life expectancy in the first group was seen as a result mainly of the exercise of political and social will, especially access to good community health programmes and a high commitment to female schooling. Whilst there is a general relationship between the purchasing-power based measure of per capita GDP and life expectancy, this is only one measure among numerous socio-cultural factors and others that influence health. There are many exceptions, the most spectacular perhaps being Sri Lanka and China, in which life expectancy is far ahead of what might be predicted based solely on economic criteria, which cautions against simple cause and effect explanations.

Tables 1B and 1C also indicate that there is not a simple correspondence between crude indicators of health care availability (highly selectively chosen here) and either life expectancy, maternal mortality, infant and under-5 mortality or other indicators of health status. There are huge variations between countries which have similar health personnel to population ratios, which means that many other factors, too numerous to cover here, must be involved in the study of epidemiological change and health care needs. To basic indicators of population structure, distribution, morbidity and mortality, need to be added sensitive socio-cultural indicators and distributional indices.

There is a manifest need for detailed within-country study of epidemiological trends, as well as comparative cross-national research. The importance of within-country research is that it may be able to highlight, for example, cultural differences, socio-economic and ethnic variations, local needs and localized maldistributions of resources. Aggregate research cannot do more than to hint at such variations.

Recent epidemiological developments in Thailand

A recent compilation of the rapid demographic and epidemiologic transitions in Thailand illustrates well what has occurred in this country and indicates what might happen elsewhere (Yongyout et al, 1992; Yongyout and Somsak, 1993). This paper suggests that Thailand is well into its epidemiological transition. There is a decline in infectious conditions, especially following good EPI coverage and a decline in malaria, tuberculosis and others. Some diseases persist, including diarrhoeal and some parasitic diseases, and viral hepatitis and dengue haemorrhagic fever. New threats emerge, however, in the form of HIV infection and other substance related disorders. There is an evident and growing burden of non-communicable diseases. Over the past two decades, infectious diseases have ceased to be the main causes of death and the three leading causes are now accidents/poisonings, cardiovascular diseases and neoplasms. Diabetes mellitus has increased from 2.5% to 3.4/4.0% between 1971 and 1987. Hypertension is as

high as 17% in some parts of the country and in Bangkok slums. The incidence of cancer has risen from 12.6 per 100,000 in 1971 to 31 per 100,000 in 1981. This might be in part a result of better diagnosis and registration but almost certainly indicates a real increased incidence. Other problems of the late transition and post transition are high rates of traffic accidents and a growing incidence of morbidity and mortality from occupational hazards, in both agriculture and industries. Last but not least, a considerable increase has been noted in psycho-social problems, including a three-fold increase in outpatients in neuro-psychiatric hospitals over the decade to 1986 and a doubling in the numbers of drug addicts seeking medical care. Consumption of cigarettes and alcohol is high and community prevalence of the above disorders is probably much higher than the official data suggest. In many ways, Yongyout and Somsak (1993) see Thailand sitting on a developmental precipice, in which from its former developing-country status, it has become a newly industrialized country, with concomitant rapid and extensive epidemiological transition challenges. Like many other countries in this situation, Thailand is having to meet new health care challenges whilst still not having fully overcome the old threats to health.

Conclusion

In terms of health policy and provision, it might be possible to use the concept of epidemiological transition to provide a basis for planning the type and scale of future health care needs that might reasonably be expected within various countries. Many authors have suggested this is a potential approach (Hellen, 1983; Phillips, 1988, 1990; Lopez, 1989; Picheral, 1989; McGlashan, 1982). However, data limitations may render this impractical. It may also unwise to use a model which assumes a linear unfolding of successive stages in what is certainly a very complex relationship (Jones and Moon, 1992). Whatever one feels, however, it is essential to look to the future. Many forms of health care provision and health education campaigns have long "lead times". Whilst primary health centres may be provided relatively quickly, new hospitals require many years of planning and building. The concept may also be useful in designing appropriate medical and

welfare curricula for educational and professional purposes, since the training of staff for the diseases and conditions they will meet in the future is more important and certainly more cost effective than an over-concentration on conditions which may have been prevalent in the past.

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Table 1 Health indices in various middle-income countries

(A)

	Population urbanized (%)	U5MR (per 1,000)		Life expectancy at birth (years)		GNP percpita (US$)
	1991	1960	1990	1960	1991	1991
Hong Kong (HHD)*	94	64	7	66	78	13,430
Jamaica (MHD)	53	89	20	62	73	1,380
Malaysia (MHD)	44	105	29	54	72	2,520
Mexico (HHD)*	73	140	49	57	70	3,030
Singapore (HHD)*	100	49	9	65	74	14,210
Thailand (MHI)	23	149	34	52	69	1,570
Turkey (MHD)	63	258	80	50	67	1,780

Note : HHD = high human development : MHD = medium human development (UNDP categories 1992)

* now high income economies but classified as 'developing'

(B)

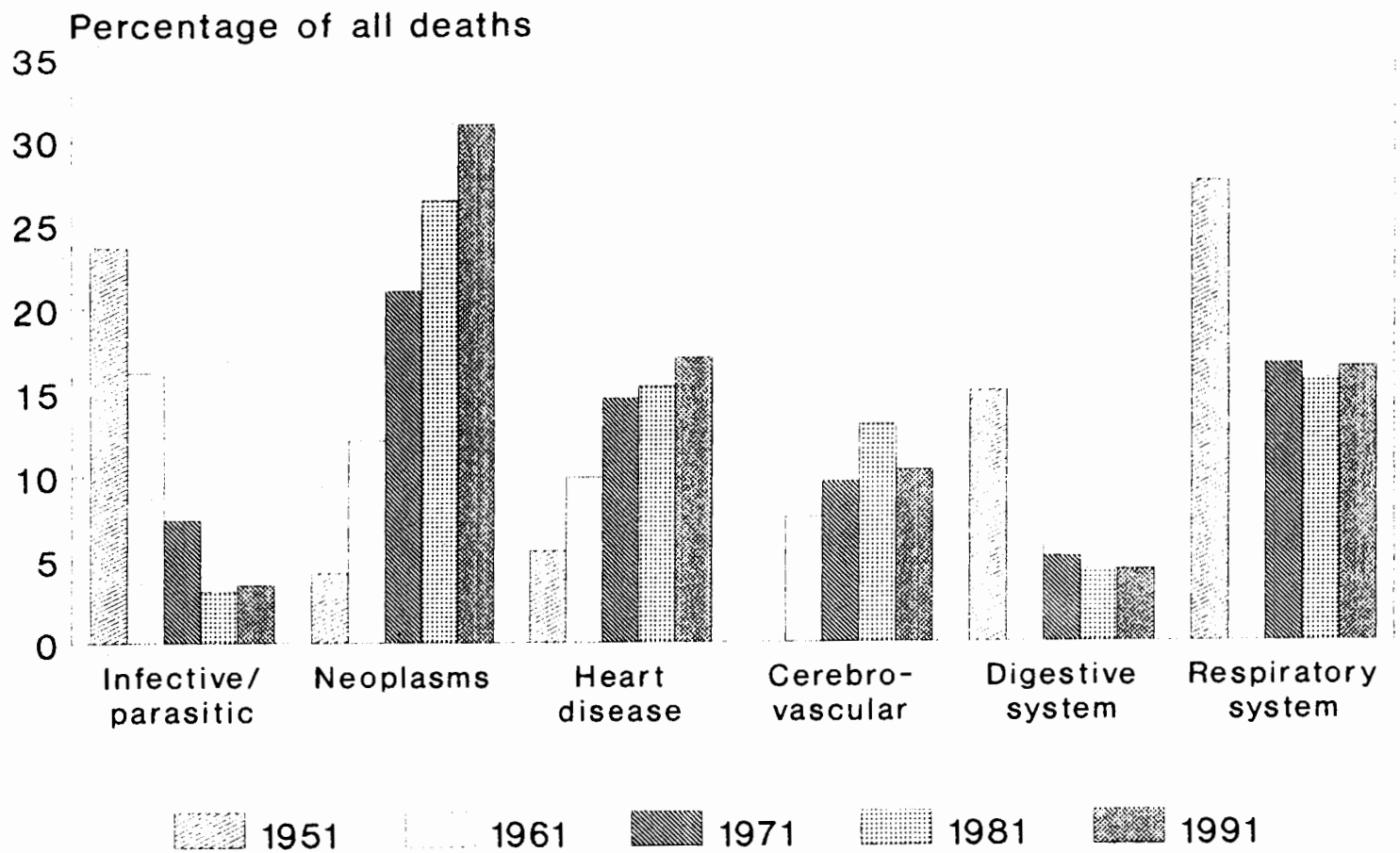
	Infant mortality rate (per 1,000 live births)		Percentage of 1 yr olds immunized		Female illiteracy (%)
	1970	1991	1989-90	1989-90	1990
Hong Kong	19	7	92	81	<5
Jamaic	43	15	38	86	1
Malaysia	45	15	69	93	30
Mexico	72	36	50	78	15
Singapore	20	6	79	89	<5
Thailand	73	27	48	91	10
Turkey	147	58	57	72	29
Average for least developed countries (1990)		115	17	57	
For all developing countries		74	24	79	

(C)

	Contraceptive prevalence %	Maternal mortality	Adults who smoke (%)	Population per Doctor	Nurse
	1989	1980-7	1985	1984	1984
Hong Kong	81	5	19	1,070	240
Jamaica	55	110	-	2,040	490
Malaysia ('85-7)	51	59	29	1,930	1,010
Mexico	53	82	32	1,240	880
Singapore	-	5	29	1,310	-
Thailand	66	-	36	6,290	710
Turkey	63	210	50	1,380	1,030

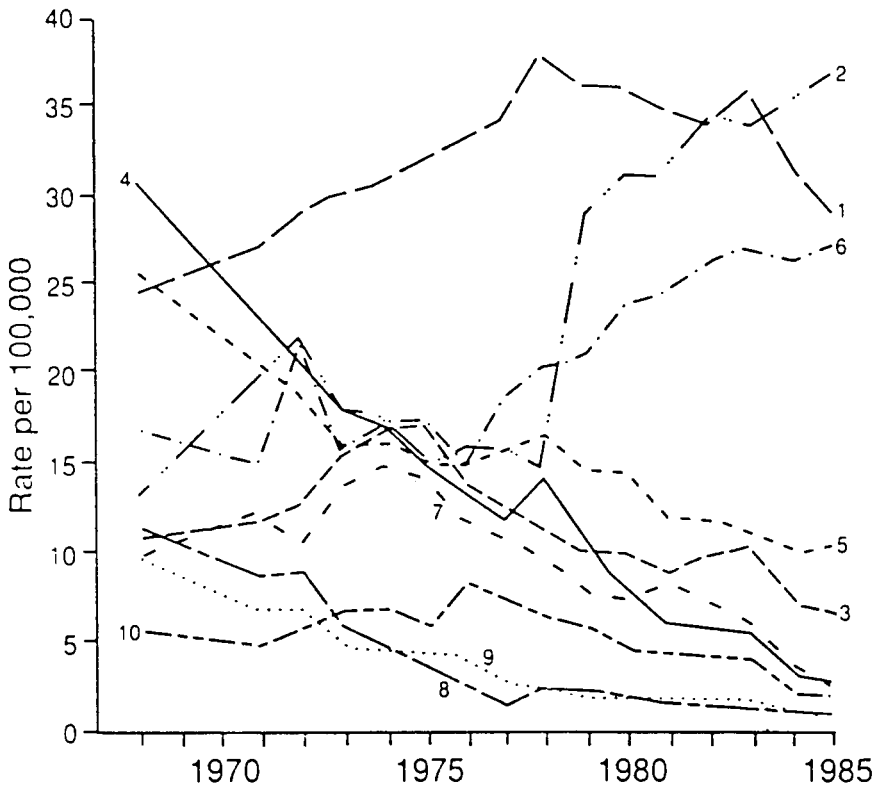
Sources: **Human Development Report 1992 ZUNDP); World Development Report 1993 (world Bank); The State of the World's Childern 1991 (UNICEF)**

Hong Kong: epidemiological change
Crude rates, 1951-1991



Source: HK Government data

Figure 2



1 Accidents and poisonings
2 Diseases of the heart
3 Pneumonia
4 Diarrhoeal diseases
5 Tuberculosis of the respiratory system
6 Malignant neoplasm (all forms)
7 Malaria
8 Avitaminoses and other nutritional deficiency
9 Diseases of pregnancy, childbirth and the puerperium
10 Diseases of the stomach and duodenum

Thailand: death rates per 100,000 1968-85
(source: IPSR, 1988)

Chapter 3

Community Participation in Family Planning Programs: Thailand's Experience

Amara Soonthorndhada

Community participation is the key to the success of virtually every community-based development project. But as this study shows, it does not always mean the same thing to everyone, which in turn affects the outcomes of development initiatives - EDS.

Introduction

Over the past fifteen years, community participation has figured prominently in the policy statements of virtually all governments and aid agencies concerned with development, and the health and population sectors are no exception. Community participation, moreover, is the cornerstone of Primary Health Care (PHC) as defined in the Declaration of Alma Ata and a key element of many nations' population programs according to the 1984 World Population Conference in Mexico.

Despite its importance for health and family planning programs, community participation is still an elusive concept with no clear definition. On the one hand, it can be defined generally as the involvement of a significant number of persons in situations or actions which enhance their well-being, e.g., income, security or self-esteem (Uphoff et al. 1979). More specifically, it can mean an educational and empowering process in which people, in partnership with those able to assist them, identify problems and needs and increasingly assume responsibility themselves to plan, manage, control and assess collective actions that are proved necessary (Askew 1984).

What has come to be realized over the years is that community participation's core element - 'people's participation in development' - as shown in these two definitions is common to virtually all programs that mobilize people to take constructive health or population actions to improve their current situations. However, what ' people' are involved, what form their participation takes, how it is developed, and the actual degree of control and responsibility beneficiaries have in a program depend heavily upon situational conditions found from the national level on down to the commumity. In some cases, it takes the form of direct participation thai is characteristic of a 'top-down' development process where people are directed to become involved. In others, it evolves into social participation, or a bottom-up approach where the people are the main (if not sole) actors in the development program.

Because community participation has different meanings and assumes different strategies in different contexts, its application for national family planning programs has been limited when compared with the expectations of policy statements. Overall though, it has entailed two main types of participatory mechanisms (Askew 1982), and these parallel the direct and social participatory processes mentioned above. *The first is the household level inundation approach where each household in an entire community is reached through direct door-to-door canvassing for potential family planning acceptors. The actors in this approach are usually local government officials. The second approach is known as the community level village depot approach and it uses local villagers and/or village organizations as central service distributors.*

In Thailand, the governmet decided in 1980 that community health and family planning improvements could best be done through a decentralized PHC system based on the village depot approach. In addition to supplying health and family planning services through government outlets (e.g., general hospitals, medical centers, health stations, midwifery centers), a program was then introduced for training selected community members as village health volunteers (VHCs) as well as traditional birth attendants (TBAs) (Debavalaya, 1987). As a result,

Thailand administratively decentralized the national family planning program down to provincial, district and community levels wherre family planning activities are provided by both government health care personnel and local non-government community-based distributors (CBDs).

The CBDs work particularly in maternal and child health (MCH) including family planning. They also work as motivatiors for MCH services such as visiting homes to provide anto- and post-natal care, providing child care guidance, serving as the lowest level of the referral service hierarchy, and distributing oral contraceptives and condoms. VHVs and especially VHCs are responsible for providing knowledge on MCH, notivating parents to have their children immunized on a required schedule, and providing community members with family pregnant women and mothers while some also distribute oral contraceptives. Thailand's family planning program policy and PHC system for providing such contraceptives through health stations, midwifery centers and local sources such as CBDs has meant that at least one effective modern contraceptive is reasonable available.

While CBDs exist in virtually all Thai villages, questions have arisen over the past five years about their effectiveness, especially as community participation motivators and the actual and preferred roles they play in health and family planning services. Once again, in most cases this has depended on the interpretation all involved give to the concept of community participation and then how it is applied at the local level.

The Study

To investigate this issue more deeply, the Institute for Population and Social Research at Mahidol University carried out a community participation in family planning study from 1989-1990. One of its main objectives was to determine the community participation perspectives of five main target groups: Community members, local leaders, policy-makers, clinic and family planning program staff, and CBDs. Through these perspectives it would become evident whether existing

policies, programs and responsibilities were meeting these target groups' expectations as well as national and community conditions. This in turn would lend clearer insights into how futrre programs would need to be improved in order to fit more closely with expectations about community participation on the on hand, and its application for family planning programs on the other.

To achieve this objective, the study used a multi-disciplinary approach for data collection. This included a quantitative survey of 400 married women of reproductive age amd 100 of their spouses. These persons represented the community member sample. The survey's aim was to determine the benefits and disadvantages of community participation in family planning, whether it was adequate or should be strengthened, and any differences between current and preferred program responsibilities. It also assessed norms, values, beliefs and experiences with community participation programs.

A focused interview questionnaire was also developed and administered to 16 CBDs individually. This survey used closed-ended questions to uncover information on community participation along similar lines to that of the survey above. In particular though, it also assessed what activities community members were more likely to participate in, be it family planning or other community development activities.

Apart from these surveys, twelve focus group discussions were organized with local leaders to assess their own perceptions of community participation. Topics discussed included the types of collective behavior characteristic of village life, how often collective activities are undertaken and by whom, their effectiveness and releavance to modern world. This information would help to determine how well community participation for family planning programs matched the naturally occurring collective behaviors and decision making processes found within rural Thai communities.

Finally, in-depth interviews were also held with 3 policy-makers and 17 clinic staff and family planning program managers. The objective was to get their interpretations of Thailand's population policy with reference to community participation. To obtain this data, four main questions were asked: the interrelationship between program implementation and the concept of community participation, awareness of government statements or intentions, desires for policy changes, and lastly their approval of existing policies.

Views on Community Participation

Clinic Staff and Program Managers

Family planning clinic staff and program managers agreed that the family planning program encouraged community participation and that the government supports and promotes community involvement by mobilizing local people to take part in program implementation. For example, the introduction of community-based distribution and the allocation of budgets to train community volunteers for village implementation proved that the government made efforts to encourage villagers to be more self-reliant.

Staff and managers also held the view that program organization had made use of commuity leaders to motivate community members to be aware of the program's aims and this has made programs more acceptable to the people. Some of the clinic staff and managers also believed that the family planning program allowed family members to make their own choices in program management by having a local community member take part in service provisioning and management so the more alternatives for providing services were available to villagers.

Furthermore, clinic staff noted that the policy of recruiting community members to participate in other development programs also strengthened their confidence in participating in the family planning program. Sone of these other

programs included group membership in village development revolving funds such as the drug fund, the mother's club for nutrition promotion and MCH/family planning activities, and training local members to work as TBAs, VHVs and VHCs for health and environmental improvement in addition to family planning.

When asked for their approval or disapproval of the decentralized family planning policy which stressed community participation, almost all managers and clinic staff agreed with the policy in principle. However, they felt that it may create confusion and conflict among community members and also may lead to some problems in management and follow-up. They foresaw that more involvement of community members might lead to less consensus among the members. For exaample, to recruit people for training in specific health activities from the many people who desire to take part in it might create selection problems and could cause conflict between those who were chosen and those who were not.

Two out of seventeen clinic staff disliked the policy of participation. They argued that participation was problematic to management in the sense that too many people involved in the program overloaded clinic staff with work in managing and supervising. For instance, in the community-based distribution program, clinic staff had to give advice about record keeping, checking supplies and dealing with problems of regularity and efficiency of service provisioning by CBDs. Rather, the clinic staff preferred to provide services at health stations so that they could check and update the records easily, and if any problems of side-effects occurred, they could manage them directly.

Nonetheless, the majority of clinic staff and program managers felt that the policy was good because it created a feeling of cooperation among community members and this would make the family planning program more successful. The components of the policy may also stimulate community members to exchangge ideas about what they would like to do. At the same time, community involvement helps the government to save funds in health service implementation and reduces the workload of the health personnel. It also made family planning more accessible

and acceptable to the people thus encouraging participation in the program. They observed that the policy would also help to encourage community members to understand the principles of the program and thus make it more acceptable.

Managers, though, pointed out that any policy which aims at creating a feeling of cooperation among community members must consider their real needs in the sense that all targets and plans for promoting the pokicy should be within the capacity of community members. Also close cooperation between government and NGOs should be considered so that the overlapping of programs, and potential competition between them, could be avoided.

Views of CBDs and Community Members

CBDs gave two main reasons for approving the poilcy. First, the government wants people to have a better quality of life by having fewer children, since a large population restricts the land available for cultivation. This is also in line with community members' desires to conserve resources and improve their lives and livelihoods. Second, participation helps the government and community to know each other and work together better. For example, in the family planning program, more participation means better accessibility to services.

CBDs, clinic staff and program managers also valued the policy of participation as an important strategy for implementing the family planning program. They agreed that promoting community involvement would lead to more cooperation in the community and would thus enable the government program to reach its goals more efficiently.

Community members also valued the policy because it made services more accessible not only for method accessibility but also having someone locally giving them advice on health problems. (They also did not need to travel to health stations which saved them time and money.) Apart from family planning services provided by CBDs, community members also mentioned that one additional benefit of having

a community-based distribution program was that other services also became more available such as referral and basic health care services. They also noted that strong community participation increases people's appreciation and acceptance of family planning.

In summary, therefore, agreement generally existed among all respondents that the community participation policy, as currently implemented, was valuable aand should be continued. Most of the benefits cited centered on the calue of community participation for increasing family planning and other services at the community level and for community members.

Benefits and Disadvantages in Increasing Participation

Respondents were then asked to assess the benefits of increasing participation in the family planning program. Community members identified two main benefits: increased knowledge about the family planning program and greater accessibility to services. If there is more participation, community members felt that people would better appreciate and accept family planning since it would help remove and persistent objections to the program's aims. Members would also have greater understanding and therefore would better participate in all activities concerning the program itself.

Clinic staff and program managers valued greater participation by community members as an important strategy for helping to manage and implement services, and they felt it is the most crucial action for making a program a success. Managers also stated that increasing participation would be a way of saving time and money, thus helping to reduce management costs further.

A question on disadvantages of more participation in the program was then asked in order to evaluate both the concept of participation and the actual benefit offered by the participation strategy. Among community members, their responses reflefted the extent of confidence they would have if more members participated in

the program. The majority felt that confusion might be the main disadvantage if more people became involved, because too many people would be giving advice. This might also lead to conflicts within the community where opposing opinions were evident. In this situation, community members strongly preferred to be advised by health personnel.

Among CBDs, only two out of sixteen mentioned disadvantages of greater participation. They noted that recruiting more people to work for the program could lead to greater interpersonal competition and tension. At the same time, if greater efforts were put into persuading members to participate in the program, this might also cause conflicts within the family. For example, if a husband or wife wanted to participaate more but his/her spouse did not, then there would be no consensus and this would make participation less effective.

For clinic staff and program managers, two continued to feel that more participation would create greater confusion in management and follow-up. Another big concern was that the quality of participants might vary, which would be a disadvantage for some communities.

Consequently, while respondents saw a benefit to increasing participation in terms of greater program participation and service accessibility, the main disadvantages were fears that the program would be self-defeating. Increased competition between villagers for CBD positions, greater tensions at family and community levels, and possible management difficulties could cause the program to backfire when community members began turning solely to health personnel in order to avoid intra-community and family conflicts.

Differences Between Current and Preferred Program Responsibilities

To better understand the dynamics of family planning program implementation, respondents were also asked who should be responsible for carrying out specific program activities. To do this, two sets of interviews were

conducted with each sample. In the first set, respondents were asked who they believed was currently responsible for providing certain family planning service components. This represented their actual perceptions of the situation. In the second set, they were asked who they would prefer to provide such service components. Answers to this question would indicate the correlation between what respondents believe is happening (results from the first interview) and what they would prefer to be happening (results from the second interview). While the answers to these questions, as noted below, appear at first to be wide ranging and complex, a surprising trend can also been seen which needed a more in-depth, qualitative analysis.

Education, Promotion and Target Setting

Overall, respondents preferred clinic staff and CBDs to be responsible for family planning promotion. Among community members, 20% felt that clinic staff are performing this function, but 40% preferred for clinic staff to more actively take on this role. Among community leaders, only 10% believed that CBDs were performing this function, but 52% wanted CBDs to work more for family planning promotion it the communities.

In both cases, therefore, a lowere percentage of respondents perceived that CBDs and clinic staff were performing this duty compared to those who would prefer it. This indicates room for improvement in CBD and clinic staff promotion of family planning at the community level.

However, and important difference exists between what community members in general prefer and what is felt to be appropriate by community leaders. In short, while community members feel that family planning promotion should be in the hands of health personnel, community leaders would prefer it to be more of a community activity via CBDs. Further research into which strategy is more effective needs to be undertaken.

In terms of educating potential users, program staff and managers preferred different groups of people to be involved in this activity even though it is now a current role of only clinic staff and CBDs. They said that community members and leaders should become more involved in the program as motivators which, to an extent, is in agreement with community leaders' views noted above.

Managerrs also felt that the government and clinic staff should be involved in target setting, which corresponds to their perceptions of who is currently setting the targets. However, program managers felt that clinic staff should be integrated more into the target setting group than what is currently being done.

CBD-Related Issues

The consensus among all respondents was that clinic staff are the actual and preferred group to continue monitoring, supervising and training CBds. Moreover, they also agreed that clinic staff should be responsible for selection CBDs.

Concerning CBD remuneration, currently CBDs are not compensated for their work either in terms of family planning program duties or other community-based development activities. They do, though, receive some benefits including free medical care for their families and recognition from the community. However, community members and CBDs strongly agreed that the government should remunerate CBDs for their work, while other respondents also saw the benefits of this practice.

Differences existed, however, concerning who should be responsible for pursuing this issue. Seventy-five percent of the CBDs waanted the government to pay more attention to this, while community members felt that either clinic staff or the government should be responsible for it. Program staff and managers thought this should be the responsibility of managerrs. Since the concurrence at the community level is for government officials to undertake this responsibility, and

program managers are for the most part government officials, serious consideration should be given to allocating this responsibility to them.

Identification of Potential Acceptors

Half of the community member respondents believed that the clinic staff should identify potential acceptors, while 74% of CBDs considered themselves suitable for this activity. Staff and managers also agreed with the CBDs, but managers would prefer that community leaders and members become more involved. This reflects previous findings where managers realized the potential significance of broader participation within the community. Community leaders, however, had a different opinion in taht they felt both clinic staff and managers should share their responsibility equally in identifying potential acceptors.

New Program and Referral Activities

There was a similarity within an among the groups in preferring clinic staff to suggest new program activities, except for CBDs who thought that they should take on this role rather that clinic staff. Community members also thought that clinic staff should help provide referral services for community members, while CBDs, staff and managers gave high preference to CBds.

Administrative and Logistical Responsibilities

Clinic staff and CBDs were the main groups that respondents wanted to manage contraceptive resupplying and provisioning to new acceptors. Senior managers, in particular, preferred this practice, however community leaderrs strongly wanted only clinic staff to resupply methods.

The CBDs and community leaders jointly thought that record keeping activities should be the responsibility of CBDs, though program staff and managers

would like community leaders to be more involved in this process. This again reflects their desire for broader community participation.

In terms of storing commodities (e.go, supplies) and administering them, community members once again voiced the opinion that clinic staff are the preferred and actual persons responsible for this, and program managers concurred. However, over 80% of CBDs would prefer this job, although only 38% perceive themselves as currently doing it. Community leaders, though, felt that both clinic staff and CBDs should andminister the supply of commodities equally.

Community members had only a vague idea about who should be responsible for financial accounting. As a result, they did not refer to any specific group. However, 36% mentioned clinic staff and 17% preferred the government. The managers preferred that they had control over financial matters.

Community members perceived that they themselves and clinic staff should manage transportation to clinics, while CBDs sugggested that they should be involved in this kind of assistance. The managers strongly preferred clinic staff to assist community members with transport.

All respondents agreed that clinic staff and CBDs should play a role in pursuing follow-up visits. Interestingly, two of the clinic staff and one manager would like community members to help each other with this activity.

Trends

Results from the above survey and in-depth interviews uncovered several very interesting trends with regard to perceptions about community participation for family planning. The most important though is the perceived focal point for family planning program responsibility and the different perspectives (personal, programmatic, conceptual) that each party uses to determine their choice.

At the first level, community members see clinic staff as the most important responsible parties when issues concerning family planning promotion; education; CBD selection, monitoring, training and supervision; referral services; new programs; and administrative/logistical considerations such as transportation are considered. This reflects their *personal perspective* that family planning is an individually-focused health issue and they are more comfortable when they receive attention and services from highly trained health personnel who are accessible to them. They also pointed out some prominent disadvantages in having CBDs in their communities. In particular, community members felt that CBDs had insufficient knowledge so they might give incorrect advicw. They also feared that CBDs would give expired or fake contraceptive pills. As a result, while they view community participation as valuable (as noted in the previous section) it equates more with ways of increasing community awareness and gaining access to services, rather that interpersonal action-oriented activities that they would prefer to be in the hands of professional health personnel. In the words of local leaders.

> *Family planning is a matter of the husbands and their wives. We do not think we can persuade them to practice family planning.*

> *Nowadays, there are many methods of birth control. People have more chocies. They can get service easily from the health stations and they can have advice from health personnel directly.*

This community member view is in contrast to those held by the other respondents. The reason for this is that community members center their view on the act of family planning itself with special attention to service obtainment and other personal considerations. The other respondents, however, are concerned with implementation as prescribed by the government policy. Hence, they look at community participation for family planning from a program perspective and as a social issue not simply a personal one. They therefore seek to place it firmly within a community context.

For example, while community leaders felt that family planning was a personal decision, they also believed that CBDs were the most appropriate persons for family planning promotion and education even more so than clinic staff. CBDs themselves overwhelmingly felt that they should be responsible for identifying potential acceptors and new program activities as well as referral services, while community members once again placed these responsiblilities in the hands of clinic staff. CBDs also noted that even though community members highly accepted the CBDs' roles and were friendly towards them, they had difficulties in dealing with community members because the latter did not take CBD advice seriously and they thought that CBBDs were not knowledgeable enough. Therefore, while community lea ders and CBDs hold a personal perspective with regards to family planning and similar to community members, by virtue of their social positions they emphasize a programmatic perspective more strongly.

At the next higher level, although government officials also see the family planning program from a programmatic perspective, they also hold a more conceptual perspective in terms of how they interpret community participation. On their part, they preferred that different groups of people, not solely CBDs or clinic staff, be involved in family planning education and referral services, record keeping, and, to an extent, follow-up services. Their emphasis was on encouraging 'community participation' in the broad sense of the term. As a result, their responses showed insufficient recognition or consideration of the different subgroups (leaders, CBDs, villagers) within the community and their perceptions and desires. Their macro-level perspective thus looked at the community as a unit instead of discrete subunits.

Overall therefore, results indicated that while clinic staff and managers have a broad concept of community participation and want to expand certain areas to encompass the community as a whole and its several community groups, two obstacles could work to block this effort: 1) community members' strong preference for clinic staff based on personal considerations; and 2) the preference of community leaders and CBDs to centralize certain program activities in their hands

rather than involve the community in general. This is a significant point, since it is often assumed that the actual point of conflict exists between government health service providers on the one hand and community people on the other. These results, however, imply that the real point of contention lies deeper and is centered more at the community level in terms of the different desires and perspectives of different community groups. Consequently, the next question becomes, "What are some of the reasons underlying this point of contention within communities?". This called for a more in-depth look at community collective behavior, decision-making and participation, and their changes over time as obtained through the study's focus group sessions.

In the Face of Change

In rural Thai communities, traditional collective behavior has take on a variety of forms depending upon the occasion. Types of collective activities are demonstrated particularly during religious functions where community members believe that contributing labor or money for religious purposes is a natural part of life and a way to improve one's future lives. Collective religious activities are conducted throughout the year. Some are performed to pay respect to ancestors, parents and the elderly, while others are practiced for psychological support such as when food is offered to spirits or dieties to help assure a good harvest. When religious or other collective ceremonies take place, everryone participates and assumes his/her responsibilities. Young people and men are willing to handle the hard work, while women prepare food and the elderly oversee all activities to ensure that everything is being done properly and in line with tradition.

Other than during religious rites, traditional collective behavior can be seen in the form of labor exchange for agricultural assistance, house building and for secular ceremonies such as durng the New Year celebration, marriages and funerals. Labor exchange for agricultural purposes occurs when community members take turns moving from one family's field to the next family's, planting, reaping or threshing in the rice field. An agreement is made between them that the

host family offers food to those who work voluntarily. The rationale for this was that farmers could help each other and thus save money and time.

Unfortunately however, this traditional collective behavior has gradually become unpopular due to many reasons. In the words of one focusgroup respondent,

> *Nowadays, farmers do not help each other without paying wages. Labor exchange is no longer effective. We have to work hard and fast, otherwise we cannot produce enough. Machines are also important, and we need to employ labor so that we can assure a good harvest. We calculate that we pay the same or less if we employ labor compared to labor exchange. At the present time, it is quite difficult to ask for help because everyone is busy and it might be too late to harvest our own produce if we have to wait for help.*

To some extent, local leaders felt that they wanted to preserve this traditional collective behavior, since it was useful to community members and maintained strong communinty ties and relationships. Without this help, leaders feared that a gap would develop between community members. Nonetheless, they also noted,

> *We cannot stop the stream of change. The younger generation, they are different from us, the older generation. They want to work outside the field and off the farm, and thus we lack labor even to share among ourselves.*

Community leaders believed that the only way to bridge this growing gap between senior members and the younger generation is to socialize the latter to follow the traditional way of life. Yet they were also resigned to tthe fact that many traditional collective activities, activities, and especially those related to economic activities, are being reduced in significance. *The effects of modernization result in changed attitudes, beliefs and values of community members. The power of the*

modern economy is stronger than tradition, anf materialism is superseding traditional relationships between community members.

How is this affecting participatory decision-making and behavior? Basically, it means that community members and their families are looking at two sources to provide for their means: communities and the society or government. This is most clearly seen in traditional decision-making and participation which have come to take on this dual perspective.

Traditional communal decision-making and participation are still found in rural Thai communities, but they are strongest when the activity is seen to benefit the entire community. In this instance, local leaders usually take on the role of mobilizing collective action for a specific need, and traditional communal decision-making plays an important part. This means that community leaders will organize and supervise members to participate in collective activities that have been mutually decided upon. These can include contributions of labor and money for constructing irrigation canals, repairing roads, building or repairing schools or temples, or other community development activities.

> *We [local leaders] request them to spare their time and resources to repair raoads or to deepen irrigation canals. They come and help each other. They know that if they do it, all the community will gain benefits. It is quite easy to have them in groups, and they work hard if they realize that everyone gains benefits. The heads of households, they are strong and suitable for hard work. The housewives and young people take part in food preparation and light work. We no long have to bother with food. They bring it with them and share among themselves.*

Problems arise, however, when development activities are not viewed as benefiting the entire community or when benefits are not evenly distributed. This operates to divide the community, and community members then begin judging

whether an activity is beneficial to them or their families. If not, their participation level dramatically declines, since they do not see how their time or labor investment helps them.

Local leaders, for example, decide on what development activities should be pursued and they are responsible for prioritizing them. They also decide on how costs and benefits will be divided among community members. This means that communnal decision-making does not necessarily mean equal benefits within the community. Communal decision-making in some situations benefits only the people in specific groups and indirectly to the community as a whole. For example, leaders noted that:

> *We connot allocate resources to everyone in the village. We receive very limited resources from the government. This year, we are provided materials to repair roads and we have to repair only the section that will be useful to the majority of people.*

> *We try our best and we feel so upset when we fail to get our needs. Villagers do not understand the process. For them, gaining means they have great and efficient leaders. In contrast, if we cannot make it successfully, they will compare us with their neighboring village headmen.*

As a result, intra-community competition for resources and interpersonal tensions can easily grow and fragment a village. Concern about this was reflected in the responses to increasing community participation and recruiting more community members for the family planning program as discussed earlier.

Participation is high, however, for development activities that have both community and individual/family benefits. Prime examples of this are the community savings and credit groups, but these are not without their own interpersonal difficulties.

Villagers appreciate very much the credit group. They need money to invest in their land and they prefer to pay low interest.

The only problem they are dealing with is that not everybody can be a member. They have to form a group with 5 to 6 people to request a loan and they have to take responsibility among the members for the loan.

During focus group sessions, most leaders agreed that villagers are highly participatory in development activities and particularly in those that fully and immediately render benefits to the community. With their limited resources, howeverr, participation is crucial.

We try to encourage community members to participate for the sake of veerybody in our village. We are poor and it is important that everyone should help each other.

We do not have enough money or resources to handle all development activities. Our needs for survival must be fulfilled immediately. We cannot wait all the time for help from the government. There are a lot of villages that need help. We must help ourselves first if we are to survive.

Discussion

The question that was raised earlier awas what are some of the reasons underlying the different ways community participation is being perceived at the community level. The first and most important one came from community leaders during the focus group session. They noted that community life has changed a lot compared to earlier days. Materialism and even the world economy iflyences greatly people's thinking, their values and norms. The leaders felt that the erosion of traditional behavior patterns, including communigy participation, is visible and

increasing. People become more monetary minded and this results in declining that have no overt and immediate economic benefits.

Villagers are therefore no longer highly dependent on each other for assistance compared to the past except in the case of religious ceremonies. For economic and health concerns especially, this trrend carries over as community members are turning more towards government services which, in most cases, they see as superior to what can be obtained within their communities. Health and family planning services are prime examples of this since they are viewed as more 'modern' and effective than traditional methods as well as being equally accessible due to the nation's extensive PHC system. Community participation for community members still means sharing ideas, but when the time comes, they will reach 'outside' for help with personal or family matters, rather than reaching into the community as was done in the past.

This is perhaps the most crucial turning point. Community life, the lives of each villager and his/her world view were traditionally deeply intertwined and revolved around the community culture and social relationships linking villagers within the community. Modern Thai society, however, has evolved rapidly. The traditional community inward focus has been replaced by a wider world view, one in which each villager places him/herself, their families and their expectations within more of a national or societally collective framework and often supported by economic rationale. Village girls, for example, no longer live, work and raise families in or near their natal community throughout their lives. Today, they migrate in great numbers to Bangkok to become factory workers or to advance their education and take on professional careers.

Each person's concept of self thus depends not only on one's community culture, but also on one's personal desires and expectations within the larger society. Family planning is a particularly relevant issue here for community members, since it reflects one's personal decisions and relies heavily since it reflects one's personal decisions and relies heavily on external provisioning. The

benefits of family planning, moreover, are perceived by community members to be largely individual- and family-based. They therefore tend to prefer services that reach from the outside, modern world and its health services directly to them. But this is not to say that they do not see a community value to participating in family planning programs. Instead, they see them as a valuable means of obtaining other services for themselves and their communities.

The real actors in the family planning program, as viewed by comunity members, are therefore the health care providers (clinic staff) and themselves as receivers. But where does this place community leaders and CBDs? The family planning program is a national development program activity, and community leaders and CBDs are the traditional and official persons responsible for this activity and who liaison with community members. Even within the PHC system, CBDs are the first level of the referral hierarchy.

Based on their responses in the focus group sessions, community leaders want to maintain community control over the program and remain an active part of it for two main reasons. First, they see this program like other development activities in that it is a way for them to maintain traditional collective behavior and decision-making patterns within the communities. One of their stronges worries in that community interrelationships and participation are breaking down. Since family planning usually conning usually concerns the younger generation, whicle the program itself is run by older community members such as the village leaders and CBDs, then the program could be a mechanism for slowing the grawing gap between generations or at least a way of initially socializing them and retaining some degree of community cohesion.

Second and relatedly, community leaders also stated that community participation is declining as community members the expense of community involvement. Increasing community members' participation in the program could very well lead to its downfall, either through increased competition or apathy when they turn to other throuht increased competition or apathy when they turn ot other

economic activities and ignore responsibilities to the family planning program. Since community leaders feel they are able to motivate community members (based on their experiences with past community development activeities), they would prefer to maintain control of the program and community members' participation at the village level and under their supervision.

On the part of CBDs, they see themselves as directly responsible for the health concerns of villagers. This is what they were selected and trained for by clinic staff, and it is the function through which they receive community recognition and status. To expand their roles more into such important areas as identifying acceptors and new program activities could substantiate and heighten their importance within the community. On the other hand, to aadopt a community participation framework as proposed by clinic staff and program managers (where duties are shared by community members in general) would reduce CBD importance. Moreover, it might even encourage community members to bypass CBDs and seek assistance outside the community by working directly with program managers or clinic staff.

Conclusion

To improve futrue programs will entail striking a balance between the interests of all parties involved in community participation for family planning. For community members, it should be recognized that they consider jparticipatory involvement more attractive and effective if it shows specific development benefits. Just participating in family planning program is too abstract since results are not immediately recognizable and family planning intself is a personal matter. Individuals only seek assistance when they feel that they are in need of services. Participaion therefore can only play an important role if basic and easy tasks are involved such as motivationg friends or relatives to practice family planning and sharing information. Community participation here focuses more on community awareness.

For communigy leaders and other village subgroups, program planning and implementation must also consider their needs, not simply those of family planning users. In most such as contraceptive users, while disregarding the needs of those who must implement the programs. Study fesults here showed several areas where they have fears and concerns about dommunity participation and its dyanmics. Further research into these needs to be made.

Data also indicate that CBDs wnat more responsibility for family planning programs. This also should not be ignored but looked into at greater depth. Does this problem stem from a lack of confidence, needs for increased training or supervision? Since it is clear that community members prefer clinic staff to provide services, studies also need to look into what roles community members think CBDs should fulfill, and then try to match these more closely with CBDs` recogniaed needs.

Finally, Program managers and clinic staff noted that the community participation policy could be a way of cutting program management costs. This should be viewed with caution, however, since it seems there will be more motivation to participate if the benefits are direct and tangible to all concerned, especially community members. To be more cost-effective, it might be worth while to see how such programs can be integrated more thoroughly with other development activities, particularly ones that already engender a high degree of community participation.

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Chapter 4

Breastfeeding and Contraceptive Use : Survey Results and Policy Implications

Panee Vong-Ek el al.

Introduction

The Bellagio Guidelines, a set of proposals aimed at elaborating the role of breastfeeding and health, recommended that breastfeeding be regarded as a potential family planning method in all maternal and child health programmes in developing and developed countries. Postpartum women should be encouraged to breastfeed and use lactational amenorrhoea as a family planning method. When properly instructed in the use of the lactational amenorrhoea method, women can control their fertility without dependence on health care providers (WHO, 1992 ; Kennedy, Rivera and McMeilly, 1989).

The guidelines authors carefully distinguished between breastfeeding in general and lactational amenorrhoea method (LAM), which requires breastfeeding women to meet certain conditions. Simply put, breastfeeding can assure effective contraception only until any of the following occurs : the mother starts to menstruate again, she gives her infant a significant amount of food other than breast milk, or the baby reaches six months of age (Townsend 1992). The maximum birth-spacing effect of breastfeeding is achieved when a mother fully breastfeeds and thus remains amenorrhoeic, i.e., she does not menstruate. When these two conditions are met, breastfeeding provides more than 98 percent protection from pregnancy in the first six postpartum months (WHO, 1992).

In Thailand modern contraceptive methods are universally available in urban and rural areas. Implementation of the breastfeeding programme has highlighted child health rather than the contraceptive benefit of breastfeeding. Leoprapai and Thongthai (1987), report results from a national survey that show breastfeeding

was spontaneously stated as contraceptive method by only one percent of women and a further one-fourth of women mentioned it after prompting. Of these women, eight out of ten had correct knowledge about how to use the method properly.

These are reasons why a study of breastfeeding and contraception is valuable even in a society such as Thailand where levels of contraceptive use are very high. If breastfeeding can be promoted as a contraceptive method in the immediate post-partum period this will reduce the need for the use of other contraceptives, many of which have harmful sideffects during this period. To understand the feasibility of Thai women accepting breastfeeding as a contraceptive method it is necessary to know their perceptions regarding the contraceptive effects of breastfeeding and whether it is felt that breastfeeding affects contraceptive use.

Data Source

The research upon which this paper is based, was conducted in urban and rural areas of Songkla and Nakhon Rachasima provinces, Thailand. The two provinces chosen are typical of their regions, each having at least one relatively large city in mainly rural populations. Multi-stage sampling was employed to select respondents. There were a total of 1,249 women selected from two districts and 4 sub-districts. Eligible respondents were women aged 15-49 years who had a surviving birth in the two years preceding the survey. This criterion was required to avoid problems of faulty recall of events, and to serve the research objective of assessing current practices and behaviour.

Results

Mothers were asked what contraceptive methods they use after delivery and whether they knew about the contraceptive effects of breastfeeding. The percentage distribution of post-partum contraceptive use for women who used contraception after their last birth is shown in Table 1 :

Table 1 Percentage Distribution of Contraception for Women Using Contraception after Last Birth by Method and Residence

Method	Residence		Total
	Urban	Rural	
Pill	31	20	26
Injectables	29	51	40
IUD	5	11	8
Female Sterilisation	22	12	17
Vasectomy	1	.2	.8
Condom	6	2	4
Norplant	-	2	.9
Natural Method	5	2	3
Other	.2	.2	.2
Total	100%	100%	100%
	(462)	(456)	(918)

The pill is the most popular method among urban mothers (31%) while 20 percent of rural mothers used the pill soon after delivery. Injectables were also used by a high percentage (29%) of urban mothers and an even higher percentage (51%) of rural mothers. As a result of recommendations of health personnel to mothers about the use of family planning to prevent a subsequent birth, the percentage of hormonal contraceptive methods is high. Over two-thirds of the women using contraception used a hormonal method. Mothers are often given the pill or injectables soon when they came to visit the clinic. For those who choose this method, female sterilisation is performed as soon as they deliver. Breastfeeding was not mentioned as a family planning method when women were asked about contraception after their last birth.

The period of initiation of contraceptive use after the last birth is shown in Table 2. By far the majority of contraceptive use is initiated within the first two months after birth. This is very soon given that the normal time for menstruation to occur in a non-breastfeeding population is around six weeks. Conception in a fully lactating women before 8 weeks is considered very rare (Kennedy, Rivera and McMeilly, 1989).

Table 2 Percentage Distribution of Contraception for Women Using Contraception after Last Birth by Period of Initiation of Contraception

Method	Initiation of Contraceptive use (months)				Total
	0-2	3-4	5-6	6+	
Pill	59	26	8	8	100(238)
Injectables	69	20	6	4	100(364)
IUD	80	15	3	3	100(76)
Female Sterilisation	100				100(155)
Vasectomy	29	29	43	-	100(7)
Condom	51	43	3	3	100(37)
Norplant	88	-	-	13	100(8)
Natural Method	36	52	10	3	100(31)
Other	50	50	-	-	100(2)

There is considerable variation in the timing of initiation of contraceptive use after birth. All women sterilised underwent the operation within the first two months after they gave birth. Perhaps most disturbing is that initiation of hormonal method was high in the first two months with 59 percent of pills users and 69 percent of users of injectables assuming use within two months of their birth and

almost all the remaining using before their fourth month. Other clinic based methods such as the IUD and Norplant were also mainly introduced in the first two months. This findings suggest that family planning clinics try to initiate contraceptive use early after birth. It is the less efficient methods that are initiated after the first two months.

To investigate the contraceptive effects of breastfeeding, mothers were asked whether they had heard that a breastfeeding women having sexual relationship with their husband would not get pregnant. The data in Table 3 show that 32 percent of mothers with a primary school education, 40 percent of mothers with secondary school education, 49 percent of mothers with a vocational education and 54 percent of mothers with a university education had heard of this relationship. Furthermore, 45 percent of urban mothers and 28 percent of rural mothers had knowledge of the relationship.

Table 3 Percentage Distribution of Respondents who Reported Having Heard of The Conteraceptive Effect of Breastfeeding by Source, Education and Residence

Having heard	Education				Residence	
	Pri.	Sec.	Voc.	Univ.	Urban	Rural
Yes	32	40	50	54	45	28
No	68	60	51	47	55	72
Total	100	100	100	100	100	100
	(813)	(247)	(90)	(99)	(600)	(649)
Source						
Health personnel	18	14	21	9	14	20
Leaflets, posters	.8	-	-	2	1	.5
Radio and TV adv.	-	-	1	-	1	-
Radio and TV pre.	.2	-	2	-	2	.5
Video at hospital	1	-	-	-	1	-
Magazine	2	6	9	25	5	4
Friends/Relatives	73	72	61	64	71	70
Others	5	5	7	-	4	6
Total	100	100	100	100	100	100
	(258)	(98)	(44)	(53)	(270)	(184)

Data on the source of information on the contraceptive effects of breastfeeding categorized by education, indicate that friends/relatives are the most popular source of information at every level of education, with two-thirds to three-quarters of respondents citing this source. Approximately 71 percent of urban mothers and 70 percent of rural mother cited this as the main source. Leaflets and posters, radio and TV advertisement, radio and TV presentations and video at the

hospital were not reported as providing any information on the contraceptive effects of breastfeeding.

Table 4 Percentage Distribution of Respondents Who Reported Having Heard of The Contraceptive Effect of Breastfeeding by Duration of Effectiveness, Education and Residence

Duration (in month)	Education				Residence	
	Pri.	Sec.	Voc.	Univ.	Urban	Rural
Up to 3	19	14	27	33	20	22
3 - 6	18	35	41	50	31	22
6 - 12	27	41	14	17	25	28
13 onwards	21	5	-	-	11	18
Do not Know	16	5	18	-	13	10
Total	100	100	100	100	100	100
	(116)	(37)	(22)	(24)	(122)	(78)

The perception of the duration of the contraceptive effects of breastfeeding are shown in Table 4. About 40-50 percent of mothers with primary and secondary education as well as more than 80 percent of mothers with university education believe that breastfeeding can prevent pregnancy within the first six months. This belief is also found for 51 percent of mothers in urban area and 44 percent of those mothers in rural areas. As recommended in the Bellagio Guidelines (Kennedy, Rivera and McMeilly, 1989), the maximum birth spacing effect of breastfeeding is achieved when a mother "fully" or nearly fully breastfeeds and remains amenorrhoeic. Under these conditions breastfeeding is effective in the first six months. Hence most women have correct knowledge about the length of time that

breastfeeding provides contraceptive protection, although this knowledge is greater among the more educated and those in urban areas.

A question about why women perceived, or did not perceive, breastfeeding to have a contraceptive effect was also asked in this study, results are shown below in Table 5:

Table 5 Reason for Belief of Contraceptive Effects of Breastfeeding by Education and Residence

Perceive as having Contraceptive effect	Education				Residence	
	Pri.	Sec.	Voc.	Univ.	Urban	Rural
Neighbours recommended	28	29	24	38	34	20
Own experiences	24	11	19	8	20	19
Amenorrhoea effect of breastfeeding	21	37	33	46	25	26
Doctors recommended	15	13	10	-	8	18
Blood become breast milk	6	5	9	-	8	8
Birth spacing	4	3	-	-	3	4
Not specify	2	3	5	4	2	5
Total	100	100	100	100	100	100
	(116)	(38)	(21)	(24)	(122)	(78)
Perceive as having no contraceptive effect						
Seen breastfeeding women get pregnant	54	37	22	45	38	57
Ever used, still pregnant	7	5	4	-	6	6
Uncertain, dependent on mothers' health	4	14	18	10	12	3

Table 5 (Continued)

Perceive as having Contraceptive effect	Education				Residence	
	Pri.	Sec.	Voc.	Univ.	Urban	Rural
Not effective as modern methods	33	42	50	38	41	32
Pregnant during menstruation	2	2	4	3	3	2
Not specify	-	1	2	3	1	-
Total	100	100	100	100	100	100
	(142)	(59)	(22)	(29)	(146)	(106)

Mothers who perceive there to be an effect rely upon either their experience or friends' experience. There is limited variation by education or by area of residence. For mothers who did not think breastfeeding had a contraceptive effect, the most frequently cited reason was observing a breast feeding mother getting pregnant. A belief in modern contraceptive methods is also high at every level of education.

To investigate contraceptive effects on breastfeeding, women were asked whether the contraceptive method they used had effected their breastfeeding. Results show that the pill, injectables and female sterilisation had affects on breastfeeding, with 37 percent, 24 percent and 3 percent respectively reporting some effect. Of the women who terminated breastfeeding because of problems 48 (31%) said that contraceptive use was involved. When asked about breastfeeding effects on the sexual relationship of husband and wife, only 2 percent (26 cases) of

eligible mothers stated that the baby woke up during sexual intercourse, or that they lost sexual feeling because of breast milk smell and unshapely breasts.

The most frequently reported contraceptive effect on breastfeeding was insufficient breast milk (76%), clear breast milk and bland breast milk (12%). Four percent reported that the contraceptives operated through their breastmilk to directly effect the health of their child.

Policy Implications

The results presented in this paper have very important policy implications. The Thai government has adopted a breastfeeding programme aimed at full breastfeeding within the first three months after birth. However, this policy seems to be in contradiction to contraceptive methods promoted for use after delivery. It is after delivery, when the mother returns to the clinic, that there is a strong emphasis on providing contraceptive services, especially the pills and injectables. However , this is precisely the period when breastfeeding can supply an equivalent amount of contraceptive protection as can other contraceptives. If breastfeeding was promoted as **both** a contraceptive method **and** an aid to improving the health of the child, it would not be necessary to supply potentially harmful contraceptives at this stage of the post-partum period.

It is recommended that if a hormonal method has to be used, the adoption of a low-dose oral contraceptives, especially the progestogen-only pills or the acceptance of injectable contraceptives, by a fully lactating woman would be preferable to the non-use of contraception, with the risk of an early pregnancy (Kleinman and Senanayake, 1984 ; Trussell et al, 1992). At the same time, it is reasonable to look carefully at the various choices of hormonal contraceptives, to ask when might be the optimum time to begin their use and attempt to devise ways in which, if there are drawbacks to the mother or infant in the use of steroidal contraceptives, these can be avoided. Certainly, care should be taken to avoid starting steroids too early in lactation.

Combined oral contraceptives should be discouraged during lactation, and should not be used in the early months as they will lower the quantity of milk. If hormonal contraception is decided on, progestogen-oly contraceptives should be used once lactation is fully established. On the other hand, there is still concern that the use of hormonal contraceptive by breastfeeding women may adversely affect infant health, because steroids are secreted in breastmilk (Trussell et a,. 1992). In addition, this study found that for some mothers there was a perception that contraceptive use at this stage had a harmful effect on their own child's health.

As the most important source of information of contraceptive effects of breastfeeding is from friends and relatives, the implementation of programmes concerning contraceptive use should be strengthened to use friends and relatives, especially in the southern area where the government is encouraging birth spacing as a family planning method. Breastfeeding should be an alternative method to use as a family planning as well as encourage mothers to breastfeed for child health.

In conclusion, the family planning programme and breastfeeding programme should be coordinated to work hand in hand in order to achieve the goal of contraceptive protection and better health for mothers and children.

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Chapter 5

Study of Family Support for Elderly People in Rural Thailand

Nittaya Piriyathamwong
and David Phillips

Rationale

Population ageing is a well recognized phenomenon in the developed world but one which has, in recent decades, begun to affect many developing countries. Since 1970, Thailand has implemented a very successful family planning program which is rapidly resulting in the decline in fertility. In part as a result, and partly due to greater longevity, the elderly population (aged 60 and over) has increased as a share of the national total. The proportion of the population who are aged has increased from 4.9 per cent in 1970 to 7.3 per cent in 1990 and it will be 11.2 per cent in 2015. The actual numbers of elderly people have been doubling every 20%) years, from 1.7 million in 1970 to around 4.0 million in 1990. In absolute terms, this means that there will be around 4.4 million more elderly in the year 2015 than there were in 1990 (National Statistical Office; National Economic and Social Development Board, 1991).

While the number of elderly people continues to rise and lifespans continue to increase, decreasing fertility also means that there are in general fewer children to care for these elderly persons. By 2015, Thailand is projected to have at least 17 persons aged 60 years and older dependent on every 100 of those aged 15 to 59 years (National Economic and Social Development Board, 1991). This will be no doubt have a powerful impact on public policy decisions influencing how resources will be distributed to care for this potentially vulnerable population.

To date, in many developing countries, it has been explicit or implicit official assumption that 'the family' will care for its elderly members. However, the ability of the family to continue to provide support for its elderly members in the

context of demographic and social changes that have accompanied modernization has been a critical concern for many researchers. Changes in family size and structure and other economic and social changes, including urbanization, migration, industrialization, and increased femal workforce participation, are influencing individual and community responses to ageing.

In many rapidly industrializing and urbanizing countries in South East Asia, Including Thailand, modernization has resulted in a number of social changes which affect women who have in the past been the principal carers (Caffrey, 1992; Phillips, 1992). These changes are associated with the gradual move from a kin-based to a cash-based economy. The changes include a breakdown in traditional extended family systems, as children now often go where there is wage work (rural or urban-industrial) and, for these workers, long absence from the parental household has become a common occurence. Women are also now moving into the labour market because they now have greater access to education (Caffrey, 1992 ; Pramualrtana, 1990). Indeed, wage-earning activities have replaced much of the previously predominant agricultural subsistence way of life for the young as Thailand modernizes and industrializes. The distorted age structure which is resulting in many rural areas has the potential to bring particular problems for elderly people, because of the breakdown of traditional family-based communual activities (Ju and Jones, 1989; Caffrey, 1992). All of these factors combined would be expected to have a major impact on the availability of children to provide care for their elderly parents.

The most recent and comprehensive study of ageing in Thialand is by ASEAN, a multi-national Socio-economic Consequences of the Ageing Project (Chayovan, 1988). This study of over 3,200 elderly Thais during 1986 found that two main problems confront elderly people in Thailand today: financial constraints and, poor health. Obviously, these two predicaments are often interrelated. The ageing rural population is generally worse off than the elderly urbanities. This nationally representative survey also found out that 50% of the elderly (defined as any person aged 60 and over) are supported by their children. If the non-working

elderly only are considered, then the percentage who are dependent on a child or grandchild climbs to 64%. The significance of children's support and care increases with age of the elderly.

Additionally, in a study of parental expectations and experiences of support from children in old age and its relationship with fertility, which took place in the rural Central and Northeast of Thailand, Archavanitkul et al. (1993) found evidence that elderly people (aged 60-74) with larger families in Central Thailand were more likely to receive inadequate support. Though most data concerning adequacy of care and support showed a majority of elderly people to be provided with adequate care, a significant number did not receive adequate financial supports, and this was true for nearly two-thirds of the elderly in the Northeast. This may indicate that it may be precarious to depend on children in old age when changing societal conditions impose economic constraints on many adult children and may prevent them from residing their parents' homes.

In terms of **formal** support for the Thai elderly, there is no general system of old age pensions in Thailand. Only employees of government and state enterprises, as well as those of certain large scale private firms, are entitled to received welfare services and pensions of one kind or another. Those who are self-employed or working for small firms generally are not (Ju and Jones, 1989). Homes for the aged ae generally regarded as a last resort for those who are either homeless, who have no relatives to live with or who are unable to live happily with their relatives. The number of elderly people in Thailand actually living in old age homes is very tiny. Furthermore, special free health care services for the elderly have just been offered since in 1992.

It seems that a belief in cultural preferences, for reliance on family support, as well as the budgetary limitations of the Thai government, will ensure that care of elderly people (both in financial and material terms) will be left largely in the hands of families. Although filial **obilgation** seems still to be strong in most Thai families, with changes in social and economic setting, as well as a steady rise in the

proportion of elderly in the population, it is not yet certain that families will be **able** to fulfil these responsibilities. No assessment of adaquacy of formal provision in Thailand can be made without paying attention to the support sources that are available in the informal support system of the elderly and the ways in which these sources are currently changing.

Objectives

The main objective of this study is to investigate the patterns of support from family members to elderly people in rural Thailand, in terms of financial support, support in kind, physical care and emotional support. Rural areas are selected for study because the majortiy of the Thai population still live in such areas and are mainly at present still engaged principally in agriculture. Thus, family support for elderly people must be evaluated and understood primarily in terms of a rural and agricultural context. Knowledge of the circumstances of the present elderly generation can serve as a basis for understanding potential problems of future cohorts. Furthermore, such understanding is essential to the formulation of future policy options and to implementing effective programes for the elderly.

The specific aims of focus of this study are summarized by the following lines of enquiry:

(1) What are the main types of support and how much or how frequently are they provided by family members to the elderly?

(2) What are the important differences in the magnitude of support provision among family members?

(3) What is the importance of the community environment in shaping choices, need for, and value of, support from the elderly person's family members? (community environment includes social norms, labour market conditions and availability of government/private social security type schemes).

The research will investigate these three main areas using the data collection strategy described in the next section.

At the end of the study, the results will be reported and put into summary form for policy recommendations. The report and summary will be published and distributed to researchers and policy makers.

Methodology

This study will be conducted by the Institute for Population and Social Reserach of Mahidol University, Thailand. The IPSR is in a position to conduct a high-quality cross-sectional sample of variable age and family formation status. The following general guidelines will be adhered to :

1. Information will be collected using structured survey questionnaires.

2. The sample will comprise of elderly people, ever married, and aged 60 to 74. Respondents will be interviewed about their needs for support and support which they actually receive.

3. The two regions selected for study will be the rural North and Northeast. This is because of their high level of out-migration and associated social change.

Focus Group Discussion

Prior to the final design and pretest of the questionnaire, two focus group sessions (FGD) will be conducted to help in the development of questionnare. These FGD will consist of two groups of six to eight elderly people, ever married and aged 60 to 74 in North and Northeast village.

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Chapter 6

Effect of Cultural Factors on Safer Sexual Behaviour Among Adolescents in Thailand

Umaporn Pattaravanich

I Background and Rational

Although HIV was reported to be transmitted by intravenous drug use, maternal transmission and blood transfusions, the most important mode of transmission in Thailand in the expanding epidemic is heterosexual intercourse. Report from the Division of epidemiology, the Ministry of Public Health in Thailand, found that about 67 % of AIDS and ARC patients during 1984-1991 had become infected by heterosexual intercourse (Rerk-Ngarm, 1992). The current AIDS situation in Thailand indicates that transmission by heterosexual intercourse is the crucial problem. Hence, there are many proposed programmes to prevent AIDS by aiming at restraining heterosexual intercourse HIV transmission. Examples include closing brothels nation-wide, disseminating information about AIDS, setting up health clinics for prostitutes, providing health care for prostitutes, separating infected prostitutes from uninfected prostitutes, encouraging infected prostitutes to leave their occupation, and promoting a nation-wide condom programme, namely the '100 % condom policy' etc. Most of the programmes can in theory prevent AIDS effectively, but it is difficult to put them into practice. For analysing the programmes to prevent AIDS, Rojanapittayakorn considered that '100 % condom policy' is likely to be the best programme at present (Rojanapittayakorn, 1991). However, although most people know about AIDS and the importance of condom use such precautions are not always put into practice (Sittitrai et al, 1992), especially by young people. We can observe the data from the Ministry of Public Health in Thailand, which show that approximately 50% of AIDS and ARC patients were 15-29 years old (1992). Thus, at present a number of public education programmes of many countries have been aimed specifically at adolescents, both students and non-students. There are campaigns about safer sexual behaviour,

which give information about AIDS and condom use, and consulting clinics (Soonthorndhada, 1992).

In Thailand, the campaign about sexual behaviour in school is not very effective because sex education is only provided in secondary schools, however most young people do not pursue their education to that level; that is only one-third of the elementary education students enter the secondary education students (Educational Planning Division, 1990). Besides in Thai society sexual behaviour is not talked about in public, with embarrassment being the greatest problem, particularly among women. Today Thai young people run the risk of becoming infected with AIDS/HIV without effective prevention. Although there are increasing attempts to implement the ' 100 % condom policy'.

Adolescent sexual behaviour and Thai culture

There are studies to suggest that the brains of males and females are constructed differently and they indicate that biological factors are strongly involved in gender differences (Money and Ehrhardht, 1976). However, current information indicates the gender differences are created by man rather than by nature. Judy Long provides a concept about gender roles, 'a culture's image of attitudes, behaviours, and feelings felt to be appropriate to females and to males' (Long, 1985, p.25). This implies that gender roles pervade all areas of female and male life, from infancy throughout the life-span. Moreover, gender roles not only affect our lives in the personal interaction or individual psychology, but are also learned in a social context. This is a process of sex role socialization in the different cultures which emerge from social ideology. The family is the basis for socialization. Gender roles are learned from the early stages of childhood, and children's early exposure to gender differentiation through other agencies leads to their concept of it. The results of gender role socialization stemming from social ideology affect the concept and beliefs about gender roles and lead to sexual behaviour.

This socialization will be examined in terms of ; the process of socialization affecting belief and practice concerning gender roles leading to sexual behaviour; and socialization influencing the norms of reciprocity leading to sexual behaviour. An attempt will be made to look at each aspect across thai culture.

1. Socialization affecting beliefs and practices concerning gender roles leading to sexual behaviour

In Western societies, the roles of male and female are based on a greater degree of freedom and equality than is found in Asia, because of the cultural background of the nuclear family structure (Komin, 1991) and a shift from a home-based system of production to an industrialized economy (Blitchington, 1984). Thus, the socialization tries to foster attributes valuable for the individual (for example, integrity, assertiveness, bravery etc.). Young people are trained to be competent members of a household. The gender role socialization stresses survival skills such as competence in cooking, housekeeping, sewing for girls, and home repairs and boys (Long, 1984). Hence, this leads to self reliance and task sharing.

Thai society socializes men and women to play their sex roles very differently. The role of the male, who is the head of his family is based on achievement and work outside the home, but the role of the female is based on the promotion of the family's happiness, love and affiliation (Komin, 1991). Thus, Thai females are socialised to try above all to promote family happiness. Moreover, most of the families in Thailand are extended families. Learning about male and female roles comes from adults who are perceived in polarized ways in their families. The children are taught to do the jobs belonging to their sex role. Daughters learn to have responsibilities in the house and sons learn to have responsibilities for their education and social life, but not any responsibilities in the house. Children are taught not only in the family but also through other agencies of socialization including the education system, the occupational group and the peer group; all of these are important for the Thai adolescent's concept of sexual behaviour. Thus, it is not surprising if young women are dominated by their

partners concerning sexual behaviour, too. The attitude of male adolescents concerning sexual behaviour is that they can have many partners whereas females can have only one partner. Besides another male attitude is that females should not request sexual behaviour. These male attitudes are accepted by females, also because of the socialization process. Attitudes towards sexual behaviour are related to attitudes towards sexual intercourse, that is, females think that they can have only one partner so her satisfaction concerning sexual intercourse should be based on love and trust (Holland et al., 1992), whereas the males satisfaction concerning sexual intercourse is based on pleasure and fun.

Men's emphasis upon sexual pleasure and young women's emphasis upon love and trust, is compounded by the lack of negotiation of their sexual relationships (eg. regarding protection from pregnancy and infection), which results in a lack of safety in sexual behaviour.

In brief, practices of adolescents's sexual behaviour stem from socialization. Females learn to trust and love their partners, so their attempts at negotiation about safer sex may be taken to indicate distrust in the partners. In addition, embarrassment in talking about sexual behaviour is a major problem which comes from socialization. Whereas males learn about sexuality only in terms of their own pleasure , and this provides for a lack of care for their partners's feeling. Males's sexual pleasure is for them the most important aspect of satisfaction, so they neglect negotiation about safer sex. Thus, we can see that it is not enough to encourage only changes in individuals, but it is also important to consider the social process which influences the balance of power between men and women to equality.

2. *Socialization influencing the norms of reciprocity leading to sexual behaviour*

Peplau et al. demonstrated the difference of traditional, moderate and liberal patterns of sexual behaviour. They used the timing of intimacy before having sexual intercourse as rough index of these patterns. They indicated that members of

early-sex couples (those who engaged in interscourse very early on in their relationship) were likely to attribute their behaviour to sexual desire. Whereas later-sex couples have a heightened perception of love through a process of self-attribution (Peplau et al., cite in Przybyla and Byrne, 1981).

In Thai society, social ideology is conservative. Although gender roles are an important influence on sexual behaviour, conservative ideology provides delay in sexual involvement with probably most couples not engaging in intercourse before marriage. This is likely to lead to care and self-disclosure towards their partners. However, most of Thai studies have never studied about background of the social ideology towards sexual behaviour. Hence, perhaps their social ideology will influence care in their partners and be related to communication or self-disclosure about their sexual behaviours, and then safer sexual behaviour is concerned because of the social ideology leading care in and communication with the partners.

In short, practice of adolescents's sexual behaviour is associated with broad social ideology. Most Thai adolescents have less rapid sexual involvement within (non-commercial) relationships than Western adolescents. It can lead to care in their partners's feeling. These are issues which demand further research in Thailand.

II. Objective

The main objective of the proposed study is to investigate the sexual beliefs, understandings and practices of adolescents in order to examine the processes whereby they construct and practice their sexuality. An understanding of these processes provides an appropriate basis for education and information about HIV/ AIDS and sexual behaviour for Thai adolescents. Investigation about sexual beliefs, understandings and practices of Thai adolescents is focused up on as follows:

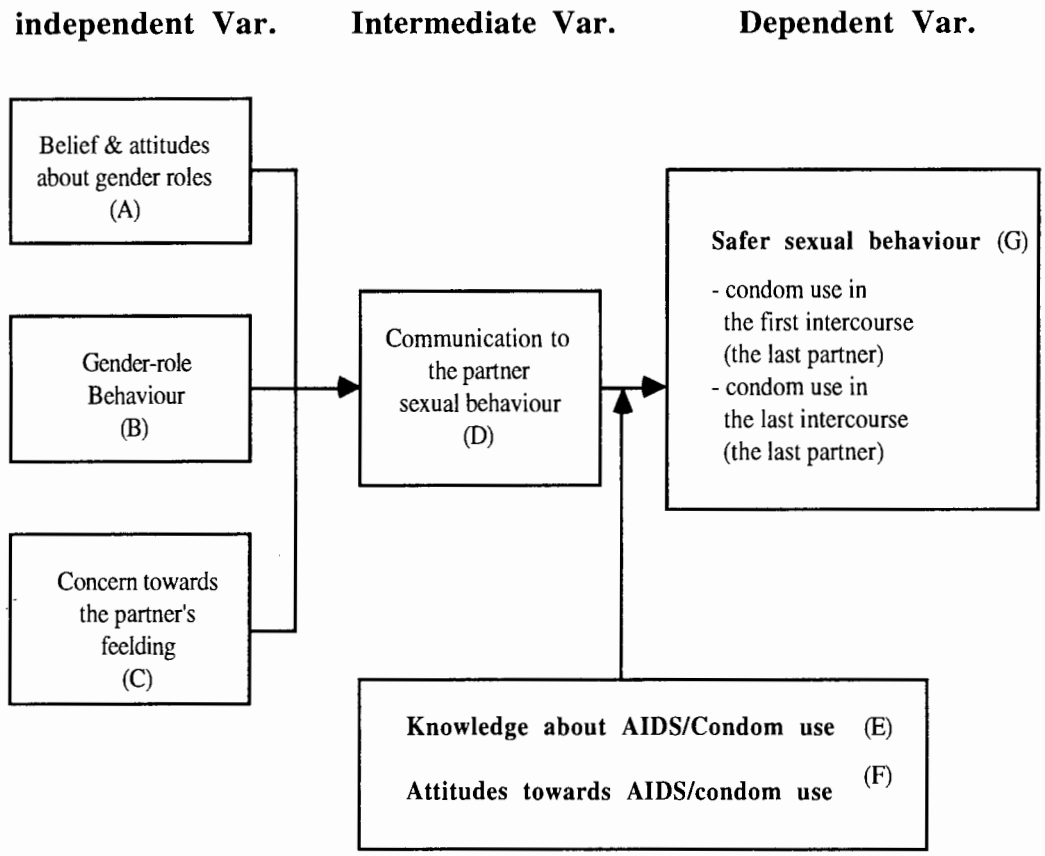
1. the influence of gender-role differences, consideration for, and concern towards their partner's feelings on the couple's communication about sexual behaviour , and

2. the effect of communication to the partner about sexual behaviour on safer sexual behaviour regarding to knowledge/attitudes about AIDS and condom use.

III. Conceptual framework

The objectives of the proposed study provide the conceptual framework being structured into four sets of variables; independent variables concerning beliefs and attitudes about gender roles (A), gender-role behaviour (B), and concerning towards the partner's feeling (C); intermediate variables concerning communication to the partner about sexual behaviour (D); control variables concerning knowledge about AIDS/condom use (E), and attitudes towards AIDS/condom use (F); and dependent variable concerning safer sexual behaviour (G).

Gender-role factors, these are beliefs and attitudes about gender roles (A); and gender-role behaviours (B), and concerning the partner 's feeling (C) effect communication about sexual behaviour (D). In addition, communication to the partner about sexual behaviour (D) influences safer sexual behaviour (G) regarding to knowledge about AIDS and condom use (E) and attitudes towards AIDS and condom use (F). Whereas beliefs and attitudes about gender roles (A) effects gender-role behaviours (B). Gender-role behaviours (B) effects concerning towards the partner's feeling (C), as well. The conceptual frame work is presented in the following figure.



IV. Methodology and study design

The survey is designed to study in Bangkok from Universities, teacher colleges, commercial colleges and vocational colleges among 15-24 year-old students. The sampling will be random from universities, teacher colleges, commercial colleges and vocational colleges (each establishment is two). The total of universities and colleges are 8. At 20 males and 20 females per university and college. This design yields the sample. Thus, 320 students will be interviewed in the study.

The questionnaire has 5 parts as follow :

1. **gender roles** contains beliefs and attitudes about gender roles, and gender-role behaviour. Students will be interviewed,

2. **concern towards the partner's feeling** will be completed by students,

3. **communication to the partner about sexual behaviour** will be completed by students,

4. **AIDS/condom use** contain knowledge and attitudes towards AIDS/ condom use and it will be completed by students, and

5. **safer sexual behaviour** will be completed by students.

In addition, in-depth interview will be utilised in qualitative approach. They will be carried out two times, before the survey to design questionnaire and after the survey to support the data from the survey. 8 respondents are interviewed in each of indept-interview.

V. Policy Advantage

This study will provide information for governmental and non-governmental organization who can utilise these findings for an increased consideration of relevant socio-cultural processes. The findings can thus contribute to the development of more appropriate information and education for young people in relation to HIV/AIDS and sexuality.

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Chapter 7

Information Provided by Rural Mothers to Their Daughters Concerning Reproductive Health

Chanya Sethaput
Umaporn Pattaravanich

Introduction

Relatively limited data has been collected in Thailand on sharing of information about sexuality and reproductive health among family members. What has been found is that the transmission of sexual information to children directly or indirectly by their parents is so low that children usually seek sex information from the world outside their family. (Yawarat Porapakkham et al. 1986) Currently there is discussion of tactics to persuade parents or the elderly to share sex education with their children. If parents can teach or give sex education to their children, they can create a positive attitude about sex for their children. When their children are grown up, the sex information they have received could be a vaccination to protect them from growing social pressures which increase their exposure to rapidly spreading social diseases. For example in Bangkok rural girls who have migrated away from their homes often find themselves in sexually vulnerable situation, some of them drift into prostitution.

The most important obstacle to sex education by parents is not because children do not want to hear it but that most parents do not share sex education with their children. In many surveys when adolescents were asked about this, they replied that they had less chance to receive sexual information from other family members than from their friends, mass media or teachers (only in cases where they were studying or had finished secondary school (Sukanda Suwanitchart and Sirinuch Kunanithipong, 1987, Pensri Pichaisanith et al, 1986; Chalongrat Insri et al, 1984). There are several reasons why adolescents may not have received any sex knowledge from their parents. First, parents or adults may have no knowledge

about sex so they cannot talk with their children about it. Second, parents have traditional values about sex that would make them feel ashamed to reveal the issue to their children. Third, although parents do not agree with premarital sex or deviant sexual behaviour, they are not willing to talk with their children because they think that when their children are grown up they will learn about it by themselves, (Newcomer and Udry 1984 citing Furstenberg et al; Reiss, 1981, Roberts 1978 and Norman and Harris 1981). Some anthropological research in Thailand reveals that mothers and/or grandmothers have occasionally told their daughters or granddaughters about sex directly and indirectly (Bencha Yoddumnern-Attig et al, 1992)

For these reasons, children and adolescents have less opportunity to obtain sexual knowledge, unless they attend secondary schools where sex education or family life education (as it is named) is integrated in some subjects. As a matter of fact, less than half of the children who finish primary schools enroll in secondary schools, especially in rural areas, the proportion of pursuing secondary education is very low. For those not attending secondary schools, especially rural children, after finishing compulsory education or primary education, many leave their villages and families to find jobs in Bangkok and other big towns. For this reason rural adolescents are disadvantaged in learning about sex either through school or from their family.

These teenagers with no basic knowledge about sex are easily drawn into a fascinating and dangerous society. If they have ever learned about sexuality from their parents or their elders before they move out, it may be useful for them by protecting them from participating in sexually risky behaviors. Importantly, sex education is not only comprised of knowledge about sex also correct understanding, good attitude and proper behaviour about sex, since it is composed of 4 aspects: biology, hygiene, psychology, and social environment.

In this study, at least 3 research questions are raised, first, "Do rural mothers tell their daughters about sex, and what do they talk about?" second,

"Does sex information given by rural mothers affect sexual knowledge of their daughters or not?" and third, "Do rural mothers with different levels of sexual knowledge give sexual information to their daughters differently or not?"

Data and Method

Data for this study are drawn from the research project entitled "The relationship between familial and non familial influences on sexual value of female adolescents in Amphoe Nang Rong, Changwat Burirum" collected in October 1991. From the household listings of 52 villages in Nang Rong, only households where there were mothers and young daughters aged 15-19 years were selected. In a household where either the mother or the daughter was absent this household was omitted from the study. It took about a month for 8 interviewers to interview 472 mothers and daughters who were present at the time of interview. The interviewers were senior students of Burirum Teacher' Training College. During the interview mothers and daughters were separated a short distance so that they could not hear the responses of each other since some sets of questions were the same.

There were two questionnaires, one for mothers and another for daughters or female adolescents. In this study, data on age of mothers, level of mothers' sexual knowledge, level of daughter's sexual knowledge, amount of sexual information given to the daughter, level of sexual information that the daughter received, and the reason for telling or not telling daughters about sex are analyzed.

Results

It is notable that socio-economic factors are not taken into account because the characteristics of study population are similar. Most mothers earn their living by growing rice and cassava. They have a low level of formal education (84.5% finished Prathom 4 or compulsory education at the time) Average years of attending school for rural mothers is 3.6 while their daughters spent 6.04 years in school

(92.4% finished Prathom 6). The average age of mothers is 45.9 and 17.0 for daughters in the study.

After testing sexual knowledge of mothers and children with same set of questions, it is found that average score of sexual knowledge of mothers is lower than that of their daughters. The full score is 16, average score of mothers is 7.3 while their daughters averaged 8.3. Probably the test is rather difficult for rural people who have only primary education especially for the mothers who have never learnt sex education in school. Meanwhile the daughters who have recently finished primary school (at about 13 years old) probably receive some knowledge during their schooling.

Asking about the sexual information given to their daughters it is amazing that rural mothers have ever talked or suggested to their daughters directly or indirectly about this. The detail of sexual information which is composed of 10 main issues or 30 minor issues are as follow.

1. Dating
   - Having boyfriend, talking with men, and going alone with men

2. Premarital Sex
   - Touching with boys, staying in secret place with boys, and keeping virginity until marriage day.

3. Mate Selection
   - Appropriate age of courtship, characteristics of spouse and the wealth of spouse.

4. Family Life
   - How to please your husband, how to take care of house, and how to prepare to have children

5. Menstruation
   - What is menstruation, prohibition during menstruation, and how to clean body during menstruation

6. Reproduction
   - How is a child born, sexual organ of man and woman, and appropriate age of having a child

7. Pregnancy
   - During what time woman can get pregnant, and in what part of body is fetus, symptom of pregnancy.

8. Contraception
   - How to protect pregnancy, how many contraceptive methods, and what are the most effective methods.

9. Sexually Transmitted Diseases
   - What are they, how to prevent, and how to cure

10. AIDS Disease
    - What is AIDS, how to prevent AIDS, and who has most chance to get AIDS.

The order of the topics on sex that mothers have ever talked to their daughters is shown in Table 1. It is found that the topics that rural mothers have discussed with their daughters most frequently is premarital sexual relation and dating. The mothers usually warn their daughters to be careful when coming into contact with males and how to avoid finding themselves alone with men. The moderately mentioned issues are about becoming a future wife. The least frequently topics they talked about are biology and hygiene (including diseases from sexual intercourse). It is possible that rural mothers do not talk about the biological aspects of sexuality because it is rather difficult and technical. Mothers

themselves may have no exact knowledge about this aspect. Some mothers may mention something about the AIDS disease because the AIDS campaign is very widespread now. It is obvious that rural mothers have little knowledge about STDs. In other words, they know about AIDS more than STDs.

Table 1 Sexual information that rural mothers ever talked to their daughters. (N = 472)

	Contents	Ever %	Never %
1.	Premarital Sex	89.6	10.4
2.	Dating	85.6	14.4
3.	Mate Selection	70.6	29.4
4.	Menstruation	68.6	31.4
5.	Family Life	60.2	39.8
6.	Pregnancy	33.3	66.7
7.	Reproduction	28.4	71.6
6.	AIDS Disease	26.9	73.1
9.	Contraception	24.4	75.6
10.	Sexually Transmitted Diseases	21.2	78.8

One important point to discuss is why rural mothers do not often talk with their daughters about sexual topics including birth control about which there are evidences that they have a lot of knowledge. When asked why they do not inform their daughters about these sexually related issues mothers give a range of reasons. Some mothers think that their daughters are still too young so it is not a good time to tell them. They will wait until their daughters are going to be married or after their marriage. Other mothers do not tell their daughters because they want them to

know by themselves and some cannot tell because they do not know what to tell them. This may also imply that rural mothers have less knowledge about sex. Some of the reasons why mothers do not talk about sex to their daughters are shown in Table 2.

Table 2 Reasons why rural mothers do not inform their daughters about sex (N = 472)

Reasons	%
Will tell when they get married	42.3
Let them know by themselves	25.3
Never think to tell	10.1
Will tell when they have boyfriends	9.6
Don't know what to tell	8.5
Will tell when they are grown up	2.5
Will tell if they ask	1.7

In this study, age of mother, sexual knowledge of mother, sexual knowledge of adolescents and sexual information given by rural mothers to their daughters are analyzed to test their relationship.

In Table 3, age of mother is divided into two groups-young (33-45 years old) and old (46-68 years old) groups ($x = 45.90$). Also, sexual knowledge of mothers is divided into two levels-low (0-7 scores) and high (8-15 scores) ($x = 7.39$). Using crosstabulation, it is evident that the older mothers have substantially less sexual knowledge, conversely, the young mothers have more sexual knowledge. Using chi-square test it is found that the relationship between age of mother and level of sexual knowledge is statistically significant at .01 level. That

is, the aging of mothers affect their sex knowledge. It is probably because the old generation has lesser chance to receive sex education.

Table 3 Percentage of level of sexual knowledge of rural mothers by age group (N = 472)

Level of sex knowledge of mother	Age of mother	
	young % (n)	old % (n)
Low	40.0 (96)	59.7 (142)
High	59.0 (138)	40.3 (96)
Total	100.0 (234)	100.0 (238)

$X^2 = 15.65939 \quad p < .01$

Another question the authors try to answer is whether older or younger mothers can give more information about sex to their daughters. By this means, sexual information given by rural mothers to their daughters are classified into two levels according to the amount of topics on sexual information the mothers give to their daughters. Scores of low level of sexual information is between 0-14 and high level is between 15-30 ($x = 14.38$) Table 4 shows that the age of mothers has no effect on the amount of sexually related information they give to their daughters.

Table 4 Percentage of level of sexual information given by rural mothers to their daughters by age group (N = 472)

Level of sex information	Age of mother	
	young % (n)	old % (n)
Low	51.3 (120)	50.0 (119)
High	48.7 (114)	50.0 (119)
Total	100.0 (234)	100.0 (238)

$\chi^2 = 03477 \qquad p > .05$

It is an attempt to find out the relationship between sexual knowledge of mothers and sexual information given to daughters. It was hypothesized that the more knowledge about sex the mothers have the more information they give to their daughters. The result does not show this difference. In Table 5 mothers who have less knowledge on sex tend to give less information on sex to their rural daughters. In other words, if mothers have more sexual knowledge they tend to give more sexual information to their daughters. However the percentage is apparently not much different. After the test, it is not found statistically significant at .05 level.

Table 5 Percentage of level of sexual information given by rural mothers to their daughters by level of sexual knowledge of mother (N = 472)

Level of sexual information	Sexual knowledge of mother	
	Low % (n)	High % (n)
Low	54.2 (129)	47.0 (110)
High	45.8 (109)	53.0 (124)
Total	100.0 (238)	100.0 (234)

$X^2 = 2.16311 \quad p > .05$

Findings from Table 6 also shows that there is no relationship between sexual information given by rural mothers and sexual knowledge of their daughters. It was expected that if mothers had given more information about sex to their daughters, their daughters should have higher level of sexual knowledge. Here, it is found that either more or less mothers give sexual information, their daughters tend to have sexual knowledge at higher level. It could be interpreted that daughters gain sexual information from other sources than their family. The findings from the research project ascertain that girls receive more information concerning sex and reproductive health from their friends and mass media than their mothers (Chanya Sethaput, 1993)

Table 6 Percentage of level of sexual knowledge of rural adolescents by sexual information given by their mothers (N = 472)

Level of sexual knowledge of adolescent	Sexual knowledge of mother	
	Low % (n)	High % (n)
Low	42.7 (102)	43.3 (101)
High	57.3 (137)	56.7 (132)
Total	100.0 (239)	100.0 (233)

$\chi^2 = .00291$ $p > .05$

Discussion

Though the authors try to search answers for their research questions the findings are not satisfactorily clear in some points. However, it is known that what are the most or less topics rural mothers like to talk to their daughters. The sexual and reproductive related subjects which mothers are most likely to discuss with their daughters are pre-marital sex and dating. It is presumably reinforcing the traditional values of Thai people on female pre-marital virginity even now. Dating is also frequently discussed among mothers and daughters. It presumably concerns appropriate behaviour and social expectation concerning how a young woman or girl should behave with men. The third frequent topic of discussion between mothers and daughters is mate selection which concerns the qualities considered important for making a good choice. the above issues all reflect the socialization process in rural families. It is noticed that menstruation which is the only bio-social topic is discussed by two thirds of mothers with their daughters. It is apparent that

menstruation is natural phenomena for all women so that mothers can talk normally with their daughters. However, some families do not discuss about sexual related topics. One reason is that the mothers have limited knowledge about them. The other reasons are that they do not want to tell because they think that their daughters are not sufficiently grown up yet if not about to marry or involved in courtship. Another reason is possibly that women in traditional settings such as rural community where people know each other well, girls are not expected to be knowledgeable about sex. Especially single women are in particular expected to be sexually innocent. That is why mothers hesitate to discuss such issues with their daughters. According to data available, one cannot assume that the mothers do not consider sexual issues as sufficiently important to address to their daughters. But the findings are not ascertained that mothers actually have less knowledge on sex and reproductive health than their (better formally educated) daughters. Even those mothers who are knowledgeable about these issues by experience are not more likely to give such information to their daughters. Theoretically, many areas of research show that knowledge alone is not a sufficient condition for an action.

These findings highlight the fact that mothers are not at present an important source of biosocial reproductive knowledge to daughters but highlights the importance of strengthening other sources of information. The study could also benefit from being contexted within the wider process of social and demographic change. The daughters are growing up in a different age to that of their mothers regarding mate selection and era-new threats to reproductive health (e.g. HIV/ AIDS). Mass media as informal education is highly recommended for rural adolescents to provide them with accurate sexual and reproductive health information.

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Chapter 8

Gender Dimensions of Sexual Feelings and Interaction of Thai Youth: Analysis of Focus Group Discussions with Young, Single Factory Workers

Nicholas Ford and Sirinan Kittisuksathit

Introduction

Sexual lifestyles, particularly of young people, are dynamic, developing in relation to a wide range of social, personal, cultural and health-related factors (Abramson, 1983). This chapter reports upon the analysis of focus group discussions concerning sexual awareness and lifestyles held with young, single factory workers in Bangkok and its environs. Thailand's industrial and urban development process entails a massive migration flow from the rural to urban areas (Phongpaichit, 1992) of which these young people are a major part. For this group the migration is a move in social, as well as geographical, space, spanning a crucial maturational period of their lives. Furthermore, this movement of young men and women is taking place within an era of increasing threats to reproductive and sexual health (Koetsawang, 1987) of which the HIV/AIDS is probably of the greatest importance (Ford and Koetsawang, 1991). The Thai government estimates that there are currently between 200,000 and 400,000 cases of HIV infection nationally (Ministry of Public Health, 1992).

It is becoming increasingly recognised that as Thailand completes its fertility transition the main concerns of its population policy are human resource development (Sussangkarn, 1993) and improving reproductive and sexual health. The focus of this study thus relates directly to the core concerns of Thailand's emerging population policy. This research project is primarily concerned with deriving practical implications for the development of strategies to foster the reproductive and sexual health of factory-employed youth.

Following a brief outline of the methodology, qualitative findings are presented pertaining to; attitudes towards sexual relationships, sexual feelings and arousal, admitted sexual experience and patterns of interaction within non-commercial sexual relationships. The main emphasis throughout is upon elaborating upon the nature of the gender construction of sexuality of the young factory workers, which is summarised in Figure 1.

FIGURE 1:

Summary of Sexuality by Gender Expression

Dimension	Young Men	Young Women
Social acceptability of premarital intercourse	Commonly first sexual experience was maturbation. Pre-marital intercourse accepted and expected for young men. No word in Thai language for a male virgin. Such young men are ridiculed by their peers.	Masturbation uncommon, considered negatively. Premarital intercourse strictly unacceptable for 'respectable' women. Such activity considered to be highly damaging to the reputation of the young woman and her family.
Attitudes to sexual feelings	Positive, open. Strong psychological sense of sexual drive which demands 'release' and justifies coercion occasionally. Sex is for enjoyment A subject discussed with humour and much slang.	Generally negative attitude to sexual feelings. Great reluctance to admit having such feelings. In the rare event (admission) of sex taking place, justified in terms of pleasing partner and sustaining relationship.
Actual sexual experience	Practically universal. Generally first (and most of subsequent) intercourse taking place with prostitutes. Belief that the level of non-commercial sex is increasing.	Very difficult to identify because of extreme reticence on the part of young women to admit sexual experience. Articulate definite steps and limits in sexual interaction - holding hands, hugging, kissing.
Attitudes to condom use and contraception	Condoms used in varying degrees of consistency with prostitutes but not with (non-commercial) girlfriends. Contraception viewed as the woman's responsibility.	Would like to know more about contraception. Generally could not consider seeking or requesting contraception because they would fear being stigmatized as sexually active.
Attitudes to negative consequences of sexual activity	The core of men's sexual freedom is that such activity has no impact upon their reputation. Hixed attitudes to the risk of HIV from prostitutes. Pregnancy is the women's problem.	The greatest perceived harm revolves around the women's reputations. Pregnancy feared because shows evidence of 'sinful' behaviour. HIV/STDs not perceived as salient issues.

Methodology

This project is comprised of three phases of data collection undertaken serially over a three-year period; focus group discussions (completed), a schedule-structured survey of 2,000 16-24 year old respondents (in progress), and finally in-depth interviews. The main objective of this focus group discussion phase is to explore the ways in which young people articulate their sexual attitudes and feelings, and to help identify appropriate concepts and variables to be subsequently quantitatively investigated in the schedule-structured survey. Focus group discussion is of course not the optimal mode of data collection for identifying the prevalence and levels of specific sexual practices. However, by stimulating debate and expression focus group discussion is an excellent means of drawing out social feelings and the ways in which people talk about particular issues, and this is precisely their use in the first phase of this study.

Eighteen (eleven female, seven male) focus group discussions were conducted among factory workers between September 1992 and the end of January 1993. Participants were recruited from a range of light industrial (garment and textile, electrical and consumption products) factories located in Bangkok, Nakorn Pathom, Samutprakarn, Cha Cheung Soa, Pathumthani and Nondhaburi. In order to establish a broad homogeneity within the groups, they were broadly structured by age (mid-teens, late-teens, early twenties) and residence. Two groups spanned the age range and residence types in order to assess the effect of such heterogeneity upon the discussion. The group discussions were transcribed 100% in Thai and fully translated into English, generating a substantial qualitative data set. All names given with quotations below are of course fictitious.

The discussion guideline commenced with the more neutral subjects of the reasons behind the migration, leisure lifestyles and living arrangements, before moving to the main themes of courtship, socio-sexual expectations for young men and women, feelings about sexuality, relationships and sexual health concerns. Predictably the young men were much more open and forthright than the young

women in their discussion of their sexual behaviour, but the women tended to elaborate more upon the nature of their relationships.

Sexual Orientation and Arousal

Thai culture has been considered fairly tolerant of non-heterosexual orientation, although there were some signs of social stigmatization of male homosexuals during the early phase of the AIDS epidemic (Cohen, 1988). In the men's discussions homosexuality was only mentioned in passing to tease individuals who claimed not to go to prostitutes. However, in the women's discussions there was open and detailed description of lesbianism (`tomboy' and `lady' relationships) within the factory and dormitory setting. In general there appeared to be greater toleration or social acceptance of female, rather than male, homosexuality. Indeed, from a preliminary review of the first 298 (224 females, 74 males) cases in the current survey, 4.5% of the women but only 1.5% of the men described themselves as being of homosexual orientation.

In the discussion of sexual feelings and arousal there was an extreme gender difference, with the young men openly describing their feelings (chiefly in terms of a drive psychology) and the young women only with great reluctance admitting that they have any such feelings at all. The young men's earliest sexual arousal was fairly openly discussed in terms of wet dreams and masturbation. The young women's reticence reflects the traditional norm that they should be sexually innocent and reserved. With developing rapport towards the end of the group discussions the young women did admit that women did have sexual feelings but that they did not show or express them.

Bo: "Usually women don't show off (express their sexual feelings) they have such feelings but don't express them" (female aged 24 years old).

The existence of sexual feelings and arousal in young men and women is not the issue here, but rather the ways in which they articulate and acknowledge such feelings and the bearing it has upon following `safer sexual' practices.

Young Men's Sexual Interaction with Prostitutes

Given the traditional double standard pertaining to the acceptability of pre-marital sex for men and women, the recourse taken by males to prostitutes is obviously a major component of the sexual culture. Most of the young men in the discussion groups reported that their first intercourse was with a prostitute, often being taken to the brothel to `Koen-Kru' - `to pay their respects to the teacher' (the prostitute as sexual teacher) by older friends or relatives. In the discussions the young men often recalled vividly their first experience of sex, the shock, excitement and disorientation and their discussion of it immediately after the event with their friends. `Pai-tiew' - visiting prostitutes continued to be part of group leisure behaviours, as one aspect, along with eating, drinking, maybe a game of snooker, of a night out with friends.

However, although visiting prostitutes is almost an accepted part of the young men's sex lives, several expressed the views that either they only frequented prostitutes in the past, but did not anymore, or visited them much less frequently than formerly - partly in response to the perceived threat of HIV/AIDS. It is possible that fear of AIDS and the partial shift away from contact with prostitutes is relating to and interacting with the increased pursuit of non-commercial sexual contact, for instance:

Chei: "Having sexual intercourse with the female in the factory is safer than going outside (to a brothel), because there is no risk of infections" (male aged 24 years old).

It is to the pattern of activities within non-commercial sexual interaction that the next section turns.

Non-Commercial Sexual Interaction

This section discusses the perceptions of the double standard, social and sexual interaction within courtship and general trends in the level of non-commercial sexual interaction among young Thais.

Both the groups of young men and women took for granted the sexual double standard in Thai society. For instance, discussing pre-marital sex:-

Pog: "It is good this way. If women do it they'll be damned but it is normal for men to do it" (Male aged 24 years old).

Moderator: "Now my question is what if women do the same things?"

Ood: "That's possible. But I think it is not good if a woman is going to get married to one man and goes and has sex with another man" (male aged 23 years old).

Tig: "No its not proper" (male aged 22 years old).

Pog: "Because this is Thai society. Women are the ones who will be damaged. Also Thai people like to gossip. If the man talks to other people then everybody knows about her and then she is considered spoiled".

Similarly, several of the young women commented on how vital it was to protect a woman's pre-marital virginity;

Ning: (referring to the social impact of intercourse) "the man doesn't become a wreck. It's natural" (female aged 24 years old).

Nang: "If a woman wants to try intercourse just once she becomes a wreck. If she later turns to another man, that man will consider her flawed" (female aged 24 years old).

Nevertheless, despite the strong recognition of dangers to a young women's reputation of engaging in pre-marital intercourse, repeated reference was made in most of the discussions to the increasing level of pre-marital intercourse among young Thais. Indeed, it is interesting to note that the young males discussed this issue with much more interest than the more common interaction with prostitutes. Both the groups of young men and women referred to a very small minority of young women who engaged in casual sex with multiple partners. Such women were described as `hoew' a word used by the young people to connote wild', `extreme', `modern' and `fashionable'. In their disregard for social convention such young women were considered highly unusual and, if their behaviour was known, would be looked down upon.

Both the young men and women felt that it is fairly easy in the urban areas to make social contact with members of the opposite sex. It is socially acceptable to have a number of `friends' of the opposite sex with whom there is no sexual or any strong emotional involvement, but rather persons with whom one can talk, joke, confide, maybe flirt a little and generally have fun. In the event of an emotional relationship being formed a friend becomes a `fan' which translates to the English word `lover' in the sense of `being in love', but certainly not someone with whom you necessarily `make love'.

The easy going and egalitarian relation with a friend is substituted by the greater seriousness of a `fan' relationship, the woman `watches herself', attempting to behave in an appropriate way - almost as if the young couple are starting to practice the traditional gender scripting of husband and wife, with the latter in a more submissive role and looking respectfully to the man as `her leader'. For instance;

Kung: "With a friend I can play (joke) but I can't play with a `fan' (female aged 19 years old).

Penn: "You can't `touch' him, if you do he'll surely kick you back" (female aged 17 years old).

Given that it was felt that very few Thai women would engage in `free' casual sex, non-commercial intercourse was felt most likely to occur within steady relationships. Although the young men valued a woman's virginity (especially as a potential marriage partner) they had no hesitation in stressing that they would take the opportunity to engage in intercourse if their girlfriend was willing.

Both sexes were strongly aware that the gender scripting within relationships was such that the man made the sexual advances and the woman was expected to resist. The process was seen to be one involving a series of steps and limits in which the young man applied various forms of personal pressure upon their female partners to agree to intercourse. The woman for example described engaging in intercourse in terms such as `submission' and `surrender'. The most common means of exerting pressure seemed to be one of emotional attrition, leading to a progressive `jai oon' - softening of the young woman's heart. Within their steady relationships some young women stated that not being `tai dan' (sexually insensitive) they did sometimes feel aroused by their boyfriend, but struggled to suppress their feelings to prevent things being taken too far.

There were definite differences in the ways in which young women in the groups described their attitude to sex within pre-marital relationships. For instance, in the following exchange;

Pear: "I think I will have no coitus before my marriage" (female aged 17 years old).

Toy: (interrupts teasing) "a good person by the national standard" and later "Nothing is certain Pear, you may suddenly meet your `boyfriend' and this way things (intercourse) may suddenly occur. Isn't it possible Pear?" (female aged 18 years old).

Pear: "Yes, but I always keep in mind that if something starts I will try to think of the face of my parents".

Toy: "Wow! A grateful child, good daughter".

The essential nature of the pattern of young Thai women's attitudes to pre-marital sexual intercourse is shaped by the tension between traditional pre-marital chastity and more `modern' romantic attitudes which acknowledge the possibility of intercourse within a committed relationship.

However, whatever the relationship context and their own attitudes to pre-marital sex, many young women also recognised that they had to be careful in their sexual interaction with their boyfriend, given that a man would think less of his girlfriend if she did not appear sufficiently reserved and innocent regarding sexuality. Within a cultural context in which pre-marital sexual interaction is increasing this actual and socially expected sexual inhibition, and innocence on the part of young women is probably an important factor militating against `safer' sex being put into consistent practice.

Probably the two most disturbing issues to emerge from the discussions concerned the inconsistency of males' condom use with prostitutes, and the inability of most of the young women to even contemplate, let alone access or actually use, contraception. Even those young men who used condoms with prostitutes were not prepared to do so with a regular girlfriend. They argued that the question with (non-commercial) girlfriends was simply whether or not to have intercourse, such women had never raised the question of condom use with them.

The young women found it difficult to acknowledge that they could be pre-maritally sexually active. Furthermore, they argued that sex could only take place within a loving, committed relationship and thus pregnancy should lead to marriage. Within such a relationship their boyfriend, as their future husband, was expected to take the lead in saying whether, and if so, what form of contraception, should be used. The young women felt that it would be extremely difficult for them to actively seek contraception as it could amount to a public admission that they were sexually active.

The women's discussion groups made very little reference to the risk of HIV infection. Basically, it appears that firstly, they feel that their own lifestyles are not high risk, and secondly, they do not like to imagine that their own boyfriends are potentially infected.

Conclusion

The aim of this chapter has been to summarise some of the qualitative findings from focus group discussions held with young, single factory workers. Such data cannot reveal the prevalence and levels of sexual behaviours, but it is useful in deriving insights into feelings, expectations, meanings and expressions of sexuality. Two major themes ran through the discussions, firstly, that the dramatic process of social change in Thailand is having an impact upon liberalizing patterns of pre-marital sexual behaviour, but that secondly, there is a continuing all-pervasive gender construction of expectations pertaining to sexuality. The changes in patterns of sexual activity are presumably linked to changing social aspirations linked to urban lifestyles and modernization (Komin, 1989), increasing occupational opportunities for women and the demographic transition (Knodel, Chamratrithirong and Debavalya, 1987), which within virtually a generation has allowed a separation of sexual activity and procreation.

Such developments which were felt to be taking place particularly within the urban areas were associated in the minds of young people with modern social

trends. The overall sexual culture of youth in Thailand may be viewed as a complex interplay of traditional sanctions and modern expectations, which are each structured in terms of the gender construction of the `double standard'. Thus there was a strong tension in the discussions with the young women between their expressions of their own behaviour and the ways they felt other young people were behaving. As in the `West' in earlier decades the core of changes in sexual culture is likely to principally relate to the social expectations and standards concerning young women's behaviour. There appeared to be a strong sense that (at least) some of the young Thai women were open to `romantic' sexual relationships which permitted pre-marital intercourse, provided it was taking place within a loving and committed relationship. However, the socialisation of young Thai women with respect to sexuality makes it difficult for them to acknowledge their own sexual feelings, let alone to be able to insist on `safer sex' in the event of intercourse taking place within a relationship. In a sense there are conflicting social pressures operating upon young women's sexuality; (external) traditional cultural norms strictly forbid any expression of sexuality, yet (internal) dynamics of courting relationships involve pressure from the partner to acquiesce to pre-marital intercourse.

Other research (Fisher, **et al,** 1983) has confirmed that "an individuals' emotional response to sexuality, will generalize and, in part, determine whether the person approaches or avoids contraception" (1983,207). Many of the young Thai women found it very difficult to acknowledge that they had sexual feelings. Also the use of effective contraception often involves a communication and negotiation process, the culturally articulated expectation that the Thai woman should be sexually `innocent' and reserved militates against her ability to express the need for taking precautions during sex. One of the complex of fears in the young woman's mind is that by openly expressing the need to take precautions (eg. condom use) she conveys an image of being sexually knowing, possibly experienced, and sexually and contraceptively active rather than passive, in interaction with her male partner. Further understanding of these issues is crucial for the development of strategies which may be able to foster consistent `safer sex' behaviours, which is a

survival imperative for the current and following cohorts of young people in Thailand.

The young themselves view the more `open' trends in sexual interaction to be similar to foreign or `Western' behaviours and associated with modern developments. However, as with other areas of social behaviour Thai culture is likely to adapt and develop these trends in its own form. Again it is important to stress that to be effective HIV risk-reduction/harm-minimisation strategies have to interact with the continuing process of the cultural construction of sexuality. A quantitative survey is being undertaken in factories to further identify the prevalence and pattern of the sexual lifestyles of Thai youth. The very reticence of young Thai women to acknowledge their sexuality may be an obstacle to obtaining reliable and accurate data upon sexual behaviour. The survey interview includes a scale adapted from the `erotophilia-erophobia' continuum (Fisher **et al,** 1983) to assess the underlying emotional responses to sexuality. There is a need to understand the implications of such factors for the development of potentially effective `safe sex' promoting intervention programmes.

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Chapter 9

Husbands' and Wives' Attitudes towards Husbands' Use of Prostitutes in Thailand

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Introduction

Thailand is facing a rapidly expanding HIV/AIDS epidemic in which infection has spread from core groups including injecting drug users, sex workers and their customers, to the wives and offspring of such customers (Ford and Koetsawang, 1991). The number of pregnant women and infants who are infected with HIV has gradually increased. One study concerning children and AIDS projected that the mortality rate of children under 5 will increase due to HIV infection from 50.3 in 1994 to 57.1 per 1000 live birth in 2000. The study also shows that the number of children under 5 of HIV mothers could total 303,217 by the year 2000 (Boonchalaksi and Guest, 1993). The study implies that if there is no effective implementation to arrest the spread of HIV/AIDS, Thailand will encounter a tremendous social problem in caring for AIDS patients and orphan children whose parents have died of AIDS.

One of the factors which is often mentioned to be of critical importance for HIV infection among the married women and their children is their husbands visiting of prostitutes without taking any protection against the transmission of HIV. One survey estimated that the average Thai married man visits a brothel twice a month (World AIDS Briefing, September,1991). The study of Sittitrai and the other (1992) found that 17% of urban married males who visited prostitute during the last 12 months had not reported using condoms everytime.

Thai males' frequenting of prostitutes is practically a social norm of Thai society. However, there is an extreme paucity of empirical research focusing on

attitudes to prostitution including husbands' and wives' attitudes. This chapter firstly reviews some of the key literature pertaining to these issues and then outlines some key features and preliminary findings of a recently commenced research project. This basically exploratory study seeks to generate information upon a specific aspect of prostitution in Thailand which has not been studied. The study aims to examine the attitudes of married couples to husbands' involvement with prostitutes and to assess its implications for the risk of HIV/AIDS transmission to the wife.

Literature review

Reference is made to the literatures concerning Thai social norms pertaining to sexuality, peer influence and condom use of married men. According to Abramson's sexual system, sexual activity is shaped by a complex interplay of social norms, parental standards, maturation and previous sexual experiences. Individuals behave sexually from their underlying cognitive structure -a reservoir of feelings and experiences developed from these four influences (Abramson,1983). In addition, the culture also determines the expression of sexuality (Smith, 1990).

Thai social norms

There are some Thai social norms reflecting the attitudes of people towards the prostitution. These attitudes encourage the patronage of commercial sex of Thai males (including married men). Rattanawannathip (1990) mentioned that Thai people always said that "a man who does not frequent prostitutes is not a real man". The men who do not use prostitutes will feel alienated from their peer groups (Abilasingh, 1991 ; Thong-U-Thai, 1991). Frequenting of commercial sex establishments by Thai men takes place within a socio-cultural context.

Moreover, some believe that prostitution is necessary for society. They feel that it protects "good" women against rape because men have another outlet for sexual relief (Rattanawannathip, 1990). For some wives, the husbands' use of

prostitutes seems to be acceptable. They think that it is better to let their husbands use prostitutes than have a minor wife, which is perceived to be a much greater threat to the stability of the family (Abilasingh, 1990; Thong-U-Thai, 1991). The study of Havanon et al. (1992) indicated that Thai society accepted that the married man who had sex with prostitutes was not generally blamed as being unfaithful to his wife. These above attitudes provide part of the social support of commercial sex as an acceptable mode of behaviour.

Influence of peer group

According to Abramson' s sexual system, the internalisation of social norms are partly shaped by peer group. The influence of peer group on behaviour has been investigated by various studies. Sawaengdee and Isarabhakdi (1990) found that most of the men who visited the brothels usually went with their friends. Havanon et al. (1992) reported that 76% of married men were almost always accompanied by others during their most recent visit. It was also found that the married men who had close friends frequenting prostitutes were more likely to be infected with STD than those whose friends did not (cited in Sirichai, 1990).

Furthermore, it can be said that peer group does not only influence males' patronage of prostitutes but also on condom use. Sirichai (1990) reported in her study that husbands who obtained information of condom use from their friends used condom in their sexual activity with prostitutes more than husbands who never received such information.

Condom use of married men

Epidemiologically the crucial issue is whether men consistently use condoms in their visits to prostitutes (both for their own and the prostitutes' sake). Sittitrai et al.(1992) found in their study about sexual behaviour and risk of HIV infection that in the last 12 months 17% of urban married males had sexual intercourse with commercial sex workers (CSW) without protection compared to

6.4% of rural married males. About 24.2% of urban married men reported visiting CSWs while only 9.5% of rural males reported doing so. The urban people seemed to have more risk of becoming infected with HIV than rural people.

Many people have an " unreasonable optimism " concerning their own as opposed to other peoples' vulnerability to health. The findings of Havanon et al. (1992) showed the patrons' invulnerable perception regarding HIV which came from their feeling that they could screen out the dangerous partners. Some perceived that discretionary sex workers involved less risk. Less attractive sex workers were also assessed to be low risk. Then, the patrons decided not to use condom since they perceived such sex workers as safe partners. They felt that they had low risk of becoming infected with HIV. This psychological mechanism was constructed in their perception to rationalise their behaviours.

Given their vulnerability to infection via their husbands' unprotected sexual interaction with prostitutes it is pertinent to consider how far wives may be able to influence their husbands' behaviour. This may be explored with reference to wives' perception of their capacity (self-efficacy) to influence their husbands, ability to communicate concerning such matters, and the psychological costs which may be considered to be involved in broaching such issues with spouse.

It is basic to conceptualisations of AIDS risk-reducing behaviour that it is one thing to wish to follow a protective practice but another to put that intention into practice (Catania et al.,1989). Bandura's (1989) concept of self-efficacy can be related to whether or how far wives feel they are actually able to persuade their husbands either not to visit prostitutes, or if they do, to consistently use condoms. A related consideration is whether wives feel they will be know if their husbands' visit sex workers.

Influencing husbands' behaviour regarding interaction with prostitutes presupposes communication between spouses on the matter. In this society most people feel very embarrassed to discuss sexual matters, especially with members of

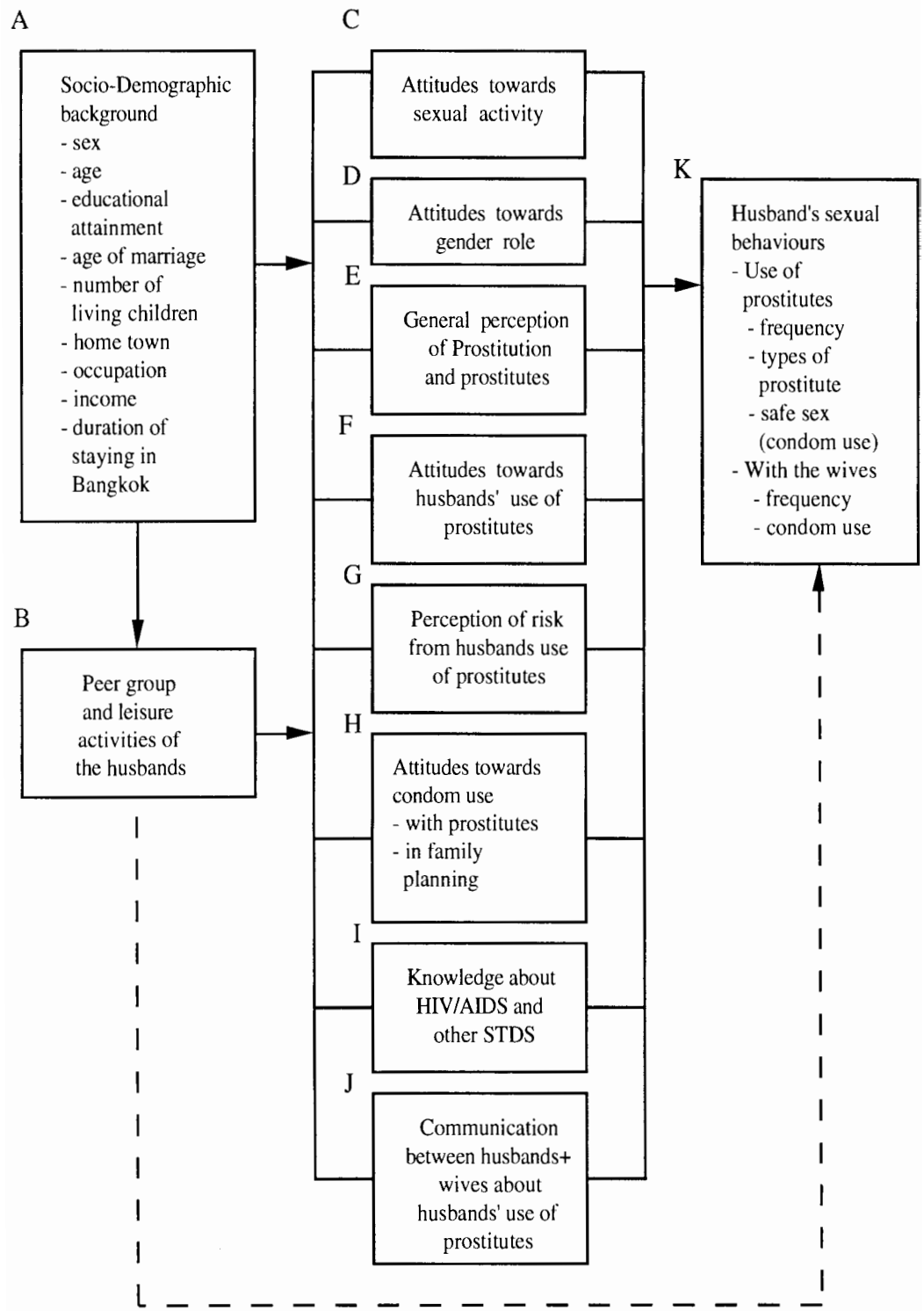
the opposite sex. Furthermore as Joseph (1989) has noted changing sexual behaviour can involve some psychological cost to the individuals involved. With respect to these matters it is possible that husbands and wives fear explicitly addressing these matters to one another, in case it causes arguments which are difficult to resolve. Some of these foregoing questions are addressed in the conceptual framework of the research project outlined below.

The research project is outlined with reference to its objectives, conceptual framework, research design and methodology and preliminary findings derived from the pilot testing of the data collection instruments.

Objectives of the study

The objective of the study is to provide information on the attitudes of husbands and wives towards husbands' frequenting of prostitutes in Thailand which can assist implementing agencies to develop programmes aimed at reducing behaviours critical to the transmission of HIV and AIDS infections, especially to the family of prostitutes' clients.

Conceptual framework



Research design and methodology

The research design involves a small-scale study using both quantitative and qualitative approaches undertaken in Bangkok.

The two types of the qualitative data collection to be implemented in this study are focus group discussion and in-depth interviews. At least 8 focus group discussions of different selected groups based on occupational status will be carried out among married men and woman who are not the same couples.

Quantitative survey will be carried out to collect data on the study variables including social, economic and demographic variables, perceptions and attitudes and sexual behaviour of the couples. A multi-stage sampling design will be utilised in the selection procedures for the cluster units. The couples in the selected households will be asked to take part in the study. Two sets of questionnaires will be used as the data collection tools: for the husband and for the wife. Approximately 400 couples (husbands and wives) or 800 respondents will be interviewed.

Progress to date

Given that the project only commenced in mid-June 1993 the only work undertaken to-date has been the translation of the data collection instruments from English to Thai, their pilot testing (three in-depth interviews and two focus group discussions), followed by the first two group discussions and first two in-depth interviews with guidelines revised after pilot testing. The pilot testing of the focus group discussion guidelines were undertaken among two groups of male and female construction workers (blue collar). The subsequent two focus group discussions were undertaken among one group of female government employees (white collar) aged 32-44 years and one group of male dock labourers (blue collar) aged 20-32 years. The group discussions seemed to take place in good atmosphere with participants taking part and expressing their attitudes. The men in particular

openly discussed their sexual experience with prostitutes. Both the group discussions and the in-depth interviews took about two hours to complete.

Although the pilot testing findings are not considered to be part of main results of the study, given that relating few changes needed to be made to the guidelines, for the sake of this outline of preliminary findings, the two sets of findings (pilot testings and initial main study) are combined the following discussion.

Preliminary findings

Whilst there is considerable overlap it is useful to structure this brief presentation of preliminary findings in term of expressed attitudes towards; prostitutes and prostitution; married men who do, and men who do not, frequent prostitution; sexual practices, communication and condom use within marriage. The findings broadly divide into general social attitudes and perceptions within their own relationships.

Attitudes towards Prostitutes and Prostitution

All groups of respondents expressed the general view that men were not wrong to visit prostitutes. However there was also a general belief that prostitution was a repulsive occupation. One of the participants in the female construction workers discussion group said that even the word 'whore' ('kra-ri' in Thai) was deeply offensive to her. Most also stated that they would not necessarily condemn a woman for being a prostitute, however they could not bear the idea of one of their own relatives becoming a prostitute. Similarly when asked about their attitude to men marrying (former) prostitutes most felt it was alright, but again they stressed that they would not allow a relative or brother to marry a former sex worker. A male white collar worker expressed the view in an in-depth interview that if the couple were deeply in love they could marry but that given general Thai social attitudes, they should not tell anyone of the wife's former sex work. Clearly further

analysis of this attitude which at first perusal seem to indicate something of a double standard in term of expressed toleration for involvement in prostitution in the general society, but not at all with respect to their own family.

The respondents discussed the reasons for becoming a sex worker in both sympathetic terms such as the pressure of poverty, and more negatively in terms of gaining a relatively high income without having to engage in hard work. The female construction workers (who derive from the same social strata as most sex workers in Thailand) were very clear in their minds that "prostitutes preferred to be sex workers than construction workers" like themselves who earn little money in return for extremely arduous and often dangerous work. Some of the respondents who expressed the view that some prostitutes actually enjoyed the job. The white collar respondents tend to also discuss prostitution in the wider context of changing social norms and growing consumerism of Thai society, which they felt was at the root of (some) parents selling their daughters, or some women their own bodies, into prostitution.

Most of the respondents (both female and male) expressed the view (widely held in Thailand) that for all its manifest faults prostitution performed an important role in society, "in providing a readily available outlet for the release of males' sexual drives," and thus reducing the incidence of rape. Only one respondent (white collar female) expressed the view tha there were many ways other than visiting prostitutes, by which men could find sexual release.

All of the respondents felt that it was impossible to remove prostitution from Thai society. One female construction worker said that although she personally would very much desire all prostitution to be removed from the world, she felt it to be extremely difficult given the nature of the male sexual drive. Others felt that the only solution would be if there were no prostitutes, thus 'no supply, no demand'. One white collar male also expressed the pressure to visit prostitutes in relation to the effects of the pervading sexual stimulation from pornographic books, videos, and movies.

Attitudes towards Men Frequenting Prostitutes

Most respondents believed that very few men had never visited prostitutes. It was generally felt that such men faced the social pressure of teasing from friends or being suspected of being 'gay'. However some of the white collar females felt that some men never visited prostitutes because it was simply not their habit, not something they found desirable. The general reasons men frequented prostitutes were considered to be self-evident to the respondents, notably to obtain pleasure from sexually skilful women, considered to be younger and more beautiful than their wives.

Most women in the discussion groups expressed the view that whilst their husbands had visited prostitutes before, they had stop doing so after marriage. It is difficult to assess whether they all really believed this, whether such a view is a "coping rationalisation" or merely reflects "face-saving" presentation within a group. Some commented that their husbands had stopped going to prostitutes because fear of AIDS.

Sexual Practices, Communication and Condom Use Within Marriage

Given that it was generally accepted that one of the main reasons for husbands visiting prostitutes was that such women were considered to be especially sexually skilful, this led naturally in the discussion to the question of whether and what the effects would be if, wives could also behave similarly within marriage. The male blue collar workers said that they found their wives to be passive and unresponsive during intercourse. They all agreed that if their wives could satisfy them in the same way as sex workers then they probably would not "pia tiew". There is clearly a basic misunderstanding about sexual expectations and desire among these husbands and wives. The female construction workers felt that they would not want to perform active sexual acts like prostitutes, considering the sexual organ to be 'dirty'. Furthermore they also felt that respectable women should not show any enjoyment of sex, and fear that if they did so, their husbands would not

trust them. This findings mirror the discussions in the chapter by Ford and Saiprasert concerning Thai women's feelings about not admitting to feeling sexual arousal. However both the male and female blue collar workers said that it was impossible for them to even discuss sexual matters with their partner.

By contrast the female white collar workers expressed different attitudes to sexual practices within marriage than their construction working counterparts. They felt that as sexual practices were covert between husband and wife then the couple should not be embarrassed to explore sexual pleasure. They tended to discuss sexual pleasure primarily in terms of meeting their husband's sexual needs, which they considered a necessity for married life and also a way of preventing him from visiting prostitutes.

In the focus group discussion, the blue collar wives said that they had never asked their husbands whether they used go to prostitutes or not. They believed that their husbands never frequented any prostitutes after their marriage. Also, they had never talked to each other about their sexual activity. All of the participants in female blue collar group agreed that sex issues were "dirty" and thus an inappropriate subject to discuss with their husbands.

In contrast, the female white collar workers (from both focus group discussion and in-depth interview) talked to their husbands about sexual issues since they thought it was an important issue for communication within the couple. Some used to ask their husbands about their experiences of visiting prostitutes while others had never asked. Most of them seemed to believe what their husbands told them, trusting their husbands. The female white collar worker who was interviewed believed that if she checked whether her husband told her the truth, her husband would think that she did not trust in him and would never tell her what he had done on future occasions. However, it was interesting to find that most of the wives did not mind if their husbands visited prostitutes but they asked them to use condom. Only two or three participants did not believe that condom use was able to

prevent HIV infection. Some said that to make sure it might be necessary to use two condoms for each coital act.

When the blue collar husbands were asked in the group the same question, most of them replied that they visited prostitutes but they had never told their wives. The reason was that their wives would be very angry if they knew. One husband mentioned that his wife used to search for him at the brothel he visited. This led to a quarrel after which he decided not to tell his wife anything about such matters.

For the male white collar workers, they themselves (from 2 in-depth interviews) told their wives about their visits to prostitutes and saw no visible reaction from the wives. One of them said that he did not generally tell her the day he went but may tell her two or three days later. He believed that this technique made her say nothing since the activity was too far past. Another white collar respondent said that he informed his wife that he used to visit prostitutes before they got married and she said nothing. Their wives had never asked them about their past sexual behaviour.

Condom use among the couple

The blue collar workers, in both male and female group discussions and in-depth interviews, said that they had never used condom within their couple. While some of the white collar females (from focus group discussion) and a white collar male (from in-depth interview) said that they used condom for family planning until they had decided to practise a permanent method of birth control. When asked the reason for not using condom, they replied that the they did not like it due to its irritation to both male and female.

For the question, if the couple had never used condom but one day the husband requested to use, what the wives would feel? All the wives said "I will suspect him". If the wife made the same request, some husbands replied that they would think that their wives would suspect them of being infected with STD or

HIV and did not want to tell them. The wives in the group discussion said that if they requested their husband to use a condom their husbands would think that they were being unfaithful.

None of the respondents believed that they were at risk of HIV infection since they believed that they or their husband would be careful due to their knowledge of the spread of AIDS. They defined risk groups as prostitutes and males who frequented prostitutes without using condom.

Conclusion

It is obviously important to stress again that the foregoing findings are highly preliminary and tentative. However they do seem to relate to some general features of Thai sexual culture to which some brief allusion may be made here. It was evident that although the topics under discussion were somewhat sensitive, they were nevertheless things about which the respondents were well aware and concerned. As noted above views expressed in focus group discussion are not accepted necessarily as reliable reports of behaviour but rather as expressions and presentations within a group setting. Such expressions are particularly important in that they pertain to the wider socio-sexual debate taking place in Thailand, partly in response to the threat of HIV/AIDS, and partly in relation to other more general social and gender role changes.

Husbands' frequenting of prostitutes is clearly contexted with the powerful 'double standard' pertaining to male and female sexuality. Attempting to place the sexual patterns in broad historical perspective it may be apposite to conceive of a traditional pattern in which the reproductive and pleasure dimensions of sexuality were separated between wife and prostitute. The respectable woman was expected to be sexually innocent and disinterested, whilst the prostitute (or concubine for the wealthier classes) was the repository of the **ars erotica** (Giddens, 1992), sexual skill and pleasure giving. It was noted in these preliminary findings that whilst the female construction workers held this traditional attitude, the female white collar

workers seemed to be expressing a more modern (post-Demographic Transition) attitude which placed an emphasis upon sexual pleasure **within** marriage. It is tempting to speculate that those divergences of sexual attitudes of the two groups of women reflects their differential social status and thence relation to a whole range of influencing factors. It is possible that the white collar workers' higher levels of education, urban background and peer group social context provided a climate from which these non-traditional attitudes were appropriated. Thus it is possible to tentatively suggest that these differential sexual expressions of the possibilities of sexual pleasure **within** marriage and lessening and male extra-marital activities, relate to some broad threads of social change in Thailand.

The findings on communications between husband and wife about sexuality and prostitution are also intriguing and seem to point to some possible practical implications . If these findings concerning misunderstanding of husbands and wives' sexual expectations and desires are indeed given further support by systematic research then they may point towards the need for strategies to enhance socio-sexual communication between husband and wife . Indeed such an approach would be part of the Thai government's current campaign which is evolving under the slogan "the Thai family to combat AIDS " Much depends upon whether these very sketchy and preliminary findings are reinforced or rejected following the completion of the qualitative and quantitative data collection and analysis .

Acknowledgements

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Chapter 10

Course Curriculum Development on Social Epidemiology

Buppha Sirirassamee

Objective

The objective of this course is to introduce the student to conceptual frameworks and the systematic study of social epidemiology. The course aims at enabling students to understand the nature of different types of disease (infectious and non-infectious) and their relationship with certain groups of population and socio-environmental situations. Through this course, students will be introduced to the relationship between the empirical evidence and the theoretical by using key examples from existing studies, theories and controversies.

Teaching Method

Lectures and discussions will be used with accompanying problem solving exercises. Slides and videos will also be shown for certain/appropriate topics. A term-paper will be assigned to a student individually or to the group of students. A field trip will be organized. There are 18 sessions in a semester (including 2 sessions of assessment).

Assessment

The evaluation of student achievement will be conducted twice during the semester : mid-term and end of term. The term-paper assigned to the student will also be evaluated. The mid-term and final evaluations carry 70% of the total marks (35% for each) and the term-paper evaluation carries 30% of the total marks.

Session	Topic/Headline
1	An Introduction to Social Epidemiology - Background information - Definition and Scope - Selected concepts and theories in epidemiology - Significance of epidemiology
2	Epidemiology : Planning for implementation - Urgent case - Short term planning - Long term planning
3	Epidemiology and Public Health Problems - Genesis of disease - Pathogenic agents - Community health problems - Community health organization
4	Health Indicators - Meaning and calculation of various types of morbidity rate - Meaning and calculation of various types of mortality rate - Sources of data in epidemiology
5	Infectious and Non-infectious Diseases - Nature and classification - Differences and relationships - Person, place, time and disease

Session	Topic/Headline
6	Etiology and Distribution of Disease - Case studies of infectious disease (e.g. AIDS, Malaria and Tuberculosis) - Case studies of non-infectious disease (e.g. D.M., Cancer and Heart disease)
7	Cross Section Study of Disease : Prevalence Survey/Study - Significance of prevalence survey - Examples of preavlence survey - Strength and weakness of prevalence survey - Analysis of disease prevalence
8	Retrospective Study of Disease : Case Control Study - Significance of case control study - Examples of case control study - Strength and weakness of case control study - Analysis of case control study
9	Prospective Study of Disease : Longitudinal Study - Significance of longitudinal study of disease - Example of longitudinal study of disease - Strength and weakness of longitudinal study - Analysis of longitudinal study of disease
10	Mid-term Examination

Session	Topic/Headline
11	Social and Behavioural Factors Related to Epidemiology - Lifestyle (e.g. eating habits, recreation/exercise, alcohol/ cigarette consumption - Social isolation/stress - Social mobility (e.g. industrial employment, tourism) - Social response to illness/health literacy - Social aspects of medical care
12	Cultural Factors Related to Epidemiology - Beliefs - Attitudes - Cultural response to illness - Cultural aspects of medical care
13	Environmental Health and Epidemiology - Physical environment - Ecological balance - Psychosocial environment
14	Surveillance and Prevention of Disease - Surveillance of certain diseases - Prevention of infectious disease - Prevention of non-infectious disease - Health promotion programmes
15	Use of Epidemiology in Health Care Planning and Health Promotion - Urgent case - Short term planning - Long term planning

Session	Topic/Headline
16	Field Trip
17	Term paper Presentation
18	Final Examination

Course Curriculum Development on Medical and Health Demography

Buppha Sirirassamee

Objective

The objective of this course is to provide knowledge (both theoretical and descriptive) about the context of fertility, morbidity and mortality in relation to changes in population structure and social problems. Knowledge about health services and public health policies is also included. It is expected that having completed the course students will be able to conduct research and work in the field of population and health efficiently and effectively.

Teaching Methold

Lectures and discussions will be used during the teaching process. Slides and videos will be shown in certain sessions when it is considered to be appropriate. A term-paper will be assigned, to a student individually, or to a group of students.

Assessment

Written examinations will be conducted twice during the semester; mid-term and end of term. The termpaper will also be evluated. Each examination carries 35% of the total marks (70% is all) and the termpaper carries 30%.

Session	Topic/Headline
1	An Introduction to medical and health demography - Definition - Variable for population change - Fertility and physiology - Relationship between population and medical & public health services
2	**Population and Fertility** Anatomy and physiology of reproductive system - male reproductive system - female reproductive system - fertilization and growth & development of foetus
3	Abortion - Spontaneous/ induced abortion - abortion and medical problems - abortion and social problems
4	Factors effecting pregnancy - Complications of pregnancy - AIDS and pregnancy - Heart disease and pregnancy - D.M. and pregnancy - Malaria and pregnancy - Thyroid deficiency and pregnancy

Session	Topic/Headline
5	Factors effecting fertility during post-natal period - Hormonal change - Breast feeding - Physical and emotional health - Socio-cultural factors
6	**Population and morbidity & mortality** Factors related to the genesis of diseases/illness - Infectious diseases - Non-infectious diseases - Health risk factors
7	Health indicators - Morbidity rate & cause of illness - Mortality rate & cause of death - Vital statistics as indicators prevalence of illness crude death rate specific death rate age-specific death rate
8	Demographic transition and epidemiological change - Demographic transition - Epidemiological transition Theory and its variants (Omran's)
9	Mid-term examination

Session	Topic/Headline
10	Morbidity and mortality of mother and children - Maternal morbidity and mortality - Child morbidity and mortality - Factors related - Health services provided
11	Morbidity and mortality of the aging population - Causes of morbidity and mortality - Factors related - Social welfare and health services provided
12,13	Morbidity and mortaltiy due to social problems - Alchoholism - Drug addiciton - AIDS - Suicide
14	**Health Services and public health policies** Medical and health services - Traditional health services - Modern health services - Primary health care - Health service utilization
15	Demographic transition and public health policies
16,17	Seminars on medical and health demography (Presentation and discussion of termpaper assigned)
18	Final Examination

Chapter 11
Curriculum on Data Analysis

Orapin Pituckmahaket

The overview of the curriculum on data analysis is structured as follows :

1) Rules of Statistics Selection in Social Sciences Research
2) Objectives of the curriculum on data analysis
3) Teaching Method of the curriculum on data analysis
4) Assessment of the curriculum on data analysis
5) Contents of the curriculum on data analysis
6) Readings List

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1) Rules of Statistics Selection in Social Sciences Research

In doing social sciences research when it is quantitative and the data are plentiful, a researcher must use statistics to help draw conclusions. A researcher knowing only the subject he want to do research is not enough. He must have statistical knowledge to analyze the data as well. The needed statistical knowledge will be applied statistics. He must know which statistics are suitable with certain data and when to use certain statistics according to the purpose of the research. The knowledge of applied statistics is quite easy to understand, but there are certain rules to apply statistics with certain data. We can see that the same statistics such as CORRELATION ANALYSIS are used differently by people from different subjects. They consider the statistic value (r value) resulting from the use of correlation analysis differently. Therefore, a researcher must understand how to apply statistics. Nowadays it is not necessary to calculate statistic values manually, we can use a ready made statistical package program with a personal computer which will help reduce much time spent in calculating values. So that, we can choose to use advance statistics in any research, but on the condition that

a researcher must have knowledge of the assumptions of each statistics which is suitable to each set of data. We must choose statistics which are suitable to the research objective as well.

Anyway, we can apply any advance statistics, but the best statistics is the one which is clearly answer to the research objective(s). For example, if we can use percentages to answer the certain research objective(s) that percentages will certainly be the best statistics for that research.

In principle, we actually choose to use statistics according to the research objective(s), the research hypothesis (hypotheses) (if there is any), the level of data measurement, the sampling technique, the data collecting, the number of data, and the number of variable(s). The best statistics is the one that answer to the research objective(s), the research hypothesis, and at the same time suitably corresponds with the character of the data used in the research as well.

To develop a curriculum on data analysis for the social sciences master degree level is to add applied statistics to the curriculum. So that, the student will understand and know how to use different statistics in analysing the social sciences data by using a statistics package program, for example, SPSS/PC+ (The Statistical Package for the Social Sciences / Personal Computer Plus).

2) Objectives of the Curriculum on Data Analysis

The aim of the curriculum is to review some statistics which allow a researcher to describe and infer relationship between variables being studied. The level of analysis was mainly restricted to bivariate statistics with an emphasis on how to manage, present and interpret social sciences data. Multivariate statistics were also briefly introduced.

3) Teaching Method of the curriculum on data analysis

Lectures and discussions are used to analyse social sciences data. Some secondary data are provided to the students for analysis with SPSS/PC+ and used for examination as a term-paper. Four term-papers using t-test, one-way Analysis of Variance, Chi-Square test, and Simple correlation and regression, are required from each student during the semester.

4) Assessment of the curriculum on data analysis

Beside the term-papers, a final examination is also be given to evaluate the student achievement. The final examination carries 20% of the total marks and the term-papers carries 80% of the tatal marks 20% for each).

5) Contents of the Curriculum on Data Analysis

There are 20 sessions in a semester (including one session of assessment) as follows:

Session	Topic/Headline
1	An Introduction to Statistics - Nature of Statistics - Basic Concepts of Statistics - Basic Types of Statistics - Levels of Measurement
2	Basic Statistics - Statistical Variables - Frequency Distributions

Session	Topic/Headline
3	Data Presentation - Types of Data - Data Presentation - Text Presentation - Tabular Presentation - Semi-tabular Presentation - Graphic or Chart Presentation
4	Basic Concept on Microcomputer - Introduction to Microcomputer - DOS (Disk Operating System)
5-6	Statistical Package for Social Sciences - SPSS/PC+ (The Statistical Package for the Social Sciences/Personal Computer Plus)
7	Descriptive Statistics - Central Tendency - Mean - Median - Mode
8	Descriptive Statistics - Measures of Dispersion - Range - Standard Deviation - Variance - Normal Distribution

Session	Topic/Headline
9	Samlping Technique - Sampling Technique - Probability Sampling - Non-probability Sampling - Sample Size
10-11	Inferential Statistics - Hypothesis Testing - Types of Hypothesis - Levels of Significance - One and Two Tailed Statistical Test - Type I and Type II Errors
12-13	Inferential Statistics - t Distribution - Degrees of Freedom. - t-test
14-15	Inferential Statistics - F Distribution - Analysis of Variance - One-way Analysis of Variance
16-17	Inferential Statistics - Chi-square Distribution - Chi-square Test
18-19	Inferential Statistics - Simple Correlation - Simple Regression
20	Final Examination

6) Readings List

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Conclusion

Nicholas Ford
and Aphichat Chamratrithirong

In conclusion we would like to express our grateful thanks to the British Council for supporting the Link between IPSR, Mahidol and IPS Exeter. This link has been of mutual benefit to both Institutes and has been a significant component underlying their expansion and development over the past several years. An ongoing exchange of concepts, skills, methodologies and research concerns has taken place which has helped both to broaden and refine the work of both Institutes.

In the introduction it was noted that one of the major objectives of IPSR, Mahidol and IPS, Exeter is to develop a transdisciplinary approach to the study of population and reproductive and sexual health which is both well grounde conceptually and theoretically, and of practical application. Our work may not yet have fully achieved this goal, but it provides a basic integrating direction for our programmatic research development. The practical or applied dimension of this work is not only in the form of policy and programme formulation but also involves a contribution to the wider social debates taking place within the media and society. As is particularly evident from the contributions on sexual culture in this volume the research has gone beyond the standard epidemiological and demographic measures of behavior to focus upon the nature of the relationships within which reproductive and sexual behaviours take place. In this work there is a reflexive relationship between research and society. The very themes under investigation such as gender roles and sexual practices are going through changes, the outcomes of which are impossible to predict. Thus the researchers increasingly need to understand and grasp these dynamic psycho-social changes and employ their systematic findings and analyses to contribute towards the general social debates taking place. In this reflexive process much will depend upon the continuing close relationships between the researchers and (government and NGO) policy-makers, programme managers and personnel, community leaders, journalists and other social commentators.

Appendix One

List of all IPSR/IPS Link Visitors

IPSR

1989/1990

Assist. Prof. Orapin Pituckmahaket
Assoc. Prof. Dr. Boonlert Leoprapai
Assist. Prof. Professor Dr. Buppha Sirirassamee

1990/1991

Ms. Panee Vong-Ek
Ms. Sirinan Saiprasert
Ms. Kanchana Tangchonlatip

1991/1992

Ms. Umaporn Pattaravanich
Ms. Nittaya Piriyathamwong

1992/1993

1993/1994

Dr. Varachai Thongthai
Dr. Uraiwan Kanungsukasem
Dr. Bencha Yoddumnern-Attig
Ms.Supanee Vejpongsa
Dr. Sairudee Vorakitphokatorn

IPS

1989/1990

Dr. Ian Askew
Dr. Nicholas Ford

1990/1991

Dr. Nicholas Ford
Mrs. Ruth Preist

1991/1992

Dr. Nicholas Ford
Mrs. Elaine Davies

1992/1993

Dr. Nicholas Ford
Ms. Elspeth Mathie

1993/1994

Ms. Sarah Blacksell
Mr. Lester Coleman

Appendix Two

List of Thai Students who have studied at the Institute of Population Studies

1974/75

Ms. Soontaree Suvipakit	Institute for Population and Social Research, Mahidol University Salaya Campus, Nakornchaisri, Nakornpathom 73170, Bangkok.

1975/76

Ms. Somboon Salyachivin	Faculty of Education, Khon Kaen University, Khonkaen.

1982/83

Ms. Yupa Thararoop	Research and Evaluation Unit, Family Health Division, Department of Health, Ministry of Public Health, Samsen Road, Bangkok.
Ms. Amara Soonthorndhada,	Institute for Population and Social Research, Mahidol University, Salaya Campus, Nakornchaisri, Nakornpathom 73170, Bangkok.
Ms. Pakavadi Sirirangsi	144/101 Soi Riansiri, Suanphak Street, Bangkhunnon, Talingchan, Bangkok 17.

1983/84

Dr. Chutima Sirikulchayanonta	252-4 Lan Luang Road, Pomprab District, Bangkok 10100.

1984/85

Ms. Panee Vong-Ek	Institute for Population and Social Research, Mahidol University, Salaya Campus, Nakornchaisri, Nakornpathom 73170.
Ms. Sumalee Pernpaengpun	Research and Evaluation Unit, Family Health Division, Department of Health, Ministry of Public Health, Samsen Road, Bangkok 10200.
Ms. Usaneya Perngparn	Institute of Health Research, Chulalongkorn University, Institute Building 2, Soi Chulalongkorn 62, Phyathai Road, Bangkok 10500.

1985/86

Ms. Supanee Jivasak-Apimas	Family Planning Research Unit, Department of Obstetrics and Gynaecology, Faculty of Medicine, Mahidol University, Siriraj Hospital, Bangkok 10700.
Ms. Worasarp Chitprasert	Family Health Division, Department of Health, Ministry of Public Health, Devavesm Palace, Bangkok 10200.

1987/88

Mr. Wilas Techo	The Population and Community Development Association (PDA), 8 Sukhumvit Soi 12, Bangkok 10110.

1989

Mr. Sophon Siriwong	The Population and Community Development Association (PDA), 8 Sukhumvit Soi 12, Bangkok 10110.

1992/93

Ms. Benjamat Terramatvanit	The Population and Community Development Sukhumvit Soi 12, Bangkok 10110.

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