Thai Health 2009

Stop Violence for Well-being of Mankind

10 Health Indicators 10 Health Issues

Institute for Population and Social Research, Mahidol University
Thai Health Promotion Foundation
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Thai Health 2009

Preface

The Thai Health Working Group is proud to release the sixth issue of Thai Health. The working group has received positive feedback from many organizations, many occupations, and all age groups. The material has been presented at various forums, and has been used for organizing activities in villages and communities. The feedback we have received encourages us to continue.

First-time readers of Thai Health Report should note that the report brings together information on the annual health situation, the physical, mental, social, and spiritual dimensions of health. For the 2009 report, the working group agreed that the issue of violence has been becoming increasingly prominent in Thai society for many years, and is having increasingly serious effects on the health of Thai people. The violence in the southernmost provinces, political conflict, violent crime, violence against children and women, and violence on television all contribute. The special issue for this year's report is **"Stop Violence for Well-being of Mankind".** The hope is to contribute to increased social harmony, so that we turn all our hands from fighting one another to building a healthy society. As with previous issues, the report is divided into 3 parts. Part one Health Indicators examines several dimensions of the health care system: 1. Health service delivery 2. Human resources for health 3. Health information systems 4. Medical equipments and technologies 5. Health financing 6. Access and coverage 7. Quality and safety 8. Health equity 9. Social and financial risk protection 10. Efficiency

Part two considers Ten Health Issues. The first issue is the political conflicts that have adversely impacted on the health of the people in recent years. The second is the reemergence of narcotic drugs; the third is the fuel price crisis and its impacts on the poor; the fourth is Thais at risk of depression and suicide; the fifth is the government's introduction of compulsory licensing, resulting in improved access to drugs among Thai people; the sixth is sexual harassment in educational institutions; the seventh is melamine in milk; the eighth is the fate of migrant workers from neighbouring countries in Thailand; the ninth is AIDS and Thai youth; and the tenth issue is the National Health Assembly, which will become an important means for advancing social health.

Part three of the report is a special article discussing the many hidden dimensions of violence in Thai social and cultural structures. It looks at the conflict in the southernmost provinces, at the struggle between state and community over resource management, and at physical, verbal, and psychological violence against individuals, family members, and gender, the main victims of which are children, women, and old people. The article suggests ways out of the violence.

The working group hopes that the Thai Health Report has faithfully documented events during the year, and that it will be a valuable source of information. We will be very happy if the report is used as a reference work and as a resource for social change.

The Working Group for Thai Health Report

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Special Issue for the Year

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- Health Financing
- Access and Coverage
- Quality and Safety
- Health Equity
- Social and Financial Risk Protection
- Efficiency

10 Health Indicators

10 Health Indicators:
How Well Do Our Health Care Systems Perform?

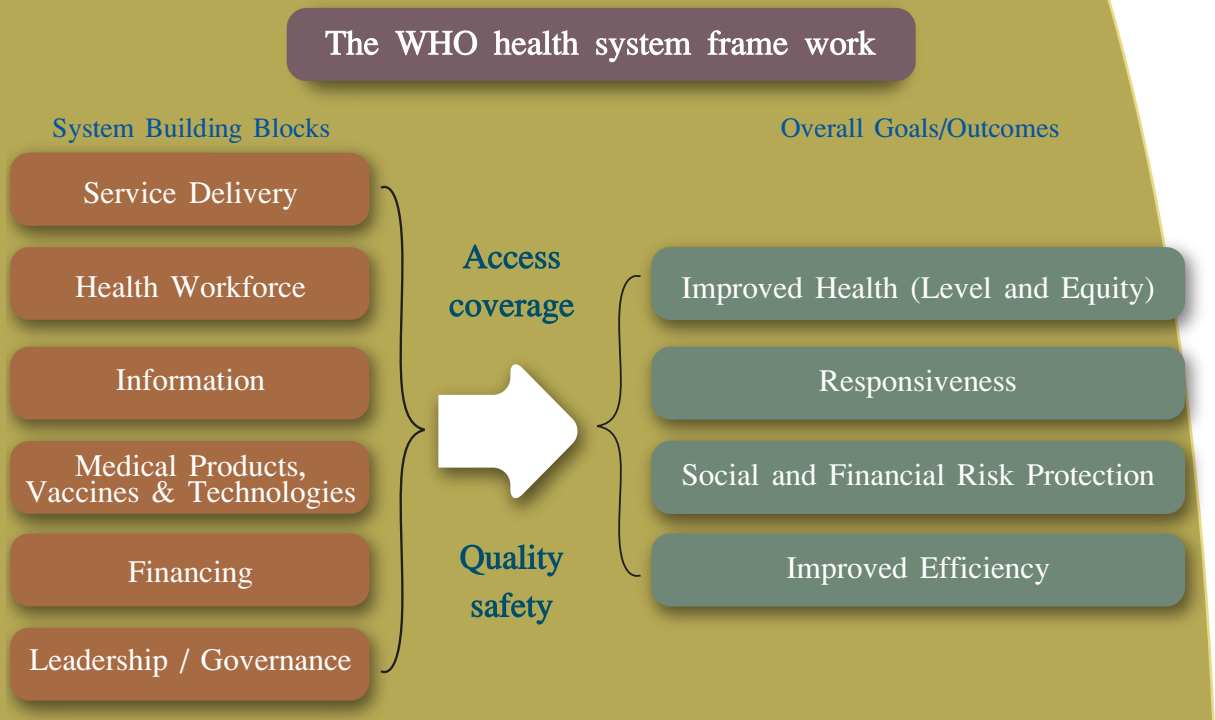
The health care system consists of six sub-systems: (1) The delivery system, including primary care, secondary care, and tertiary care; (2) the health workforce; (3) the information system; (4) medical technology such as medicine, medical equipment, diagnostic devices, and treatment devices; (5) health financing; and (6) leadership and governance.

These six sub-systems have four main objectives: (1) to promote health and health care equity among diverse population groups; (2) to ensure that health services respond to the health care needs of the population; (3) to ensure social and financial security; (4) to improve the efficiency of the health workforce and technology.

In achieving these four goals, it is important emphasize the accessibility and coverage of health care, as well as quality and safety.

The Thai health care system has been developing in all the dimensions listed above. The provision of health services in particular covers all levels and localities. There is a good referral system that links the different parts of the health care together to increase access to health services. In addition, Thailand has had universal health care coverage since 2001, which has resulted in excellent access to health care including access to preventative and basic medical care. The system has also provided social and financial risk protection for households. Nevertheless, coverage by some parts of the health system has remained low, including screening services such as cervical screening, high blood pressure screening, diabetics, and hyperlipidemia. This has reduced early detection and prompt treatment.

Issues requiring continual development include the equal distribution of the health workforce to prevent disparities between rural and urban



Source : WHO. Everybody Business: Strengthening Health System to Improve Health Outcomes: WHO's Framework for Action. 2007. Geneva, World Health Organization.

areas and between cities where social, economic and political differences exist. Health providers and medical technologies are highly concentrated in big cities rather than small towns and rural communities. The government should take measures to strengthen the motivation and status of health providers working in disadvantaged rural communities. At the same time, the government should conduct cost-benefit analyses of medical technologies, particularly diagnostic and therapeutic, including cost and distribution.

The quality and safety of health care, including incidences of medical errors, is an important factor in the survival of patients. Statistics from hospital records reveal that 35 percent of deaths in the hospitals result from medical errors. About half of the errors can be prevented. The most common cause of death in the hospital is hospital-acquired infections or nosocomial infections. Emphasis should be placed on improving adherence to hospital-acquired infections standard.

National health expenditures have increased significantly, from 147,837 million baht in 1995 to 248,079 million baht in 2005. Curative care accounts for about three quarters of total health expenditures, compared to only 5 percent for prevention and health promotion. The proportion invested in health promotion and disease prevention programs should be increased.

Thailand has a relatively good health information system, which leads, to some extent, to evidence-based policy formulation. However, improvement in the information system is needed, particularly in relation to the coverage and timeliness of data.

Health Service Delivery

Thailand has invested to improve all aspects of the health system. This has ensured 4 out of 5 out-patients to use the community health system. However, there are still differences in the quality of the health system, particularly between Bangkok and other parts of the country.

1

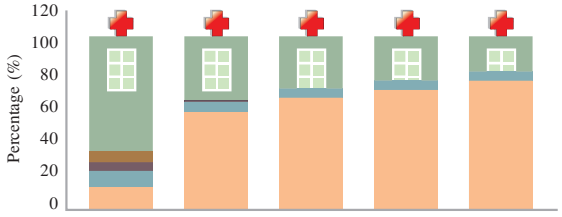
The Thai health system has been expanded to provide health care services at all levels from primary to tertiary. At the primary-care level, there are community health facilities which are easily accessed by the community, providing basic medical care, health promotion and prevention of diseases. The coverage of the primary-health care system in Thailand is widely regarded to be excellent. At present, there are over 9,000 community health centres nationwide. Every district has a community hospital, so there are over 700 community hospitals. Tertiary care consists of health facilities which are fully equipped with expensive medical instruments, resources and specialized staff to provide sophisticated medical services and treatment. Recent statistics indicate that community health centres and community hospitals are the most popular source of health care and about four in five patients used the out-patient health services at the government health facilities.

Ideally, a heath care system should be focused on health facilities at the primary level because the provision of health services at this level is cost effective and appropriate for the majority of the population who are facing minor illnesses. Due to their proximity to the community, primary health providers understand the socio-cultural backgrounds of the families and communities in which health services are provided.

Government hospitals under the administration of the Ministry of Public Health (MOPH) also play a crucial role in providing health services at the provincial and regional levels. The significance of these government hospitals is evident in the Central and Northeastern Regions of the country. Government hospitals account for 62 percent of all hospitals in the Central Region and 85 percent in the Northeast. In contrast, the share of the private hospitals is as high as 67 percent, or around two thirds, of total health facilities in Bangkok. The second largest share of private health facilities is in Central Region, at 30 percent. The regional disparity in health facilities reflects the extent of differences in social and economic conditions in the regions. For example, the ratio of hospital beds to population is 1 to 740 in the Northeast compared to 1 to 223 in Bangkok, a factor of over three between the two regions. One possible explanation of this disparity is that there is a higher concentration of private hospitals in Bangkok than in other regions. About one in four private hospitals are located in Bangkok. Most of the Bangkok hospitals are relatively large hospitals, with over 200 beds.

The disparity in health care facilities, and the importance of economic status, is also evident when comparison is made between provinces in the same region. Wealthy provinces are better off in terms of the number of hospitals and the ratio of population to hospital beds than poor provinces. Moreover, teaching hospitals and medical schools are located in a few politically and economically important provinces in each region, which contributes to the unequal distribution of health care services between provinces. Differences in health care facilities also affect the use of health services. For instance, the number of in-patients is much higher in the provinces with a higher number of hospital-beds than lower hospital-bed provinces. In other word, access to health services is better in the former provinces than the latter, indicating to some extent the existence of inequities in access to health care.

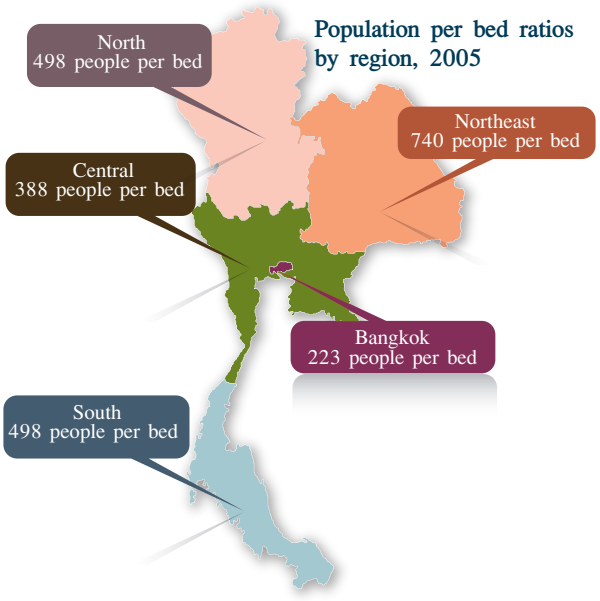
Proportions of hospitals by agency and region, 2005



	Bangkok	Central	North	South	Northeast
Private Sector	66.9	30.1	20.2	15.4	11.4
Local administration	7.3	0.0	0.4	0.0	0.0
State enterprises	4.0	1.7	0.0	0.5	0.0
Other ministries	12.1	6.2	6.0	6.1	4.1
MoPH	9.7	62.0	73.4	78.0	84.5

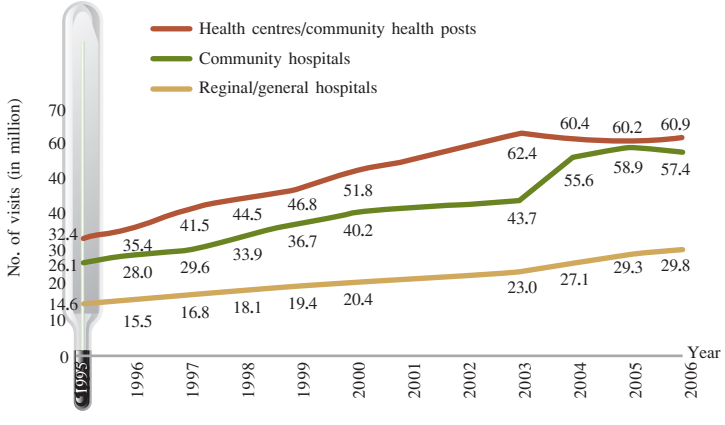
Source: Thailand Health Profile 2005-2007

Population per bed ratios by region, 2005



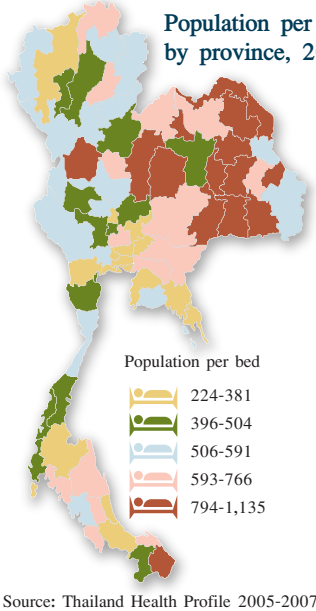
Source: Thailand Health Profile 2005-2007

Trends of out patients (OPD visits) by level of MOPH health facilities, 1995-2006



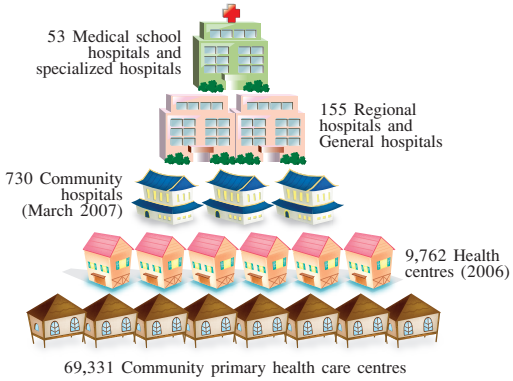
Source: Thailand Health Profile 2005-2007

Population per bed ratios by province, 2004



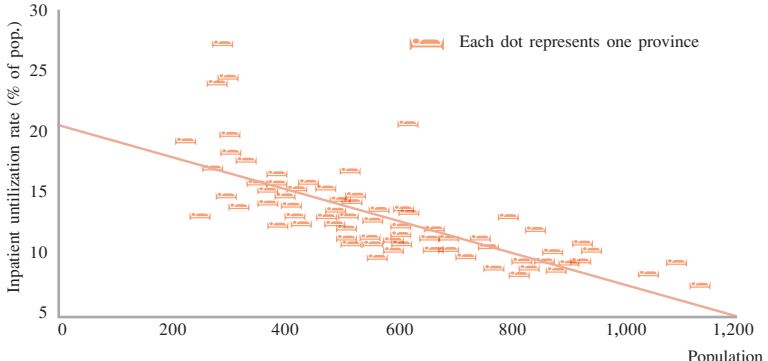
Source: Thailand Health Profile 2005-2007

Type of health facility in the public sector, 2007 (Excluding Bangkok)



Source: Thailand Health Profile 2005-2007

Relationship between the rate of inpatient service utilization and population/bed ratios at provincial level, 2004



Note: The provinces with more beds per the population will have more inpatients, while those provinces with fewer beds will also have fewer inpatients.
Source: Thailand Health Profile 2005-2007

Human Resources for Health

2

The shortage of Human Resources for Health (HRH) is currently the major problem threatening the Thai Health system. Overall, the proportion of doctors for 2,500 people is 1. Comparing to other countries with a similar level of economic development (in relation to Gross Domestic Product), the doctor shortage in Thailand is significant.

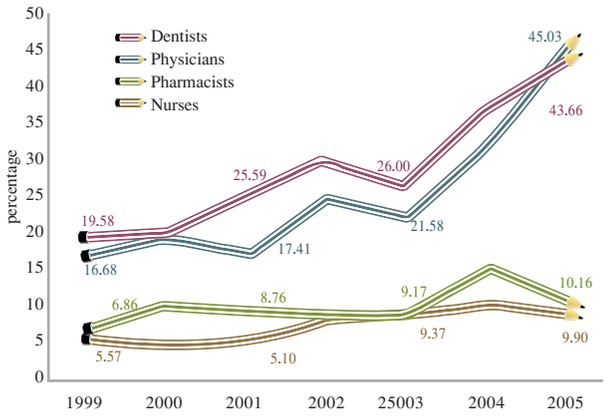
Nevertheless, the Thai government has been increasing the number of future doctors to solve the HRH shortage problem. In 2006, more medical, dental and nursing students were recruited into the education system. There was an increase in the number of medical students by about 50 percent from 2002.

Despite the future increase in the number of medical staff, the distribution of HRH has been found inequitable, particularly the inequitable distribution between rural and urban areas. The poor and remote area in the Northeast of Thailand where the majority of the country resides has the highest ratio of population per one health personnel. In 2004, the ratios of population per doctor, per dentist, per pharmacist and per nurse of the Northeast region were 8.5, 4.4, 2.8 and 3.6 times higher than those of Bangkok, respectively.

In relation to work settings, the majority of HRH work under the Ministry of Public Health, except pharmacists. The proportion of pharmacists working in private sector was slightly higher than that of the public sector (54 percent).

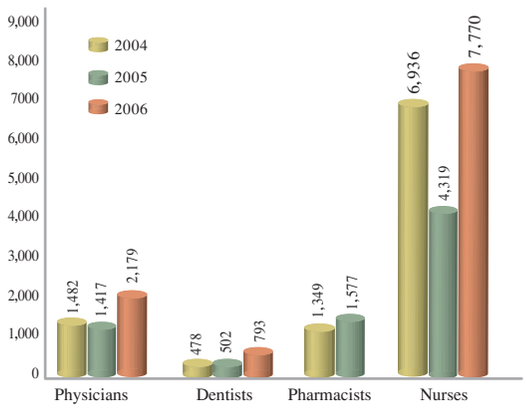
To attract and retain HRH working in rural and public facilities, the government has implemented ranges of measures. Increase the HRH production is among the measures used by the government. The implementation of local recruitment, local training and hometown placement approach has been initiated in which students recruited locally, train at local academic institutes and are posted near to their hometown after graduation. Compulsory public service has been seen as important measure to increase HRH in rural areas. In this approach, HRH were compelled to serve the public for 2-4 years after graduation. If they beach the contract, they are fined. This combined with various forms of incentives that have been implemented, such as, financial awards and career advancement schemes has resulted in an improvement of the HRH distribution, particularly in rural areas.

Annual resignation rate of health workforce as % of total new entry in 1999-2005



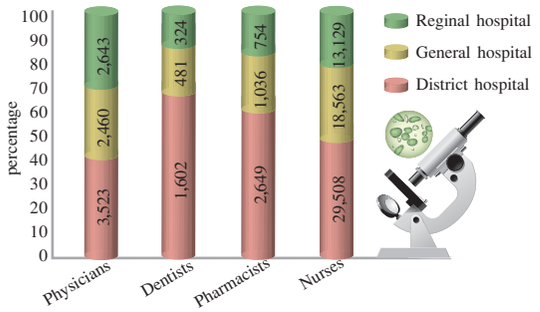
Source: Personnel Division, Office of Permanent Secretary for Public Health cited in Thailand Health Profile 2005-2007

Annual production capacity of Health workforce in 2004 2005 and 2006



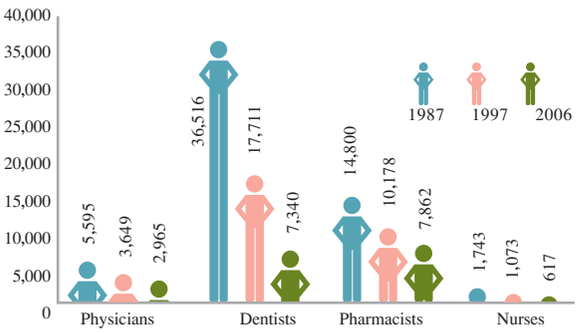
Source: Thailand Health Profile 2005-2007

Proportion of health workforce by size of hospital in 2006



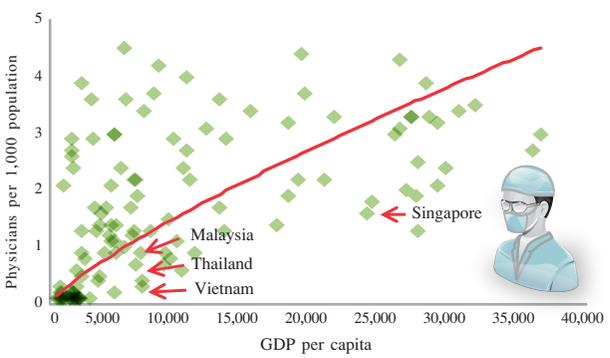
Source: Report on Health Resources 2006, Bureau of Health Policy and Plan cited in Thailand Health Profile 2005-2007

Population per health workforce in 1987, 1997 and 2006



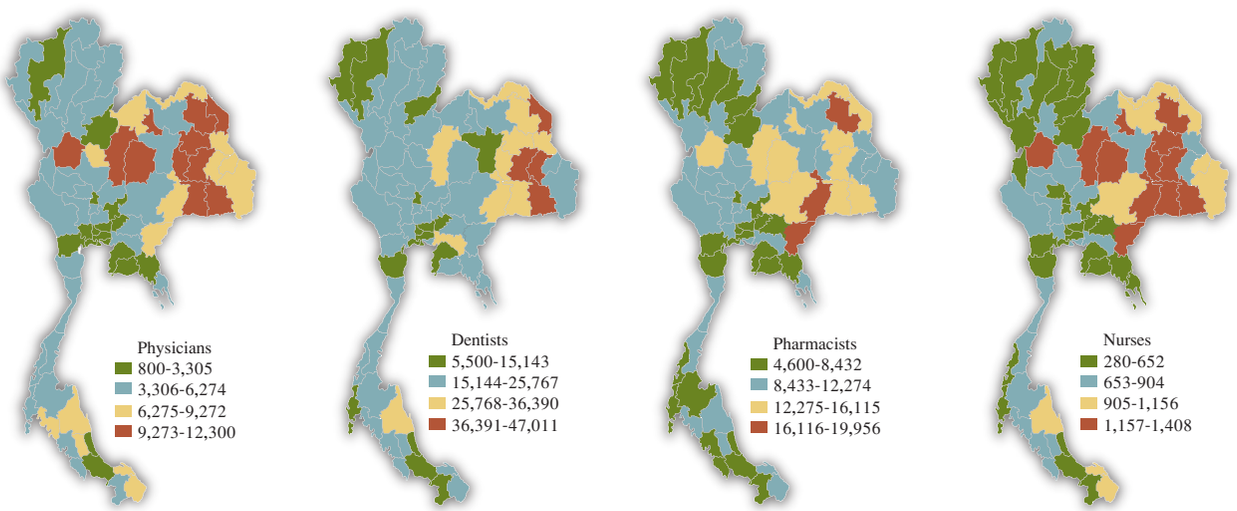
Source: Thailand Health Profile 2004-2004 and 2005-2007

Physicians per 1,000 population and GDP per capita



Source: World Development Indicator 2002 and World Health Report 2006

Geographical distribution of Health workforce in 2007



Source: Report on Health Resources 2004, Bureau of Health Policy and Plan, MOPH

Health Information Systems

3

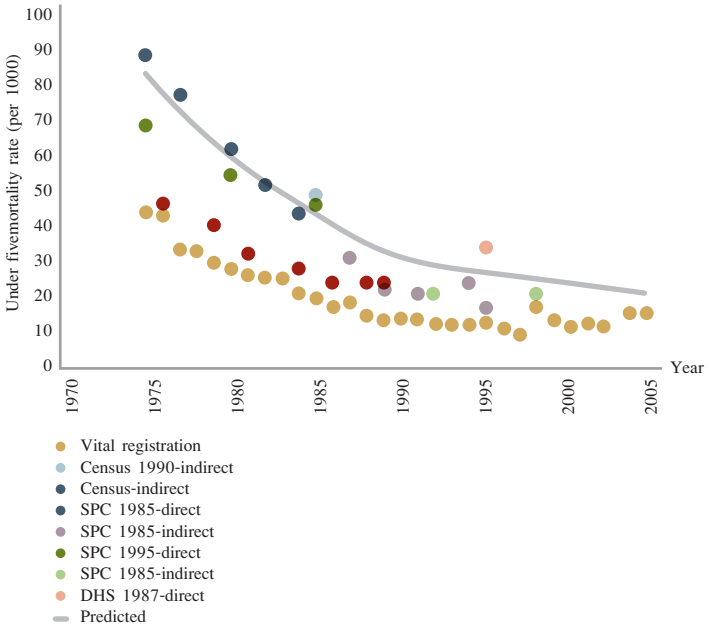
The health information system is an essential component of the country health system. It provides information about health status, health risk factors, and other factors affecting health and the health care system. All this information is important for policy formation and for raising public awareness about current health issues.

In Thailand, sources of health information include the death information system and the morbidity information system. Death information currently relies on the information drawn from the vital registration system. The coverage of death registration has gradually been improved. Based on the Survey of Population Change in 2005-2006, the estimated coverage rate of death registration is 95.2 percent. However, it is observed that the coverage rates vary by age of deceased. Infant deaths, the child-mortality rate (the rate of deaths for people under 5) and maternal deaths are much lower when calculated from deaths recorded from death certificates than when calculated from other sources. There are also problems with the quality of the cause of death data recorded in the death certificates. In Thailand most deaths (or 65 percent of total deaths) occur outside of hospitals. For these deaths, information on cause of death is supplied by lay persons, especially village heads and non-medical persons.

There are several existing sources of information on morbidity in Thailand. These include the National Notifiable Disease Surveillance, the Disease Registry, and the Hospital Record Database, such as cancer registry and database of patients. A major concern regarding these information sources is the lack of population coverage of the data. For example, not all private hospitals participate in the heath system and that only a fraction of the required information can be obtained. Data obtained from population-based health surveys is another important source of health information. So far there have been several health surveys conducted on a regular basis such as the Serosentinel Surveillance Survey and National Survey of Health and Health Examination. Moreover, a number of surveys on health behaviour are also carried out, such as the Survey of Sexual Health Behaviour and Survey of Cigarette Smoking and Alcohol Drinking.

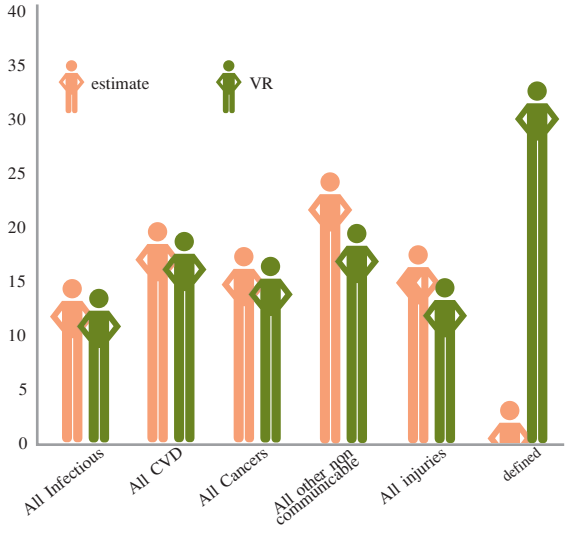
In summary, there are several health information systems operating in Thailand, providing valuable information on health situations and related health issues. Although this information is not perfect, with problems with coverage and quality, the information can be very useful as an evidence base for policy formation and law making. There have been several prominent success stories in the use of health evidence, such as the use of surveys and administrative statistics prior to the introduction of the health insurance policy, the tobacco control policy, and health inequity monitoring.

Under five death rates by source of data, 1970-2005



Source: Hill, K. et al. 2008

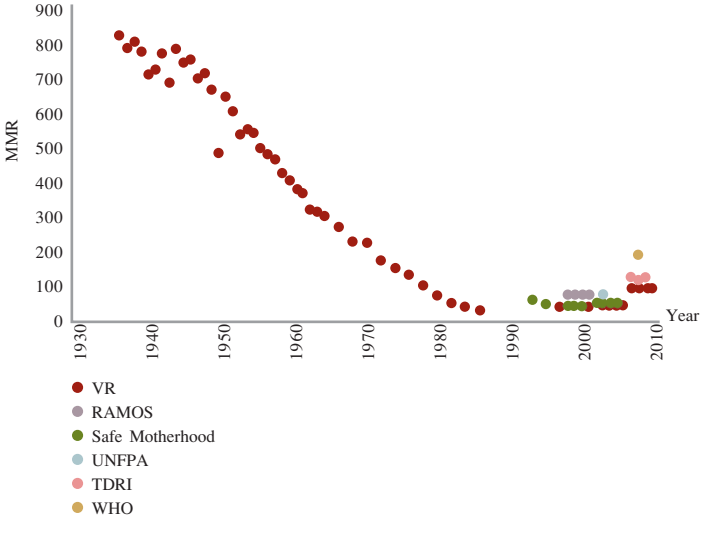
Broad causes of death from the vital registration system (VR) and verbal autopsy (VA) estimated: male, Thailand, 2005



Source: Porapakkham, Y. et al. 2008

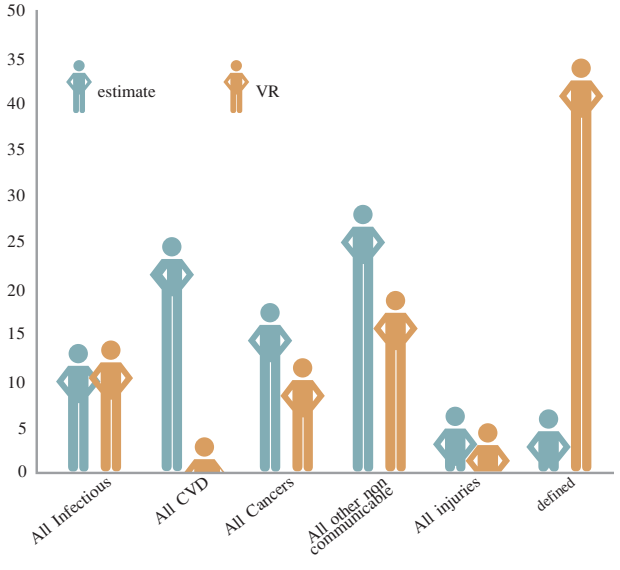
Note: A verbal autopsy is a method of finding out the cause of a death based on an interview with next of kin or other caregivers.

Maternal death by source of data, 1930-2010



Source: Vapattanapong, P. 2008

Broad causes of death from VR and VA estimated: female, Thailand,2005



Source: Porapakkham, Y. et al. 2008

Number of surveys from surveillance, health records and administrative records where information about health and indicators of health inequity are available

	Health financing	Coverage or availability	Health care utilization	Quality and responsiveness	Health status	Health risk
Geographic (Province, urban vs. rural)	3-0-2	4-1-3	11-8-3	2-0-0	11-10-3	10-6-1
Demographic (Sex, age group)	3-0-2	4-0-2	12-8-2	2-0-0	12-9-2	11-5-0
Social Eduation, occupation)	3-0-2	4-0-2	10-4-2	2-0-0	11-5-2	11-4-0
Economic (Wealth, income, consumption)	3-0-0	4-0-0	7-1-0	2-0-0	9-1-0	7-1-0

Source: Tangcharoensathien, V. et al. 2007

Notes: The first number in each cell represents the number of surveys from the surveillance system, the second number in the cell represents the number of surveys within health records and the final number represents the number of surveys from administration records.

Medical Equipments and Technologies

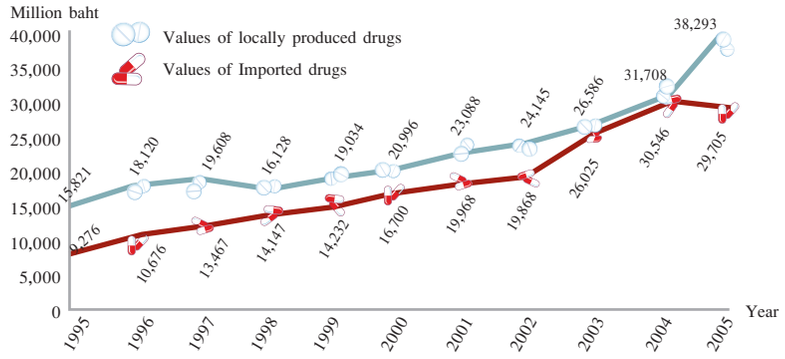
Thailand is increasingly using medical technology. In 2005 15,799 million baht was spent on technologies for prevention and diagnosing diseases. However, access to medical technologies is only available in the capital city and in developed areas.

4

Medical technology includes medicines, medical supplies and medical equipment. There have been dramatic improvements in medical technology over time. The forces for improvement come from both the supply and the demand side. The demand side, or consumers of new technology such as service providers and patients want high quality, effective and rapid services. Due to the huge demand for medical technology, there has been a rapid advancement in technology and increasing utilization of the technology for therapeutic care and medication. The rapid growth in technology can be seen in the continuous increase in the production of modern and innovative drugs and medical equipment. These new drugs and medical equipment have been imported into the country at a rapid pace. As a result there are record numbers of expensive medical equipment such as computed tomography scanners (CT-scanners), magnetic resonance imaging (MRI), extracorporeal shock wave lithotripsy (ESWL) and Mammography.

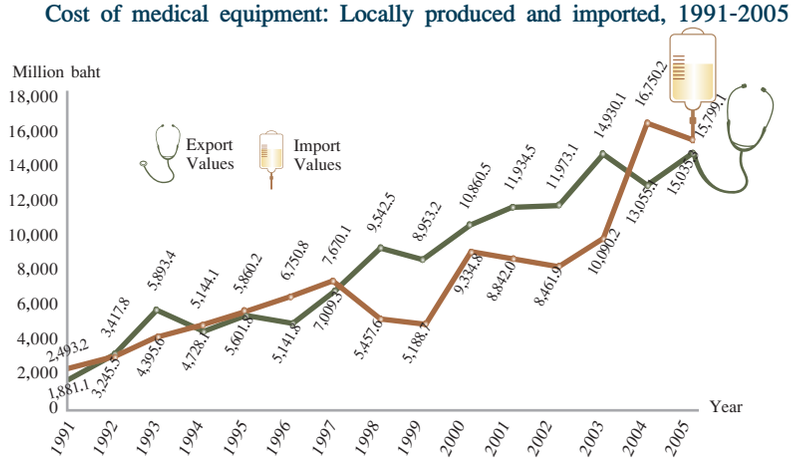
Access to medical technology is a major challenge because modern and expensive technologies are highly concentrated in Bangkok, mainly at large, privately-owned hospitals. For instance, two-thirds of all MRIs are in Bangkok and two-thirds are owned by private hospitals. The CT-scanner is a cheaper and less-advanced technology. Only one-third of CT-scanners are located inside Bangkok and about 80 percent are privately owned. Consumers generally pay out of their own pockets to use privately-owned technologies. There are 2.2 CT-scanners per 1 million people in the Northeast region, but nearly 10 times as many per one million people in Bangkok. More expensive medical equipment is even more concentrated in Bangkok and in privately-owned large hospitals. This disparity in medical technology leads to major inequities in health care. The widespread availability of this expensive medical technology inevitably raises question about whether it is worthwhile for individual patients or the health system and society. The cost of services is expected to rise dramatically due to the introduction of new and expensive technology, which adds more burdens to consumers, individually and collectively. Decisions on whether to use new medical technology such as new vaccines and modern medical equipment should be based on sound evaluation, and whether the technology can reduce mortality, strengthen the quality of life for individuals and benefit society as a whole.

Price of modern medicines: Locally produced and imported, 1995-2005



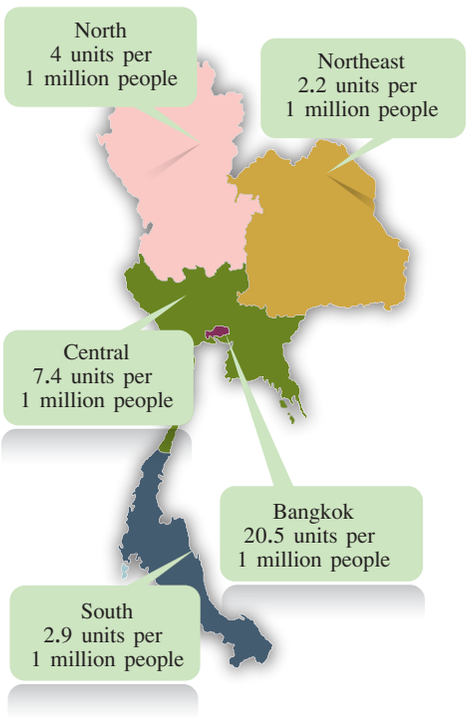
Source: Thailand Health Profile 2005-2007

Cost of medical equipment: Locally produced and imported, 1991-2005



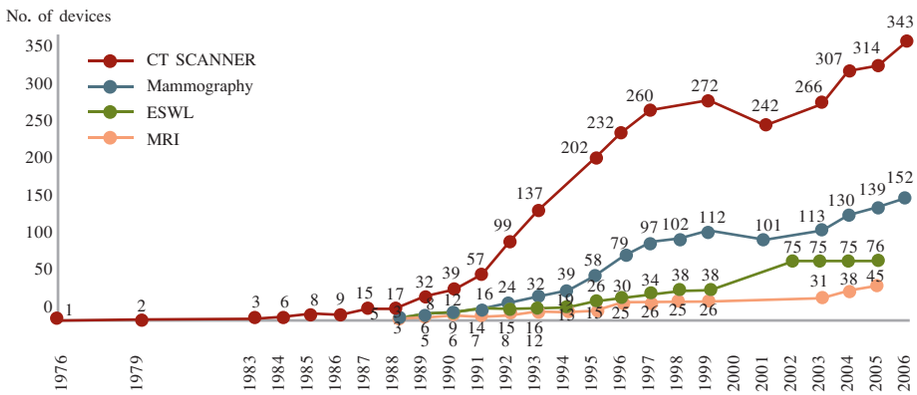
Source: Thailand Health Profile, 2005-2007

Number of CT scanner by region, 2006



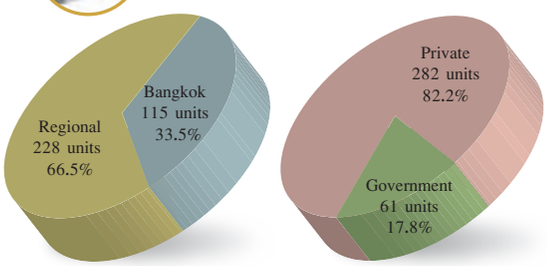
Source: Thailand Health Profile, 2005-2007

Number of selected medical equipment, 1976-2006

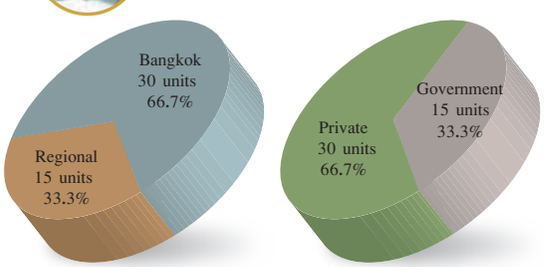


Source: Thailand Health Profile 2005-2007

Number of CT-scanner, 2006



Number of MRI, 2005



Health Financing

5

The amount of money spent on health, per capita increased by 1.6 times, increasing from 2,486 baht in 1995 to 3,974 baht in 2005. The majority of the increase has been for hospital care rather than for health promotion.

During the previous decade, health expenditure in Thailand increased dramatically, rising from 147,837 million baht in 1995 to 248,079 million baht in 2005, an average annual growth of 6.6 percent which was similar to the annual Gross Domestic Product growth rate of 6.4 percent. As a percentage of Gross Domestic Product, Total Health Expenditure (THE) was 3.5 percent in 1995, reaching 4 percent in 1997, the year Thailand faced an economic crisis. After the crisis the ratio decreased to be 3.3 percent in the year 2001. After the implementation of the Universal Coverage Scheme the ratio increased and reached 3.7 percent in 2002 before stabilizing at 3.5 percent GDP by 2005. Per-capita health expenditure rose from 2,486 baht in 1995 to 3,974 baht in 2005, a 1.6-fold increase during the decade.

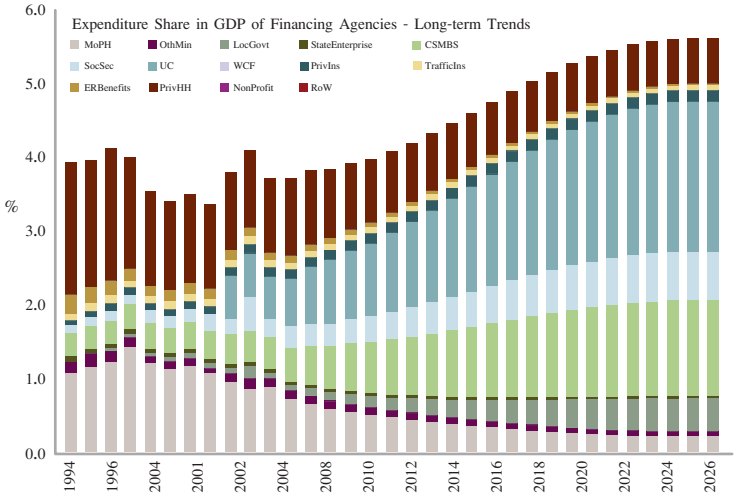
Thailand has expanded health welfare in order to reduce household spending such as the Free Medical Care Scheme for the Poor, the Low-Income Card, the voluntary Health Card Scheme and the Universal Health Care Coverage Scheme in 2001. After 2002 till 2005, public-financing agencies played the major role at 63-64 percent of THE. Of this, the household expenditure declined from 43 percent in 1995 to 27 percent in 2005 of THE.

Considering health functions, health expenditure dominantly spent for curative services at three quarters; resulted in only 5 percent of THE were for preventions and health promotion services in 2005. This implied that government spending on health would be affordable in the long run. One of policy message is that Thailand should invest more, especially significantly increase in investment on health promotion and disease prevention program which should be used for cost-effective interventions.

One main challenge of health care financing in Thailand, especially the UC scheme, is the affordability and sustainability of the government subsidy. Two recent policy interventions, namely universal coverage of Renal Replacement Therapy (RRT) for End-Stage Renal Disease (ESRD) and Antiretroviral Therapy (ART) for HIV/AIDS patients, will have an enormous impact on the government's health budget. Once the policy on universal access to RRT is implemented (by October 2008 for UC members and March 2009 for the Social Health Insurance (SHI) members); the government will spend more than 5,000 million baht in the first year of the policy implementation and this will increase to 74,355 million baht, accounting for 12.2 percent of THE.

Most of THE is spent for curative services, not health promotion and disease prevention. Should the profile of Thai health expenditure mainly focus on curative services rather than health promotion and disease prevention activities?

Long term forecast of Total Health Expenditure, as percent of Gross Domestic Product by sources of finance



Source: Scholz W et al, 2008

MOPH = Minister of Public Health
OthMin = Other Ministries
LocGovt = Local Government
StateEnterprise = State Enterprise
CSMBS = Civil Servant Medical Benefit Scheme

SocSec = Social Security Scheme
UC = Universal Health Care Coverage
MOPH = Minister of Public Health
OthMin = Other Ministries
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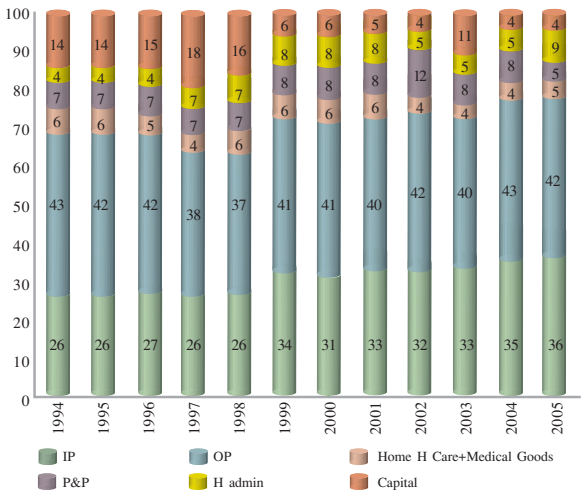
StateEnterprise = State Enterprise
CSMBS = Civil Servant Medical Benefit Scheme
SocSec = Social Security Scheme
UC = Universal Health Care Coverage

It is important to note that expenditure on CSMBS increased by 26 percent between 2006 and 2008. This escalation intensified inequity of the government subsidy among the three public schemes.

Profile of Thai Health Expenditure



Source: National Health Accounts in Thailand, 1994-2005

IP = Inpatient services
OP = Outpatient services
Home H care+Medical Goods = Medical goods dispensed to out-patients

P&P = Prevention and public health services
H admin = Health administration and health insurance
Capital = Gross capital formation

Budget analysis of universal access to renal replacement therapy

	1st year (assuming 2004)	4th year (assuming 2007)	16th year (assuming 2020)
Estimated budget on RRT for all ESRD patients, using unit cost at 350,000 baht/patient/year (million baht)	5,400	19,881	74,355
As % of total UC budget	7.4	21.6	37.6
As % of total health expenditure	2.3	7.0	12.2

Source: Kasemsap V., Prakongsai P. and Tangcharoensathien V., 2005

Projected costs of the National Access to Antiretoviral Program for People Living with HIV/ AIDS (NAPHA), 2001-2025

NAPHA Policy	2001	2005	2010	2015	2020	2025
ART cost (million in 2004 USD)	10.9	130.8	355.4	483.4	507.0	477.0
AIDS budget (million in 2004 USD)	37.2	67.2	55.2	71.2	91.7	118.1
Health budget (million in 2004 USD)	1,130.7	1,253.7	1,623.0	2,101.2	2,720.3	3,521.7
ART as a share of AIDS budget	29%	195%	644%	679%	553%	404%
ART as a share of the health budget	1%	10%	22%	23%	19%	14%

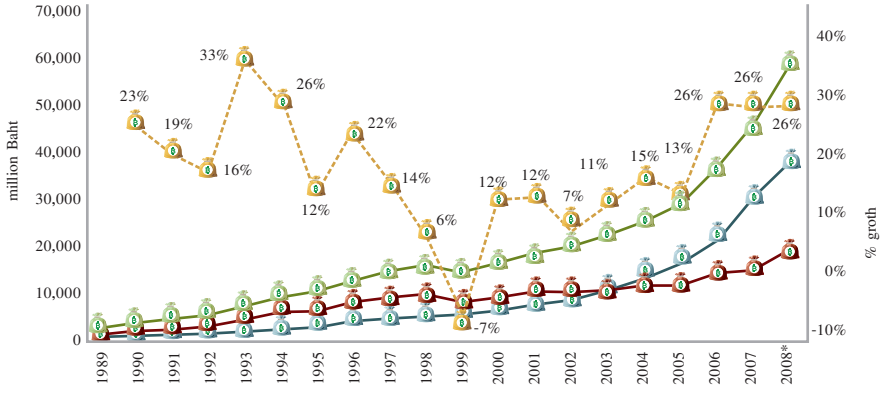
Source: Revenga A. et al., 2006

Total Health Expenditure (THE), 1995-2005

Indicator	1995	…	2001	2002	2003	2004	2005
THE, million baht	147,837	…	170,203	200,768	210,368	225,652	248,079
THE, % of GDP	3.53	…	3.32	3.68	3.55	3.47	3.49
Public Financing Agencies, %	47	…	56	63	63	64	64
Out-of-pocket, %	43	…	33	28	25	26	27
Other Private Financing Agencies, %	10	…	11	9	12	10	9
THE, Baht per capita	2,486	…	2,732	3,197	3,335	3,641	3,974
THE, USD per capita	100	…	61	74	80	90	98
Exchange rate (baht/USD)	24.9	…	44.5	43.0	41.5	40.3	40.3

Source: National Health Accounts in Thailand, 1994-2005

Expenditure of Civil Servant Medical Benefit Scheme during 1989 and 2008



Note: * Expenditure for 2008 is extrapolated from 6 months actual spending

Source: Ministry of Finance, Comptroller Generals Department

Access and Coverage

6

Thailand has increasing been improving the health system. Essential services are broadly covered, in particular childhood vaccines and providing ARV medications for HIV+ people. Nevertheless, there is a need to extend screening services to cover all diseases so that the Thai population can receive proper care in a timely manner.

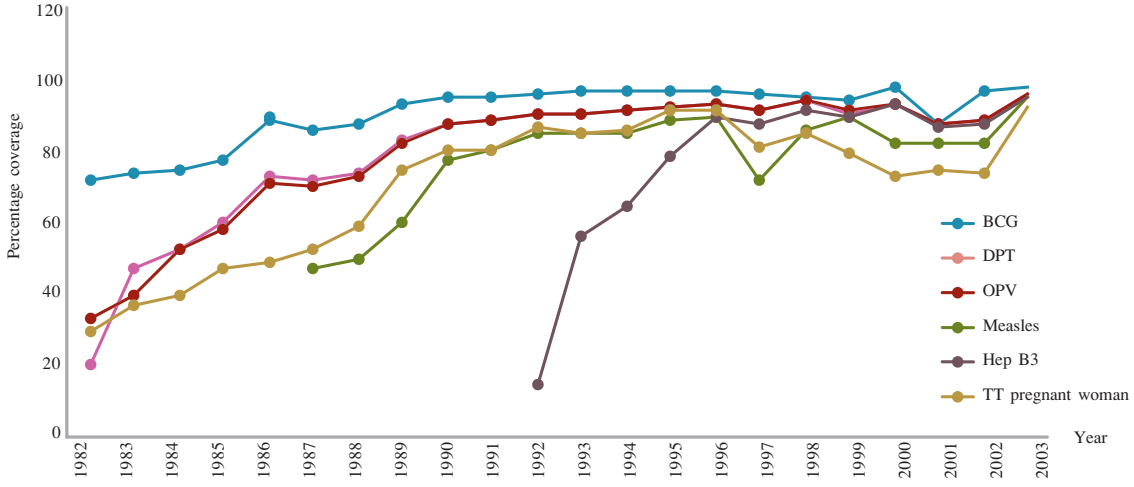
Over the last three decades Thailand has improved its coverage of essential health services and interventions for Thais. The improvements in coverage have been in essential vaccines, antiretroviral drugs (ARVs) for HIV/AIDS patients, sustainable condom use by female sex workers, and emergency medical services. However, there is still low coverage for screening cervical cancer, screening and access to appropriate medical care for hypertension, diabetics and hyperlipidemia and poor coverage of helmet and safety belt use.

The national immunization coverage in Thailand for all types of vaccine has been high for a number of years. The coverage in 2002 was 98 percent for BCG, 90 percent for DPT and OPV, 84 percent for measles, while the lowest rate was for tetanus toxoid for pregnant women, in which the coverage was only 75 percent. Hepatitis B3 vaccine, which was introduced only in late 1992, has reached almost 90 percent of children since 1996. As a result of such high immunization coverage, the morbidity rates of such preventable diseases have declined.

Since October 2003, the Ministry of Public Health has also implemented the policy on universal access to ARVs by providing all HIV/AIDS patients who need them with ARVs through the expansion of the Universal Coverage benefit package. The coverage of ARVs has increased significantly from approximately 2,000 cases in 2000 to more than 100,000 cases in 2006, and exceeded 125,000 cases in 2007 after the compulsory licensing measure was introduced. Currently, Thailand focuses on both treatment and prevention, for example a campaign to promote condoms has increased condom use among adolescents, although the rate among female adolescents is still low.

Weaknesses within the Thai health system includes: a lack of screening for diseases and the existence of a high number of patients who have never had any diagnosis, particularly for hypertension, hypercholesterolemia, diabetics and cervical cancer.

Coverage of immunization against vaccine-preventable diseases in different target groups, 1982-2002



Source: Modified from Thailand Health Profile, 2005-2007

Proportion of drivers aged 14 years and over using safety belts from 1991 to 2006

Use of safety belt	1991	1996	2000	2001	2003	2006
Vehicles with safety belts						
Constantly used	4.3	35.8	25.9	27.1	23.5	31.3
Occasional used	11.7	28.0	32.2	44.2	39.7	45.2
Never used	12.6	6.3	13.9	12.1	32.2	21.9
Vehicles without safety belts	64.6	29.9	--	4.4	2.4	1.6

Source: Health and Welfare Surveys in various years

Proportion of motorcyclists aged 14 years and over using helmets from 1991 to 2006

Use of helmets	1991	1996	2000	2001	2003	2006
Constantly use	7.2	29.0	32.0	16.1	16.0	18.6
Occasional use	21.7	55.4	44.2	64.3	49.5	59.7
Never use	11.0	6.0	15.8	10.3	32.8	21.7
No helmet	59.8	9.3	--	9.1	--	--

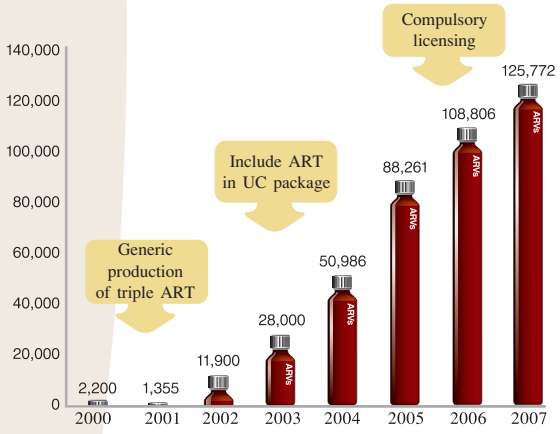
Source: Health and Welfare Surveys in various years

Number and percent of women aged 35-59 years having cervical cancer screening in the past five years by residential areas, 2006

Residential areas	Municipality (%)			Non-municipality (%)		
	Never screened	Screened beyond five years	Screened within five years	Never screened	Screened beyond five years	Screened within five years
Bangkok	46.6	18.1	35.3	-	-	-
Central	38.6	16.6	44.8	40.3	15.8	43.9
North	28.6	9.9	61.5	30.3	8.2	61.6
Northeast	31.5	13.3	55.6	33.1	12.2	54.7
South	35.8	14.6	49.7	43.9	15.8	40.3
Total	39.0	15.6	45.5	35.6	12.6	51.8
Population	**1,395,691**	**557,843**	**1629,956**	**2,786,729**	**985,895**	**4,054,705**

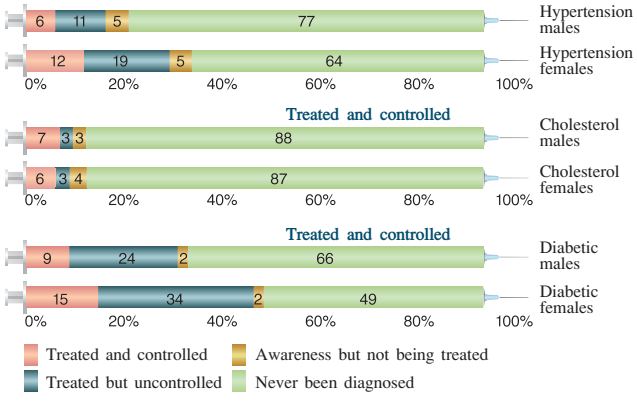
Source: Reproductive Health Survey 2006

Number of HIV patients receiving antiretroviral drugs (ARVs) from 2000 to 2007



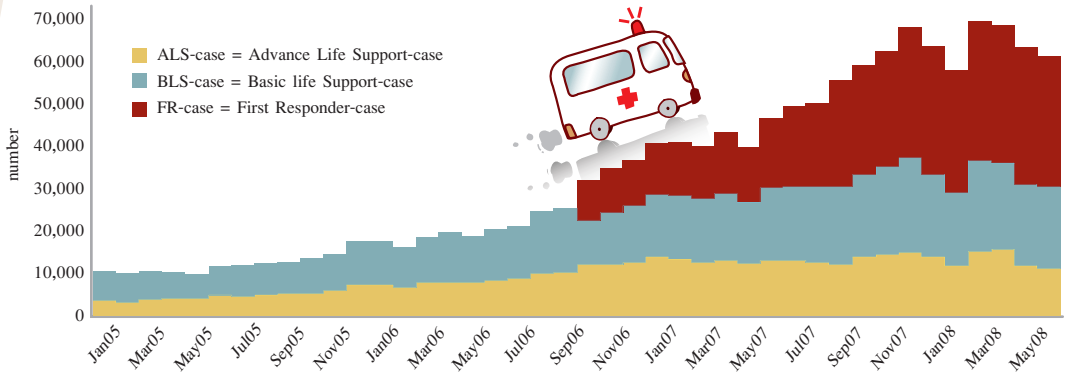
Source: Wibulpolprasert S., 2008

Proportion of those not diagnosed and diagnosed with hypertension, hypercholesterolemia and diabetics



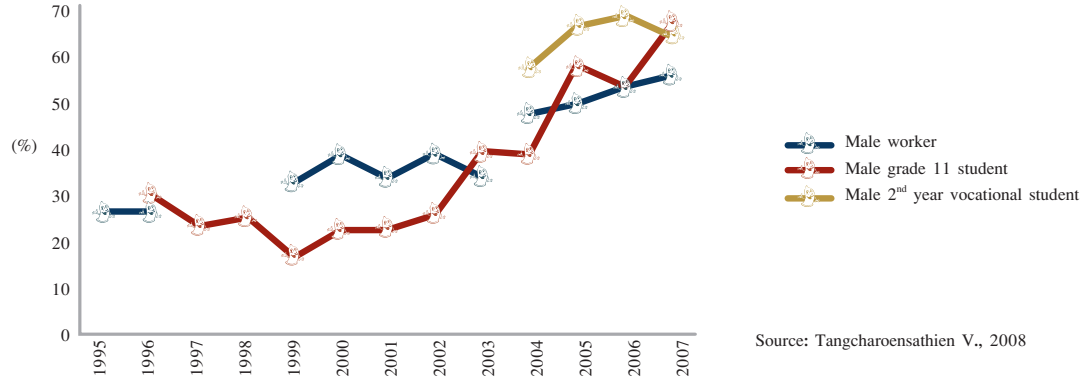
Source: National health examination survey III, 2004

The number of emergency medical services (EMS) from 2005 to 2008



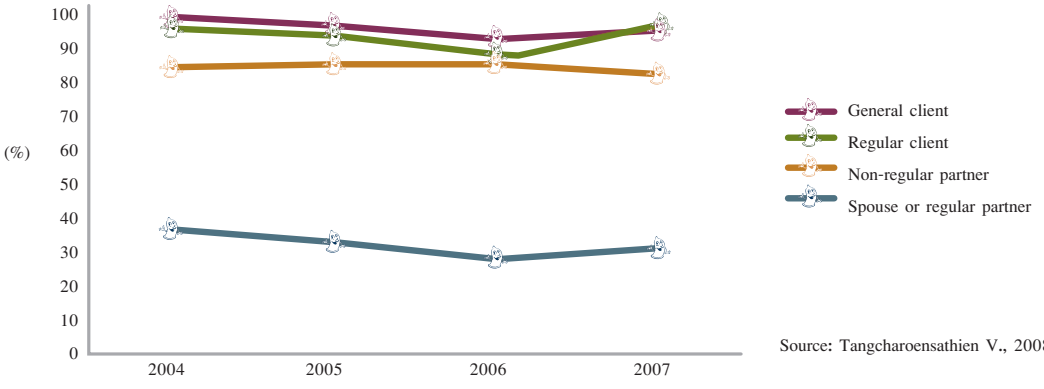
Source: National Health Security Office, 2008

Percentage of respondents who consistently used condoms when having sex with a non-regular sexual partner in the past year, Thailand 1995-2007



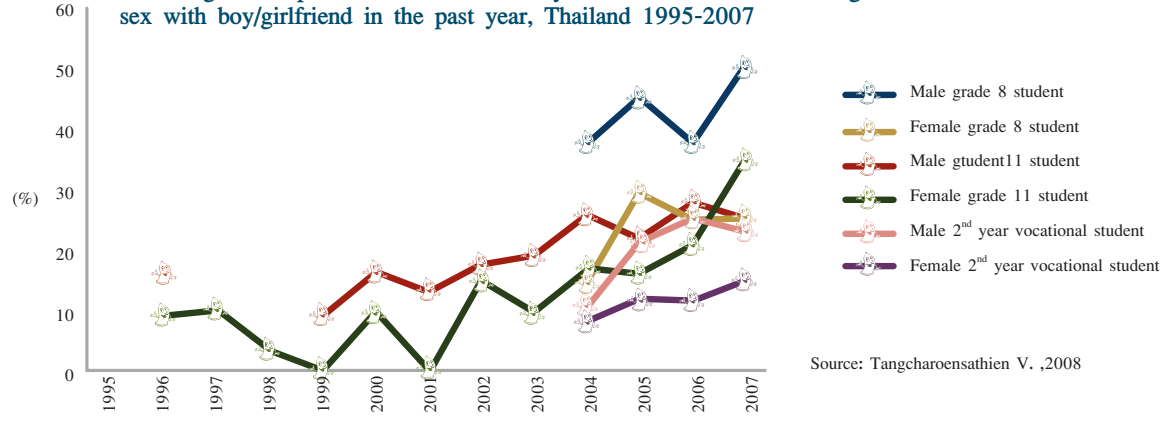
Source: Tangcharoensathien V., 2008

Percentage of female sex workers who consistently use condoms when having sex with clients in the past month, 1995-2007



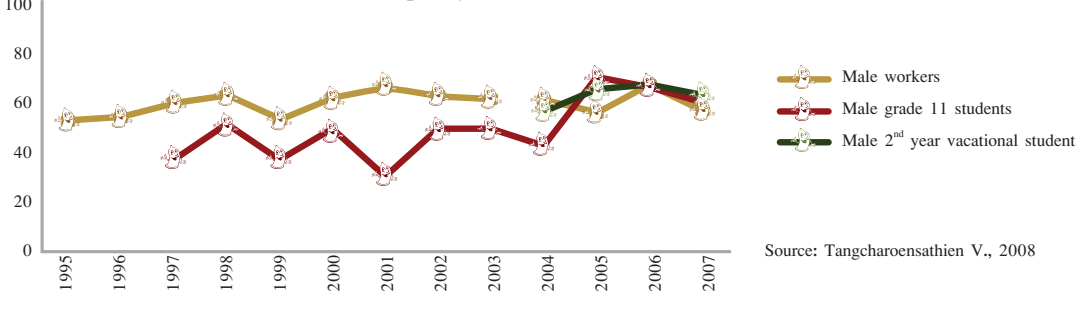
Source: Tangcharoensathien V., 2008

Percentage of respondents who consistently used condoms when having sex with boy/girlfriend in the past year, Thailand 1995-2007



Source: Tangcharoensathien V. ,2008

Percentage of respondents who consistently used condoms when having sex with female sex workers in the past year, Thailand 1995-2007



Source: Tangcharoensathien V., 2008

Quality and Safety

7

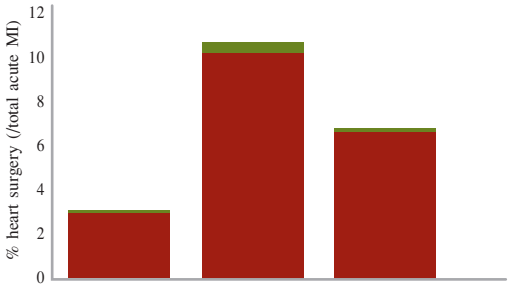
Of the in-patients who died while receiving hospital care 35 per cent had adverse event. Over half of these unwanted cases could have been prevented.

Quality of care is an essential aspect of the performance of a health system. A health system aims to improve the physical, mental and social well-being of individuals. Quality health care therefore entails the provision of quality medical services and the prevention of potential harm or adverse effects from health care. In other words, patient safety is an important dimension of the quality of care. The health service should protect patients from adverse consequences of care, which may lead to loss of life or impact on patients' or families' quality of life and social and economic well-being in the long term.

The quality of health care, particularly therapeutic care can be measured through the outcome of treatments, such as the case fatality rate. However, when the case fatality rate is used, care needs to be taken with interpretation, because there are many factors that lead to the loss of life, and some are not related to the quality of care. These include the severity of the disease at the time of admission and the potential capacity of the health facility to provide the required health services. Details analysis into the outcome of health care suggests that poor access to advanced diagnostic and therapeutic procedures and delay in receiving medical treatment leads to adverse health outcomes. For instance, among the patients with MI, the probability of dying increases if there is an increase in duration before the patients received treatment after hospital admission (or duration between hospital admission and treatment initiation).

Another dimension of quality of care is medical malpractice, which may lead to adverse healthcare outcomes. Studies have shown that 35 percent of patients' death appeared to have involved adverse events. Adverse effects contribute to about half of all patient deaths. Most of the adverse events are avoidable or preventable. The most common adverse event is nosocomail infections or hospital-acquired infections. It is common knowledge that the practice of standard precautions is an effective way to avoid such infections. In order to have positive health outcomes, health providers should not only provide medicine and medical care, and apply appropriate technology at the right time, but also should minimize the occurrence of any form of potential harm and adverse events.

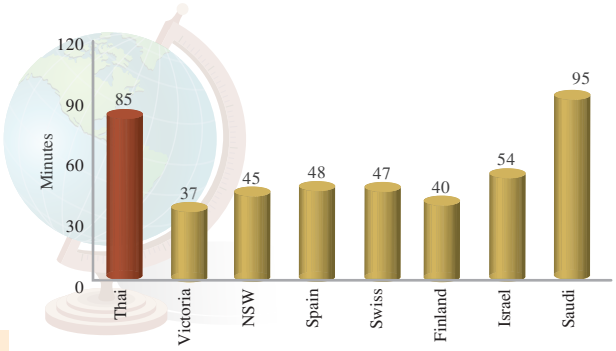
Percentage of patients undergoing the removal of coronary obstruction and coronary bypass by type of health care benefit, 2005



The Universal Coverage	Civil Servant Medical Benefit Scheme	Social Security Scheme	
2.90	9.93	6.45	% Removal of coronary obstruction
0.13	0.46	0.18	% Coronary bypass

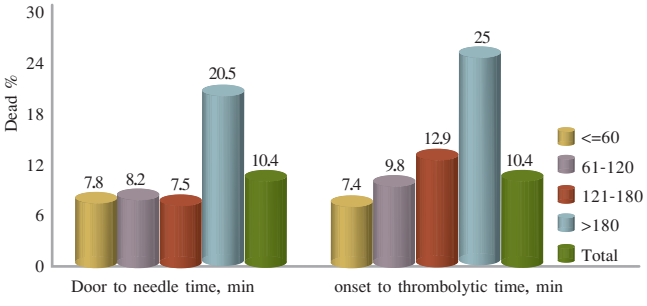
Source: Faramnuayphol P., 2006

Period of time between hospital admission and onset of medication (Thrombolytic) in ACS patients comparing Thailand and selected countries



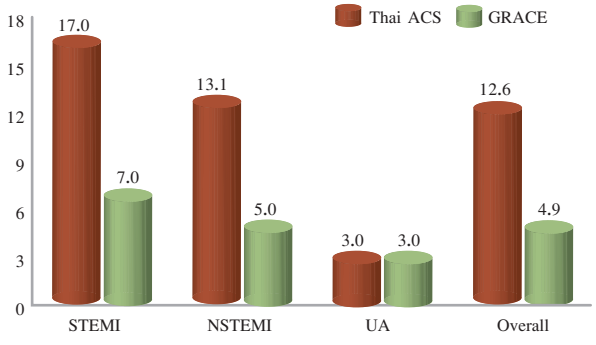
Source: The Heart Association of Thailand under the Royal Patronage, 2006

Case fatality rate among ACS patients by duration of medication



Source: The Heart Association of Thailand under the Royal Patronage, 2006

Rate of case fatality due to Acute Coronary Syndrome (ACS) in Thailand and developed countries



Source: The Heart Association of Thailand under the Royal Patronage, 2006.

Note: GRACE is the Global Registry of Acute Coronary Events

Percentage in-patient death due to adverse events

Occurrence	No.	% of 279 (95%CI)
AE	98	35.1 (29.5-40.8)
Drug AE	7	2.5 (0.7-4.4)
AE Death	43	15.4 (11.1-19.7)
Preventable	53	19.0 (14.4-23.6)

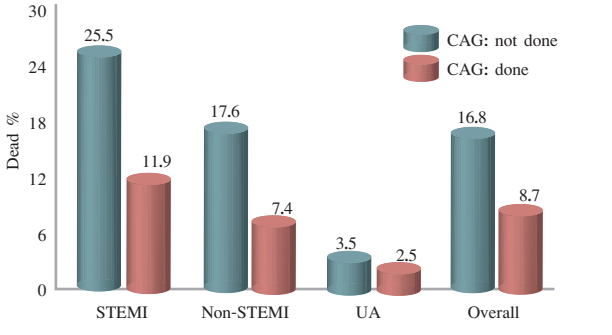
Source: Kessombon P. et al., 2005

Type of adverse events

Item	Clinical conditions*	No. (%)
1	Nosocomial infection	86 (30.5)
2	Death	53 (19.0)
3	Treatment complication	41 (14.7)
4	Pressure sore	12 (4.3)
5	Drug adverse event	10 (3.6)
6	Cardiac arrest	8 (2.9)
7	Neurological deficit	4 (1.4)
8	Others	9 (0.4)
9	Operation on wrong organ	0
10	Fall	0
11	OB-GYN complication	0
12	APGAR score<6 at 5 min	0

Source: Kessombon P. et al., 2005

Case fatality rate in ACS patients with and without CAG test



Source: The Heart Association of Thailand under the Royal Patronage, 2006

Health Equity

8

The investments in health have enabled greater numbers of Thais to receive health care. This is especially the case for poor people who are able to gain hospital care as a result of the Universal Health Insurance scheme. Everyone has clearly seen this improvement. Infant mortality is an indicator of the quality of health care. Among poor families the infant mortality rate has fallen from 40.8 per 1,000 births in 1990 to 23 in 2000.

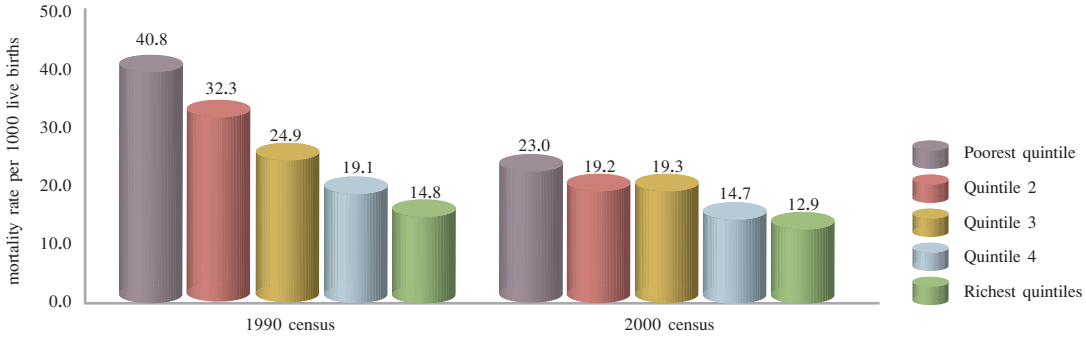
Thailand has made marked improvements in health equity due to the expansion of the health insurance coverage provided by the three major public health insurance schemes. The Civil Servant Medical Benefit Scheme covers around six million government employees and their dependants; the Social Security Scheme protects approximately nine million employees in the formal sector from non-work related health care expenditure; and the Universal Coverage scheme covering approximately 47 million people (~75 percent of the entire population) who were not previously beneficiaries of the Civil Servant Medical Benefit Scheme or the Social Security Scheme.

During 1992-2006 the poorest decile of Thai households spent, on average, a higher percentage of their household income than the richest decile. Nevertheless, inequity in health spending has improved because the proportion of household spending on health to income of the poorest (first) decile significantly decreased from 8.17 percent in 1992 to 2.23 percent in 2004, whilst that of the richest decile has slightly decreased from 1.27 percent in 1992 to 1.07 percent in 2004.

The pattern of health service use also indicates greater equity. For instance, the increase in utilization of primary care and secondary care levels of the lower income quintiles lead to a significant improvement of equity in ambulatory service use.

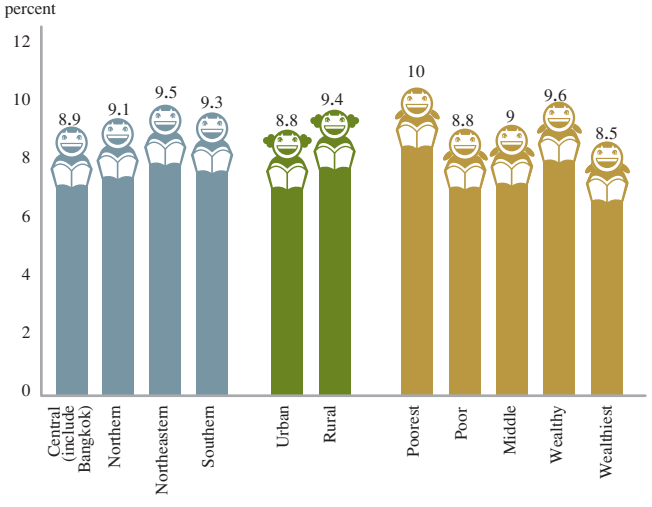
Despite the above mentioned improvements within the Thai health system inequalities still exist between different socio-economic groups. The rich-poor mortality gap in under-five mortality rates (U5MR) still occurs. Furthermore, the survey of self-reported health assessment by the National statistical Office and International Health Policy Program, Thailand has revealed approximately two-thirds of the poorest quintile was affected by physical and mental health problems, which was significantly higher than that of the wealthiest Thais.

Child mortality by quintile of household economic status from 1990 and 2000 census



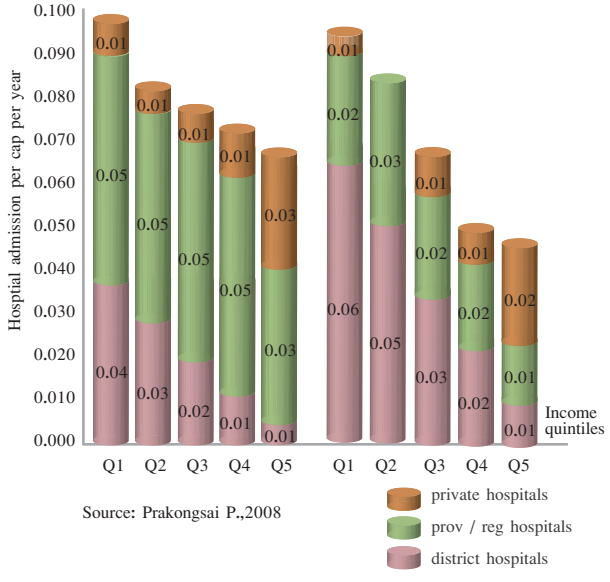
Source: Vapattanawong P. et al., 2007.

Percentage of live births below 2500 grams by residential areas and economic status of Thais, 2005-2006



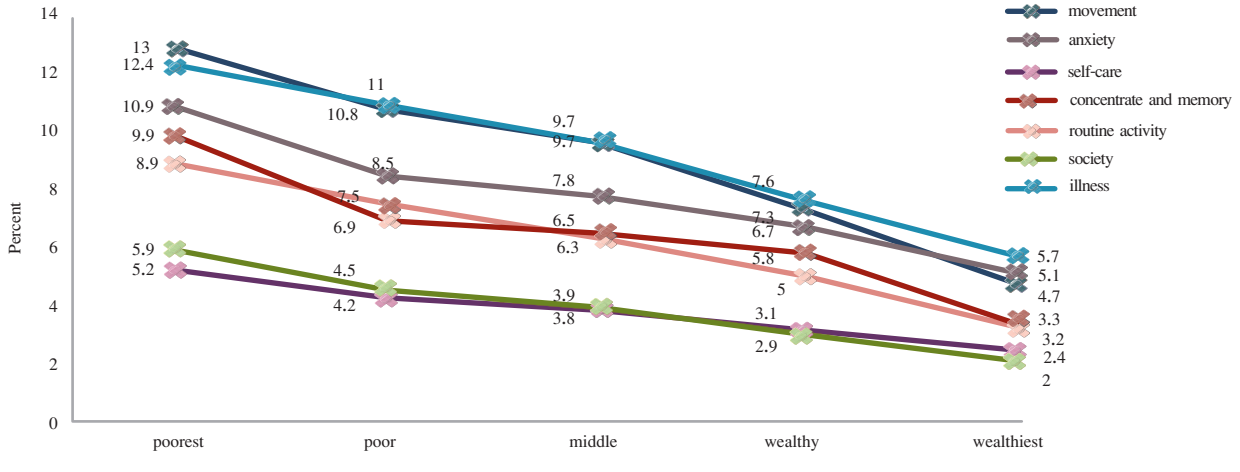
Source: The Multiple Indicator Cluster Survey (MICS) December 2005-February 2006

Hospitalization by different types of health facility and by income quintile in 2001 and 2003



Source: Prakongsai P.,2008

Self-reported health status of Thais by economic status in 2003



Source: Trangcharoensathien V. et al., 2006

Social and Financial Risk Protection

9

The introduction of the Universal Health Insurance scheme has reduced the proportion that families, with financial difficulties, spend on health from 31 per cent in 2000 to 14.6 percent in 2007. The scheme has reduced the proportion of families becoming destitute as a result of medical costs as medical expenses on in-patients have fallen from 11.9 per cent to 2.6 per cent in the same period.

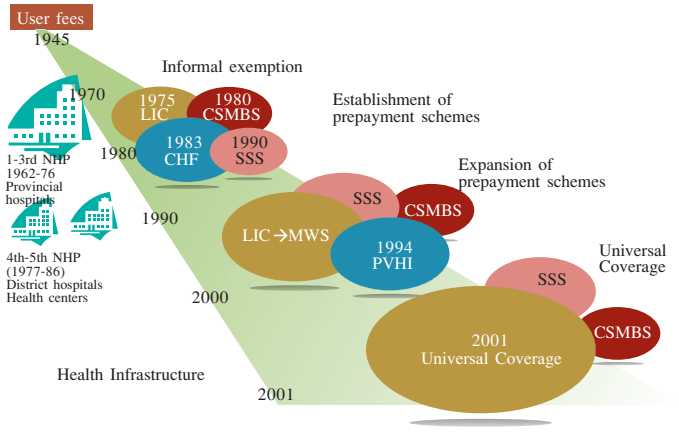
Thailand' first health insurance system - the Low Income Scheme - was established in 1975 and catered for the country's poor. This was followed by a scheme for government workers and their dependents in 1980. Further, a voluntary community health insurance scheme started in 1983 for those who were not eligible for the Low Income Scheme. For those in the private sector a social security scheme was established in 1990 to cover non-work related illnesses. From 1990 onward, there was rapid expansion of health insurance coverage resulting from the growth of the Low Income Scheme to cover other groups such as older people, children aged below 12 years, students, disabled persons, veterans and monks. Further developments occurred, first with the community financing scheme evolving into the Health Card Scheme - a publicly subsidized voluntary health insurance scheme, and secondly with the Social Security Scheme expanding to cover all workers in small enterprises.

At the beginning of this century there was a strong social movement demanding universal healthcare coverage. After the general election in 2001, the newly government announced a policy on Universal Coverage by incorporating the Low Income Scheme with the Health Card Scheme extending them to cover those previously uninsured and protecting the poor against medical care costs.

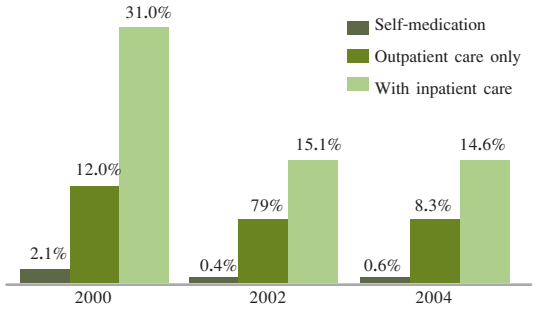
As a result of the Universal Coverage providing financial risk, households facing catastrophic health expenditure declined significantly. Households using in-patient care and faced crippling health expenditure reduced from 31 percent in 2000 to 14.6 percent in 2004.

The same result occurred for poor households using out and in-patient care. The number and share of households facing post-out of pocket impoverishment in 2000 and 2004 decreased significantly in the households using in out-patient care and in-patient care (3.8 to 1.5 percent and 11.9 to 2.6 percent respectively). This indicates the effectiveness of the Universal Coverage policy in providing financial risk protection against impoverishment from medical care costs and better enabling Thais to gain health care.

Historical development of achieving universal coverage from 1945 to 2001

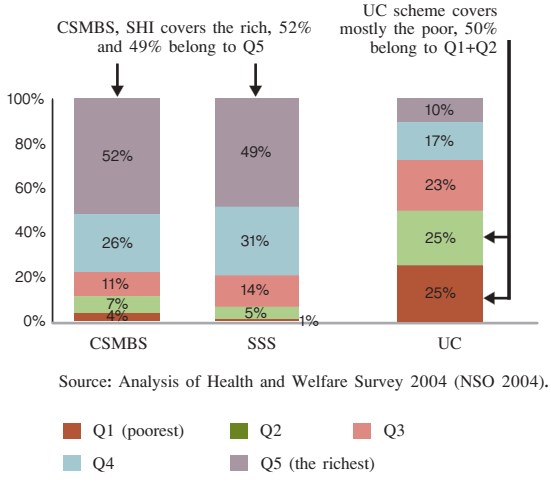


Incidence of catastrophic health expenditure by types of health care prior to and after Universal Coverage



Source: Limwattananon S, Tangcharoensathien V, and Prakongsai P. 2007.

The distribution of income quintiles among different public health insurance schemes in 2004



Source: Analysis of Health and Welfare Survey 2004 (NSO 2004).

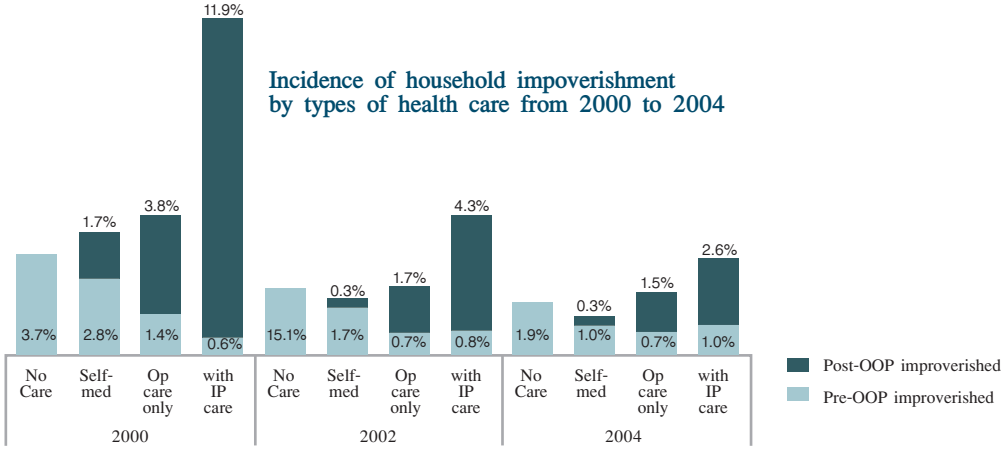
The incidence of pre- and post-UC catastrophic health expenditure between the poorest and richest quintiles in 2000-2006

Pre-post UC incidence of catastrophic expenditure
Households with health payment > 10% of total consumption expenditures

	All households	LIC/VHC UC –E/-P
Year 2000		
Quintile 1	4.0%	2.7%
Quintile 5	5.6%	7.1%
All Quintiles	5.4%	4.7%
Year 2002		
Quintile 1	1.7%	1.7%
Quintile 5	5.0%	6.1%
All Quintiles	3.3%	3.2%
Year 2004		
Quintile 1	1.6%	1.6%
Quintile 5	4.3%	5.2%
All Quintiles	2.8%	2.6%
Year 2006		
Quintile 1	0.9%	0.9%
Quintile 5	3.3%	3.0%
All Quintiles	2.0%	1.9%

Source: The Household Socio-Economic Survey (SES), Analysis by International Health Policy Program

Incidence of household impoverishment by types of health care from 2000 to 2004



Source: Limwattananon S, Tangcharoensathien V, and Prakongsai P, 2007

Efficiency

10

The Thai health system is very efficient when compared to other developing countries, particular for primary health care and health insurance.

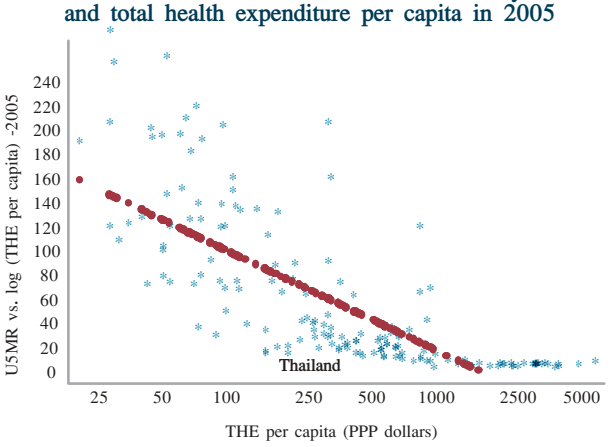
The Thai health care system's efficiency of resource use can be determined by comparing the reduction in the child-mortality rate (death among those aged under 5 years) compared to total health expenditure per capita. Scaling up primary health care (e.g. universal coverage of immunization and skilled birth attendance) while creating a health system with low inequity are likely to be the main reasons for such efficiency achievements.

The primary health care system plays a pivotal role in health achievements and efficiency improvements of the Thai health care system. Contracting the district-level health providers to provide primary care and close-to-client services for Universal Coverage beneficiaries is an important means of ensuring efficient and rational use of services while ensuring proper referral systems. The transport costs incurred by households using these close-to-client services are also much lower. When the majority of Universal Coverage members who are poor and residing in rural areas can actually exercise their rights in using a comprehensive range of services provided by the primary health care network, it results in equity in health service use and efficient use of public resources.

Using fee-for-service reimbursement to pay health care providers of the Civil Servant Medical Benefit Scheme sends a strong signal to healthcare providers who are supreme commanders of health resources to provide more diagnostics, medicines, and probably unnecessary medical treatment. Empirical evidence consistently confirms Civil Servant Medical Benefit Scheme beneficiaries receive more branded and more expensive medicines than beneficiaries in other public health insurance schemes. Moreover, evidence shows that Civil Servant Medical Benefit Scheme beneficiaries have higher hospital admission and greater cesarean section rate than other schemes. It is found that even though Civil Servant Medical Benefit Scheme finances five times higher per capita, clinical outcome is more or less similar to beneficiaries of the Universal Coverage scheme.

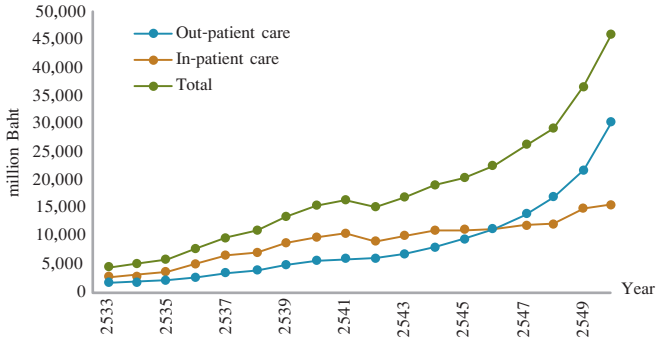
1. In the Thai health care system, the problem of over-use of medicine, especially expensive antibiotic drug and new medical technologies is not only found with the Civil Servant Medical Benefit Scheme, but it is also evident in health service provision of private for-profit health care providers. The limited capacity of the government to regulate private for-profit providers facilitates inefficient use of public and private health resources.
2. The 10th National Development Plan of Thailand makes the following three policy recommendations for improving efficiency in public health resource use:
3. On burden of disease, there is an urgent need for developing a national agenda on control of HIV/AIDS, road traffic injuries, harmful use of alcohol and tobacco, and overweight and obesity which are major disease burdens in Thailand.

The correlation between under-five mortality rate and total health expenditure per capita in 2005



Source: Limwattananon S. analyzed from the World Health Survey (WHS) data, WHO

Reimbursement for out-patient and in-patient care of the Civil Servant Medical Benefit Scheme (CSMBS) from 1990 to 2007



Source: International Health Policy Program, 2008

Thirty low-income countries with the highest average yearly rate of reduction in mortality rate among children aged under 5 years from 1990 to 2006

	Countries and Territortes *	Total Population in thousands (2006)	Average yearly reduction in mortality (1990-2006)	Mortality rate for children < 5 years + (2006)	Number of deaths for children < 5 years (2006)	Estimated maternal mortality ratio (2005) #
1	Thailand	63444	8.5%	8	7000	110
2	Vietnam	86206	7.1%	17	28000	150
3	Peru	27589	7.1%	25	15000	240
4	Brazil	189323	6.5%	20	74000	110
5	Indonesia	228864	6.2%	34	151000	410
6	Syria	19408	6.0%	14	7000	130
7	Egypt	74166	5.6%	35	64000	130
8	Sri Lanka	19207	5.5%	13	4000	58
9	Nepal	24641	5.5%	59	47000	830
10	Morocco	30853	5.5%	37	23000	240
11	El Salvador	6762	5.5%	25	4000	170
12	Ecuador	13202	5.4%	24	7000	210
13	Turisia	10215	5.1%	23	4000	100
14	Dominican Republic	9615	5.0%	29	7000	150
15	Laos	5759	4.9%	75	12000	660
16	Bangladesh	155991	4.8%	69	277000	570
17	Honduras	6969	4.8%	27	5000	280
18	Iran	70270	4.7%	34	48000	140
19	Bolivia	9354	4.5%	61	16000	290
20	Kazakhstan	15314	4.5%	29	8000	140
21	Eritrea	4692	4.3%	74	14000	450
22	Guatemala	13029	4.3%	41	18000	290
23	Philippines	86264	4.1%	32	73000	230
24	Turkmenistan	4899	4.1%	51	6000	130
25	Haiti	9446	4.0%	80	22000	670
26	Nicaragua	5532	4.0%	36	5000	170
27	Paraguay	6016	3.9%	22	3000	150
28	China	1320864	3.9%	24	415000	45
29	Cuba	11267	3.9%	7	1000	45
30	Malawi	13571	3.8%	120	68000	1100
Total		2545732			1433000	

Countries are ranked according to progress for Millennium Development Goal4. *Countries with Gross National Income greater than US$5000 per person and less than 100 000 births per year were excluded.

+ Per 1000.

 # Per 100 000.

◖ Politics of polarization - Thais divided ◗

◖ Reemergence of narcotic drugs due to political weakness ◗

◖ Food crisis and fuel price crisis:
the poor suffer the most ◗

◖ Crisis strikes ...
Thais are at risk of depression and suicide ◗

◖ Life versus vested interest:
The government introduces compulsory licensing (CL)
based on the right to life ◗

◖ Sexual Harassment at Educational Institutions:
Time for a Systematic Solution ◗

◖ Milk contaminated with Melamine ...
Global vigilance and Thailand's responses ◗

◖ The deaths 54 Burmese and the fate of the Rohingya:
Human trafficking? ◗

◖ AIDS threats Thai youth because of unsafe sex ◗

◖ The first steps of the National Health Assembly:
Social innovation in health policy ◗

10 Health Issues

1 Politics of polarization-Thais divided

For over three years, Thailand has experienced political conflicts which have devastated the society. As a consequence, apart from Myanmar, Thailand is now ranked the lowest in Southeast Asia on the recent happiness index conducted by the Global Peace Index. The confrontation between Thais people started from political tensions and later turned in political polarization, and now these seems limited prospects for reconciliation.

Proceed to divided society

The fierce confrontation between the two sides broke out in 2006, with one side shouting "Thaksin fight fight" and the other "Thaksin out. This political tension has lead Thailand into deep social division. Mr. Anand Panyarachun, the former prime minister, contended that Thailand has reached the stage where the country is fragile and volatile, that people link virtually all matters with politics, leading Thailand to be a "the stage of national division"

The military coup on 19 September 2006 resulted in a redrafting of the constitution. However, in the national referendum only slightly more than half of the people (58 percent) agreed with the new draft. This narrow margin has led international media journalists such as Sean Crispen to argue that Thailand is moving backward to become a less democratic country. An interesting political analysis written by Seth Mydans contended that the "No" voices to the new constitution particularly from the North and Northeast reflected deep polarization in the country which will inevitably affect the up coming general election. The polarization of politics will remain for a long time. Christ Bakers, a British historian, also believes that Thailand's biggest political crisis has yet to come.

Not long after these views were publicized in the international media, there have been gradual increases in the signs of polarized politics. This began with the landslide victory in the general election by the governing party or People Power Party (PPP) where many members of PPP had a close link with Mr. Thaksin Shinnawatra or former members of the Thai Rak Thai party. Mr. Samak Sundaravej, the PPP leader, was sworn in as the new Prime Minister.

On 28 March 2008 or approximately 2 months after Mr. Samak took office, the People Alliance for Democracy (PAD) announced the first mass protest at Thammasat University. The protesters then marched on Rajchadamnoen Avenue and blocked off the Makkawan Bridge. The PAD stated that the reasons for this mass protest were to (1) uproot the "Thaksinomics", (2) call for the resignation of the government, who they claimed to be the proxy for Mr. Thaksin Shinnawatra, and (3) to oppose the redraft of the constitution which would absolve the former prime minister of any wrong doing.

The PAD used the yellow shirt as a symbol of their protest. At the same time the opposition of the PAD came out to protest against them. The opposition of the PAD called itself as "Democratic Alliance against Dictatorship (DAAD)" which later changed to "National United Front of Democracy against Dictatorship (UDD)". It used the red

shirt as its symbol. Both camps have created social events to support and legitimize their movements.

The situations have become intensified and could turn to a hostile confrontation between Thais. According to the Global Peace Index, Thailand was ranked the lowest among Southeast Asian countries except for Myanmar, because of fears that the protestors might turn to violence and social uprising.

An article written by Mr. Surachart Bamrungsuk, a lecturer in security at Chulalongkorn University, pointed out that the result of the general election cannot solve the political conflicts which occurred before and after the military coup. The confrontation will persist and will have a great impact on politics for many years to come. The two camps will use whatever means to fight against one another with no compromise and may become so extreme that they may eventually turn to civil war. The most important question right now is that how we can prevent a civil war from breaking out.

Since then, a yellow shirt and a hand-like clapper has become the distinctive symbol of the PAD, and the ASTV has become their communication television channel. Meanwhile the UDD has used a red shirt and a foot-like clapper as their symbols with their television program "the truth today" televised on the public television channel 11, as their main communication channel. The UDD has expanded its alliance into a wider movement, not merely to support Mr. Thaksin as originally staged, but also to include the redrafting of the constitution and democracy and power.

Fueling violence

The prolonged street protest against the government by the PAD has worried many Thais after the Prime Minister, Mr. Samak Sundaravej, appeared on the television on 31 May 2008 announcing that his government would take tough action to clack down the protestors. This resulted in a huge turnout of people to join the PAD amidst the volatile situation. Mr. Parinya Thaewanaruemitkul from Thammasat University together with many groups had described themselves as "white power" and acclaimed that it is acceptable if people have different ideas, but violence is unacceptable. Government moves to clamp down on protestors were later downgraded where instead the police officers were sent to negotiate with protestors to move the protesting site away from the government house.

The longer the PAD protested, the more strategies were used. These ranged from satellite protests by small groups to significant government organizations, non-violent protests, and rallies against ministers who were on public duty or visited their constituencies. Both camps have expanded their alliances and supporters outside Bangkok, which has widened the confrontation.

The first violence broke out on 24 July 2008 when the PAD publicly announced that they would stage the mass protest at Nong Prachaksilapakom public park in Udonthani province. A local protest group named "kon rak udon or we love Udon" turned out and clashed with the PAD protestors, resulting in many injured. Although the brutal scenes were released and televised nationwide, there was even more violence in many part of the country, including Bangkok.

Human Rights Watch, the international human rights organization, has condemned the Thai government and government officials who turned a blind eye to the violence which has erupted from time to time. Similarly Thai intellectuals have publicly criticized the violence. However, it seems as if the confrontation has become so deep that no one listens to any criticism.

People were waiting for violence to erupt, even though the PAD always claimed that they had strictly observed a non-violent strategy. On 26 August 2008 the PAD began satellite rallies in several places, notably with the seizure of the National Broadcasting Authority of Thailand (NBT) or formerly the public TV channel 11. The protests were widely publicized in all media. There were pictures apparently of the arrest of protestors and various kinds of weapons including wooden stick, knives, guns, and metal bullets. On the same day, the government was expelled from its office after the PAD had taken control of the government house.

Finally, the government declared on 2 September 2008 a state of emergency in Bangkok. This followed a clash between the UDD and PAD on Radchadamnoen Avenue, which left one dead and at least 40 injured. Another incident of violence erupted in Chiang Mai where the red group attacked and later killed a father of a PAD member from the province. This incident shocked the residents of Chiang Mai province

At that moment Thailand was filled with dread, incidents of violence appeared to erupt daily, and the rule of law was no longer enforced. Protests were staged in many places nationwide, several government offices were seized by protestors, airports were closed, water supplies and power were cut off from the government offices, state railway stopped operating, and number of blasts were believed to have been planted in Bangkok.

The international media reported the violent situation in Thailand. Mr. Nuntawat Boramanun, an expert in public law from the Law Department of Chulalongkorn University said "At this point where each side takes a firm stand on their own interest, I am not sure in the end which of these two sides will get more benefit. It is most certainly however that the country will be lost and huge losses will occur." Dan Fineman, a senior financial analyst of the Credit Swiss, argued that with level of tension Thailand may find it hard to keep the situation under control. After comments like these, Thailand will no doubt be closely watched as a dangerous country.

In the meantime the political turmoil has impacted on the country's economic situation. Mr. Thanawat Polwichai, the Director of the Economic and Business Forcast Center of Commerce University, states that the current political turbulence had cost the country 19,000-35,000 million baht.

No rooms for middle ground

Mr. Niti Eiowsriwong, a social critic, has argued that the current extreme conflicts between the two groups will inevitably put the society into a stage of paranoia and distrust. It will be hard to find neutral people who are willing to do whatever they could to overcome the crisis. A similar view has been stated by Mr. Pongtham Paothai; that the confrontation has come to the point where violence can be widespread, comparable to the discrimination against the skin colour in the West in the recent past. Both sides stand firm and refuse to step back, driving the country into a dark situation leaving no way out. What no longer exists in Thai society is a middle ground between the two ideologies. In the end, whatever side wins or loses, the damage to the country will be complete and all that will remain are ruins.

Such statements turned out to be true when the journalists were attacked while on duty reporting the situation. Some journalists with the slogans "stop violence" on their shirts were also targeted. Many of them avoided being attacked by simply changed their shirts.

An incident on 7 October 2008 prompted Thai society to reconsider internationally acceptable guidelines in dealing with demonstrators. Thai officials fired tear gas into the crowd of protestors who were picketing the parliament house in attempt to prevent Mr. Somchai Wongsawat from entering the compound to addressing the government policy. This crackdown on the protestors left two people dead and hundreds were injured. The pictures of the brutal clashes later appeared in the media. This situation shocked the nation and Thai people were sorrowful once again.

Mr. Noppadon Kannika, Director of ABAC Academic Network for Happiness Observation and Research, conducted a series of surveys assessing the Gross National Happiness Index (GNHI) in Thailand. From its total score of 10, the survey conducted in August revealed that the GNHI among Thais was 5.82. However, the survey conducted between 7 and 11 October indicated the big drop in the GNHI in Thailand to 5.64. The two leading causes of unhappiness among Thais are politics and economic problems.

After the government cracked down on protestors on 7 October 2008, several groups and individuals attempted to seek ways to stop confrontations and stop the violence. An inauguration meeting was held at the convention hall at the Public Broadcasting Authority of Thailand, bringing together several members of Network for Peace through Dialogue such as Mr. Sumet Tantivejchakul, the Secretary-General of Chaipattana Foundation, Mr. Gothom Arya from the Center for Peace Studies of Mahidol University, Mr. Pramon Suthiwong, Chairman of the Thai Chamber of Commerce, Dr. Wanchai Watanasap, the peace advocate at the King Prajadhipok's Institute, and 170 organizations appealled for all sides to stop violence, use all means to avoid the confrontation, and begin a peace dialogue.

At the same time the Rule of Law Thailand network led by Mr. Thanet Arpornsuwan, Dean of Arts Faculty of Thammasat University, called for the public to stop three things: (1) stop organizing and bringing out people to confront each other, (2) stop supporting the PAD, (3) stop bringing Thailand towards anarchy and military coups.

Many parties and individuals in the country responded positively to the campaign calling for non-violent solutions to the political conflicts, including General Prem Tinnasulanon, Chair of the Privy Council, and Mr. Somchai Wongsawat, the Prime Minister. An ABAC poll indicated that about 94 percent of the respondents agreed with the campaign to stop violent clashes. However, the PAD had opposed the ideas and strongly criticized the proposition.

Seth Mydans, a reporter for the New York Time and the International Tribute Herald based in Bangkok, reflected in his article after the crackdown on protestors led by the PAD on 7 October 2008 that Thailand is cut in half. Each side is rigid, only wanting to win over the other. This is completely at odds with traditional Thai values. It is extremely outrageous.

PAD-led protestors occupied Donmuang Airport and Suwannabhumi Airport in the end of the year. They declared the end of the last protest on 3 December 2008, after the Thai Constitutional Court ordered the dissolution of the People Power Party and its coalition parties. The opposition party, the Democrat Party, then had a chance to form a government. No progress has yet to be made to bring concerned parties to the table for peace dialogue.

Coincidentally, the Daily Telegraph of the UK ranked Thailand 7th out of 20 countries in the world as a highly dangerous country. They stated the Thailand is facing the political turmoil, leading to the declaration of emergency decrees at the two main airports in Bangkok.

Thai society divides

The long protests will undoubtedly impact on the country's economy. According to Mrs. Amara Sripayak, Senior Director of the Economics Department, Bank of Thailand, the economic consequences of the airport closures were much worsen than that of the outbreak of SARS. There as an estimated decline of about one million tourists as a result of the closure of the airports, compared to the loss of about 1.8 million tourists due to the tsunami. National unity and solving the political stand off are among the top priorities of the new government led by Mr. Abhisit Vejjajiva.

The prime minister, Abhisit Vejjajiva, has asserted that the government may not be able bring the political conflicts to an end now. However, the government will do whatever it can to minimize the scale of political conflicts, and to bring about unit. He stated that he believed unity would be restored eventually. He also promised to serve all Thais regardless of their political interest or the colour of their sides. It seems as if all parties involved have realized the importance of the task of bringing the conflict to an end will not happen quickly.

Even on the day when Mr. Abhisit made his opening address to the parliament, he had faced anti-government protesters who blocked the parliament. There was a one-day delay in delivery of his speech and a change of venue from the parliament to the Ministry of Foreign Affairs. This was followed by satellite rallies by the red group, who carried not only the foot-like clappers but also eggs. The protesters threw eggs at Mr. Chuan Leekpai, a member of the Advisory Board of the Democrat Party, during his visit to Lampang province. A number ministers were chased by the anti-government protesters. All of these were tactics used by the PAD.

By late February 2009, the Democrat party led government released the official records of crimes committed by the protesters of both sides. The reported crimes since the protests broke out until 10 February 2009 were 145 cases in 18 provinces from 7 police bureaus. Of the 145 cases, 46 cases were completely investigated; 43 cases were reported by the PAD and only 15 cases were completely investigated; 102 cases were filed against the PAD and only 31 were completed. According to the existing sources of information about the violence during the period since the military coup on 19 September 2008 onwards, there were 11 persons killed and 1,121 injured.

To end the polarization of politics, extremism on both sides must be stopped

In 2009 the street protests have changed completely from the yellow-clad or PAD to the red-clad or UDD. Thai society has divided and the conflict has deepened for the last 3 years. Various organizations and social critics have together urged the public to join hands in opening an area without taking side where people can exchange their ideas. The government suggested the King Prachathipok Institute as a neutral place to take the lead in political reform. The opposition party also approved the move, hoping to restore national unity along with the upcoming new round of political reform.

Surachart Bamrungsuk, security and strategic studies expert, pointed out that the political polarization comes the extremism on both sides. He predicted that it is likely that Thai society may face political atrocities with hunting and killing of suspected enemies. Thus the country may face severe confrontation.

The way to avoid confronting extremisms is to increase the maturity and courage of all sides, leading to negotiation, compromise, responsibility, and willingness to forgive previous wrongdoing.

Timeline of key events between September 2004 and February 2009

25 September 2004	Protesters demanded Police Lieutenant Colonel Thaksin Shinawatra step down. A crowd gathered at the Royal Grounds and then proceeded to the central business district. Some people agreed with and others opposed the move. The protests lasted for years and ended after the military coup.
19 September 2006	A military coup took place to oust the government led by Police Lieutenant Colonel Thaksin Shinawatra
30 May 2007	The Constitutional Court ordered the dissolution of Thai Rak Thai party
22 July 2007	A clash between the Democratic Alliance Against Dictatorship (DAAD) and polices in front of General Prem Tinsuranond's residence
19 August 2007	A national referendum on Thailand's draft constitution was accepted (58 percent agree and 42 percent disagree, and invalid votes accounted for about 2 percent)
23 December 2007	The People Power Party won the general election and Mr. Samak Sundaravej, the party leader sworn in as the prime minister on 6 February 2008 (He ended his premiership on 18 September 2008)
25 May 2008	The People's Alliance for Democract (PAD) started a protest demanding that Samak step down, occupied the government house since June, and rallied at many public places to put pressure on the prime minister
26 August 2008	PAD seized the government NBT television station, blockaded three ministry compounds, and occupied Government House
2 September 2008	Clashes between DAAD and PAD left one person dead and about 40 injured. As a result Mr. Somchai Wongsawat had ordered the state of emergency in Bangkok
9 September 2008	The Constitution Court disqualified Mr. Samak Sundaravej after finding him violating the charter as an employee of a private company hosting cooking show program "Munching Talking"
17 September 2008	Mr. Somchai Wongsawat sworn in as a prime minister (ended on 2 December 2008 after the People Power Party was dissolved)
7 October 2008	Police fired tear gas into the crowd of protestors in front of the parliament house, leaving 612 injured and 3 dead
23-26 November 2008	PAD led protestors blocked the government's temporary office at Don muang Airport, demanded that Prime Minister Somchai Wongsawong resign and marched to close Suvarnabhumi Airport on 26 November
2 December 2008	The Constitutional Court's dissolved the People Power Party based on election fraud
3 December 2008	PAD put an end to its protesting
15 December 2008	Special National Assembly convened and selected Mr. Abhisit Vejjajiva, the leader of the Democrat party, as the prime minister
31 January 2009	Leaders of the UDD gathered at the royal ground and led the protestors to blockage the government house demanding an immediate resignation of Mr. Abhisit Vejajiva.

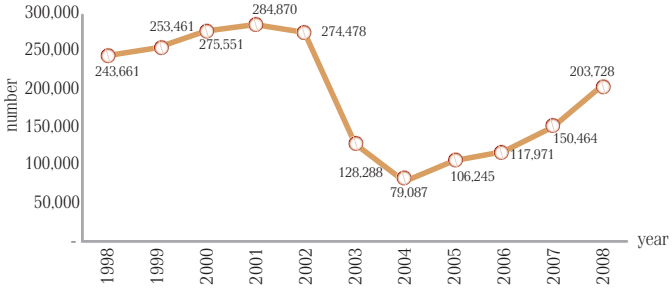
2 Reemergence of narcotic drugs due to political weakness

The reemergence of narcotic drugs as a serious social problem can be seen from the fact that in 2008 there were as many as 203,728 drug offences recorded by the police. Concerns have been widely raised that drug users are getting younger and younger. A survey on the prevalence of drug use in Thai households revealed that during the period between late 2007 and early 2009, children and young people in particular have become the preferred target for the spread of methamphetamines. Bangkok was found to have a greater variety of drugs than other regions.

Thailand and drugs problems

Thailand has long faced drug problems, both as a drug trafficking route from neighboring countries to other countries, and through an increasing prevalence of drug abuse among various groups. A significant turning point in Thailand for drug problems was when the government led by Prime Minister Thaksin Shinawatra launched the "war against drugs" policy.

Figure 1 Number of drug crimes between 1998 and 2008



Source: Kulapa Wajanasara and Kritaya Archavanich. 2008. Calculated from the number of 5 group criminal cases statistics. Available from http://www.royalthaipolice.go.th/[http://statistic.ftp.police.go.th/dn_main.htm

This policy aimed to eliminate drugs within three months (1 February to 30 April 2003) by implementing tough measures against drug dealers. The government claimed that drug abuse was a serious threat to the country and that drug crimes were having an enormous impact on society.

The implementation of this anti-drug policy resulted in a rapid decrease in the total number of methamphetamine seized by the police. The official statistics have shown that the total number of methamphetamine dropped from 96 million tablets in 2002 to 71 million (about 25 percent reduction) in 2003. It dropped further to 31 million tablets in 2004 (56 percent reduction), and 13 million in late 2006 to early 2007. Similar downward trends were also observed for the annual number of drug crimes, which fell about 53 percent between 2002 and 2003. However, annual drug crimes bounced back rapidly between 2005 and 2008 and reached well over 200,000 cases annually, or about as many as the recorded cases during 1998 to 2002 (see figure 1). This high prevalence in 2008 to early 2009 reflects to some extent the reemergence of drug abuse particularly methamphetamine.

Reemergence of drug abuse due to political weakness

During the political problems following the military coup, the formation of the new government in late

2007, and up to the present, the army and police have been preoccupied with political unrest in Bangkok and other big cities. As a consequence, little attention has been paid to the control of narcotic drugs. As discussed above, the statistics on drug crimes have rapidly increased since 2006, followed by a huge number of arrests nationwide. Drug crimes appeared almost daily on the front page of the newspapers (see Table 1). This reflects the fact that drugs have reached younger people. For instance, female school students in year nine formed a drug gang; a monk was arrested for selling methamphetamines in the temple compound; and there has been an increase in selling and taking drugs among upper secondary school students and vocational students in several provinces.

Table 1 Total number of drug crimes committed by children and young people during 2005-2008

Fiscal year	Number of crimes
2005	6,323
2006	8,227
2007	9,733
2008	11,671

Source: Department of Juvenile Protection, Ministry of Justice [http://www2.djop.moj.go.th/stat/show_stat.php]

In early 2008, Police Major General Udom Raksiladham, Deputy Commissioner of the Narcotic Suppression Bureau, indicated that drug trafficking often occurs during the festival seasons when there are many people traveling from place to place. In these circumstances, drug traffickers can easily disguise themselves. In October 2008, Police Major General Udon Narongsak, Chief Commander of Chiang Rai Police, reported that approximately 53 factories established along the border in Chiang Rai province continue to produce methamphetamine to supply the Thai market. It is expected that the methamphetamine will be continue to be trafficked into the country.

The market price of methamphetamine reflects how well the problems have been tackled by the government officials. Police Colonel Dusadee Arayavud, Deputy Commissioner of Department of Special Investigation, reported that the success of methamphetamine control can be judged by its market price. During the 3-4 years when the war on drugs policy was being implemented, the market price of one methamphetamine pill was around 300-400 baht while the cost at the production site was only 40 baht per pill. Nowadays, methamphetamine is trading around 100-200 baht whereas the cost at the production site is about 30-40 baht per pill.

The warnings about increasing trends of drug abuse have received little public attention. The ABAC Poll organization released results from a national survey of drug abuse in Thailand, covering 40,000 respondents. It was found that during 2007 and early 2008, children and young people were the groups most vulnerable to methamphetamine abuse. It was also found that a variety of drugs are available and used particularly in Bangkok. Nevertheless, the government has not done enough to tackle drug problems among children and young people, due mainly to its preoccupation with political conflicts.

An evaluation of the three-month (1 April-30 June 2008) program "Thais join hands in overcoming drug problems" in 33 provinces found that drug problems have followed a path of "smaller size to be greater severity". They appear to be far fewer meeting places, but with much greater drug use. The evaluation stated that the current political instability is the most important barrier to overcoming drug problems.

Squadron Leader Dr. Boonreung Trireungworarat, Deputy Director of the Medical Science Department, stated that the estimated number of drug addicts in 2008 was about 500,000. Of this total, about 70 percent or 300,000-400,000 people were the drug addicts. Methamphetamine was the most popular drugs.

Dr. Wasin Bumrungcheeb, a psychologist specializing in alcohol and drug addiction at Manarom hospital, a private psychiatric hospital, has argued that drug problems will become more serious for seven reasons.

(1) An economic downturn leads to increases in unemployment, with in turn increases the number of drug sellers

(2) The price of drugs become cheaper and drugs become more widely available

(3) Youth and the public regard drugs as normal

(4) Marketing strategies are used to attract consumers

(5) Current social circumstances leave parents little time to raise their children appropriately

(6) Inappropriate child raising leads to lack of self discipline, making people vulnerable to drug abuse

(7) Discontinuation of drug control policy due to political instability

Young Thais are at risk of drug abuse

In 2008, Police General Kowit Watana, the Minister of Interior and Director of the Narcotics Suppression Bureau, have high priority to tackling drug problems. He issued Board Order Ref 8/2551 outlining a plan for "90 days free from drugs". The plan was implemented between 3 November 2008 and 31 January 2009. However, it seems to have had little effect on the prevalence of drug abuse.

In late 2008, several organizations, including the Office of Narcotics Control Board (ONCB), reaffirmed the scale of drug problems in 2008 and stated that they would remain significant in the coming years. Based on ONCB's records, from January to June 2008 there were 62,409 reported drug crimes involving 67,185 persons. The most affected areas include Bangkok, provinces in the Central and Northeastern regions. The most vulnerable populations were people aged 15-24 years, unemployed people, and low-paid workers. The upward trends in recorded drug crimes indicated the rise drugs abuse and the severity of the problems.

Miss Suwannee Khammun, Deputy Secretary General of the National Economic and Social Development Board (NESDB) has argued that the social situation in the third quarter of 2008 lead to a 43 percent increase drug crimes compared to the same period in the previous year. Methamphetamines accounted for 66 percent of the total.

Similar results were obtained from surveys tracking the drug situation over 2003-2008 conducted by the National Statistical Office. It was found that there was a reemergence of drug use due to the availability of drugs. Drug use in education institutions increased from 22.5 percent in 2003 to 34 percent in 2008.

According to the available information from the Information System Group of the Office for Children and Juvenile Justice Development, the number of crimes committed by children and young people involving in drug abuse during the months of January to November 2008 was 10,208. Out of this, 5,900 cases, or about 58 percent, involved methamphetamines. Methamphetamine crimes were the leading crime committed by children and young people.

The situation in Prachaubkirikhan Province is representative of the current state of the epidemic. Mr. Panchai Bowornratanapran, the Governor of Prachaubkirikhan province, has declared a curfew after learning that methamphetamine has been spread in the province. Young people under 18 years of ages are not allowed to go out alone after 22.00 hours.

Figure 2: Occupation of children and youth before arrested

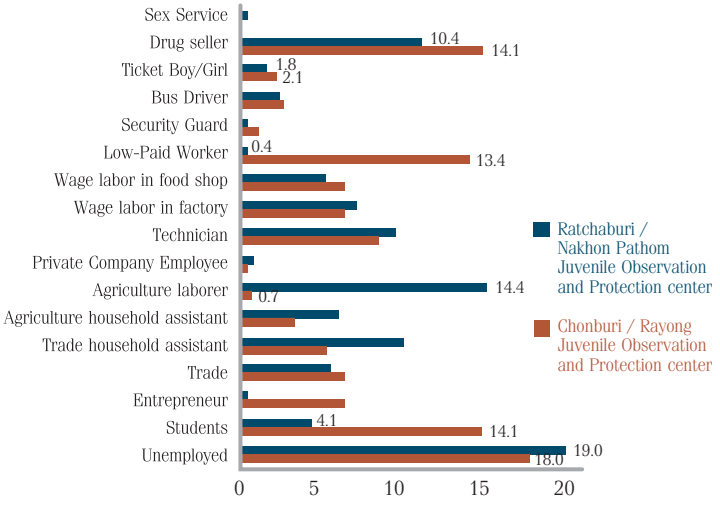
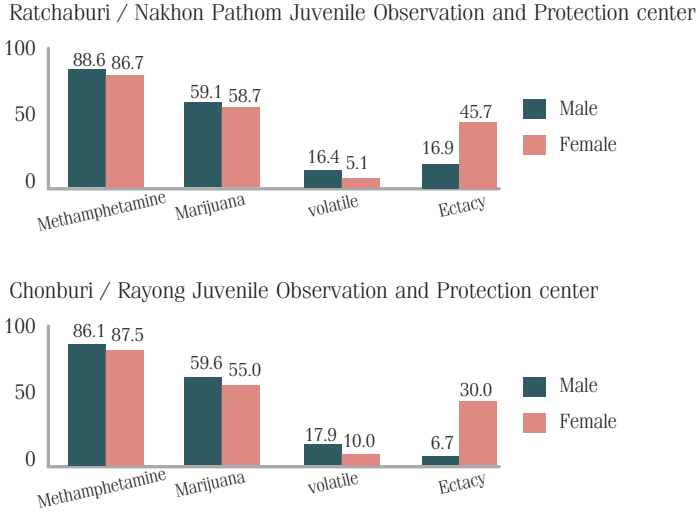


Figure 3: Proportion of 4 most common drug use by sex

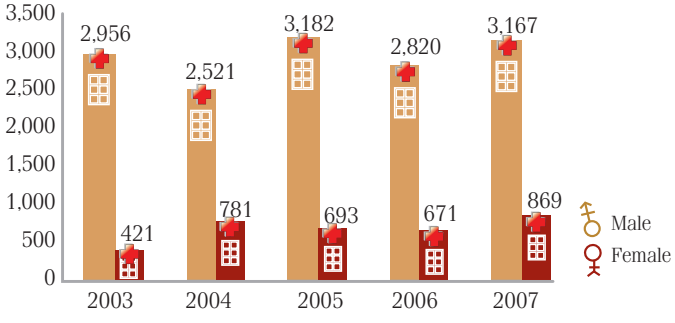


Source: Social Research Institute (Research Unit for Drug Addict and Its Consequences), Chulalongkorn University. 2008. Situations of drug abuse among young people in the Juvenile Observation and Protection Centres and Juvenile Vocational Training Centres. [http://www.abacpoll.au.edu/acsan_thai/index.html]

According to Police General Pacharawad Wongsuwon, Commander of the Royal Thai Police, there have been reductions in all types of crime in 2008, except for gun and drugs crimes, which have risen significantly.

After the Prime Minister Thaksin Shinawatra launched his "war on drugs policy" in 2003-2005, over 2,500 people were killed. This raised concerns of among human rights groups internationally. Research conducted by Miss Manorat Supornsahatrungsri, a student in the Economics Department, Thammasat University has indicated the critical issue for Thai society is that drug sellers have begun to target children and young people in educational institutions. Education institutions have become a meeting and selling places for drug users and dealers. Many students have become drug dealers themselves. Moreover, female students have become involved in drug use and addiction. Customers are becoming younger and younger.

Figure 4 Number of drug addicted at in Thanyarak Institute between 2003-2007



Source: Thanyarak Institute (http://www.thanyarak.go.th)

The Research Unit for the Studies of Drug and Its Social Consequences, Social Research Institute, Chulalongkorn University, conducted research investigating drug use among young people at Juvenile Observation and Protection Centre in four provinces. It was found that the young people most involved in drugs were unemployed, agriculture laborers, former drug sellers, and students. Methamphetamine was the drug most commonly used, followed by marijuana and "Estacy" or "Ice" or "skate", which was regarded as drugs for high society people and more popular among female than male youth (Figures 2 and 3)

Data from the Tunyarak Institute, which is one of five government drug treatment centres, show that the drug addicts who received treatment during the period of 2003-2007, 80 percent were male (figure 4), and most were was poor, particularly the unemployed (figure 2). The economic crisis is predicted to be worsened in 2009 as more than 100,000 persons have been laid off work only in the first two months. The unemployed will be hit hard and as a result some of them might turn into drugs.

Table 2 Number of drug addicted at Thanyarak Institute according to occupation

Occupation	2003	2004	2005	2006	2007
Wage labor	851	1,348	1,654	1,400	1,122
Trade	283	282	298	366	442
Government service	97	119	143	111	147
Students	237	67	62	25	48
Agriculture	110	108	134	87	101
Fishing	1	3	1	5	2
Unemployed	1,601	1,273	1,496	1,390	1,606
Othere	64	68	66	107	564
Not specified	133	33	21	0	4
Total	3,377	3,302	3,875	3,491	4,036

Source: Thanyarak Institute (http://www.thanyarak.go.th)

Concerns are being raised for how young Thais and Thai society can proceed. The worsening drug situation has impacted on all aspects of society including physical health, the family, the economy, and the development of the nation. The gloomy political climate has slowed government efforts to curb drug problems for over 2 years. **The biggest gap in government policy on drugs is strategies focusing on keeping young people away drug selling and addiction.**

3 Food crisis and fuel price crisis: the poor suffer the most

In late 2008 and early 2009, the economy suffered dramatic shocks and there was an unprecedented increase in oil prices. This resulted in massive and continuous increases in the cost of public transport fares of all kinds, in food prices, and in basic consumption items. The economic recession also lead to an increase in the number of workers being laid off and high unemployment. Low income people were and will be hardest hit. The World Bank has warned Asian countries that high inflation including increased food prices will have a much greater impact than the financial crisis in the US. In Thailand the poor are worse hit because expenditure on foods in the region accounts for about 31-50 percent of household income.

The high prices of rice as a result of fuel prices has become the world food crisis

The food price crisis has hit the world market, combined with high inflation triggered by the high oil prices. The situation has been worsened by financial fraud by "hedge funds" and by the US economic recession, caused by the mortgage loan crisis. If the increase in oil price was the only burden, while the world biggest economic such as in the US and Japan continued to grow, it would have offset the high oil prices and minimized its potential effects. The prospect of economic growth would at least ensure rising income in the population, which would offset the rising costs of food and fuel.

This world is facing hard times this year because so many catastrophes have occurred. Natural disasters have occurred in many countries, causing grave reductions in agricultural production, which in turn pushed up the price of basic consumption foods and plants. The US economic downturn has severely impacted on their domestic economic, and also on countries exporting to the US. Therefore, the biggest economy country in the world can no longer stave off global economic crisis. Meanwhile the sky rocketing of fuel prices is further exacerbating the crisis. As a result, many countries are starting to produce bio-fuel, an alternative energy source based on food plants. For example, the US, the biggest fuel consumer in the world, has an alternative energy policy in place to minimize the expenses incurred by the imported fuel.

The impact of the alternative energy, in other words, the expansion of plant growing for ethanol production, in turn worsened the high food prices in the world market because food plants have been used to feed the ethanol factories. The low value of the US dollar and high inflation at that time has lured the speculators to investing in low risk consumer goods such as agriculture products, fuel and metal.

All these reasons have led to the unprecedented and unacceptably high prices of goods. Furthermore, the food price crisis has also led the exporting foods countries to reduce their exports in order to reserve foods for domestic consumption. For instance, Vietnam and India have reduced their exports of rice. Rice is a staple food for about half of the world population.

In 2008, the fuel prices reached nearly 50 baht per litre

In early 2008, the continuation of high fuel prices shocked the Thai people. The retail price of fuel increased almost daily until it broke the record for the most expensive fuel in history, when diesel was sold at 45 baht per litre. Similar increased were recorded for other types of oil.

The consequences of rising oil prices was that small and retail gas stations in upcountry areas were hard hit. Mr. Manoon Siriwan, an expert in energy and petrochemicals, stated that 2,000-3,000 small gas stations closed down and medium size stations gradually reduced their investment in Thailand. Although large scale gas stations have yet to be closed down completely, the returns were poor. The major factor contributing to the collapse of gas stations was due to the government's policy either directly or indirectly to prevent the price floating according to the world market price.

In the mean time, passengers on all kinds of public transports including taxis, public buses, boats, private buses, and cooperative buses, had to bear large increases in fares, which were put up to accommodate the rising oil prices. Trucks and fishing boats went on strike, demanding that the government supply cheap fuel.

Meanwhile private car owners flocked to get their engines altered so that they could use LPG, which was about three times cheaper than gasoline. This resulted in overload at car garages, even when the cost of installation of gas engine was put up to 30-50 percent. As a result, the number of LPG cars increased sharply from well below 100,000 cars to more than 1 million cars. Moreover, Thailand has since April 2008 transformed from gas exporting country to gas importing.

However, Lt General Poonpirom Limpatapanlop, the then Minister of Energy, had few concrete measures to deal with the oil crisis apart from a few conventional ideas such as ordering public places to turn air-conditioners to 25 degree, take off suits at the ministerial meeting, and limit speed of public vehicles to 90 km per hour.

Famine

The fuel price crisis has a far reaching impact reaching beyond food prices because fuel is a basic component of production and transportation. Consequently many countries are facing a very difficult time. Mr. Ban Kee Mun, the UN Secretary General, has warned the international community that if the food price crisis remains, the problems will inevitably become more complicated and trigger further problems, which will undermine economic and social development and security.

Similarly, the issue of food prices was an urgent agenda included in the meeting between the World Bank and the International Monetary Fund (IMF). Meanwhile the Asian Development Bank (ADB) had announced that the era of low food prices had come to an end.

Before long, the phenomena of food crisis affected Thais' daily life. There was a shortage of food, particularly rice and cooking oil, which used to be abundantly available in the market. These food items have become incredibly expensive.

Amidst this chaos a big question being raised was what went wrong with Thailand. The country known as the biggest rice export country, but rice has no longer available for domestic purchase. This prompted Mr. Samak Sundaravej, then prime minister, to announcement that Thailand had sufficient reserves of rice to feed the Thai population. The high rice price will certainly benefit the farmers. However, the farmers strongly argued that the current high price of rice could not be applied because they had sold their rice well before the crisis and sadly the farmers had to buy the expensive rice for their own consumption.

Dr. Kwanjai Komes, Secretary General of the Thai Rice Foundation under His Royal Patronage, one of the best-known rice experts, contended that the current unprecedented dramatically increase in rice price is the most astounding incident in his 68-year life. It is likely to be considered as a problem rather than good news for Thai farmers.

Along with the notoriously high rice price, farmers whose rice paddy has yet been harvested were confronted with a new problem: rice theft. Burglars were stealing rice either from the field or from the rice ban. This forced farmers to take tough measures to guard their rice from theft.

Suan Dusit Poll, Suan Dusit Rajabhat University, conducted a survey between 12 and 19 April 2008. This survey aimed to investigate public opinion regarding the rice issue. Individuals from a wide range of occupation nationwide were included. It was found that since the occurrence of the rice price crisis, Thai people have changed their rice consumption behavior. They were more careful about buying and cooking just the right amount of rice and not wasting any. People stopped consuming jasmine rice and replaced it with cheaper rice.

The high price of rice did not stay for very long. The rice price began to fall only a few months after Mr. Mingkwan Sangsuwan, then Minister of Commerce, told farmers to stock their rice and sell it at the high price of 30,000 baht per ton in the near future. In fact, the market price of rice never went up that high. Instead the government had to intervene and purchase at the price of 14,000 baht per ton instead.

Mr. Witoon Panyakul, Secretary General of the Earth Net Foundation, indicated that this current crisis is the bursting of a rice bubble because the rice cultivation only a takes a period of about 90 days. Therefore, it is not viable in the long term to store rice until the price has gone up as the government claimed.

Although rice and cooking oil are available in the market again with falling prices, and also the fuel price was expected to drop to the lowest level for four years by the end of this year, living costs have continued to rise. For instance, white sugar increased by 5 baht per a kilogram. The costs of almost every item for daily living were up even, before the crisis coupled with the world economic recession. Low income Thais continue to suffer most during the crisis.

Economic crisis is a crisis for the poor

Mrs. Thananoot Treetipbut, Secretary-General of the National Statistical Office, released the results of a survey on the impact of the economic crisis, which found that 62 percent of respondents were affected by the crisis, in particular the increasing price of consumer goods. Average household expenses had increased from 14,500 baht per month to 16,105 baht per month. Moreover, the data from the first 10 months in 2008 suggested that Thailand's poverty might reached the same level as it had in the 1997 economic crisis.

The findings of a survey on the consequences of the economic crisis at the grassroots conducted in late 2008 by the Center for Economic and Business Forecasting, University of the Thai Chamber of Commerce, also pointed in the same direction. It showed that everyone, regardless of occupation, was having increased debt, high living costs, declining income and low savings. It seems likely that the poor will be badly affected by the economic crisis.

The government led by Mr. Samak Sundaravej responded to the economic crisis on 15 July 2008 after a Ministerial Meeting on that day, approving the so-called "Six measures in six months through the crisis for all Thais". These include cuts in the fuel excise tax, free quotas for water supplies and power, and free buses and trains. These measures have been applied even in Mr. Abhisit Vejjajiva's government. Despite the implementation of such measures, the economic worsened crisis.

At the end of November 2008, Thailand has once again faced the problems of employers laying off employees in factories manufacturing automobile and car parts factories, electrical goods, and electronics.

Mr. Thanavat Ponvichai, Director of the Center for Economic and Business Forecast, University of the Thai Chamber of Commerce, believed that the global economic crisis will eventually lead about to 700,000-900,000 Thais becoming jobless. Nikon Thailand

Limited, the camera-manufacturing giant located in Rojana Industrial Park in Ayutthaya province was the first manufacturing company to lay off its 700 workers without warning. The incidence led the Ministry of Industry to examine closely the issues of dismissal of workers. During economic crisis many manufacturing companies will close down.

Until 30 December 2008, 47 factories, the majority of which were electronic parts manufacturing in Ayutthaya province, laid off about 10,000 workers, and 22 factories were likely to be closing down. In late February 2009, the Ministry of Industry released official data showing that during the period of 1 January to 20 February, 163 factories closed down and about 17,474 workers were out of work. Furthermore, 355 factories employing about 132,130 workers, were highly like to terminate the employment of their workers. These workers can be classified into two groups: 62,856 workers at risk of being laid off, and 69,274 workers likely to get less bonuses or reduced working time. The majority of the affected factories produce garments, computers and electronic, home products, metals, and automobile. The top five provinces with high numbers of laid off workers are Samutprakarn, Pathumthani, Ayutthaya, Bangkok, and Chachoengsao.

Although the fuel price has dropped rapidly since late 2008, this seems to have had little effect on the high price of goods. Almost all commodity producers, including commodity manufacturing giants such as the Uniliver and Sahapat, and retailers including food venders, noodles venders, bakery, building construction shops, and agricultural shops, have pointed to high costs of capital and other costs apart from the cost of transportation. It is fair to say that the government can only strictly control the public transport and that the fares have been slightly dropped due to cheaper fuel price.

Private universities were not affected by the economic crisis in 1997 but they were badly hit in the 2008 crisis. Many undergraduate students have enrolled in a cheaper education institution resulting in a stabilizing or even a shrinking of undergraduate enrolment in many prestigious private universities. Moreover hundreds of students did not turn up for registration as they intended to, but instead enrolled at Rajabhat Universities where tuition fee, expenses and living cost are much cheaper. Another sign of the crisis is the shrinking in MBA enrolment, even in some leading state universities.

People are unhappy: the poor must adjust and fight the hardship

It is feared that during the economic crisis, people will get more depressed. An ABAC Poll was conducted in 18 provinces asking respondents about the political crisis, economic crisis, and social opportunities during the past 30 days (late January and early February 2009). It was found the economic crisis impacted on the food prices of 62 percent of the respondents, the careers of 58 percent, and job insecurity for 57 percent. About 51 percent of respondents were seeking work and moonlighting for additional income, and about 50 percent felt that the crisis had somehow affected their living conditions.

Amidst the living cost crisis, low-income earners in Thailand have altered their behavior to reduce spending on items, particularly non-food items such as clothing and accessories, and entertainment expenses. Meanwhile, instant noodles, a Thai economic indicator, have had huge increases in sales, even at increased prices.

The northeastern residents in a group called “I-san People in 19 Provinces for Democracy”, released a petition urging the government to immediately respond to solve the economic crises, including the fuel price crisis, the rice price crisis, and high price of sugar. Delay in coping with these issues will be inevitably lead to increases in other costs of living and will hurt people in all walks of life. The group also urged the government to resolve the farmers’ debt problem, and ensure fair daily wages for low income laborers.

4 Crisis strikes... Thais are at risk

In 2008, Thailand faced troubles on all fronts throughout the year, including recurring political turmoil, an economic downturn worsened by the "hamburger effect" which shows no sign of improvement, and increases in unemployment to well over 100,000 persons in the first part of 2009. All these factors have led many Thais to become depressed. Both joblessness and recession have a significant mental health impact, particularly depression Forcing some be commit suicide.

Suicide rates in Thailand

According to WHO, approximately 1 million people die from suicide annually, or about 2,739 suicide deaths per day, or 114 per hour, or 2 per minute. In 2020, the number of people who chose to end their own life is estimated reach 1.5 million people. Based on Ministry of Public Health data, Thailand is ranked number 71 in the world, for the problem.

1998-2007 Data on numbers of death are available from death certificates administered by the Department of Administration, Ministry of Interior. According to this data, the average annual deaths from suicide in Thailand during 1998-2007 were 4,442 per year. The suicide rate peaked at 8.6 deaths per 100,000 persons, or about 5,200 deaths, in 1999, due to the economic crisis. However, the number of suicide deaths dropped to 3,458 deaths, or 5.5 deaths per 100,000 persons, in 2007.

There are clear regional differences in suicide death rates in Thailand. The North has the highest rate in the country, particularly in Chiang Mai and Lumphun Provinces, where the suicide death rates were the highest for 10 consecutive years, at 21.3 deaths per 100,000 persons in Chiang Mai and 21.4 in Lumphun. The suicide death rate for the whole kingdom for the average 10 years was 7.1 deaths per 100,000 persons. The lowest suicide death rate was found in the South, particularly in provinces where the insurgency was occurring, such as Pattani (1.2 per 100,000 persons), Narathiwat (1.4 per 100,000 persons), and Yala (2 per 100,000 persons).

It is assumed that contextual differences between the North and South can to some degree influence the people's decision to end their own lives. However, we have yet thoroughly investigated how culture, religious and economic factors influence people's decision to commit suicide.

2008 The information Centre, Plan Division, Department of Mental Health, has collected data on the number of deaths from suicide occurring in January to December 2007. The data were obtained from the Ministry of Interior's death certificates. It was

found that during this period there were 3,458 deaths from suicide - 2,703 males and 755 females. The top three provinces with high numbers of suicide deaths were Chiang Mai (227 deaths), Chiang Rai (132 deaths), and Bangkok (122 deaths). In terms of suicide death rates, the top three provinces with the highest death rate per 100,000 people in order of significance were Lumphun (16.23 deaths), Chiang Mai (13.58 deaths), and Chanthaburi (10.66 deaths).

Depression is a major risk factor leading to suicide among Thais

Depression is a leading cause of suicide. According to the Ministry of Public Health, about 90 percent of the persons who successfully commit suicide have a depressive disorder. Women are more likely to attempts to suicide than men, but men have a suicide rate that is three times higher than women.

Moreover, it was found that suicide among Thais is associated with drugs (50 percent) and alcohol use (35 percent) because both drugs and alcohol reduce decision-making ability. Therefore, drug or alcohol use among those who have thought of death are at high risk of committed suicide.

The World Health Organization, the World Bank and Harvard University have predicted that depression will be the second leading cause of death after coronary health disease globally in 2020, and that the problem will be particularly serious in developing countries.

In Thailand, a survey conducted by the Department of Mental Health found that the prevalence of depression in the country as a whole was 4.76 percent or about 3 million persons. During the period 2004-2006, only 116,847 depressed patients received treatment in hospitals. The main reason for lacking proper treatment is that many depressed people are not aware of having symptoms or do not think of the symptoms as a mental disorder.

The political and economic crises of 2008-2009 will not have an immediate affect on mental health. Instead, there is likely to be a delay of about two years before depression prevalence rises. This was what happened after the 1997 economic crisis: a sharp increase in the number of depression patients occurred in 1999-2000. Therefore, it is expected that depression will be rising among Thais over the next two years.

Proactive services by the Department of Mental Health

The political and economic storm in 2008 and 2009 have impacted greatly on the mental health and living conditions of many Thais. The Department of Mental

What is depression?

Feeling sad or depressed can be a normal reaction when people lose someone or something they love or are under stress. The situation is considered to be abnormal once the symptoms have worsened and involve the body (loss of appetite, fatigue, lack of sleep, weight loss), mood (persistent sad, crying, loss of interest or pleasure in activities), and thoughts (pessimism, worthlessness, hopelessness, though of death), and other difficulty concentration and remembering, poor personal relationships. All these symptoms inevitably affect the ability to carry out daily activities or work, which will impose a large burden on the family and community and may eventually lead to suicide.

Someone with symptoms of depression is considered to have a psychiatric disorder. This disorder can be treated by having proper care, visiting a psychiatrist regularly, and taking medication for at least six months.

Health is responsible for providing mental health care. It has set out a mental health plan to providing mental health services nationwide.

Dr. Chatri Bancheun, Director of the Department of Mental Health, has said that "the department has provided outreach mental health services through a mobile team known as visit for treatment team. The team consists of qualified mental health personnel. It will visit the affected areas, particularly those where there is violence such as the three provinces in the deep south."

Those who are affected are often left with an invisible scar that may later develop into post-traumatic stress disorder (PTSD), and often followed by depression in the case of loss. The majority of depressed individuals are not treated by qualified health professionals. Some isolate themselves from other people. The mental health mobile team will go out and get to know the community to identify, screen and assess mental health problems, so that basic health care can be provided.

The prevention and control of depression is an important policy of the Department of Mental Health. In 2009, the focus will be on system development and improving access to mental health care services, particularly in mental health organizations and the MOPH health facilities at the provincial level. The following systems will be put in place.

1. A screening system administered by trained individuals, village health volunteers, and community leaders to assess people's stress levels using simple questions
2. An evaluation system run by health personnel using questionnaire
3. A medical diagnosis system for further diagnosis of high risk cases
4. Treatment guidelines and standards with special attention on medication and a wide range of psychotherapy
5. A monitoring system using monitoring forms every 6-8 months after treatment
6. A system preventing recurrence of depression to reduce the chance of suicide

In an area with high suicide rates, such as Chiang Mai, Chiang Rai and Lumphun, the Department of Mental Health, through Provincial Psychiatric Centers, will work collaboratively with the province. The provincial psychiatrist will lead this mental health team and the team will receive support from the Provincial Governor, and Provincial Medical Officer. The mental health activities will be monitoring by the regional mental health center.

To improve access to mental health services, the department has launched a 24 hours hotline counseling service using phone number 1323. According to department records on numbers of users since May 2007, well over 50,000 people have accessed the hotline services. There has been an upward trend in numbers of users over time. The majority of the hotline users are those who have mental disorders, adaptation, stress, relationship difficulties, and sex problems.

Self-care and care of other

The Department of Mental Health has speculated that the number of death from suicide will increase in 2010-2011 due to the consequence of economic and political crises in 2008 and 2009. This time the number of deaths will be much higher than in 1999.

Deaths from suicide have been continually monitored. It has been observed that the rates of death from suicide have increased consistently since the military coup on 19 September 2006. For example the rate increased from 5.8 deaths per 100,000 population in 2006 to 5.9 deaths per 100,000 population in 2007 and it is expected to have reached 6 death per 100,000 in 2008.

Dr. Wachira Pengchan, Deputy Director of the Department of Mental Health, pointed out that the Tom Yum Kung crisis occurred whilst Thailand was stabilized politically and that all parties were very cooperative in resolving the economic problems. Nowadays Thailand is facing a double burden due to simultaneous political and economic problems. These

crises will impact on a wide range of people, from the middle class to people at the grass-roots.

If the unrest and political conflicts persist, many people will be feeling under pressure or stress. The can lead to mental health disorders, particularly among those who lack coping mechanisms.

None the less the Political Stress Syndrome (PSS) is not considered to be a mental health disorder, but is an emotional and intellectual response to events, which may occur among people who are participating or closely observing the events. The symptoms of PSS includes physical problems such as headaches, restlessness, heart palpations, and numbness; mental problems such as irritation, confusion, aggression, temper, and hopelessness; and behavioral and relationship problems such as quarrels in the family, a lack of self control, and thought of retaliation using violence means.

The danger signs of depression (see Box) are not meant to attract attention, but the depressed persons nevertheless may be signaling for help. If we pay attention and keep a close watch over someone who may be close to developing depression, we can prevent the loss and reduce the number of depressed persons committing suicide.

Stress relief methods

The Department of Mental Health has given advice on practical ways to release stress. These methods are focusing on the relaxation of muscles, which leads to peace of mind.

Contract and relax the muscle by sitting comfortably and contracting the muscle for about 10 seconds, then relaxing the muscle and repeating the process over again for about 10 times. The contraction will increase muscle tension and feelings of stress, while relaxing will release the tension. This relaxation technique can be applied to any body muscle, for example, clenching hands and contracting arms, raising or curling eyebrows, tightly closing eyes and shriveling the nose, taking deep breaths and raising the chest, back and shoulder, sucking the stomach and contract the pelvic floor, raising legs and flexing the toes, and so on.

Warning signs and symptoms of depression

- Complete change in ways of eating and sleeping such as starving, restlessness
- Aggression, self destructive tendencies, or violence against others
- Isolation from family or friends
- Running away from home
- Inability to concentrate; neglecting responsibilities
- Using alcohol or drugs
- Refusing to study or work, without providing reasons
- Self-neglect
- Changes of behavior
- Complaining about symptoms, without medical reason
- Talking or thinking about death; giving significant belongings away to others
- Talking about self harm; joking about or outlining a plan to take his/her own life
- Threatening or trying to harm

Deep breath using the abdomen diaphragm. Take a deep breath slowly to puff up the stomach and hold for a second, then exhale to flatten the stomach.

Basic meditation. Sit cross-legged or in a comfortable sitting position in an quiet place and then concentrate on breathing in and out.

Silent technique. Sit or lie down in a private place, then close the eyes to avoid distraction and breath slowly.

Besides taking care of yourself, you should also note whether behavioral changes are occurring among other people you know.

5 Life versus vested interest: The government introduces compulsory licensing (CL) based on the right to life

"Access to medicines has been improved through a major reduction of prices, enhanced international funding, a greater recognition of the need to find a balance within the intellectual property system, as well as the use of some of the TRIPS flexibilities by certain WTO Members"

DG Pascal Lamy, WTO Director-General (9 December 2008)

Thailand exercises its right to issue compulsory licenses on three patented essential drugs

In 2006 and 2007, Thailand's Ministry of Public Health announced the use of Compulsory Licensing (CL) on three patented drugs, including two antiretroviral drugs (Efavirenza and Lopinavir+ Ritonavir) and an antiplatelet drug (Clopidigrel). The government's use of compulsory licensing has resulted in a three-fold increase in access to antiretroviral drugs (see Figures 1 and 2). More than 6 million tablets of the anti-platelet drug have been distributed to hospitals under the government universal health coverage scheme nationwide. In the past, only 10 percent of the population could afford this drug.

In 2008, the government imposed compulsory licensing on another four drugs. This appeared to have a similar effect on patients' access to essential drugs, because of the use of imported cheap generic drugs from India (See table,page 52). The benefit of the government's use of patent is not only limited to Thailand, but also affects the wider global community, as Mr. Pascal Lamy, WTO Director-General, has noted.

Figure 1 Record used of Efavirenz 600 mg, 2006-2009

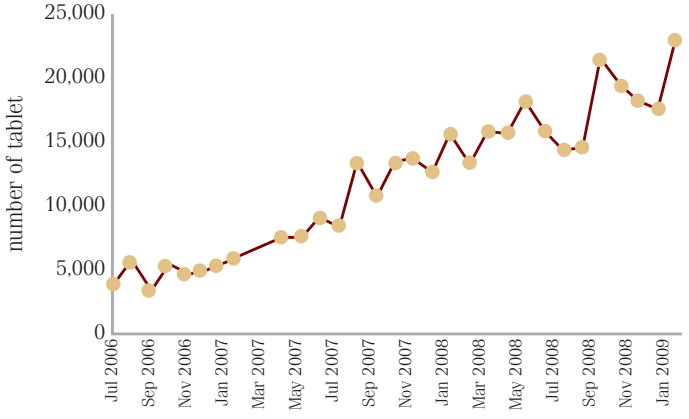
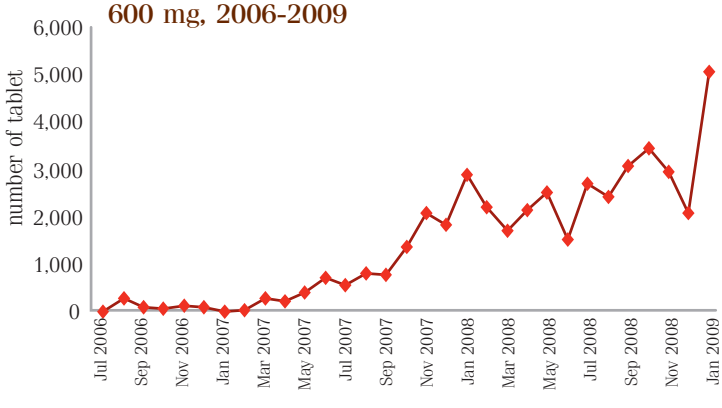


Figure 2 Record used of Lopinavir/Ritronavir 600 mg, 2006-2009



Source: Suwit Wibulpolprasert, Ministry of Public Health, Thailand

However, the road to access to essential drugs is not always easy. It is a battle against vested interests.

Table Comparison of drug prices before and after the government issued CL

Name	Price of patented drugs before CL policy	Price (USD)		
		Patented drugs after CL policy	Generic version	Difference (time)
Efavirenz	58 per month	24 per month	10 per month	5.8
Lopinavir / Ritonavir	1,800 per year	1,000 per year	780 per year	3
Clopidogrel	3	1.3	0.04	75
Letrozole	7	2.2	0.1	70
Docetaxel	900	450	37	24.3

Source: Suwit Wibulpolprasert, 2008.

Note: Erlotinib is under the procurement process. Imatinib is available for free for income earner patients under the universal coverage scheme by using the model drug from Novartis under the special project of the Glivec International Patient Assistance Program (GIPAP).

In 2008, Thailand announced the use of CL on cancer drugs: lawful and satisfactory

In early January 2008, Dr. Mongkon Na Songkhla, then Minister of Health, granted licenses to four anti-cancer drugs:

1. Lung cancer drug with generic name Erlotinib and trade name Tarceva®
2. Breast cancer drug with generic name Letrozole and trade name Femara®
3. Lung and breast cancer drug with generic name Docetaxel and trade name Taxotere®
4. Medication for chronic leukemia with generic name Imatinib and trade name Glivec®

However, the government stated that it would not impose CL as long as the pharmaceutical industry has supplied the patented drugs free of charge to the government universal health coverage scheme. Although the agreement was signed in January 2008, the implementation was to take a year, ie. until January 2009, to take effect.

Based on a report prepared by the WHO Working Group, consisting of delegates from WHO, WTO, UNDP, and UNCTAD, who visited Thailand providing technical assistance and the analysis of compulsory licensing, the implementation process for CL by Thai government was in agreement with Thai and international legislation. The report also recommended that Thailand should take a flexible approach both before and after the implementation of CL to increase access to drugs.

Nevertheless, when the new government took office, Mr. Chaiya Sasomsab, the new Minister of Health, immediately criticized the implementation of CL even before the government released its policy. Mr. Chaiya says "The announcement of CL is satisfactory but imperfect." It needed to be reconsidered because it would affect Thailand exports. He continued criticizing Doctor Mongkon Na Songkhla of rushing to sign the agreement right at the end of his term. Mr. Chaiya totally ignored the fact that the government use of CL on the 4 cancer drugs was far better handled and transparent than that of the first 3 drugs, resulting in the delay of the formal announcement to early 2008, not long before Doctor Mongkon Na Sangkhla stepped down from his ministerial post.

Attempts to review the CL by the new Minister of Health led to widespread opposition from groups of patients, professionals, doctors, pharmacists, academics, and NGOs

Dr. Jiraporn Limpananon, Department of Pharmacy, Chulalongkorn University, stated that "A person who oversees the Ministry of Public Health must protect Thais interest in access to drugs. If the reconsideration of CL ends up with the cancellation of CL, this decision will affect Thailand as follows: 1. difficulties accessing drugs; 2. difficulties negotiating with drug firms, because Thailand no longer has the threat of CL, meaning that firms will not drop the price of drugs; 3. without CL, household expenditures on drugs would rise substantially"

Opposition to the review of CL policy has not been confined to Thailand, but has extended internationally. Twenty-six member of congress from the US Democrat party wrote a letter to the US Trade Representative opposing the imposition of Special 301 Report to block an access to drugs among Thais. Meanwhile nine international legal experts also wrote a letter to Mr. Chaiya and Mr. Samak Sundaravej, the Prime Minister, stating that

"The new Government of Thailand is of course free to reassess the policies of the prior government, but it should not do so based on a legally incorrect analysis of the legality of the previously issued licenses nor based on an inaccurate assessment of the risk of

punishing trade sanctions by its largest trading partners. In the past, the Thai government, including predecessors of the current government, has made wise decisions to provide low-cost, and subsequently free, medicines to the Thai people. The government has increasingly recognized the importance of promoting and preserving health and of ensuring a present and future supply of affordable life-saving and life-enhancing medicines. Patent holders would like to have complete freedom to charge whatever they like, but their desire for unrestricted profits is at variance with the government's interest in spending money wisely, in building a more competitive market for medicines, and in promoting pharmaceutical capacity in Thailand."

In the conclusion of the letter, the legal experts have recommended that Thailand should not only maintain its existing compulsory licensing, but also preserve its sovereign right to issue such licenses in the future and maintain a credible threat of licenses for price negotiating with drug companies.

In response to this opposition, the Ministry of Public Health reluctantly appointed a Working Group to review the government's compulsory licensing of anti-cancer drugs. The Working Group consisted of medical specialists, public officials, NGOs, and patient groups. The main task of this Working Group was to study the money that could be saved through CL and the possible loss from the exports. It was found that if drugs from firms other than the patent-holders were used, expenditure on the three drugs could be reduced by 269-538 million baht in 2008, and by 560-940 million baht in 2012. Over five years the government could save 2,088-3,748 million baht."

This information has yet to be used in formulating policy. Dr. Siriwat Tiptharadol, the Secretary-General of the Food and Drug Administration, and Chairperson of the Committee to Negotiate the Price of Patented Drugs, has been transferred to take up an inactive position as an inspector. The government also sacked the Pharmaceutical Board chaired by Dr. Vichai Chokevivat, who was also the Chairperson of the Committee to Support the Implementation of the Government Use of Patents, which led to the filing of a law suit against the government. Many civil society groups have put pressure on the government and have filed complaints to Petition Commission to impeach Health Minister Chaiya Sasomsab. They say that he has violated the constitutional law and has damaged the national interest.

Opposition to compulsory licensing

There has been strong support for the action taken by the Thai government in imposing compulsory licensing. However, there has also been much criticism and calls for Thailand to abandon CL. Mrs. Barbara Whitesell, US Trade Representative in Asia and Pacific Region, during meeting with ministers and secretary-generals of Ministries of Commerce, Forreign Affairs, and Public Health, called for the cancelling of the Free Trade Agreement between the US and Thailand. The US has put pressure on Thailand and requested that the government submit a plan protecting intellectual property. It has threatened to include Thailand in the Priority Watch List (PWL).

Meanwhile Mr. Peter Mandelson, EC European Commissioner for External Trade, wrote to Commerce Minister Mingkwan Saengsuwan stressed that compulsory licensing, while allowed by the WTO rules, should be regarded as a last resort option and that negotiations and collaboration with pharmaceutical companies should be sought. The EU is hoping that this will be the line of the new Government.

The above criticism has been strongly criticized by the TransAtlantic Consumer Dialogue (TACD) Working Group on Intellectual Property:

"If the U.S. and the EC (and EU member states) exert pressure every time Thailand issues compulsory licenses...as citizens of the US or Europe, we expect our governments to honor the terms of the 2001 Doha Declaration. There is nothing in the Doha Declaration or the TRIPS that makes the use of compulsory licenses a "last resort." Thailand does not have a WTO obligation to negotiate with patent owners before issuing a compulsory license for its own public health programs. Thailand certainly has no obligation to have such negotiations supervised by U.S. and European governments."

Multinational pharmaceutical companies have attempted to have CL withdrawn

- **Dropping the price of patented drugs.** An attempt has been made to drop the price of Plavix in return for Thailand canceling the existing compulsory licensing. Apart from lowering prices, the company has also offered to provide tablets free or for a reduced price of 5 baht for patients under the national universal health care scheme while patients belonging to other schemes such as

Social Security and Civil Servant Medical Benefit would be charged at the existing price of 70 baht per table. Many hospitals, impressed with the offer, have requested that the Health Ministry clarify the CL policy.

- **Criticizing the quality of generic drugs.** Drug companies release information on the quality of imported generic versions and Bioequivalent Studies (BE Studies) for imported drugs, aiming to discredit generics. This tactic combined with reduced drug prices has created great frustration among doctors. In fact, special attention has been paid to the matter concerning the quality of the licensed patented drugs. These drugs meet the standard set by the FDA and none of those claims were substantiated. In addition, tests were conducted by the Department of Medical Science. At present the licensed drugs have been distributed to over 200 public, private and university hospitals nationwide, with no concerns yet raised. In response to this issue, the FDA, in press conference, backed the quality of the licensed drugs such as Clopidogrel.
- **Enforcing rules trapping generics.** The Department of Intellectual Property, Ministry of Commerce, took the opportunity while raising concerns about pirate CDs, to push for an Office of Prime Minister resolution dealing with the violation of intellectual property rights ... which also included more that 30 drafts from all organizations overseeing the intellectual property of the private sector, including FDA, which is responsible for the certification of registered drugs for the consumer protection. As a result, the organization oversees consumer protection but also deals with intellectual property law enforcement. This is consistent with the demands of the US and EU for FTA negotiation and is an attempt to get generics classed as counterfeit drugs in the WHO meeting with the leaders of Group of Eight or G8.

Beyond access to medicine, we also win over people

Amidst this struggle between life and vested interests, there is a a growth of civil society support for the implementation of compulsory licensing.

The Thai Network of People Living with HIV/AIDS has been a major force in taking a firm stand on universal access to drugs. The Kidney Disease Association has joined force and shared their experiences. Treatment of terminal stage of kidney failure has been included in the universal health coverage and social security beneficiary. Likewise, a network of cancer patients initially formed by patients from several hospitals began to make their voice heard concerning the issues of access to drugs. Lately the network of mental health patients has called on the government to issue compulsory licensing on psychiatric drugs.

The movement by civil society is not only limited to the matters concerning continuation or cancelling of compulsory licensing. It has also extended knowledge on the universal access to drugs of all Thais, proposed in the First Thai National Health Assembly. Strategies include:

1. collaboration with the health network
2. supporting patient groups to engage in health care and health promotion
3. supporting efforts in setting national drug prices to realistically reflect the cost of living
4. enhancing the development of pharmaceutical production in the country
5. maximizing the benefit or diminishing obstacle from the use of law
6. encouraging proper use of drugs
7. research and development of new drugs

A number of international groups have drawn on Thailand's experience with compulsory licensing. For example, the Civil Society of Columbia has called for the Columbian government to take a humanitarian stand over providing universal access to essential antiretroviral drugs such as Lopinavir and Ritonavir. In China, the Chinese Intellectual Property agency invited the international law and pharmaceutical experts and Thai representative to discuss experiences in using flexibilities in intellectual property agreements including compulsory licensing. Without doubt, virtually every battle involvies resistance and hostility as experienced by Thailand.

The road ahead

The fight for balancing profits and access to essential drugs is far from settled. No single group is strong enough to win the fight. Only if all civil society and patients join forces, raising public awareness in recognizing the basic human rights to access to health care can the battle be won.

6 Sexual Harassment at Educational Institutions: Time for a Systematic Solution

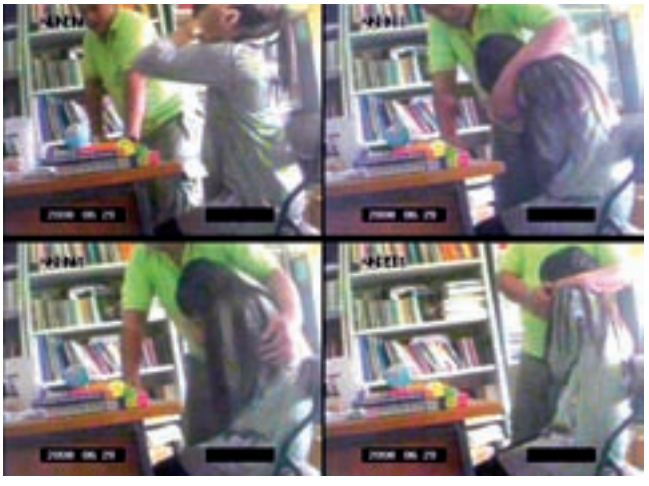
Sexual harassment is an ever-present form of violence that can affect anybody. Incidents of sexual harassment catch public attention and attract condemnation every time they happen. There was increased media coverage of sexual harassment in 2008, and several high profile incidents occurred in schools. The fact that these incidents occurred in educational institution made them particularly noteworthy. Schools are responsible for training and teaching young people. They have high social standing and are assumed to be safe places for young people.

Sexual harassment at education institutions

Sexual harassment at educational institutions can be divided into two broad groups: harassment occurring in school and harassment occurring at university. Sexual harassment in primary and secondary schools may involve a teacher or an adult who is respected and superior. The adult takes advantage of or threatens a young student to make them accept or conceal an unwelcome sexual advance. Sexual harassment in university sometimes has the appearance of mutual consent. But it involved the abuse of power by a teacher, taking advantage of students who want good marks in return. Moreover, sexual harassment sometimes occurs through senior students abusing their power over younger students.

A teacher sexually harassed a student is seriously break of discipline

The media regularly carries stories of teachers sexually harassing students. In 2008 there were 16 incidents reporting in newspaper (see Table on page 59). Of these, three involved primary school pupils, 11



involved secondary school students and two involved university students. The majority of the victims (73 percent) were aged 13 or younger, and the rest (27 percent) were 14-18 years old. In most cases, the harassment took place while teachers and students were taking part in school activities such as music rehearsals or sports training. The teachers often tricked or persuaded the students into providing sexual favors. In many cases, the teachers abused their power to force students not to disclose the sexual activity to other staff. The Office of the Teachers' Civil Service Commission (OTCSC) has compiled records of sexual harassment that have been investigated by the Discipline and Lawyer Group. It found that 96 teachers employed by the Office of the Basic Education Commission broke the code of conduct and have been punished. Of these teachers, 24 committed adultery, or were involved in pornography or sexual harassment. The number of incidents of sexual misconduct increased from the 2006 fiscal year, when there were only 20 cases.

The teachers' code of ethics in the teacher and education personnel regulation 2004 Article 94, Section 6 states that teachers involved in sexual harassment of pupils or students are severely violating the disciplinary code. An attempt has been made to set standard on ethics for government teachers and public servants in the education sector. However, the

code emphasizes neutrality and conflicts of interest of public services, rather than addressing the sexual harassment. It only deals with sexually harassment superficially, through the statement the staff "must not harass or sexual threaten, assault, flirt or have any improper sexual conduct with students, other staff or visitors".

Exchanging sex for good grades

Two particularly notorious incidents occurred in educational institution in 2008. The first was when a university lecturer asked a female year 3 student to see him in his office. He told the student that she had low mark in the exam but that if she agreed to sleep with him, she could have a good mark. The student refused and the teacher asked her to perform oral sex. The student refused and said that as a teacher he should not behave like this. He grabbed her and attempted to rape her. The student fought back and was able to escape.

The student talked with her friends before telling her parents and reporting the incident to the police. The case could not be prosecuted because of lack of evidence. The police advised the student to hide a tape recorder in her bag and go back to the teacher to ask him about her mark. The teacher behaved the same way and offered the student a good grade in exchange for having sex with him. After sneaking out from the teacher's office, the student handed the tape to the police. The court then issued a warrant to arrest the teacher.

The teacher was arrested in his office in the university and was accused of committing immoral conduct. He was made to confess in front of the University President. An investigation found that in the past one female student was sexual harassed by the same teacher, but the student managed to escape. His behavior was widely known among students.

Since the incident was disclosed to the public, Thais witnessed an apology from the President of the University. He said that he regretted the incident, and that he apologized to the general public for not being able ot control his staff to properly. He said that the behavior was a gross violation of codes of conduct. He also apologized to the affected students, their parents, and the university community.

The university took several remedial measures. It dismissed the lecturer. An investigating committee was appointed to look into the incident. A Dean assessed the grading process for that subject in the previous year. In the long term, the university will focus on prevention measures to avoid further such incidents. Because the accused was a lecturer, sexually harassment was a severe breach of professional standards.

Only two months later, while the same university was arranging a public place for meeting with students to occur, a second incident occurred. An Associate Professor abused his power, offering a good mark in exchange for sex. A female student in year three reported the incident to the police. The student also told the police that when she took a subject offered by the professor in the previous semester the professor had asked for her mobile number. She had thought that this that was a common method for communicating with students.

The professor often rang her using flirtatious language and asking for dates. She had never accepted his offers and had avoided him. The professor had threatened her that if she did not cooperate, she would have trouble with her exam. After the exam she found that all other students received A grades, but she received a very low mark. In the next semester, she had to take a subject offered by the same professor. The professor took whatever opportunity he could to verbally harass her, and make sexual advances. The victim was forced to face the problem alone. She contended that she went to see her advisor and asked for an advice about the incidents but was told only to be careful and that nothing could be done.

"Given no other way out, I decided to talk to the police. The police suggested carrying a hidden video camera to an appointment with the professor in his office. As anticipated, the professor asked to see me in his office. I carried a video camera as planned. Once I

entered his office, he approached and hugged me and asked to do more. But I tried to avoid him by telling him that he could do so some other time and that I had to go because my friend was waiting downstairs. He kissed me on my cheek before letting me go. I then went to report to the police and gave the evidence for further investigation."

The recorded pictures and voice were important evidence implicating the teacher. The records were also released to the media. There has been widespread criticism of the poor student support system and of the university's investigations. There were widespread rumors about sex scandals, especially concerning attractive female and male students sleeping with teachers in exchange for good marks. There were also a number of letters of complaint. But sadly nothing can be done without strong evidence. Since the incidents were disclosed, the National Commission for the Prevention and Suppression of Corruption has finally addressed the issue of the abuse of power by teachers. It has declared that forcing or persuading a female student to accept sexual relations in exchange for exam marks is immoral conduct, which is in violation of criminal law. It is illegal for a person to abuse their power or to coerce or persuade a person to give them any advantage, according to Article 148 of the Criminal Law.

Ethical standard for teachers

The Civil Servants in Higher Education Regulation 2004 states that the act of taking improper advantage and seriously defaming, insulting, or harassing colleagues, students, pupils or the general public is a severe breach of the code of conduct. In addition, the Civil Servants in Higher Education Commission announced an Ethical Standard in Education Institutions in May 2007, covering ethical standards for all levels of government service in higher education. One of the core principles is not using power over students to commit an immoral act, and sexually insulting or having sexual relations with students is the most serious break of the code of ethics. However, these statements are merely rhetoric, and have no impact on practice. The regulations have also been endorsed by all universities as applying to personnel administration and professional ethics. For example, the regulation of Chulalongkorn University on personnel administration 2008 states that serious sexual insults or threat, or defamation, abuse, or harassment of colleagues, students, or university visitors, are serious breaches of discipline.

Since the two sexual scandals, Thammasart University, where a Code of Ethics has existed since August 2006, has ruled that a lecturer is forbidden to take advantage of students, individuals, and society in any form. The Thammasart University Administration Committee has circulated to all staff practical guidelines for lecturers in dealing with students.

(1) Sexual relations or sexual comments with students, regardless of consent or force, is a serious misconduct which violates the code of ethics of lecturer. In such cases, the university will impose severe punishments for the serious break of discipline.

(2) To minimize opportunities for such incidents, faculty should arrange a common room for student counseling or meetings which is visible from outside the room. If a counseling room cannot be arranged, or the meeting is arranged in the lecturer's office, the office door must be left open or folded up, in order to avoid suspicion.

(3) The Student Affairs Division should work with the Faculty of Social Administration to set up a complaints centre and to resolve student and staff problems through an easy access channel such as a telephone number and electronic access. In addition, the centre should communicate with related offices or directly to the university administrators.

Moreover, Thammasart University has revised its regulations on the discipline and appeals process. Its 2008 complain procedures state that (1) improper changes to students' exam marks, sexual comments to students or pupils, adultery, and obscene remarks are serious breaches of codes of conduct, and will result in dismissal. In addition, university regulations and ethical codes on sexual comments will be strictly enforced.

The Higher Education Commission has established a website (www.mua.go.th/clean or www.mua.go.th) with the slogan "students join hands to nurture the institution". The website provides a channel for filing complaints about sexual harassment. In the past two months, about 20 complaints were filed. Anonymous investigations were undertaken, which found that six lecturers had been involved in sexual harassment of students. The commission has forwarded the investigation to the relevant authorities for further action.

In addition, the High Education Commission has instructed universities to review records for the years 2002-2007 concerning lecturers who were involved in sex scandals and had been disciplined or dismissed. Over the period, 410 cases were resulted serious disciplinary action for sexual harassment of students. Twelve individuals were blacklisted, six people at government universities, three at state autonomous universities, and three under the Higher Education Commission.

Indecent activities at student initiations

Sexual harassment in educational institution is not limited to physical abuses as described above. It also includes other forms such as the initiation ceremonies for new university students, where senior students abuse their power, forcing newcomers to participating in supposedly entertaining activities. In fact some of the activities include contents and actions that symbolize directly or indirectly sexual acts. An example is the mia ngoo or snake's wife song which includes the words "one baht is watchful, nothing better than snake's wife, can touch, can palpate, but do not penetrate the hole"; or the song satri mee song geep, 'a woman has two creases', which includes the words "a woman has two creases, to use for cliping the enemy's thing, an enemy got one piece, to use for penetrating a woman's thing, a woman said good, and ask for more from the brother enemy"; or the song "when I was raped, he told to me to stand parted, one or two times I don't mind, but five or six times"; or the song "where are you going this evening young sister? To go to the first kilometer one, to go there to get tugged by the gigolo."

These songs constitute sexual abuse and sexual harassment. They are a form of verbal abuse. They make fun of the circumstances that lead to violence against women and children.

Solving the problems in educational institution at all levels

Educational institutions are one of the main institutions responsible for molding and creating new generations. All educational levels from school to university should maintain its integrity, both academic and ethical. Educational institutions should deal seriously with those who seek sexual advantage of all forms in educational institutions, where hopes and expectation are very high. Although the Ministry of Education has imposed regulations and codes of ethics for teachers and lecturers, administrators often do not want to publicly disclose incidents because of the risk to the institution's reputation. This often results in the victims having to face the problem alone.

The public apology by the president of the university described above, and the immediate amendment of regulations and codes of ethics together with the establishment of a system to monitor students and staff is an example of good practice. However, the challenge for the Ministry of Education is that, if educational institutions do not take the issues seriously and do not legally pursue the cases, or try to cover up the incidents, the administrators should be punished as well. But the more important challenge is that, as an educational institution with a mission to

strengthening society's knowledge and wisdom, they should address the root causes of the sexual harassment in Thai society. They need to create an anti-sexual harassment culture, and a new view of the victims of sexual violence, abolishing the stigmatization or social labelling of victims, and empowering them to stand against the problem. At the meantime, all educational levels should be strengthening understanding about the root causes of sexual abuse, particularly the power struggle between the harasser and victim. Support for research into the Thai context is needed, exploring ways to address the problem in the long run.

Incidents of sexual harassment reported in the print media in 2008 (16 incidents)

Published Date	Harasser (province)	Victim	Situation
14 January	Music teacher	Year 7 student (aged 12)	Rape in the music room
29 February	Thai language and computer teacher (Ratchaburi)	Female student (aged 11) (since year 4)	While pretending to teach, approached from the back, touched the genital area, and inserted a finger into the vagina
29 February	School principal (Chonburi)	Year 7 student (aged 13)	Invited three students to his office, and touched their bottoms and embraced them
24 March	Thai language teacher (Khonkaen)	Year 7 student (aged 13) 5 students	Entered the classroom and tried to physically harass, kiss, and rape; offered money
25 March	Physical Education teacher (Singburi)	Year 4 student (aged 10)	Call students to the physical education class and sexually abused them
28 March	Vocational teacher (Lampang)	Year 7 student	Sexually abused and made threats if victim disclosed the act
24 April	University lecturer	student	Forced student to perform oral sex in exchange for good marks. (Similar there incidents had occurred earlier, including rape in a car causing a student to become pregnant, dismissed*) but accusations and all reports were
09 May	Physics teacher (Srisaket)	Year 12 student (aged 17)	Told student that taking to buy uniform but instead took to motel
29 June	University lecturer	Year 3 student	Abused and persuaded to sleep with lecturer, in exchange for grades. The student used a hidden video camera to take pictures used as evidence
06 July	Boxing teacher (Chantaburi)	Vocational student year 1 (aged 16)	Forced to go to a hotel and raped
22 July	Principal of secondary school (Sakonnakorn)	Secondary school student	Physical abused female students, touched breasts and bottom
30 July	Teacher (Phisanulok)	Year 8 student	Physical abuse and then bought gift in exchange for not reporting the incident
08 October	Computer teacher (Chonburi)	2 male students year 6 (aged 12)	Kissed, told to take off trousers, and physically abused
30 November	Principal of Sport School (Surin)	4 male student year 7 (aged12)	Physical abuse, coercion and touched penis. Gave money to not tell others
13 December	Director of college (Chiang Mai)	Year 12 student	Touched breasts and abused on the bus
24 December	Arts teacher (Chachoengsao)	Year 9 student (aged 16)	Sexual abuse for 2 years

* Other cases were raised in the seminar on 'Sexual Harassment in University...problems and solutions' organized by Program of Woman and Young Studies, Thammasat University, 8 May 2008.

7 Milk contaminated with Melamine... Global vigilance and Thailand's responses

The discovery of melamine in milk in China explained the mystery of why many Chinese children were falling ill from kidney stones. It also raised fears among consumers in other countries where milk and foods were imported from China. It is a serious scandal that has badly shaken the global food industry.

Melamine found in milk from China

Current methods for testing the quality of milk do not directly measure protein content. Instead the test measures nitrogen content, which is a component of amino acids in milk proteins. If the nitrogen content of tested milk meets the standard, the milk is considered to have sufficient protein.

Liquid milk producers in China unethically added water to increase milk volumes and then confounded the quality testing process by adding nitrogen-rich melamine. With the melamine, the milk could pass the standard test for protein content.

The scandal unfolded on 12 September 2008 when the Chinese government recalled milk products across the nation for testing. The tests were prompted by one baby dying from kidney stones, and several babies falling ill from the same disease. These babies had been fed milk powder manufactured by the Sanlu Group. Representative from Sanlu Group accepted that some lots of milk powder produced before 6 August 2008 were contaminated with melamine. The company has recalled more than 700 tons of product.

On 23 September 2008, the Chinese Ministry of Health reported that the number of small children who had become ill from drinking milk tainted with melamine had increased from 6,244 cases to 54,000 cases. Meanwhile many countries have started testing Chinese product and found melamine in food. As a result imports of many Chinese products have been cancelled:

- *Hong Kong* found melamine in ice cream and yogurt, and barred the Yi Li brand
- *Brunei, Singapore, Malaysia, Bangladesh, Gabon and the Philippines* banned Chinese milk product or recalled milk product
- *France* banned all products made of milk from China, Vietnam and Nepal; stopped selling Chinese milk product; and strictly tested these imported products
- *Taiwan* banned all milk products and non-dairy creamer from China and recalled all these products
- *Japan* asked 90,000 companies to help test imported products for melamine; Maruda food company recalled bread which contained milk products from the Yi Li company, and Nischin recalled all products containing milk manufactured in China

Measures imposed by Thailand's Ministry of Public Health

The Thai Food and Drug Administration (FDA) within the Ministry of Public Health was the government organization with prime responsibility for tackling the melamine crisis. In mid-September 2008, the FDA began to request retailers and distributors to temporarily remove Chinese milk and diary products and food with milk ingredients. In addition, the FDA also ordered all ports to hold all shipments of raw dairy products from China for inspection, to ensure the products were not contaminated with melamine. Products were issued with a certificate before being released into the market. The FDA also recalled and removed from shelves all Chinese milk and diary products that had been imported into the country before the melamine scandal, and ran tests on a

sample of the products. Only products that were free from melamine contamination were allowed back on the shelves.

In addition, the Provincial Health Office and other local organizations began to vigorously inspect milk products, and prevent smuggling of milk products and foods contained milk from neighboring countries. Meanwhile, a public relations campaign was conducted to educate the public about the melamine and advise consumers to avoid purchasing milk products not carrying the Thai FDA-approved label, or products with no Thai label or no information on country of origin. Consumers were also encouraged to provide authorities with information on suspected products or smuggling of products.

While the sample of 1,500 products were collected for testing by the Department of Medical Sciences, the FDA set up a war-room team headed by Dr. Rangsan Pirakij, Deputy Secretary-General of the FDA, to monitor the situation and to set melamine safety standards in food.

The Ministry of Public Health issued Notification Number 311 (2008) entitled "Food Prohibited for Production, Import or Sale". The announcement is effective from 10 October 2008. It instructions for public organizations, retailers, distributors, manufacturers, and importers, must be strictly observed. If the Public Health Ministry finds food products contaminated with melamine, the offender will be prosecuted and with a maximum penalty of 2 years in prison or a fine of 20,000 baht. The Thai FDA has set safety standard levels of melamine and its derivatives such as cyanuric acid, ammiline and ammilide in food as follows:

1. In modified milk for infants and modified milk for follow-up formulas for infants and young children, and other milk powders, the limit was set at 1 mg per kg.

2. In food containing milk ingredient such as food supplement for infants and young children, pasteurized milk, sour milk, ice cream, biscuit, etc., the limit was set at 2.5 mg per kg.

Melamine-contaminated products

Tests run by the FDA between 26 September 2008 and 24 February 2009 revealed that two dairy products had high melamine levels. These were the Mali brand non-sweetened condensed milk with the palm oil formula, and the Dutch Milk brand powdered milk. Both were made from imported Chinese products. Melamine was also found at high level in another 22 products, such as biscuits and crackers. Detailed information on the products listed is available at the FDA website (http://www.fda.moph.go.th/www_fda/fda_melamine/index-melamine.php).

Unconfirmed sources have been quoted as saying that the Chinese government knew about the melamine in milk in April or May 2008, but did not want to release the information during the Olympic Games, which were hosted by China. The Thai FDA also responded slowly to the scandal. The very first sample of products collected by FDA was tested by a private laboratory but melamine was not found. However, the same sample was tested again by the Department of Medical Sciences, Ministry of Public Health, which found melamine at a very high level.

Learning from mistakes

Melamine-contaminated milk products which resulted in six infant deaths and about 294,000 children becoming ill. The Chinese government ordered the arrest of all people involved in the melamine-tainted milk scandal. On 22 January 2009, the Intermediate People's Court in Shijiazhuang city of Hebei Province, sentenced Tian Wenhua, Sanlu's former board chairwoman and general manager, aged 66 years, to life in prison and fines of over 20 million Yuan, when she was found guilty for producing and selling milk contaminated with melamine. Three other former Sanlu executives were given jail terms of between 5 and 15 years, while two other defendants who added melamine into milk before selling it to Sanlu were given death sentences.

The inspection of Sanlu products has been broaden, and products from many more companies have been tested. As a result, 21 additional companies were found selling melamine-tainted milk. Twenty-two companies in China have set up a fund worth about 1,100 million yuan to compensate the families of dead and sick children. It proposed to offer each family with a dead child 200,000 yuan, and each family of a sick child 30,000-50,000 Yuan.

Recently, Associate Professor Yaowamal Kacharoen, Animal Sciences, Faculty of Agiculture of Khon Kaen University, has invented a test kit for testing melamine in water, drink, and food. Many manufacturers are interested in further developing this test kit and it is being commercially manufactured.

In addition, the development of testing methods for accurately and rapidly detecting melamine in food products and animal feeds is needed. The existing testing method based on nitrogen content has loopholes that may allow similar sandals to develop.

What is melamine?

Melamine is an organic compound that forms a white, crystalline powder and is water soluble. It has a high nitrogen level, equal to about 66% of its mass.

If melamine is combined with formaldehyde, it produces melamine resin or durable thermosetting plastic, which is used for making melamine form, formica, glue, plate and whiteboard.

Melamine has relatively low toxicity, but it is harmful if swallowed, inhaled or absorbed through the skin in high doses. Over long periods it can lead to kidney stones or renal failure. Symptoms in infants who were fed on melamine-contaminated milk include crying while urinating, vomiting, pupil constriction or acute renal failure, small stones in urine, high blood pressure, and swelling. Most of the afflicted people are young children who were mainly fed on milk. These children received much larger doses of melamine than adults, and their renal function was not fully developed.

In 2007, melamine was found in wheat gluten and rice imported from China for making pet food in the USA. Many cats and dogs have died from renal failure.

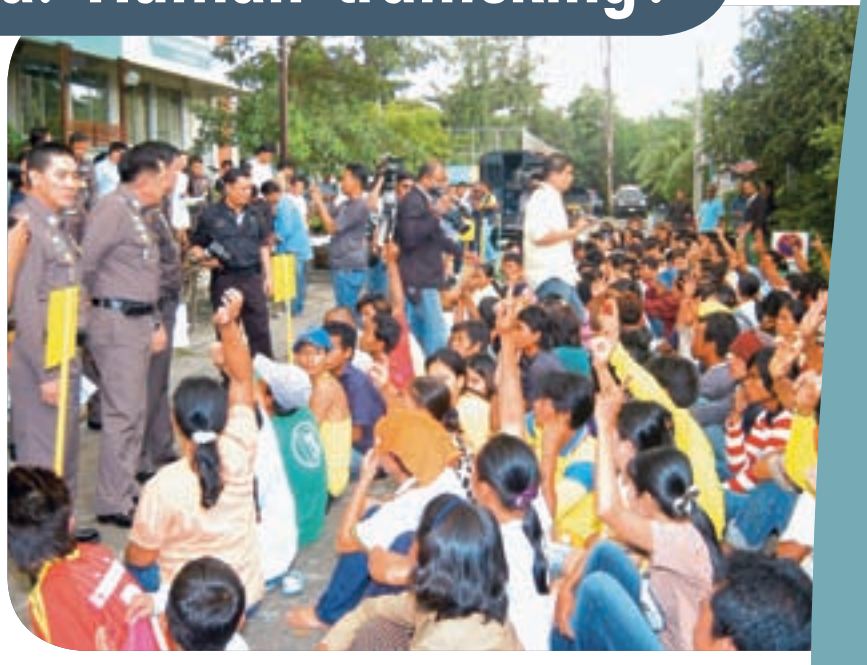
Source : "Question and Answer about Melamine". http://www.fda.moph.go.th/www_fda/fda_melamine/index-melamine.php

Table Summary of dairy products contained melamine above the standard level Test results between 26 September 2008 and 24 February 2009

Details of products	Name of company	Origin	Melamine level
1. Mali non-sweetened condensed milk with palm oil formula	Thai Dairy Industry Ltd.	Thailand	92.82 mg per kg
2. Shuangwa full cream milk powder	Dutch Milk	China	1.20 mg per kg
3. Koala Koala-shaped biscuit with cream chocolate	Sun Food Trading Ltd.	China	3.16 mg per kg
4. Julies peanut crackers with cream	Markins International (Thailand) Ltd.	Malaysia	2.52 mg per kg
5. Julies cheese sandwiches	Markins International (Thailand) Ltd.	Malaysia	7.96 mg per kg
6. Julies cheese sandwiches	Markins International (Thailand) Ltd.	Malaysia	3.42 mg per kg
7. White Rabbit Creamy Candy	No information	China	3.85 mg per kg
8. Orphic chocolate	No information	China	34.37 mg per kg
9. Omoto cream cracker	Markins International (Thailand) Ltd.	Malaysia	6.08 mg per kg
10. Hajuku cream-coated biscuit with strawberry flavor	Yantai arari confectionary & Food Co., Ltd.	China	5.07 mg per kg
11. Hajuku cream-coated biscuit with strawberry flavor	Yantai arari confectionary & Food Co., Ltd.	China	7.16 mg per kg
12. Koala Koala-shaped biscuit with cream chocolate flavor	Sun Food Trading Ltd.	China	28.86 mg per kg
13. Koala Koala-shaped biscuit with cream milk flavor	Sun Food Trading Ltd.	China	5.60 mg per kg
14. Koala Koala-shaped biscuit with cream milk flavor	Sun Food Trading Ltd.	China	31.68 mg per kg
15. Koala Koala-shaped biscuit with cream strawberry flavor	Sun Food Trading Ltd.	China	4.19 mg per kg
16. Koala Koala-shaped biscuit with cream strawberry flavor	Sun Food Trading Ltd.	China	15.55 mg per kg
17. Cocoa Chocolate biscuit Koala's March	Soon Seng Huat (Singapore) Pte LTD.	Singapore	5.66 mg per kg
18. Cocoa Chocolate biscuit Koala's March	Soon Seng Huat (Singapore) Pte LTD.	Singapore	18.45 mg per kg
19. Chocolate snack KOALA FAMILY PACK	Malaysia & Singapore Sehat Ekonomi Supermarket	Malaysia	3.03 mg per kg
20. Koala Koala-shaped biscuit with cream strawberry flavor	Sun Food Trading Ltd.	China	2.89 mg per kg
21. Koala Koala-shaped biscuit with cream milk flavor	Sun Food Trading Ltd.	China	2.60 mg per kg

Source : http://www.fda.moph.go.th/www_fda/fda_melamine/bytypeNo.pdf

8 The deaths 54 Burmese and the fate of the Rohingya: Human trafficking?



In April 2008, Thais were alarmed at the discovery of 54 bodies-17 men and 37 women-plus 21 injured, among a total 121 illegal migrant workers from Myanmar in a modified cool container truck. Then Thailand appeared in international headlines after the Thai navy took Rohingya who traveled to Ranong province out to sea and set them adrift without engines or supplies. Question were raised about the links between these indicents and human trafficking in Thailand.

The incident of 54 bodies from Myanmar is just the tip of the iceberg of human trafficking

The migrant workers were secretly taken by a broker from a fish farm in Ranong Province. They were travelling in a container truck to Pang-nga and Phuket Provinces. After the truck driver found that many workers crammed into the container had suffocated to death, he abandoned the truck because of fears of being implicated. The incident happened near Baan Kluay, Moo 3, Tumbon Naka, Amphoe Suksumran, in Ranong Province.

This incident is neither the first nor the last occurrence of unsafe international migration. A similar incident occurred in 1995 when a truck, tightly covered with canvas, and filled with over one hundred Burmese workers travelled from Ranong Province to Phuket Province. When the truck reached Pang-nga Province, it was involved in an accident. The truck burst into flames, which killed 30 workers, with 50 more being severely injured. Over the period of 2006-2008, there have been 14 similar incidents in Thailand, resulting in 106 deaths, 149 injuries, and 15 missing persons.

These incidents indicate serious violations of the human rights of migrant workers in Thailand. They are the consequence of exploitation by employers and by the brokers who brought them into Thailand For more than 20 years, migrants from neighbouring countries have crossed into Thailand in search of work and security. The major push factors for migration are economic hardship and political conflicts in the home countries, combined with a rise in demand for cheap labour in Thailand. Together these factors have attracted many migrant workers in search of a better life.

Thailand has lacked a good national policy on migrant workers. Instead, policy has focused on the management of illegal migrant workers, and has contributed to widespread corruption and human trafficking. Thailand is known as the centre for international labour migration in the Greater Mekong Subregion (the six countries or regions of Thailand, Myanmar, Cambodia, Laos, Vietnam, and Yunnan Province of China), but also as a centre for human trafficking.

For decades regional mobility has been mainly characterized by illegal migration, which often involves illegal trafficking of migrant workers, especially from Thailand's neighbouring countries.

The incident of the Rohingya boat people was in the international media spotlight in late 2008 and early 2009. The media were critical of the Thai authorities for repelling the boat people who reached Ranong Province. According to interviews with surviving boat people, they were pushed back into the ocean in very dangerous circumstances and were harassed. This incident became a diplomatic crisis for the Thai government. After the incident, many media and the government officials have claimed links between this incident and current forms of human trafficking.

As a result, this issue has received increasing attention from the government, the general public, and civic society actors whose work is related to migrant workers.

The link between human trafficking and forced labour

Human trafficking is linked to forced labor. This viewpoint is reflected in the government's views on the deaths of 54 Burmese migrant workers. Mr. Noppadon Patama, Thailand's Minister of Foreign Affairs has said that the "Thai government will be collaborating with the Myanmar government in combating international human trafficking. At the moment the two governments are discussing the possibility of drafting a Memorandum of Understanding against human trafficking and we are ready to tackle the problems concerning illegal migrant workers from Myanmar followed the Memorandum of Understanding which both countries have signed."

The issue of human trafficking has been widely recognized by the international community and by many national governments. Among ASEAN countries, human trafficking has received attention for over 10 years:

- In 1997, the issues of women and child labour were raised for the first time in the informal ASEAN leaders meeting, which set guidelines and collaborating procedure to solve regional problems including women and child workers
- In 1998, ASEAN leaders approved the Hanoi Plan of Action for cooperation in fighting trafficking in women and children and forced labour
- In 2004, the 10th ASEAN Summit held in Vientiane signed a declaration against trafficking in persons, particularly women and children

TIn Thailand, before the 2008 law on prevention and control of the human trafficking was issued, previous trafficking law was focused mainly on women and children. Also the trafficking was narrowly defined as trafficking in persons, particularly in women and children, for the sex trade. This can be seen in the various inter-governmental agreements:

- The 1999 Memorandum of Understanding on Common Guidelines and Practices for State Agencies was concerned with Victims of trafficking in women and children
- The 2003 Memorandum of Understanding on Common Operational Guideline for Government Agencies Engaged in Addressing Trafficking in Children and Women (Number 2); Memorandum of Understanding on Operations between State Agencies and NGOs Engaged in Addressing Trafficking in Children and Women; and Memorandum of Understanding on Operational Guideline for NGOs engaged in Addressing Trafficking in Children and Women
- The 2003 Memorandum of Understanding between the Royal Thai government and the Government of the Kingdom of Cambodian on Bilateral Cooperation for Eliminating Trafficking in Women and Children and Assisting Victims of Trafficking"
- 2004, drafted the Memorandum of Understanding entitled "Cooperation of the countries in the Mekong Subregion against trafficking in persons
- The 2005 Memorandum of Understanding between the Royal Thai government and the government of Laos PDR. on cooperation to combat trafficking in persons particularly women and children.

The Prevention and Suppression of Trafficking in Persons Act 2008, effective on June 2008, prohibits any forms of trafficking in persons including forced labour which covered trafficking in infants, children, women, old people, and men. This law lays down heavy penalties, equivalent to that of serious crimes, which is different from the previous Act.

The death of 54 Burmese migrant workers as described earlier has led to arguments over whether these people were the victims of human trafficking. In the end, the answer was that the incident happened before the new Act on the Prevention and Suppression of Trafficking in Persons was in effect. Nevertheless, there were people supporting both sides of the argument.

Professor Vitit Muntarbhorn, internationally renowned human rights expert, stated that

"It is good that we are arguing whether or not the affected persons were the victims. It means that we are confused, and we have to discover what exactly happened. We have to look at assistance to the victims and the claims by persons representing the victims, and to help the authorities in handling cases. The main question is how to combine different methods from each side. The authorities treat the workers as illegal migrants and thus their response is prosecution and deportation based on immigration law. **My suggestion is that the assumption must be that those affected are victims and that we must use a social welfare approach in dealing with them.** Therefore, a clear order must be issued that whenever there are victims the cases must be transferred from the Bureau of Immigration to other related agencies such as Ministry of Social Development."

The roles of 'brokers' and cross border labour smuggling

The Prevention and Suppression of Trafficking in Persons Act 2008, defines the victims of trafficking as individuals who have been subjected to recruitment or purchase or selling, transportation, transfer, harboring, receipt or detention by means of coercion, threats, abduction, bribery, deception, abuse of power, abuse of authority, the giving of money or gifts to parents or guardians, for the purposes of exploitation either for prostitution, sex exploitation, production or distribution of pornography, slavery, begging, forced labour, forced removal of organs for commercial purposes, or other equivalent abuses

Hence, **cross border smuggling of workers and human trafficking are closely related.** Brokers or agents have become a significant part of both processes. By law, migrant workers cannot move freely from place to place and thus they often rely on the brokers' networks. The Labour Rights Promotion Network has conducted a qualitative study exploring the processes through which migrant workers become involved in human trafficking. It was found that there were many forms of trafficking relating to recruitment, transfer, exploitation, restriction of freedom of movement and other abuses. According to the study, the brokers or agents can be classified into 10 groups as follows.

1. Cross-border transporter. This is a broker who organizes a transfer of migrants from the border into Thailand. This broker will arrange the transportation and set the price, which depends on the nature of the transport route.

2. Job recruitment broker or factory broker. Most of these types of brokers are migrants who have been living in Thailand for an extended period. They typically know many employers or factories, and can speak fluent Thai. Their charges depend on the type of job.

3. Broker who deals with the authorities. These brokers are often well-known among migrants and know a great deal about the authorities. They will deal with the authorities if the migrant workers are arrested. Their charges is range from 5,000 to 10,000 baht.

4. Migrant card/document agent. Most are Thai citizens who are acquainted with the official registration system, such as applications for work permits, resident registration, and health cards. They normally charge at least twice the actual fees. For instance, the fee for the application for a work permit is 3,800 baht per person, but agents typically charge the migrants about 5,000-10,000 baht.

5. Agents involved in sending migrant workers home. These agents know the authorities who responsible for the deportation of illegal migrants. The agents provide arrange for the migrants to temporarily visit their families. Charges range from 2,000 to 3,000 baht.

6. Agents taking migrant to hospitals. Most of these agents are migrant workers who can speak Thai and have lived in the area. The agents offer to accompany and deal with health providers on behalf of the migrant workers at the hospital. The fee for this service is about 500 baht per visit.

7. Creditors are Thais or foreigners who provide informal loans to migrant workers with very high interest rates.

8. Remittance broker. The majority are wealthy foreigners who own a mobile telephone in the country of destination. The process to remitting money home is that a broker in Thailand makes a contact via mobile phone to a broker in the country of destination to give an agreed amount of money to the family of the migrant worker. The broker will deduct a fee of 10-20 percent from the remittances.

9. Sub-Contract agents are normally influential Thai nationals who supply migrant workers to factories.

10. Brokers of trafficking in people are agents who recruit and transfer migrants for the purposes of illegal business such as prostitution, forced labour and sweatshops.

Brokers are not always implicated in human trafficking. Human trafficking will happen when the trafficked people are deceived into working in other places. However, the situation of migrant workers from the three neighbouring countries is not straightforward and it is difficult to draw a clear line. Only a few migrant workers know what work they will be doing in Thailand.

Many people migrate to Thailand for non-economic reasons, including human rights violations in their home countries. Moreover, migrant workers are often not allowed to leave their residence or workplace in Thailand.

In some cases the brokers are relatives or close friends, and migrants willingly use their services, and are not subject to use of force or coercion, abduction, or deception. The major concerns of migrant workers include employment conditions, which are often different from what the migrants were told before migrating. The industries in which migrant workers often face such problems include, for example, agriculture, factories, construction, fishing and seafood processing, domestic worker, and begging. (Young children are sometimes forced into begging.) These workers can be considered as trafficked because often the pay is very low and the workers are vulnerable to exploitation.

In March 2008, when police raided a factory producing prawn food in Samut Sakorn, which were able to rescue 300 Burmese forced workers. The authorities identified 20 male workers out of a total of 74 workers as victims of human trafficking. The victims of trafficking were hand cuffed and transferred to a government refuge while the rest of workers were charged as illegally entering the country and working, and were detained while awaiting deportation.

Rohingya: The complexity and confussion of labour exploitation, human trafficking, and fled for life

Rohingya have a number of reasons for journeying to Thailand: searching for work, fleeing from human rights violation in their own country or Myanmar, and transiting to Muslim countries such as Malaysia. The issue of the Rohingya boat people is complex.

On the one hand the Rohingya are illegal migrant workers; on the other they are fleeing from fear of death. The complexity of the situation as led to variation of the way people understand the situation, and in the way the situation has been handled. For policy markers who emphasize national security reasons, repatriation is the preferred approach. Sunai Pasuk, Coordinator of Human Right Watch in Thailand, has argued that-

"The procedures used with Rohingya at present affects the situation of the Rohingya because the actual procedure is that once the Rohingya enter Thai territory illegally, they must go through the immigration procedures. But if they are arrested, they are transferred to the Immigration Office for investigation. If they were proved to have entered illegally, they are deported through the appropriate procedure back to the country of origin. Thailand has observed the international procedures in handling illegal migrants including the Rohingya people. Thailand's practices are better than those in some neighbouring countries. However, there have been changes in the

approach towards Rohingya since 19 September 2006, because of national security reasons. I have to say that there is misunderstanding and wrong assumptions are made by the military about the threat posed by the Rohingya people. In fact they want to continue on to Malaysia."

Sunai has pointed to the link between human trafficking and the Rohingya boat people. *"The brokers receive 20,000-30,000 baht per person from Rohingya. Some borrow money to pay for the fees and some have become debt bonded. With such obligations, they have to use whatever means they can to reach the destination. If they are arrested or deported, they will try to make another journey on whatever route either in land or by sea. Body searches of arrested Rohigya people will always find a telephone number, which is the contact number of the broker. Many brokers have been traced. They can be Rohingya, Thai or Malaysian. They are identified and arrested. However, at present, we are wrong to focus on the Rohingya as a threat to national security. In actual fact, the focus should be on the brokers. "*

The fact that the Myanmar government has refused citizenship to the Rohingya people has complicated the issue further. It is not possible to use the protection mechanism, including the application of the GMS Declaration of Cooperation. If the Rohingya people are not citizens of the ASEAN countries, they are not covered by the ASEAN Declaration of Cooperation either.

The internal factors in the country of origin, and the status the Rohingya people, raises questions about how to deal with the overlapping status of the Rohingya people, or whether to seek new way to interpret the issues. Existing approaches are often not appropriate, particularly for people who have fled from danger or for international migrant workers. The procedures of government organizations, which emphasize national security reason and rapid repatriation of illegal migrants, has led to questions about whether the authorities are in fact reinforcing trafficking and indirectly driving some people to become victims.

How can we deal with the complexity of human trafficking?

Smuggling in persons and human trafficking are complex phenomena with no clear boundaries. Incidents involving the smuggling of migrant workers have resulted in tragedy and the loss of lives, and have demonstrated the lack of a clear distinction between migrants in search of work and victims of human trafficking. How should we respond to images of the rescue of migrant workers including children, women and men, or images of the Rohingya boat people?

First, globalization has made the world smaller and travel is much easier and quicker. This opens up several channels for people to search for a better life politically and economically, particularly the poor in neighbouring countries. However, the border is closed due to the strict rules of sovereignty. It is inevitable that human trafficking and broker networks involved in transport migrants across the border will arise and become a threat to other people who also cross the border. Thailand and Thai society in general must take a tough stand to ensure that migration is safe. Without doubt, this needs a long-term policy on managing migration that will take account of all aspects relating to migration.

Second, the rule of law in relation to assisting of victims of trafficking should leave no gaps to allowed further crimes against victims. At the same time, these migrant workers should be viewed as people in search of work to give themselves a better life. Law enforcement should facilitate this. Many workers, even though they are the victims of trafficking, are in debt. Deporting migrant workers without taking this into account is creating a new vicious cycle of human trafficking.

Lastly, the current migration phenomena involve multidimentional push factors in the country of origin and unclear policy on international migrants. Migrants can therefore have many different statuses. The example of the Rohingya people clearly illustrates this problem. Thailand and Thai people should be aware that under current circumstances the country should address the diverse statuses of different groups of migrants. Coupled with proactive foreign policy and emphasis on human rights, this would curb trafficking in persons.

In the meantime, efforts should be made to advance policies for stateless people and to establish a mechanism in the region to solve regional problems of statelessness. Last but not least, it is essential to design policies towards international migrant workers that take into account the real situation. Plans of action should be prepared for both origin and destination countries in order to promote quality of life. This is the only way to eliminate human trafficking in the long term.

9 AIDS threats Thai youth because of unsafe sex

Treatment of AIDS with antiretroviral drugs results in longer and higher quality lives for patients. There has been a down-ward trend in the number of death from AIDS in Thailand. However, a major concern is that Thai youth are still vulnerable to HIV infection because of their risk behaviours. There has been increase in the number of the new AIDS cases among young people. The epidemic of HIV/AIDS among young people should be closely monitored in Thailand and action should be urgently taken.

From the global situation to the situation in Thailand

The recent UNAID report on the global AIDS epidemic indicates that, globally, there were about 33 million people living with HIV in 2007. The annual number of new HIV infections fell from 3 million in 2001 to 2.7 million in 2007. It is estimated that about 45 percent of new HIV infections were among young people aged 15-24.

In Thailand, since the first HIV infection patient was detected in 1984 up until 2007, the estimated number of HIV infections was 1.1 million. Of these people around 585,830 had died from AIDS. The average annual number of new HIV infections is 12,787 persons. The most vulnerable group is young people aged 15-19, among whom infection has become more widespread. Data collected from many provinces in 2008 illustrate the problem.

Chiang Mai. The Provincial Health Office has collected data over the past 2 years. It has found that young people aged 12-15 are the most vulnerable group for HIV infection, overtaking housewives and working age groups.

Surat Thani. The Provincial Health Office has carried out a Behavioural Surveillance Survey among young people, which revealed that 22 percent of male students at Matthayom 5 (year 11) have ever had sexual experiences, and that among these, only 41 percent used condom. Among second-year vocational students, about 45 percent had ever had sex and 51 percent had used a condom. Among conscripts, 92 percent had ever had sex and only 40 percent used condoms.

Sa Kaeo. A Behavioural Surveillance Survey among secondary school students (year 11) revealed that 20 percent of male students and 10 percent of female students had ever had sex, while only 30 percent used a condom at first sexual intercourse.

Nationally. According to hospital records on AIDS in 2008, sexual intercourse is the main cause of HIV infection, accounting for about 84 percent of AIDS cases and an increasing trends of HIV infection among

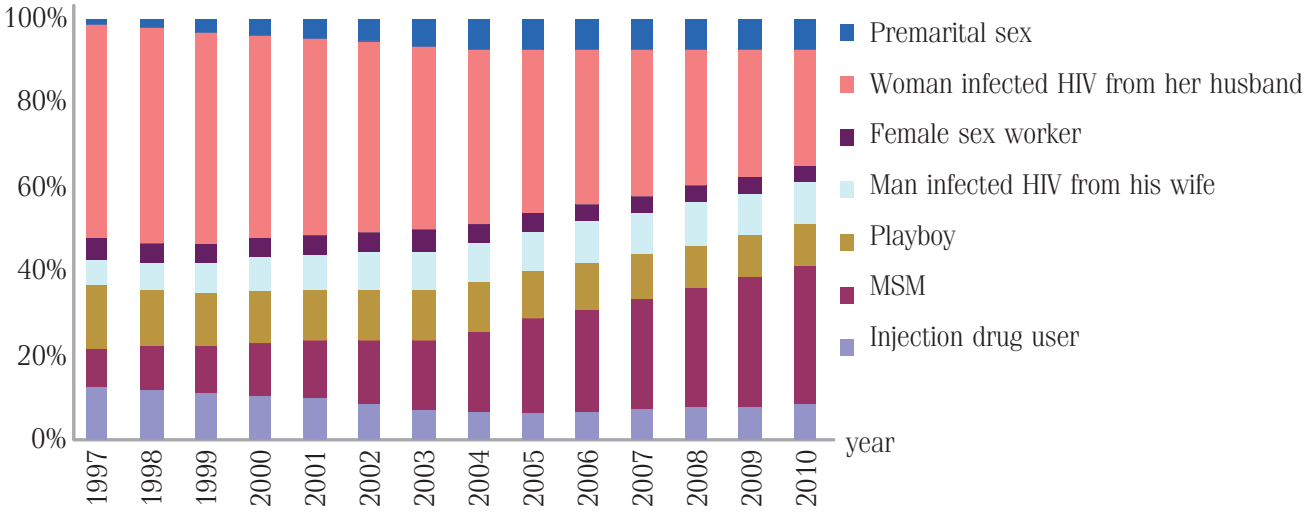
young people aged 15-19. Dr. Anupong Chitavarakorn, Director of the Thailand Global Fund To Fight AIDS, Tuberculosis and Malaria, under the Department of Disease Control, Ministry of Public Health, has concluded that "Thailand has an increase in new HIV infections every year of at least 12,000 person. Nearly 90 percent of the infections are a younger and younger ages. In particular, among students the incidence rate has increased from 5 percent to 13 percent where as among those aged 15-19, it has increased from 10 percent to 17 percent."

The Epidemic Information Centre, Bureau of Epidemiology, has documented on 28 February 2009 that the total number of HIV/AIDS infections during the period of 1984-2008 was 353,020. Of these, 30,399 were young people aged 15-24, or about 8.6 percent of total cases. The Bureau of Technical Development and Support for HIV/AIDS Prevention, Department of Disease Control, has conducted an analysis using the database of new HIV infections to estimate the proportion of new HIV infections for the period 1997-2010. It found that the proportion of new infections has consistently increased in only two population groups: people having premarital sex and men who have sex with men. Among other groups, rates have either dropped or stabilized as a proportion of new HIV infections (see Figure). It can be assumed that most of the premarital sex cases are young people.

Changing sexuality is a cause of risk behaviour among young people

Curiosity, physical development, sex drive, and changes in social environment all influence young people to have their first sexual experiences. Many young people engaged in unsafe sex with boyfriends or girlfriends. Often young people who take risk mistakenly believe that having sex with someone they know is safe and does not place them at risk of HIV infection, unlike having sex with sex workers.

Estimated proportion of new HIV infection by population groups, 1997-2010



Source : Bureau of Technical Development and Support for HIV/AIDS Prevention, Department of Disease Control, Ministry of Public Health. 2008.

Easy access to sexual content in the media has influenced young Thais engaging in sexual activity at young ages. Studies have shown that 82 percent of male students and 48 percent of female students have had access to X-rated movies, and that 53 percent of male students and 18 percent of female students have had access to pornography websites.

The decision to take on a risk sexual life is another factor increasing the risk of HIV infections among young people. This includes cohabitation among students, sex among friends, and competitions for the highest number of sexual acts. An opinion poll among teenagers found that 21 percent wanted to have sex with their boyfriends or girlfriends on Valentines Day.

Promote sexual health services

Although young people have become more vulnerable to Sexually Transmitted Infections (STIs), including HIV/AIDS than other population groups, young people are less likely to use health services. In dealing with the problem of STIs among young people, the Department of Disease Control, Ministry of Public Health, has proactively implemented sexual health services through increasing access to safe sexual heath care.

The work began with the establishment of 'Bangrak Youth Clinic' in Bangrak Hospital in late 2007. It aims to be a model clinic for the control and prevention of HIV infection through the provision of voluntary HIV testing and STIs test and treatment services for young people aged 10-24. The clinic operates every Saturday at 9.00-15.30 hours. So far, young people are satisfied with the services and friendly staff.

Love care campaign 'Dare to love, dare to check'

Ten private clinics under the National Health Security Office that work with young people aged 14-24 at risk of developing STIs and HIV/AIDS in Bangkok are:

Kluaynamthai clinic 70 Rai Community Branch, Klong Teoy Medical Clinic, Bang Pai Medical Clinic, Wat Pai Kaew Medical Clinic, Vipavadee Soi 2 Medical Clinic, Tabsuwan Medical Clinic, Medipro Medical and Health of United Center Buliding Branch, Medipro Medical and Health of Muang Thai Patara Complex Branch, Rua Pra Roung Medical Clinic of Ramkhamhang 39, and Wor Por Medical Clinic and 3 health centres under Department of Health, Bangkok Metropolitan Administration (BMA - Bang Sue Health Centre 3, Din Daeng Health Centre 4, and Prachatipatai Health Centre 9. A 'Love Care Station' was established to provide reproductive health services such as STDs test and treatment, family planning, and pap smear test.

For the basic screening services, contact the call centre at 1330 extension 4 every day at 16.00-22.00 hrs, or the website www.lovecare station.com. In cases of referring to further diagnosis or treatment, present your ID card together with an access code from the call centre or the website to receive services free of charge at those 13 clinics. Your personal information will be kept confidential at the clinic only and will only

The data on condom use and knowledge about safe sex among young people who had visited the clinic were collected. It was found that male youth have good knowledge about condom. However, they often leave condoms in high temperature places such as car or motorbikes, where the heat can damage the condom. Female youth lack knowledge about how to use condoms. The clinic provides health education for STIs prevention using computer assisted health education programs, with staff providing additional information if needed. In addition, the clinic, from time to time, conducts public relation campaigns such as 'Gla Rak Gla Check' or literally 'Dare to love, dare to check'. (see BOX)

Plans to amend a regulation on HIV testing for children under 18 years

According to WHO, HIV testing and prompt treatment with antiretroviral drugs in case of positive test, without waiting for lower CD4 levels, can save the lives of 100 percent of people with new HIV infections. Although the cost of this service is very high during the first 10 years, the much higher cost of AIDS treatment could avoided.

It is estimated that there are about 400,000 Thais with unidentified HIV infections, who are spreading HIV to others. If people with these unidentified HIV infections are tested for HIV and receive early treatment, there would be minimal adverse consequences on health and lowered treatment costs.

At present, young people aged less than 18 are increasingly vulnerable to HIV infection. The Medical Council organized a meeting with working groups, networks, and organizations working on HIV/AIDS on 17 December 2008. The meeting aimed to have a public discussion on the Medical Council Guidelines for HIV testing in children and young people. The meeting concluded that children under 18 years of age and not married can undertake an HIV testing without parental consent, but must receive full counseling before and after the test.

A survey was conducted among 1,998 youth in 20 provinces on HIV testing. The survey found that 86.3 percent of youth knew that HIV testing was a prevention measure and wanted to take the test. Seventy-eight percent agreed with voluntary HIV testing without parental consent.

The results of the hearing will be used to revise the Medical Council guidelines. The draft the regulation should be completed within 1-2 months, and will be effective thereafter. In the mean time, a central committee consisting of HIV/AIDS experts will be employed, and a draft regulation will be piloted in health facilities.

The Ministry of Public Health will initiate random testing for HIV among youth to monitor the HIV epidemic. Testing will be voluntary, and undertaken at an anonymous clinic where the personal details of users and the test results are kept confidential. The Ministry of Public Health will cooperate with the Ministry of Education to implementing the programme in schools at secondary and tertiary levels, as has been done in the past for drug tests among youth. If the policy is successful, it can help control and prevent HIV infections.

Speed up promotion of condoms as part of Thai sexual life, beginning with first sexual intercourse

It is clear that **the main cause of the HIV/AIDS epidemic in Thailand is unsafe sex**. Unsafe sex is a major problem in Thai society, because the rate of condom use is very low at the first sexual intercourse **particularly among youth.**

An analysis of research on sex, sexuality and AIDS by Kritaya Archavanichkul and Kanokwan Tharawan (2008) revealed that **the use of condoms is not part of Thai sexual culture**. Thai people, both men and women, **have learned about sexual intercourse without thinking of condoms**. As a result, they believe that condoms will reduce sexual pleasure.

Therefore, public health campaigns must enhance knowledge about sexuality in Thai society. The campaigns should address non-coercive or unforced sex, safe sex norms to avoid contracting diseases or unplanned pregnancy, and promoting responsible sex as the basic foundation of every sexual relationship.

Campaigns promoting a new sexual culture need to spread the message that responsible sex mean sex with a condom. For oneself and for others, this is genuine safe sex behaviour.

10 The first steps of the National Health Assembly: Social innovation in health policy

Although the first National Health Assembly (NHA) was not formally established until the passing of the National Health Act in 2007, the NHA had in fact been held over the preceding seven years. Forums were held to exchange knowledge among a wide range of stakeholders, including the pubic and private sectors, community groups, NGOs, and academic and professional institutions. It used participatory processes to reach consensus on healthy policy at the national level.

History of the National Health Assembly

The pilot National Health Assembly was first unveiled in Thailand in 2001 as part of a social movement for national health system reform. The main task at that time was to advocate for the National Health Bill. Getting the bill passed took around six years, and was passed in March 2007 (see BOX). The purpose of the NHA was to provide a public forum where all stakeholders could exchange views and find solutions for health-related issues affecting individuals, community groups, and society as a whole, in a participatory, consensus-based way. The NHA is an important social institution for developing healthy public policy. It is an annual forum for civil groups and organizations to exchange their views, and to work together on health policy.

More than 900 health assembly forums were convened in a wide range of forms, in accordance with the National Health Act. The health assemblies can be classified into: Area-Based Health Assemblies, which are forums based on the areas such as provincial health assemblies and regional health assemblies; Issue-Based Health Assemblies are forums convened based on health issues, such as the health assemblies on chemicals and agriculture, or on children, young people and the family.

The National Health Act 2007 defined the National Health Assembly as “a process in which the relevant public and state agencies exchange their knowledge

and cordially learn from each other through a participatory and systematically organized forum, leading to recommendations on Healthy Public Policies or Public Health." It is the responsibility of the National Health Commission to organize an annual NHA. The first NHA was held on 11-13 December 2008 at the UN Convention Centre, Bangkok.

Getting to know the first National Health Assembly

The First National Health Assembly under the National Health Act was organized by a committee with 37 members. The members included delegate from 22 networks which were selected from 76 provinces. Four delegates were selected from NGOs and civil society organizations, professional bodies, academic, and state agencies and political parties. Four further delegates were chosen from the Area-Based Health Assembly and Issue-Based Health Assembly. The remainder delegates were other experts. The organizing committee consists of four subcommittees: 1) Administrative Subcommittee to set the agenda, 2) Special Subcommittee examining each agenda in detail, 3) Evaluation Subcommittee, and 4) Public Relations Subcommittee.

The organizing committee for the First NHA, chaired by Dr. Suwit Wibulpolprasert, oversaw the plan and organized the assembly. It synthesized views and recommendations proposed by the Area-Based Health Assembly, Issue-Based Health Assembly, and other forums. It also prepared an agenda to submit to the National Health Commission for further development into policy formulation, and to report back to the NHA in the following year.

In selecting topics for inclusion into the NHA, the committee encouraged submissions from stakeholders. As a result, 68 proposals were submitted from about 50 organizations. The selection criteria of the assembly were the urgency of the issue and the breadth of its impact on the national citizens' health. Individuals or organizations, whose proposals were selected, were appointed to review and document the issues. The first NHA approved 12 topics and 2 urgent issues, as priority topics for the healthy public policy. More than 1,500 people, including 178 nationwide delegations belonging to political parties, academic, public agencies, private organizations, and civil society organizations attended the first assembly.

Resolutions from the First NHA (1+13): Decree on National Health System and thirteen health topics

The first NHA approved the following 14 resolutions.

1. Statute on National Health System. The National Health System is among many significant topics discussed at the first conference. The statute is a conceptual framework for devising policy, strategy, and action plans in health. In accordance with the National Health Act, the National Health Commission (NHC) is responsible for preparing the Statute on National Health System by taking into consideration inputs from the NHA, and for submitting the statute for approval by the Council of Ministers. The NHC will inform the Cabinet of the approved statute which will then submit it for Royal endorsement before the statute takes effect. All concerned government agencies and other organizations have obligations to act upon the resolution. The NHC will review the statute on national health system once every five years to reflect changes in circumstances. In addition, under Section 47 of the Statute of Health System, there are at least 13 essential issues within the health system.

The First NHA accepted the contents of the draft Statute on National Health System. It requested that the Secretary-General of the NHC submit NHA comments to the committee overseeing the draft of the Statute on National Health System, to be incorporated into the draft statute before submission to the NHC. The Statute will be widely publicized to inform the public about the statute and to encourage government agencies, professional bodies, academic, private sector

and civil society to apply the resolutions, and support the process for putting the resolutions into practice. The networks of NHA will report on progress on the implementation to the NHA every two years.

2. Universal access to medicine among Thai people. Although medicine is one of four essential needs for human beings, many people lack access to it. Patents have led to monopolies in imported patented pharmaceutical products, which have driven the drug price even higher. In addition, Thailand has still not introduced a policy on drug prices, and commercial drug prices therefore often do not reflect the actual costs of production. To attain the national policy of universal access to medicine in Thailand, the NHA approved a strategy of Universal Access to Medicine, which has seven components. These include cooperation to improve access to drugs, supporting patient groups to increase access to drugs and to be involved in health promotion, support a system for setting reasonable drug prices, develop a domestic pharmaceutical industry, make the most use of legislation, enhancing the appropriate use of drug, and research and development in new drugs. The NHA requested that the NHC push for the approval of this strategy, so submit a draft of the action plan to Cabinet, and to put the action plan into practice.

3. Health care reform in multicultural areas in the southernmost province was recommended by local organizations and was approved by the NHA. The policy on health care reform in multicultural areas in the southernmost provinces contains six recommendations. 1) Re-establish regional and local administrative bodies such as the Department of Southern Border Provincial Administration and Development, the Southern Border People's Assembly, the Council of Religious Scholars, development of Islamic law or alternative justice system, and so on; 2) Reform of the justice system, such as establishing an independent complaint committee, and improving and revising the principle of Islamic law; 3) Education policy, such as developing support mechanisms for local alternative education; 4) Economic policy such as establishing an economic council for the southern border, and establishing centres for halal food sciences; 5) Social, tradition, cultural reform to comply with the local way of life and consistent with the principles of Islam; 6) Health and medical care, public health, environment and safety.

The NHA requested that the NHC push through the recommendations, or propose to the government to put them on the national agenda. The NHA networks will monitor implementation of the recommendations.

4. People's participation in international free trade negotiations. The assembly agreed to set up a committee to study and monitor international trade negotiations that may have adverse or favorable impact on health and health policy. It is also aims to support the participation of stakeholders in studying and monitoring trade negotiations and in investigating the impact of existing agreements. In addition, it supports civil society actors' participation in proposing draft policy for the process and procedures for international agreement to conform with the 2007 Constitution of the Kingdom of Thailand. It supports public relations campaigns on the matters, and calls on government agencies to set up mechanisms for public feedback and complaints.

5. Agriculture and food crisis. It was agreed to support an action plan for the development of comprehensive organic agriculture at community and local levels. Food security is to be achieved by developing food security indicators appropriate for the Thai context, and documenting the food security situation every three years. A chemicals surveillance system for users and consumers should be set up. A system should be established for economic welfare and security and equity among small farm holders. Native plans should be expanded and preserved as part of a sufficiency economy. All these things are to be achieved through the combined efforts of local administration organizations, local government agencies, and NHA networks.

6. Strategy on the control of alcohol consumption. The NHA agreed that the control of alcohol consumption must be put forward by the NHC as a national and local priority. Alcohol controls must be strengthened through the development of national strategic plans by all relevant government agencies. Local policies must also be developed for managing problems related to alcohol consumption.

7. The role of local administrative authorities in managing health, natural resources, and the environment. The assembly agreed to several recommendations regarding the roles of local government. The recommendations included promoting the role of the local administrative organizations as

the core body in formulating local policy on health and resource and environment management; organizing meetings for local area-based health assembly; strengthening the skills of local staff to take on roles in formulating local public policy; and implementing evaluations of health, natural resources, and the environment.

8. Equity in access to and use of essential health services. The most important principle is to ensure that all Thais attain health security through health insurance and equal access to essential health services. The assembly agreed to several recommendations, including enhancing health facilities to provide high-quality health care that responds to the needs of the majority; promoting local administrative organizations to provide basic public health services; to encourage people's participation in health insurance coverage schemes at all levels; pushing for informal workers to be covered under an appropriate health insurance scheme; to prepare a work plan to accommodate primary health services every ten years; improvement of the efficiency and management system of the three public health insurance schemes by proposing a plan for reforming health insurance scheme every five years to minimize any discrepancies and enhancing efficiency.

9. Impact of media on children, young people and families. The assembly agreed that government agencies should lobby for the setting up of a fund for creative media production, to produce a wide variety of media of all forms, such as computer games, and public media that are appropriate for children, young people and families. Consumers were also encouraged to participate in providing feedback and the production of creative media, promoting the creation of mechanism for media awareness, and strengthening existing mechanisms for screening media products and advertisements which may have adverse health effects on consumers, especially children, young people, and families.

10. Sexual health: sexual violence, unwanted pregnancy, and sex issues relating to HIV/AIDS and STIs. Issues related to sexuality have been on the rise and have become serious national public health problems. The approved forum approved several resolutions regarding sexual health to strengthening society's defenses and to raise awareness on sexual health through a wide range of measures such as providing comprehensive sexuality education, strengthening counseling systems at all levels, providing comprehensive and friendly sexual and reproductive health services for all groups, and establishing a refuge and centre for the protection of victims of sexual violence.

11. Health impact assessment system. It was agreed that the NHC should appoint a committee on the development of systems for health impact assessment. The committee should be responsible for developing systems, mechanisms, models, organizations, criteria, and methods for assessing the health impacts from the implementation of policy. The recommendation also stressed the application of assessment system and mechanisms before, during and after the implementation and at all levels through participatory processes.

12. Public healthy policy for informal workers. The assembly agreed on the need for policies to address the establishment of social security and access to social security scheme among informal workers. It also proposed the development of networks for occupational health and working environment, and complaint mechanisms and centres for providing counseling. Government agencies should support the provision of appropriate health services. Local administrative organizations should be encouraged to develop public healthy policies for informal workers.

13. Promotion the relationship between health providers and patients and their relatives. The assembly agreed to recommendations for policy development to address the relationship between health providers and patients and their relatives through the following strategies: recognize of the urgent need for relationship-building in the health system; develop mechanisms to improve the relationship, such as draft legislation safeguarding patients from medical malpractice; developing a complaints resolution centre as a mechanism for settling conflicts in health services through peaceful means; promotion of friendly health services; developing a medical legislation process; and reform of ethics procedures among health professional bodies. The NHC should set up participatory mechanisms for monitoring and evaluation of the implementation of the recommendations within the Working Group for National Health Resource Development.

14. Economic crisis and protection of the health of Thai people. The assembly recommended that the

government implement social security measures, such as increasing the budget for the national health coverage scheme; the prevention of HIV infection and provision of antiretroviral drugs to people living with HIV/AIDS; supporting renal replacement therapy; developing preventive measures to deal with economic impacts on the poor, elderly and disabled; provide rehabilitation services for the jobless, unemployed, and laid-off; establish surveillance and monitoring units to monitoring the economic impacts; and setting short- and long-term measures for preventing and coping with the consequences of the economic crisis.

Thai society should watch closely the next steps of NHA

The First National Health Assembly ended successfully with full cooperation from all stakeholders. It has 1+13 agreements and recommendations. The challenge ahead is moving the health policies into concrete action, with full participation of stakeholders, including state agencies, central government, parliament, local government, academic, general public, and civil groups.

Moreover, the future challenges for the NHA are, first, the development of mechanisms and procedures to support its networks in voicing their concerns and genuine needs; and second, managing the procedures whereby authorities, academic institutions, and professional bodies can fully participate in moving the NHA forward.

The National Health Assembly from 2001 to 2007

2001: Piloting the National Health Assembly

The first year of the NHA began with a hearing to identify material to be included in the framework for the National Health System. Several forums were held at the regional level. Issue-based forums were carried out, and public announcements supporting the draft national health bill were made. A 'market for health care reform' policy was developed to educate the public and establish networks, with the motto "through community wisdom, develop healthy Thais."

2002: Drafting of the National Health Bill through "enhanced networking, expanding relations, thinking and acting together, as the route to health"

The NHA at the provincial level, including Area-Based NHA and Issue-Based NHA, extended participation, and contributed to the drafting of the National Health Bill, under the motto "enhance networking, expanding relations, thinking and acting together, as the route to health". This was presided over by Prime Minister Thaksin Shinawatra. It passed the first hearing but was then delayed. This led to the "good citizens' action", as people exercised their constitutional rights under the 2007 Constitution, to accelerated the legislative process by collecting 4,700,000 signatures and submitting the petition to the House Speaker Utai Pimjaichon.

2003: Inspecting the draft National Health Bill through "using knowledge and consideration for consensus"

The assembly was focused on significant issues under the slogan "using knowledge and consideration for consensus". Six issues were selected as a starting point: agriculture enhancing health, safe food for sustainable health, public policy and environment, local wisdom on health, holistic health services, and management of human resource in health. Important outputs included the establishment of a committee on policy studies of the proposed resolutions, followed by the preparation of policy and strategy documents and procedures to push forward the implementation process among relevant agencies. This led to a revision process and the utilization of the policy.

2004: Stress on "Food and Agriculture for health: threats from chemicals"

Work this year focused on supporting Area-Based NHA, both at provincial and regional levels, and Issue-Based NHA, particularly those concerned with children, young people, and disabled people. However, the

main focus of the forum was on food and agriculture for health which was also raised in the NHA under the slogan "safe agriculture, hazardous free food, suffering free life". There were ten sub-themes including the power of the family in teaching the young, disabled health assembly, local and community and the management of health security, the impacts of free trade agreement on health, people's involvement in public policy development, the creation of healthy civil society with social and cultural capital, the process of healthy community, the power of local wisdom on health for community, the continuation of Thai health legend, and people politics and health system reform.

2005: Focus on "happy living"

Way of life was the core issues of this year, with the slogan "health living". Support procedures were modified for the area-based and issue-based health assembly by inviting interested networks to submit a proposal requesting support. Altogether, 64 proposals were submitted. Four forums were also added to the NHA: an initial forum, building healthy family and community, sufficiency economy for happy living, building healthy society and environment. The technical team collected and synthesized the resolutions and reported to the NHA.

In addition, there were 12 sub-themes as follows: turning the southern crisis to happy living; the power of children, young people, family and old people; "public living and healthy city"; local administrative authorities and the building of health for happy living; Thai wisdom; Thai-style health; succeeding through happy living; the National Health Act as an instrument for building happy living; strategy of healthy Thailand for Thai happy living; public policy on environment for happy living; development of public policy for happy living; media and the building of happy living; local and community and the establishment of health insurance for happy living. This year's forum concluded with the announcement of the nine intents for social movement to achieve happy living.

2006: Focus on "sufficiency economy for a healthy society"

This was the continuation of the previous year forum, healthy living, but used the sufficiency economy as its driving force. It was supported by area-based assemblies in 15 provinces: Payao, Prae, Nan, Pichit, Nakhonsawan, Ubonrajchathani, Udornthani, Klasin, Nakhon Pathom, Trad, Ratchaburi, Kanachanaburi, Supanburi, Songkhla, and Nakhonsithammarat. The aims of this year's forum were "exchange, learning, scaling up, building confidence, pushing for policy", through sharing knowledge and experiences among individuals and organizations applying the sufficiency economy principles. It also aimed to apply the sufficiency economy in developing public policy such as the policy on Asia Health Centre and Health Insurance along Sufficiency Economy, business and sufficiency economy, health for all, properly use of drugs, and development of Thai healthy living indicators.

In addition, there were nine other proposed issues including the local community management of pesticides, development of friendly health services, legislation and healthy living society, children and young people and knowledge about media, guideline for health impact assessment for Thailand, a decade strategic plan for human resource in health, quality of life of the disabled, satisfied communication, and sufficiency health. The forum concluded with the announcement to conform to the principle of sufficient economy and five guidelines.

2007: Forum for driving and learning the process for developing health statute

Although the National Health Act 2007 was promulgated in March 2008, all related systems and mechanisms were still being developed. Hence this year's forum was organized to push forward the establishment of a system and four mechanisms under the National Health Act: a system for formulating the statute on national health system, the development of public policy and health strategies; and knowledge management in health care reform. The primary mission of this forum was to push forward all proposed systems and mechanisms to the National Health Commission for further action.

4 for Notable Thai

Yasothon hospital won the UN Public Service Award for improving the delivery of services

On 23 June 2008, the United Nations Public Service Day, the UN presented a certificate to Yasothon Hospital in recognition of it winning of the 2008 UN Public Service Awards for its success in improving the delivery of services.

The hospital has developed its delivery service system in emergency and other health services to enable easy access to health services for a long time before wining the award. The improvements include: 1) expansion of outreach health services to communities under its jurisdiction; 2) extension of service time; 3) improving the hospital's atmosphere, turning it into a hotel-like environment; 4) improved hospital sanitation; 5) staff training for authentic service behavior; 6) establishing a one-stop service; and 7) making available various choices of services.

The continuous improvement of its service delivery, administration, and technical aspects has resulted in successful outcomes in providing health services. For example, in the course of the implementation of the program, the average waiting time at the out-patient department reduced from 6 hours to approximately 58 minutes. Moreover, 92 percent of the clients were satisfied with the services and the number of complaints reduced remarkably. Instead clients have filed compliments since the program was put in place.

Such proficient and hard work allowed the hospital to defeat its rival hospitals in Thailand and 98 countries in this year's competition. It is the first time ever for Thai public health institution to win this prestigious award.

Participating in public movement to have the first alcohol control for health legislation in Thailand

The public movement campaigning for alcohol control in Thailand began in July 2003 with the national campaign against alcohol consumption during the Buddhist Lent or ngod lao khao phan sa. In the meantime, the Ministerial Resolution approved in principle the establishment of the National Committee for Alcohol Consumption Control and enforcing time limit for alcohol advertising appeared on television. Since then the anti-alcohol campaign has intensified, and at the same time there has been increases in the number of organizations participating in the campaign activities. Later in 2003 these organizations formed the Stop Alcohol Network. In 2004, the Centre for Alcohol Studies (CAS) was established. These developments have strengthened the movement against alcohol and revealed the numerous dark sides of alcohol consumption, leading to public calls for controls of these unusual goods. Alcohol consumption causes addiction and has severe health consequences, particularly among young people.

The National Committee for Alcohol Consumption Control agreed to form the daft legislation for liquor control on 26 May 2005. Public hearing and a series of seminar were also conducted subsequently. Since Dr. Mongkon Na Songkhla took office as the Minister of Health, he had pushed for the legislation process and proposed the draft in the Ministerial Meeting and later it was passed on 28 November 2006. The draft legislation was then included as one of the top agenda for the National Legislative Assembly. Meanwhile several civic society groups organized the nationwide activities and prepared petition for support of the legislation. They were able to gather 13 million signatures and submitted to the assembly.

The draft has been extensively and heatedly debated throughout the process, not only in the assembly, but also outside the parliament. Alcohol consumption control became one of the major issues of public concern in 2007. Eventually, the National Legislative Assembly approved the draft legislation on 21 December 2008. This was the last legislation passed by the assembly. The current law has been in effect after the King issued the royal endorsement of this law on 14 February 2009.

The major targets set by the current law include: (1) reduce the number of new alcohol drinkers and delay the ages at which alcohol drinking is initiated among young people, (2) reduce the volume of alcohol drinking as a whole, and (3) minimize losses caused by alcohol drinking such as traffic accidents, violence and health problems.

Contributions to the Health of Thais

"The community nurse" - A new movement for health care in the community, by the community, for the comunity

The community nurse is a social innovative which emphasizes the communities taking responsibility for their own community health care. The community will select a local person who is capable of providing holistic care to the community. The selected individual will receive extensive formal training from a school of nursing. During the training process, they will be extensively coached by physicians, nurses, and other health providers from local health facilities

The community nurse for community health care program aims to overcome the problem of the shortage of medical doctors, and to reduce the overcrowding at community hospitals and provincial hospitals. Medical doctors will have more time to provide quality medical services to those who are in greatest need of medical care. One of the main features of the policy is that these community nurses are local people. They understand the local lifestyle, cultural, and living conditions, and have easy access to the community. Their personal links with the families and community make it easy for them to take good care of the people, just as if they were their own relatives or families. Moreover, the health services are provided in the community, so travel time and costs will be reduced.

Within four years, there will be 624 locally-born community nurses who will be based in all sub-districts in Thailand providing health care to the community. Three types of organization have been working together to implementing this program: educational institutions, hospitals, and the local administrative organizations. Support has been provided by the Thai Health Promotion Foundation and the Nursing Council. These organizations together can contribute training in nursing care, provide knowledge about communities, and provide financial support throughout the training.

3

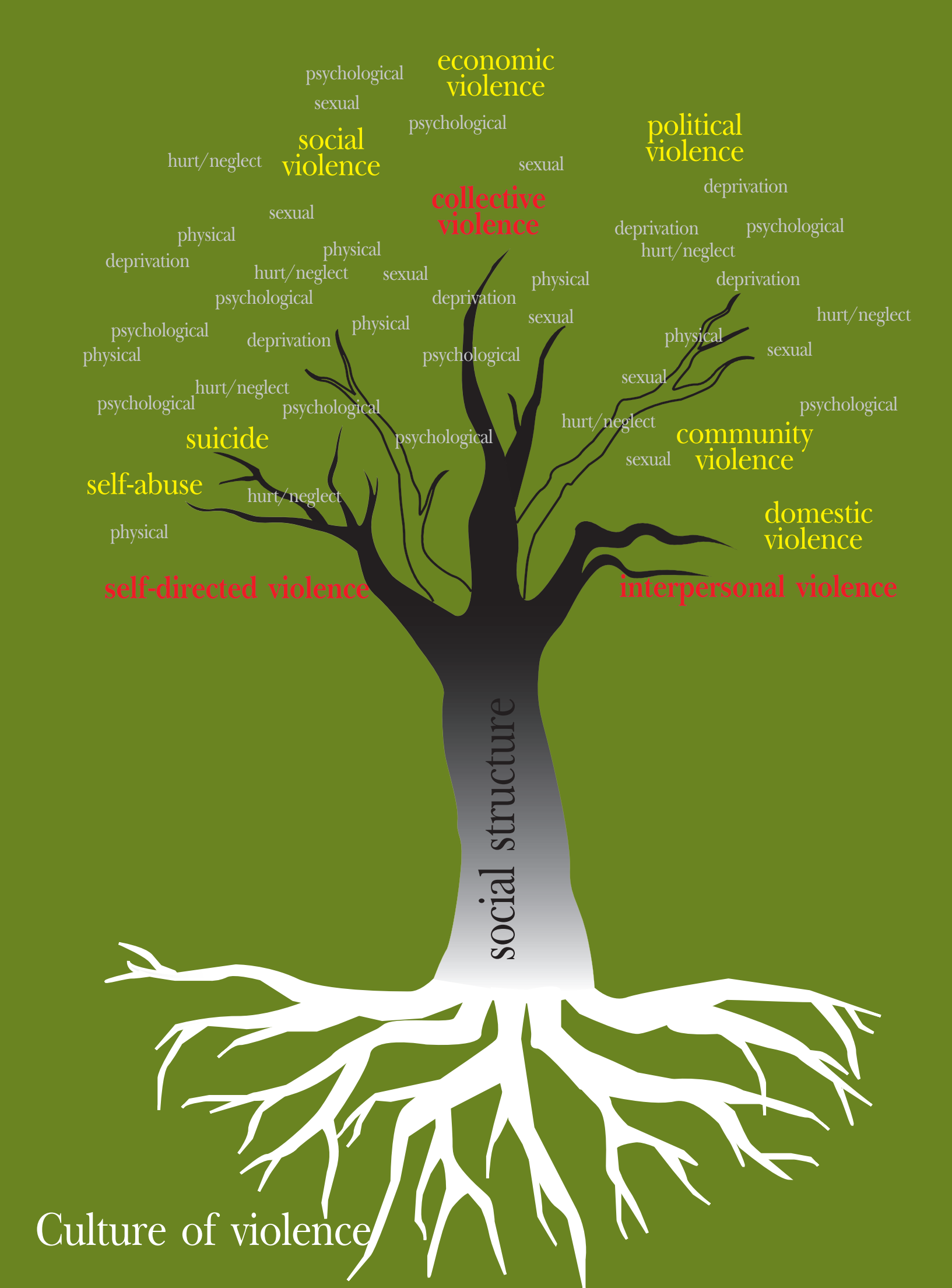
The seventh year which 99 percent of Thais have access to the universal health insurance coverage

In 2001 the "Universal Health Insurance Coverage" or "30 Baht Scheme" was introduced in Thailand. This scheme was trialed in a few provinces before being scaled up to all provinces. In 2006, the scheme was redesigned to provide health services to all without charge. This was to boost the access to public health care for all Thai residents and at the same time to extend its the benefits to cover chronically ill patients, so they could receive quality medicine and proper treatment with no extra cost.

In 2008, the scheme extended health care benefits for the card holders, including (1) patients with kidney diseases could receive dialysis and kidney transplants; (2) patients could access treatment with essential expensive drugs such as cancer drugs, age-related muscular degeneration drugs, and antifungal drugs; (3) flu vaccinations for chronic patients; (4) methadone treatment for drugs addicts who want to stop taking drugs permanently; and (5) lifting the limited access to emergency care use from two times per year to unlimited access to emergency medical services, even at health facilities other than that specified in the health card.

It is pleasing to see that Thailand has come so far in terms of health care coverage. A full 99.16 percent of its population is covered with the health insurance scheme, covering treatment for nearly all diseases.

4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community violence
sexual
self-abuse
hurt/neglect
domestic violence
physical
self-directed violence
interpersonal violence
social structure
Culture of violence

for Well-being of Mankind

1 The World of Violence

The world has seen various forms of violence incurred by humans, from fighting and killing between individuals or groups to wars over power between countries. There is also hidden violence which may not be clearly seen, but its consequences can be felt. These incidences happen repeatedly in our everyday life, to the extent that sometimes we are not aware they are violence.

The World Report on Violence and Health launched by the World Health Organization (WHO) indicates that every year more than 1.6 million people from all walks of life die as a result of violence. Much more have received physical and mental pain inflicted by others or self-abuse. Overall, violence is one of the leading causes of death in adults.

In Thailand, violence is one of the 10 leading causes of death according to the Bureau of Policies and Strategies, Ministry of Public Health. The number of victims of violence has alarmingly soared. Children are suffering from physical and mental pain caused by adults who are supposed to care for and protect them. Adolescents and youth in and out of schools are both victims of violence in the forms of bullying, assaults, or self-abuse. Some have fallen into the trap of abusing drugs. Some are victims of crimes. Women are physically and sexually abused by men, of whom many are intimate partners. Elders, the fast growing group in the society, have been abandoned or maltreated by their caretakers or their own children. There are many other forms of violence caused by conflicts arising from differences in languages, economic approaches, religions, political ideologies, and social status.

In today's globalized world, violence has been increasingly complicated and severe, in parallel with the increase in the world population, city expansion, economic growth, and technological advancement. For power and competition, modern technologies are used to serve ideologies of violence that leaves people divided, exploited, discriminated against, and hurt more than ever before.

Disturbingly, these various forms of violence happen and exist any time and anywhere, at homes, in schools, workplace, on streets, or even places deemed holy such as temples. Thus, there is almost nowhere we can escape from violence.

Regardless of its form or motivation, violence not only causes physical and mental suffering of people involved, but it also results in social problems, hinders collaborations and creativity, and reduces the opportunity of humans living together in peace. In other words, violence is a threat to human well-being.

Violence, which is prevalent in today's society, did not come from nowhere, nor is it influenced by human genes or instincts. It is created by humans, from conflicts that we haven't learned how to resolve in the right way, or from social and cultural structures that support violence which make humans egocentric and ignorant of relationships with others. These factors reproduce themselves through transfering attitude and practices from generation to generation.

The positive side is that since violence is created, it is therefore not unavoidable or cannot be prevented. However, to avoid or prevent ourselves from it, the society must be critically aware of violence and its consequences both short-and long-term. As long as its root causes at the individual and structural levels haven't been tackled, violence still plays its role.

For a peaceful life, society needs to be aware of the threat from violence and work together to stop it. It must be tackled at the very root cause as it is the threat to well-being of mankind.

2 Violence: Nature and Diversity

Jew* a 34 year-old woman with a high school diploma has been married for 8-9 years. Jew has a son and is pregnant with her second child. Recently, she decided to flee from a rented house she had lived with her husband to stay with a rescue shelter for women because her husband imprisoned her in the house for 3-4 years.

Jew said that her husband was 'unreasonably jealous'. "After a bit more than a year of our marriage, he not only let me meet any men, but also did not allow me to meet any person. He did not let me keep in touch with anybody, no matter whom. I couldn't go anywhere without being 'escorted' by him, let alone going to work or meeting friends. When I went out with him, he would not let me look at any man. I could only look at the sky and my feet. When we ate out, he would choose a table attached to the wall and forced me to sit facing the wall. I could not look at anybody especially a man. When I felt frustrated and did not give in, he would hurt me. It then became even more severe. He started locking me in the house when he went to work and asked his elder sister who is better off to take care of our son. When our son came to stay with me during the weekends and he had to go to work, he would lock both of us in the house. When my younger brother and sister visited us, my husband let only my sister stay overnight with us. My brother had to go back or stay elsewhere. Although my husband provided me with life necessities when I was locked in the house, he didn't give me money as he was afraid I would run away. In fact, I ran away many times before, but he came after me and persuaded me to go back with him. I used to poison myself in an attempt to commit suicide, but he found me and took me to the hospital in time.

*False name

Violence has a broad definition. It covers those that are actions and those that are not, which will or may affect directly or indirectly the physical and mental health, lives, development, and rights of the victims as well as the perpetrators.

Kate* a 19 year-old girl, used to pursue higher vocational education. She didn't look lively as most girls in her age. Her relatively large eyes show tinges of anxiety and pain. She decided to leave her parents' house to stay in a rescue home. Kate was a victim of drug-facilitated rape by a male friend. As a consequence, she was pregnant. Kate was so embarrassed that she did not tell anyone about it. Finding herself pregnant, Kate told the friend and asked for his responsibility, but he told her to get an abortion and left her. Her parents soon found out about the pregnancy. She had to drop out of school. Disapproving of the incidence, her parents kept scolding at her. Her dad beat her and accused her of tainting the family name. In the end, he forced her to move out of their home. Today, Kate lives in the rescue home, but she doesn't know what will happen in the future. She has nowhere to go and no idea what she will do.

*False name

Uncle Somwang,* a 70 year-old man, is a poor farmer. He lives in a dilapidated hut with a wife who has a chronic illness. In the first 10 years of their marriage, Uncle Somwang had a farmland which was inherited from his parents. He could sufficiently make a living and raise two sons and one daughter without debts.

30 years ago, an irrigation system was developed. Farmers in the area could grow rice twice a year, but with high investment from costs associated with farming machines, fertilizers, pesticides, and harvest labour. Without much cash, Uncle Somwang had to borrow money from lenders many times. Rice market prices, however, did not collaborate. In some years, Uncle Somwang barely made profit. Sometimes he could not repay his loan and had to borrow new loans just to repay old loans. His debts started piling up and his wife was getting ill without knowing the actual cause. Uncle Somwang suspected that she was poisoned from pesticide as she used to work as a labour spraying pesticide in corn farms. Many villagers who worked in corn farms were experiencing similar symptoms. What Uncle Somwang regards as the worst experience in his life was that a lender forced him to sell his farmland to repay his debts. From that point, his life has changed. His grown-up children left home to find work in the city. In the beginning, they used to come back or send him money, but as time went by his children's visits or supports became less frequent and started to disappear. A few started their own families and stopped sending money to their parents. Uncle Somwang thinks that his family had collapsed. Today, he and his wife live by themselves in extreme poverty.

*False name

Teacher Juling Pongkanmoon, known by those close to her as Teacher Jui, was from a small village in Chiang Rai Province. She devoted her life to teaching children in remote areas of Narathiwas Province and died as a result of the unrest in the three southern most provinces in January 2007.

In 2006, while teaching in Bann Gujingrupa School, Ra-ngae District, Narathiwas Province, she was held captive by a group of insurgents and was hit until her brain was severely injured. Despite the medical team's best effort to rescue her, Teacher Juling was in a persistent vegetative state. Thai people prayed for her hoping that she would recover, but Teacher Juling passed away peacefully after eight months of remaining in the critical condition.

Thailand has lost another great teacher due to social and political conflicts in which Teacher Juling was not involved. She is one of over 3,000 victims who died from the unrest since 2005.

Violence experienced by the above cases has happened repeatedly in the Thai society, as in many other societies in the world. These few examples tell us that violence has many forms and result from many causes to the extent that it is difficult to clearly understand violence. Nonetheless, if we want to prevent or mitigate violence, we need to start by understanding what violence really is and what are the nature and root causes of it.

International Perspective

In the *World Report on Violence and Health,* WHO defined violence comprehensively as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation." The use of physical force also includes threats and intimidation.

Violence is not limited to using physical force or arms, but it also includes exercising "power" against others. Physical assault resulting in injury or death is no doubt a form of violence. However, using power to force others to do what they do not want to or to prohibit them from doing what they have the right to do is also considered violence; for example, a husband imprisoning a wife in their house (Jew's case above), a teacher using his authority to force a student to have sex with in exchange for a better grade, or a supervisor using unfair judgment to order a shift in a subordinate's position as sometimes reported in the news.

Violence does not necessarily come from physical acts only. Verbal acts; such as a threat to harm someone, disclosing other's personal information, tainting someone's reputation with untrue stories; which cause fear, stress, anxiety or agony of others, are also examples of violence. In addition, neglect or acts of omission is considered violence as well, such as neglecting needs of children, elders, or other members in the household.

Consequences of violence are not limited to direct physical injuries or harm, but include psychological impacts such as embarrassment, shame, and deprivation, which cause deterioration in mental health or negative impacts on way of living.

Apart from using physical force or power over others, self-abuse is also violence such as committing suicide (regardless of the outcome) or self-mutilation. Violence can happen between an individual and a group or between groups of people; for example, one person bombing a public place, fighting between youth gangs, street riots resulting in injuries or inconveniences of others (e.g. street blockage), government officers using arms to end a peaceful demonstration, or wars between countries in some regions in the world.

Lastly, violence is an intentional and purposeful act, except violence caused by negligence or an accident.

In short, violence has a broad definition. It covers those that are actions and those that are not, which will or may affect directly or indirectly the physical and mental health, lives, development, and rights of the victims as well as the perpetrators.

Social Perspective

From the social perspective, violence is what hinders, decreases, impedes, or suppresses the capacity of an individual. Consequently, s/he cannot reach his/her goal in life as could be. This applies to both *the actual goal the individual has set and what the individual* could have achieved if violence did not happen. The goal can be in any aspect from health to life development (education, work, relationships with others, etc.).

If *Somchai* lost one of his eyes due to an injury from a bomb that was placed in a trashcan, the impact that *Somchai* received wouldn't be only his physical and mental suffering. His life goals would also be diminished or vanish. He might be forced out of a job due to the eye impairment. His family might lose income. His children might not have an opportunity to study further as they should. All these represent *Somchai's* inability to achieve life goals due to violence. His life situation after the bomb incidence would be dramatically different from what he could have been if he had not faced such violence.

Likewise; teenage girls who are rape victims; wives beaten by their husbands for a long time; children abandoned by their parents; elders neglected by their children/grandchildren; farmers forced to sell their farmlands to repay debts; heartbroken teenagers who shot their intimate partners and committed suicide afterwards; teachers, civilians, and government officers who have been injured or died from the southern unrest; are all acts of violence in different forms and contexts. What violence has in common is that it hinders, decreases, impedes, or prevents its victims from reaching the goals they should have achieved.

From the cases above, we could pose questions in a different angle to understand the nature of violence. For example, is it true? If Jew's husband did not imprison her in their house, Jew could have a job, could earn more money for herself and her family, and at least would have freedom to go anywhere as other married women can.

Is it true? If Kate did not experience the drug-facilitated rape, she would not have become pregnant. Is it true? If her parents treated her with understanding, she would continue her education until earning a degree. She would then have a job and future like other teenagers. Or at least, she would not be abandoned as she is now.

Is it true? If the society had a fairer credit system, Uncle Somwang would not have to borrow from a non-traditional lender with a high interest rate until he became bankrupt and lost his farmland and his family.

In the community, society, and country levels, violence also impedes, decreases, and suppresses the capacity of communities and societies. In other words, their capacity is lower than what they should have.

Is it true? If the unrest in the three southern most provinces did not erupt, the three provinces would be in a much more peaceful situation than today.

Is it true? In the past 2-3 years, if Thailand had a government that listened to its people's voice and had a

team of administrators who were honest and without personal interests, Thailand would not experience never-ending demonstrations and riots and would not intervened with a coup d'etat which has resulted in uncountable negative impacts on the country's democracy development process and economy.

And, is it true? If the ongoing political demonstrations in the past 3-4 years took place in a peaceful manner, not in uncontrollable turmoil to the extent of seizing the government house and the airports, the Thai society would be more peaceful than today, Thai people with different political beliefs would not become polarized, and our economy would not be in such deep recession as we are now despite external factors.

In this perspective, violence causes gaps or differences between the potential capacity of individuals, communities, and societies; and their real situation.

The Dependent Origination *(itappaccayatā)* of Violence

Another important aspect we need to understand is that *violence is both cause and effect in itself. A form of violence may be an effect of another existing form of violence and at the same time, it can cause another form of violence.* For example, inequality is deemed social violence which may be caused by an unfair income distribution policy which is also a form of violence called structural violence (see the next section). At the same time, inequality can lead to other types of violence such as poverty and health problems of underprivileged populations. This example illustrates how violence 'reproduced' itself and remains prevalent.

This is '*itappaccayatā*' or the dependent origination of violence, the process in which violence relies on another violence to emerge. Simply put, when one thing exists, another thing, therefore, exists. When one thing happens, another thing then happens. This process enables us to stop violence by eliminating the root cause of violence. For instance, if we could eliminate structural violence, other types of violence will decline.

Diverse and Complicated

Violence comes in various forms. To make it simple, we can categorize violence as (1) self-directed violence such as suicide or self-mutilation; (2) interpersonal violence or violence caused by interpersonal relationships such as fighting, rape, violence in family, violence in community, violence in schools; and (3) collective violence such as gangsters' fighting, conflicts between interest groups or groups of people with different political ideologies, religions or cultures, as well as unrest by armed minorities and insurgency.

All types of violence may involve different forms of violent acts including 1) *physical violence* such as self-abuse and violence inflicted by others resulting in physical injuries or death; 2) *sexual violence* which can be verbal or physical acts for sexual purpose such as verbal molestation, stalking, forced-sexual intercourse, sex work, sexual inequality and sexual repression; 3) *psychological violence* including verbal or physical violent acts that leads to victims' psychological suffering, anxiety, or depression; and 4) *rights violation* through discrimination or hindrance to basic rights to which an individual is entitled.

Johan Galtung, a Norwegian sociologist and a principal founder of the discipline of peace and conflict studies, has categorized violence into three levels consisting of direct violence, structural violence, and cultural violence.

Direct Violence is an act (or non-act) which results in oneself or other's physical or psychological injuries. It is the type of violence with which we are familiar. We can easily identify the perpetrator, the victim, the injured, and how severe the injury is. Examples of direct violence include a husband beating a wife, a teacher hitting a student, a woman suffering from sexual abuse, gangs of teenagers fighting in a concert event, demonstrators clashing with government officers. Direct violence is obvious appearing at the surface level. What appeared on newspapers is mostly direct violence.

Structural Violence is violence incurred form unfair policies, laws, political and economic systems. It also includes centralized political and economic power which causes "damage" on people or certain groups of people in certain areas by rights violation, discrimination, exploitation, suppression, and prevention from access to resources and life necessities. This leads to poverty, gaps between the rich and the poor, and social conflicts, which often result in violence in the forms of resistance and conflicts between the people and the government

system or between people themselves. These may cause direct violence such as injuries as described above.

Structural violence exists in every society. The only difference is the severity of it. In the Thai society, there are groups of people or organizations from the civil society sector which are fighting the government for different issues, for example; the Assembly of the Poor; the groups opposing the construction of Pakmoon and Rasisalai Dams; the environmental group opposing the construction of a potash mine in Udon Thani Province; Bor Nok Local Conservation Group and Ban Krude Natural Resource and Environment Conservation Group in Prajuab Kirikan Province; as well as the network of people against the gas pipe project, the construction of the Thai-Malaysia Natural Gas Refinery, and its related industries in Songkla Province. There are many other political groups that are well known such as the People Alliance for Democracy (PAD) and the United Front of Democracy Against Dictatorship, which have different political activities causing direct violence with different levels of severity.

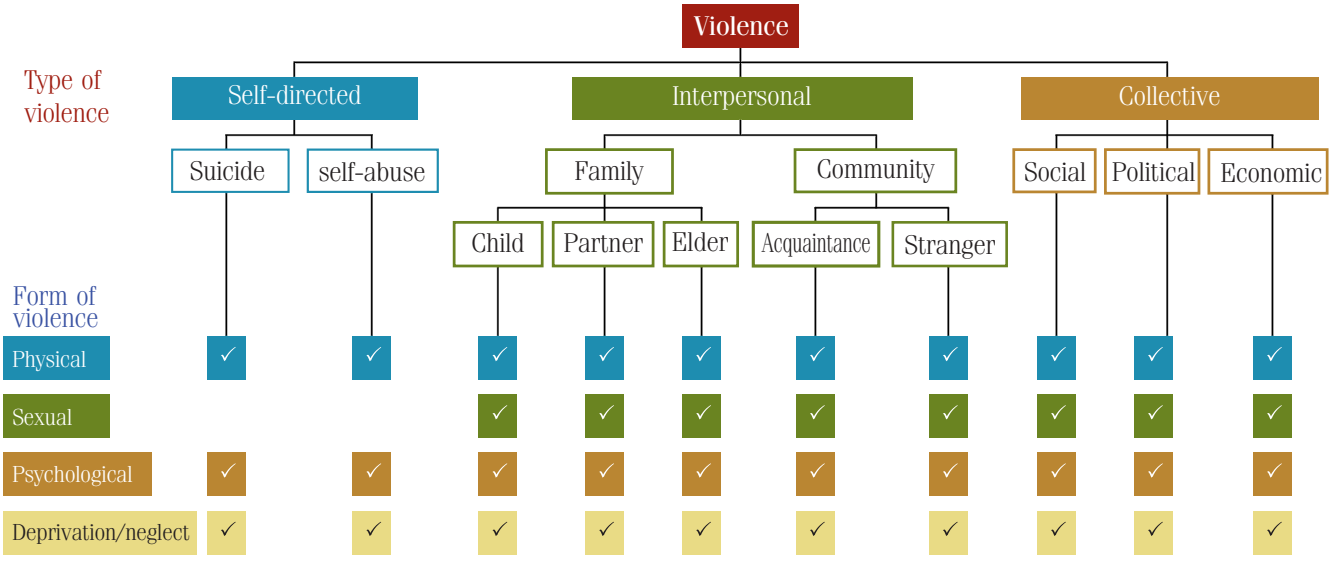
The emergence of these groups is due primarily to structural problems, which, generally, are unfairness, intransparency, and the state of not having good governance to govern and manage different levels of the society.

However, structural violence does not come in the form of resistance only. It can appear in the form of "hidden violence" which we may not be aware that it is actually violence. To illustrate this, if the majority of people are still poor even though the country is abundant with resources, poverty is a symptom of structural violence. Similar cases are; for example, the majority of people are still suffering from a preventable illness despite the fact that the country has advanced medical technology, or children are still malnourished even though the country is a food exporter and calls itself the world's kitchen. All these are forms of violence caused by social structure.

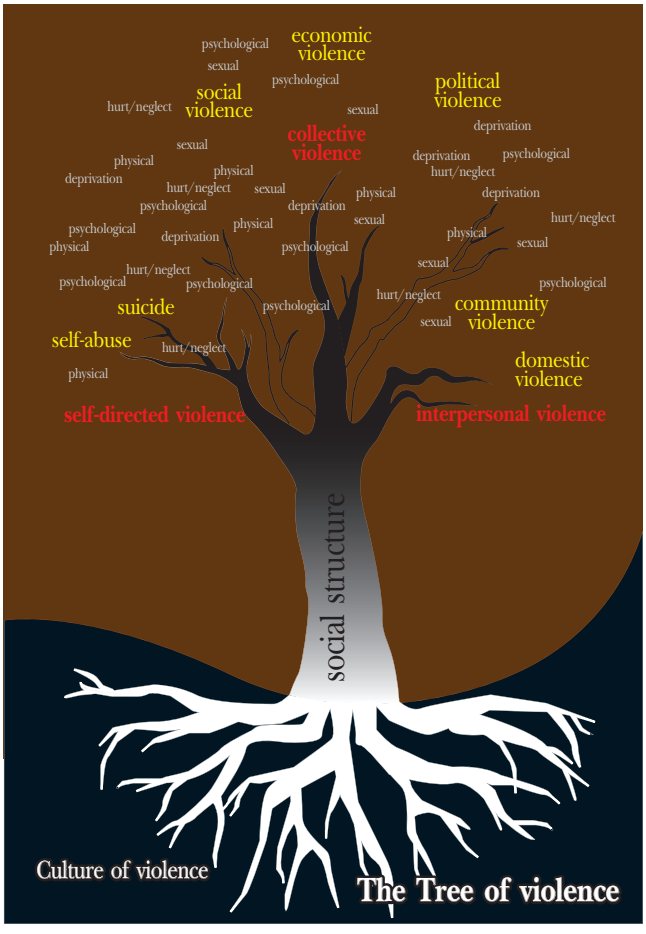
As it is deeply rooted in social structure, violence, either intentionally or unintentionally inflicted by its perpetrator, securely exists in the society. Structural violence, therefore, cannot be eradicated by eliminating the perpetrator. We may be able to make changes on individuals, but as long as the unfair structure exists, structural violence will still remain.

Cultural Violence is violence resulted from belief systems, ways of life, and practices and norms, which are deeply rooted in cultures and have long been inherited through, for example, religions, traditions, and social principles. Akin to structural violence, cultural violence does not directly cause physical and mental damage, but it supports, endorses, and gives right to

Type and form of violence



Source: World Health Organization 2002.



direct and structural violence. It influences people to perceive certain acts which are violent, to be nonviolent, and therefore are acceptable. For instance, parents can beat children when they are disobedient since parents are regarded as children's highest patrons. Teachers can beat students if they badly behave because teachers are entitled to train and educate students. A husband can rape a wife as she has the duty to gratify his sexual needs. Government officials can exercise their power over civilians because they are the rulers.

In Johan Galtung's opinion, the three levels of violence are inseparably interconnected among all forms of violence. For example, the act of rape constitutes direct violence (a man using his physical power to force a woman to have sex with), structural violence (loose laws, a criminal justice system that is not stringently enforced) and cultural violence (sexual double standards, in which women and men are treated differently and women are regarded as sex objects).

If we draw an analogy between the world of violence and a tree, noticeable direct violence, whether it is physical, mental, sexual, or related to rights violation, is comparable to branches and leaves of a tree. Their strength and growth depend on the strength of the tree trunk which is comparable to social structure. The more the social structure is supportive of violence, the faster the violence will grow and become strong. However, the tree trunk as well as branches and leaves will not grow well, unless the tree has strong roots that can absorb enough water and nutrients to feed every part of it. Likewise, violence keeps expanding because cultural factors are supporting it at the root level. Cultural violence is difficult to notice. In many cases, we cannot see it or do not aware that it is violence just like when we cannot see tree roots.

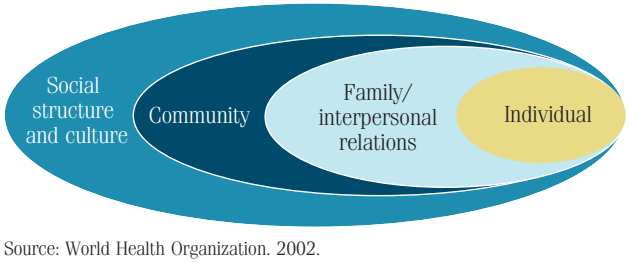
Causes of Violence

Regardless of a type of violence, it is not caused by only one factor. Many studies have confirmed that violence is a result of many factors in various levels which are interrelated, from the individual to community and social levels. This means violence does not depend entirely on its perpetrator only, but also on external factors. This perspective helps us look at violence as a whole from an ecological standpoint.

Through this analytical approach, we may find that a man has a behaviour of abusing his wife due to his own characteristics (he may have sadistic tendencies); due to relationships in his family (the couple may have family conflicts or fight all the time, or he may have absorbed violence since childhood through his parents' violence); due to the community in which he lives (the community may be weak, without sufficient social capital); and due to the society and culture in which he has grown up (the society may have weak justice system, or culture and traditions give power to husbands over wives).

Taking this perspective into practice, to be able to reduce violence in the society, we must deal with factors at all levels so that they are not supportive of violence. This is extremely challenging.

Model explaining violence



Source: World Health Organization. 2002.

3 Violence in Thai Society: An Inconvenient Truth

Although we do not want to hear about it, we cannot refuse that many forms and levels of violence exist in Thai society. Below are only some examples to illustrate the severity of violence. These examples include fatal abuse (suicide and homicide), sexual violence, domestic violence, youth violence, abuse of the elderly, and structural violence including political and economic violence.

Suicide and Homicide: A Problem Common with Men

Information compiled and analyzed by the Health Information Branch of the Bureau of Policy and Strategy, Ministry of Public Health, shows that in five years (2003-2007) suicide (self-violence) and homicide (interpersonal violence) combined are one of the 10 leading causes of death in Thailand. It has held 8th or 9th rank for a long time. In the reporting period, suicide and homicide accounted for 11-15 deaths per 100,000 people. This excludes death from accidents and poisoning, which is ranked 2nd among the 10 leading causes of death, and has been for so many years.

According to the statistics in 2007, suicide caused more deaths than homicide, accounting for 6 deaths per 100,000 people, higher than 5.5 deaths resulting from homicide. These two causes constituted approximately 2 percent of deaths from all causes.

Ten most important Causes of death among Thais per 100,000 people, 2003-2007

Causes of death	2003	2004	2005	2006	2007
All cancers and tumours	78.9	81.3	81.4	83.1	84.9
Accidents and poisons	56.9	58.9	57.6	59.8	56.7
Heart disease	27.7	26.8	28.2	28.4	29.3
High blood pressure and blood clots in the brain	34.5	34.8	29.2	24.4	24.3
Lung infections	23.9	26.3	22.4	22.0	22.5
Kidney disorders	19.2	18.6	20.2	20.6	21.5
Diseases related to the liver	13.0	12.0	14.6	14.4	13.9
Suicide, homicide and others	**14.8**	**11.7**	**11.8**	**11.1**	**11.5**
Viral infections affecting the immune system	26.8	18.3	12.8	10.5	8.8
Tuberculosis	11.0	9.7	8.9	8.3	7.7

Source: Health Information Division, Bureau of Policy and Strategy, Ministry of Public Health

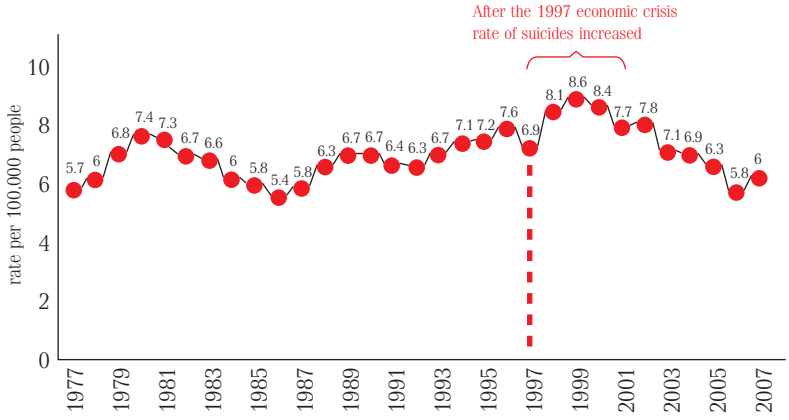
Number and proportion of murdered and suicide victims, 2007

Deaths resulting from violence	Number of cases	Rate per 100,000 people	Percentage of violent deaths	Percentage of all deaths
Homicide	3,467	5.5	48.0	0.9
Suicide	3,755	6.0	52.0	0.9
Total	7,222	11.5	100.0	1.8

Source: Health Statistics 2007

In the past 30 years, suicide rates have slightly fluctuated between 6-8 cases per 100,000 people. The rates significantly increased in the 2-3 years after the 1997 economic crisis due to economic problems which abruptly changed many people's lives. Those that could not adjust to the situation might have been under extreme stress and depression and, as a result, possibly committed suicide.

Suicide rate per 100,000 people, 1977-2007

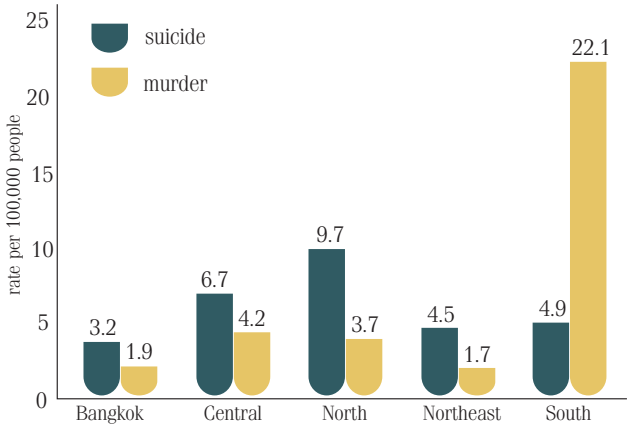


Source: Health statistics 1997-2007

At the regional level, deaths from violence significantly vary. In 2008, excluding Bangkok, in the South, death rates from murder were the highest (22 persons per 100,000 people), in the North the suicide rate was the highest (10 persons per 100,000 people), while rates of both causes in the Northeast are the lowest. This may demonstrate a difference of society and culture. Only in Bangkok, a big city and more developed in every field than other regions of the country, the rates of murder and suicide were lower than in other regions. This issue is unexpected because normally, life in major cities is highly competitive and highly individualistic; people tend to have conflicts and high stress, causing murder and suicide. Nevertheless, it is pleasing to see such low rates of murder and suicide in Bangkok.

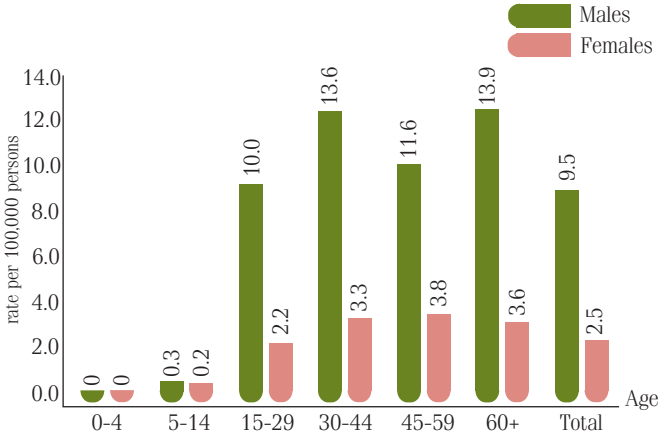
The rates of murder in the South are very high because of the impact of the unrest in the three southern border provinces, which has continued for 5 years and shows no signs of ending.

Death rate from suicide and homicide, by region per 100,000 people, 2007



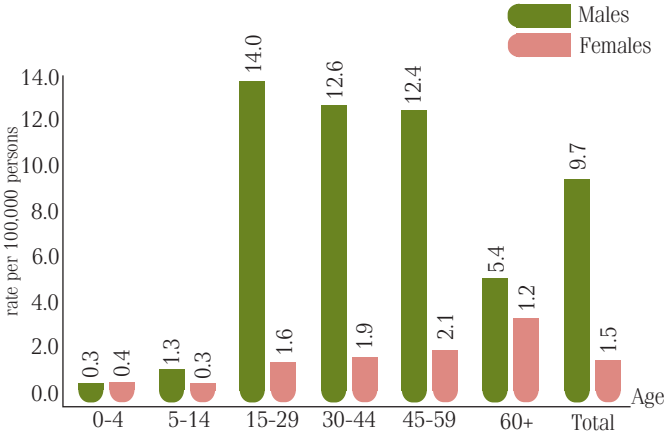
Source: Health Statistics 2007

Death rate from suicide by age and sex per 100,000 persons, 2007

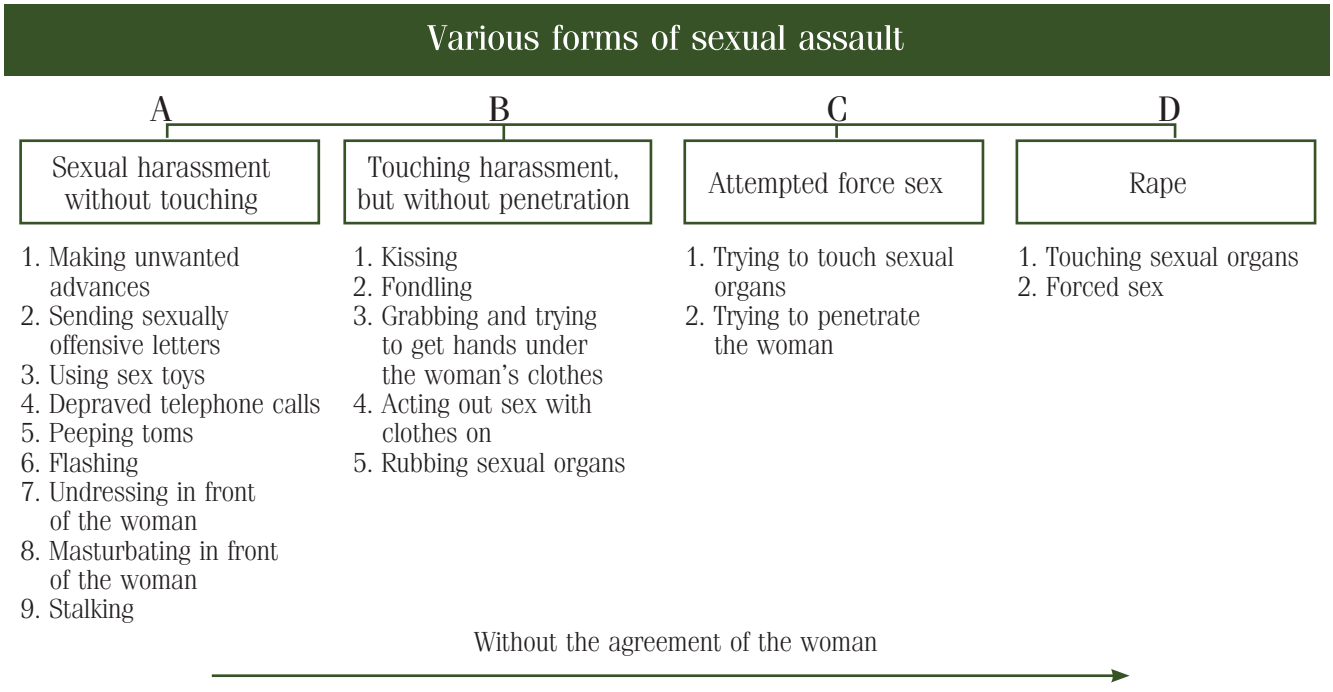


Source: Health Statistics 2007.

Death rate from homicide, by age and sex per 100,000 persons, 2007



Source: Health Statistics 2007.



Source: Kritaya Archavanichkul 2008.

There are obvious differences between males and females and between different age groups concerning violence. The majority of deaths from violence, namely from homicide and from suicide, occur among men; the rate is approximately four times higher for men than for women. The highest numbers of deaths from violence are in the age group 15-59 years, working age people, but, the highest death rates from suicide are among elderly (age 60 years up), while the highest rates of murder are in adolescents and the working group age between 15-59.

However, death rates from violence that are presented are only one part of all violence and perhaps just a minority part. For a more completed picture, we should also consider the injuries due to violence because the injury (particularly the physical injuries that require medical care) is a major public health problem.

For example, in 2004 statistics on injuries caused by self-injury and being harmed (excluding other causes such as accidents) totalled 189,016 persons, representing 16 percent of all injuries which 4 percent was from self-injuries, another 12 percent was harmed by others. Women inflicting self-injuries were about two times more than men, but men were injured by others about 5 times more than women.

Among adolescents and young people aged between 15-29 years, men were injured about eight times more than women. The same age group of males had a rate of injuries twice that of the next highest age group 30-44 years. With such a high rate of injuries, it is important that society should focus on this young group, so the levels of violence can be reduced.

Sexual Violence: Women are Perpetual Victims

Sexual violence covers all forms of behaviour that has a sexual intent and in which the person who is the target does not agree or consent. Or the person may agree to a future action, but when the act takes place they are unwilling to accept the action (due to a violation of standards, tastes, immorality or because of health problems). Such behaviour could be a form of assault, verbal harassment, harassment through eye contact, or through physical contact all with a sexual connotation. The key of this issue is that the other party (which is usually a woman) is unwilling to accept or is not ready for this behaviour.

But the term, "not ready", is an important provision and which is very difficult to interpret. This is especially the case when placing this type of violence into the context of legislation, as it is difficult to find evidence to prove that the person was not ready. Further, in many cases there is indirect forcing, based on the superior social status of the perpetrator. This is typical of sexual

violence that occurs in schools between teachers and students, which was widely reported during the past several years.

In a practical meaning; sexual violence encompasses gender discrimination, forced prostitution, trafficking, violent sexual acts between couples (whether as husband and wife or in any other relationship) and sexual blackmail through the taking of photographs, or video clips.

Sexual violence can occur in every type relationship, not just people of the opposite sex but between same sex partners. This type of violence can occur between strangers who have never known or seen each other before or from a person well known, such as friends, pupils and teachers, husbands and wives, fathers and children etc. Those perpetrating this sexual violence can be of all ages and sexes, and can be individuals or groups.

Due to the complexity of the problems, to tackle sexual violence is a great challenge.

Situation assessments on sexual violence have been limited, unlike suicides, self-harming and murders. This is because most of the act of sexual violence is invisible and most victims do not want to reveal themselves. Thus, there are no complete sets of data indicating the true extent of the problem. Thus the 1997-2007 statistics of the Royal Thai Police on the number of people reporting sexual harassment would be a fraction of the true number of cases that took place. Many people do not want to notify the police because they feel fear, dishonoured or threatened.

Nevertheless, the statistics of the Royal Thai Police over the past 10 years indicate that sexual violence is increasing over time. In 2007, there were 5,269 reported cases of sexual crimes (rape, sexual assault), which on average means 14 people every day, or one ever 105 minutes was raped.

Although, the number of reported rape cases has increased over time, the number of arrests has not increased. During 1997-2001, the number of arrests was quite stable. However, from 2002-2007, the numbers decreased. This significant reduction can not be explained by the available data. However, a change in the responsible agency or an adjustment in a definition may be the cause of the decline.

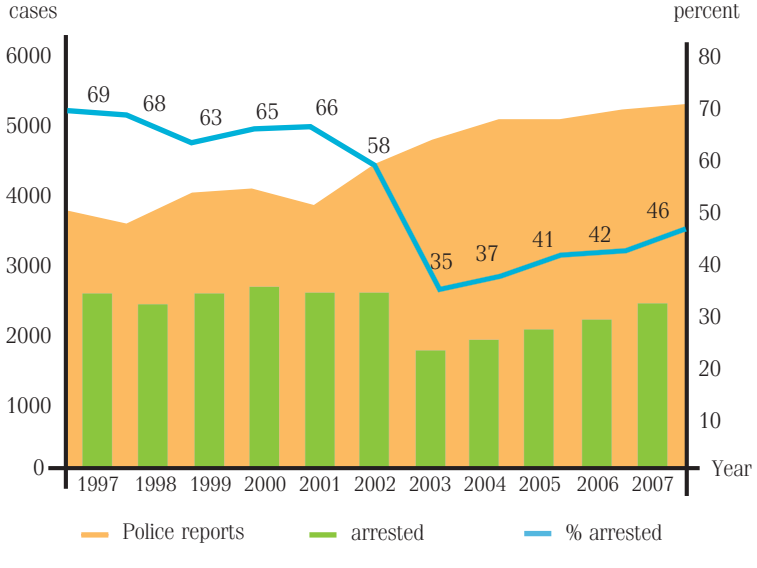
Another source of information that can be used to assess sexual violence is news reports and articles that are published on the internet. The diversity of stories published by the media reflects the level of concern that society has towards sexual violence.

A survey and analysis of news reports and articles by the Institute for Population and Social Research, Mahidol University in collaboration with the Women's Health Advocacy Foundation under the support of the Thai Health Promotion Foundation concluded that sexual violence in Thai society has increased both in the quantity and in the level of severity. Between 1998 and 2007, there were 17,529 reported cases about sex in newspapers and on the Internet. Some of these cases may have been double-counted due to the database management and different sources referring to the same act.

From the 17,529 cases the most reported story about sex was about violence, including rape (38 percent), other forms of sexual violence i.e. prostitution, women trafficking and deception (26 percent) and abortion (5 percent). The rest of the cases included stories about reproductive health, sex education, sexual diversity, gender relations and issues related to sex and the media, which combined accounted for 31 percent of all reports.

Currently, there is no other form of sexual violence that is as problematic as rape given the dramatic increase in

Number of reported sexual abuse cases and the percentage of arrests, 1997-2007



Source: Division of Data and Information, Office of the National Police Force

reported cases. Further, the increased incidence of rape reflects a decline in morality and moral judgement within the society.

Between 2003 and 2007 the number of reported rape cases in the survey was 1,379. More than half of the victims (58 percent) were raped with no physical harm, 13 percent were both raped and harmed, 16 percent were raped and murdered and 13 percent were raped repeatedly. Most of the rapes were committed by fathers, step-fathers or teachers. The victims were mostly around 18 years old. In 60 percent of the rape cases, the rapists were known by the victims such as friends, teachers, and neighbours. In a quarter of the cases the rapists were strangers, while there was no information indicating who the rapist was in 7 percent of the cases.

Another disturbing piece of information is that most of the raped victims were girls under 18 years of age (the range in rape victims went from 13 months to a woman who was 105). In 28 percent of all rape cases the rape were done by more than 1 person and 32 percent of murdered victims are girls under 18 years of age. This fact indicates that the safety of women, especially those under 18 years are of great concern.

Most raped and murdered victims were under 18 years of age and most rapists are acquaintances of the victims, including siblings and relatives. This reflects the nature of sexual violence; it is not just about the act but it is about power relationships between adults and the young and especially between men and women in society. This obstacle is a challenge in solving sexual violence problems. The things that have to be done are more than punishing the wrongdoers but need to include eliminating its cause, which is deep-rooted in the societal and cultural structure.

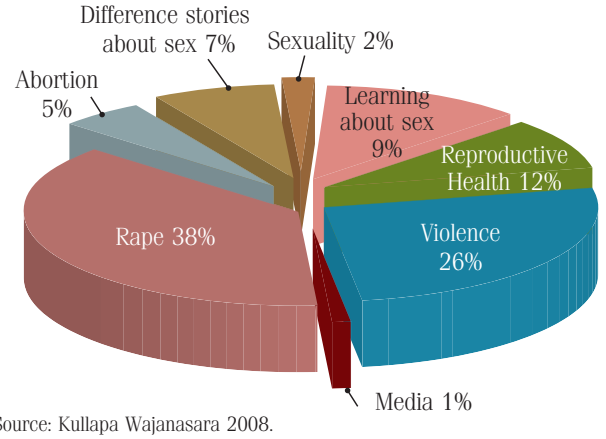
Dr. Kritaya Archavanichkul, the project manager of the survey referred to above concluded that *"The information from this study and from the government's statistics both consistently indicate that sexual violence ranks as the first problem involving sex in Thai society".*

Domestic violence: The neglected problem

Sometimes, **domestic violence** is seen as "normal" and is not considered by many people as a social problem. This is because it occurs frequently and is close to people; so much so that they get use to with it. In addition, certain dimensions of this form of violence is deeply rooted in the complexity of tradition and culture, which sometimes act as its "immunity".

The Act for Protection of the victim from Domestic Violence, 2007 defines this form of violence as *"any acts that are aimed to harm physically, mentally, or in a health manner, any acts that have intention to harm physically, mentally, or health of people in the family, or use of force or power of authority to dominate a person in the family to act, not to act or to admit something illegitimately. Reckless actions are excluded."*

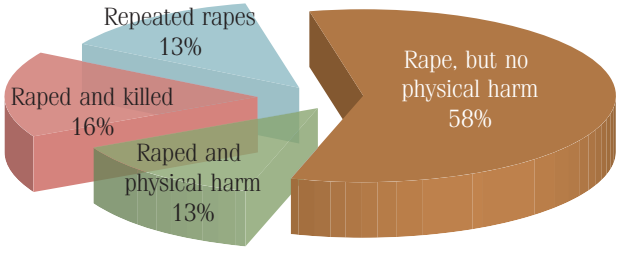
Sexual issues reported in the mass media, 1998-2007



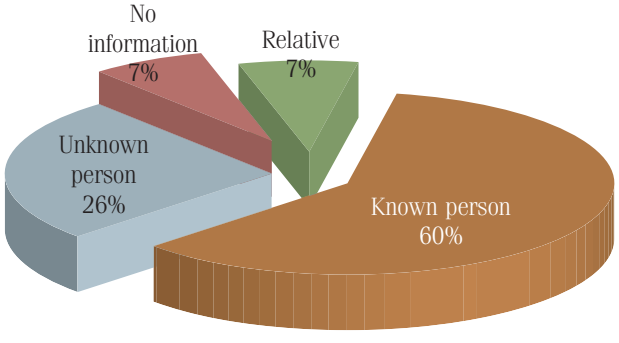
Source: Kullapa Wajanasara 2008.

Note: N = 17,529, though some articles were covered more than once.

Types of rape reported in the mass media, 2003-2007



Relation between the rapists and the victims reported in the mass media, 2003-2007



Source: Kullapa Wajanasara 2008.

Note: The number of reported rapes was 1,379. Cases reported more than once were excluded.

Most domestic violence victims are women, girls or the elderly. Since this occurs in private domestic premises, many people believe that outsiders should not get involved in the issue. Because of this nature domestic violence is a "silent threat" that deteriorates family health over time, especially during periods of dramatic economic and social change, as is happening in these days.

There are distinct patterns of this kind of violence, especially in the form of violence between wives and husbands, in children, in the elderly, which will be presented subsequently.

Violence between wives and husbands: The matter of tongue and teeth?

According to a WHO report published in 2002 violence between wives and husbands exist in all societies, both in developed and developing societies and among the rich and the poor. It includes both physical and sexual violence and can cause physical and mental injuries from which the damages are hard to assess.

Violence between wives and husbands can take several forms. It could be just a quarrel due to an inconsistency of opinions or misunderstanding on an issue but not the desire to control the partner. In certain cases, violence is used to control the other person, to make them to do as perpetrator wishes. For example, husbands beat up wives because the wives "are not doing their jobs as housewives", or wives' may payback their husbands by castrating them due to infidelity. Some use violence as a retaliation on the other, e.g. wives who cannot bear being beaten by husbands over and over may grab knives and stab back to hurt the husbands or even to kill them.

Thai society usually depicts violence between wives and husbands as a battle between the "tongue and teeth", which implies that such violence is normal for those living together, which could lead to some conflicts and not violence.

But if we think thoroughly, we will see the enlightened truth that this saying reflects inequality between wives and husbands. It does not matter whether husbands or wives "act" first but in most cases those who are injured physically or mentally are mostly women. Nonetheless, the societal norm that "Couple's fighting should not be bothered by others" because "they will eventually consolidate" needs to be challenged if improvements are to be made.

How severe is the violence between wives and husbands? Information from Domestic Violence and the Health of Women (published in 2003), indicates that it is a critical problem in Thai society.

This study sampled women aged 15-49 years of age in Bangkok and Nakornsawan province. The study showed that 2 out of 5 women had experienced at least one kind of violence through their life time, either physically, sexually or a combination of both. Among those who had experienced violence, more than half of them had suffered from repeated forms of violence. Further, most of the perpetrators were husbands or their partners.

The pattern of physical and sexual violence against women takes several forms, for instance physical violence can range from pushing, bumping, throwing things, hitting, beating, punching, kicking, dragging, making one suffocate, burning or hurting with weapons. Sexual violence includes using force to initiate unwanted sex where the woman has to agree as she may fear she will not to be loved by her husband; fear of being hurt, or fear that her husband may have someone else; up to being forced by the husband to do sexual activities in ways that they do not want to, resulting in bad-feelings, low self-esteem, feeling disgusted or feeling that it is unnatural.

The health consequences of this can range from minor injuries including bruises, sprains and pains up to major injuries and bleeding that require medical attention. Some cases might be even fatal. Another important finding of this study is that there is an emotional and mental impact on women who experience physical and sexual violence. A higher percentage of women with violent partners were more likely to think about suicide (38 percent of women in Bangkok and 33 percent in Nakornsawan province) compared to those who had not experienced violence (16 percent in both sampled areas). Those who had experienced both physical and sexual violence were more likely to think about suicide compared to those who had experienced one type of violence. The data also indicates that of those women who were victims of violence and had ever thought about committing suicide, one third of them had attempted to end their lives. This indicates that special attention should be given to women who are victims of physical and sexual violence.

Violence against Woman

A study of 2,816 women aged 15-49 years old in Bangkok and Nakornsawan in 2000 about sexual and physical violence against woman highlighted the following:

The extent of the violence

23 percent of married women and those in long-term relations in Bangkok and 34 percent in Nakornsawan have been injured as a result of violence from their partners at least once.

30 percent of women in Bangkok and 29 percent in Nakornsawan claimed that they had been sexually assaulted by their husband or partner.

Combining the two forms of violence mentioned above, 41 percent of women in Bangkok and 47 percent in Nakornsawan had been inflicted with either physical or sexual violence from their partners.

Injuries

From all the women who had suffered from physical violence, 51 percent of them in Bangkok and 44 percent of them in Nakornsawan were injured during the attack. Of these, 31 percent in Bangkok and 23 percent in Nakornsawan had to seek medical treatment for the injuries.

Violence during pregnancy

4 percent of the women who had been pregnant had been physically attacked during their pregnancy. Roughly one-in-three of these women indicated that they had been punched or hit in the belly. In nearly all of these cases the perpetrator had been the women's husband or partner.

Non-partner physical and sexual violence since the age of 15 years

8 percent of the respondents in Bangkok and 10 percent in Nakornsawan indicated that they had been physically abused by someone other then their partner after they turned 15. In most cases the women indicated the attacker was a family member.

6 percent of the women in Bangkok and 3 percent in Nakornsawan had been sexually abused after they turned 15 by a man who was not their partner.

45 percent of the women in Bangkok and 21 percent of the women in Nakornsawan who had been sexually abused were attacked by a stranger

Sexual abuse and rape before the age of 15

9 percent of the women in Bangkok and 5 percent in Nakornsawan indicated that they had been sexually abused before the age of 15. In most cases the women indicated it was a stranger who did this to them.

Of all the women in the study who indicated that they had had sex, 4 percent in Bangkok and 5 percent in Nakornsawan indicated that their first sexual experience had been forced.

Impact on health

In Bangkok 20 percent of the women who indicated that they had been physically or sexually abused also indicated that their health was bad. This compares to 13 percent of women whose health was bad, but who had not been abused. In Nakornsawan 27 percent of the women who had been abused had bad health, compared to 18 percent of those who had not been abused.

38 percent of women in Bangkok and 33 percent of the women in Nakornsawan who had been abused physically or sexually by their husband or partner had thought about committing suicide; this compares with 16 percent of women who had not been abused but had thought of committing suicide.

Who they turn to, to get help

37 percent of the women in Bangkok and 46 percent in Nakornsawan had not told anyone that they were victims of domestic violence. Of the cases who had spoken about their troubles most of them had turned to either their own parents or to a family member from their partner's family.

Only 20 percent of the women in Bangkok and 10 percent in Nakornsawan who had suffered from various forms of violence had sought official assistance, such as from a medical officer, a police officer, a religious leader or a local leader.

The reasons why these women sought help was that they were unable to cope (44 percent in Bangkok and 31 percent in Nakornsawan) or they had injuries that needed to be treated (31 percent in Bangkok and 26 percent in Nakornsawan).

Source: Kritaya Archavanichkul et al 2003

Information from Ministry of Public Health's Crisis Centres for Child Abuse and Violence against Women that operate in 297 public hospitals nationwide (Table 2) confirm the survey results. In 2007, 8,172 (43 percent) out of 19,068 clients who visited the centre were women of 18 years and older (deemed as adults). Most of them were married, had intimate partners or had cohabited with partners.

The violence that brought these women to the centres resulted in physical injuries, abnormal mental state (extreme stress or depression resulting from family problems, husband's undesirable behaviours, or husband's having another woman) and sexual abuse (unwanted or forced sex). These abuses were usually caused by husbands, boyfriends or acquaintances. This reveals that abuse and violence that women suffer are more often domestic and their partners are the culprits.

The Women Status Promotion Association, a private organization dedicated to providing support to women affected by different kinds of problems and issues, has data confirming that the more prominent abuses faced by women are sexual and physical abuses. Data collected over a course of eight years (2000–2007) reveals that three-fourths of women supported by the Association's Emergency Home were sexually abused. For example, they were pregnant from a boyfriends or partners who did not take responsibility for the pregnancy or later abandoned them.

One-stop Crisis Centres

One-stop crisis centres – known officially as Crisis Centres for Child Abuse and Violence against Women were established in 1999. Since then, the one-stop crisis centres have become a pilot project and such centres have been established in 23 different provinces. Each centre has a team consisting of a doctor, a nurse, a psychologist, a social worker, a representative from the private sector and a police officer. This team provides both physical and psychological care, a safe place to stay and financial and legal assistance.

On the 12 of August 2004, to celebrate the auspicious occasion of her Royal Highness Queen Sirikit's 6th Royal Cycle these centres were given the name "one-stop crisis centres". The number of hospitals involved in the project was increased to 104, increasing the number of provinces involved in the project. Further, a national hotline with the number 1669 was established.

The Ministry of Public Health is expanding the one-stop crisis centres and it is planned that by 2014 there will one such centre in each government hospital throughout the country. This will include such centres in 729 community hospitals, and in 9,760 community health centres. This will enable victims of violence to easily access services. It will also enable such services to old people who are victims of violence. Further, the centres will provide protection and be vigilant against all forms of violence.

The number of children and women receiving help from the 'one-stop crisis centres' is increasing each year. As a result of the increasing number of hospitals involved in the project in 2007 there were on average 50 cases per day, or on average 2 people every hour who were receiving support from these centres. This figure is likely to be an under estimation of the real need, as there is likely to be many other women and children who are victims of violence, but who did not seek assistance from the one-stop crisis centres, or from a police station. The simply kept it silence because of shame or because they did not want the perpetrators who were members of the family to be in trouble.

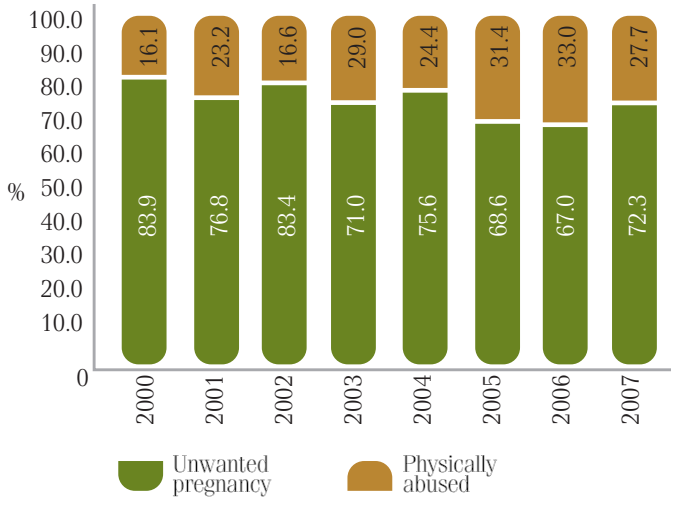
Number of child and female victims of violence receiving assistance from the one-stop crisis centres, 2004-2007

Year	Number of hospitals with cases	Number of child and women victims of violence	Average (cases/day)
2004	70	6,951	19
2005	109	11,542	32
2006	110	15,882	44
2007	297	19,068	52

Source: The Division of Health Service Promotion, Ministry of Public Health

It is acknowledged that information from the Crisis Centre, Emergency Home or other organizations not mentioned in this document will not reflect the true level of violence in the community, as the data is based solely on those receiving services from the centres. A large number of women who are victims of violence decide not to use these services and therefore are not included in the reports. In addition, these centres do not exist in every region in the country (the Ministry of

Problems experienced buy women who sought assistanc emergency shelters, 2000-2007



Source: Association for the Promotion of Women's Status, 2008

Public Health plans to expand such centres to cover 729 community hospitals and 9,760 health centres over the period of 5 years starting from 2007), hence the reports underestimate the true extent of violence. Nonetheless, the available data are suffice to confirm the fact that abuse to women, especially those caused by their intimate partners, deserve serious attention from all concerned.

Various studies conducted both in Thailand and abroad come to similar conclusions that the more obvious causes of violence by husbands include alcoholic consumption, relationship problems, poverty, child raising, addiction to gambling, aggressiveness and power control or superiority. However, these are only obvious causes. Other causes are subtle and embedded in social and cultural structures and are intangible. A relationship that places authority on men over women is a case in point. Thus, a sustainable solution to violence between husband and wife should take into consideration not only the individual level concerns but also a modification to social and cultural structures.

Child and Violence

Child and violence consists of two parts; namely, violence affecting children (child abuse) and violence by children to others (abuse by children). These issues, though prevalent in Thailand for a long time, have only been addressed in recent decades and are discussed along the issues of violence to women, both of which are important parts of domestic violence.

● Child Abuse

Child abuse entails all forms of inappropriate treatments to children, be it abandonment, sexual abuse, physical abuse, and mental health abuse. Certain kinds of abuses and violence embedded in social and cultural structures allow opportunities for adults (parents, teachers) and the society to abuse children but are not deemed as violence or abuses. These include whipping, discrimination based on age, child labour, sexual exploitation, kidnapping, being misled by the media, pornography, drugs and different forms of vices. Even the school admission system which dismisses those who do not score high enough falls into this category because it takes away the opportunities to pursue a preferred course of studies from children. It is difficult to estimate the level of violence against children due to the lack of reliable systematic data at the national level. Nonetheless, existing data suggest a worrisome scale of violence, especially direct and domestic violence.

A figure in 2007 from the Crisis Centre of the Ministry of Public Health shows that half of its clients were children under 18 (9,579 out of 19,068 cases) and among these there were three to four times more girls than boys. Most cases of violence were direct which include, by degree of frequency, physical, sexual, mental abuses and being abandoned. Mostly, those causing these violence and abuses are those having a close relationship to the children. These include parents, relatives, friends and acquaintances; strangers are found in a small number of cases.

Like in the case of violence against women, the reported number of abused children is much lower than what actually happens. Possibly, a number of affected children do not receive service from the Crisis Centres as adults perceive their problem to be minimal and thus discourage them from seeking help. Further, children often do not know where to turn to, or the adults limit their access to help, as they were the perpetrators of

the violence, especially if the adults were parents. This further decreases the chance for the children to receive help unless the case is really serious. In other words, the number of children receiving help as a result of violence; may only be the tip of the iceberg, meaning a lot more children are being abused but are unable to seek help.

Violence in the education system has forced society to question if schools are a safe space for children since those who cause the violence are the teachers and fellow students.

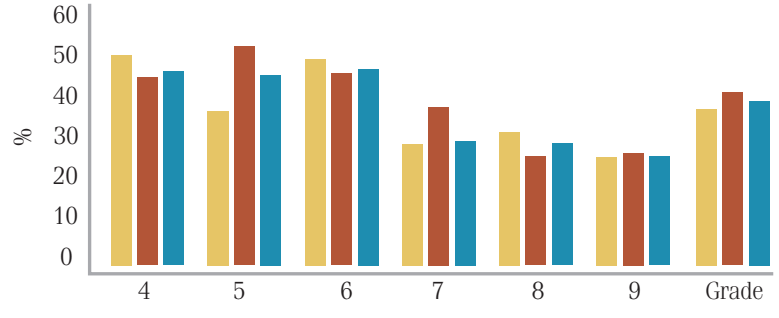
Whipping is a form of punishment that originated a long time ago in the Thai education system. The whipping rod has played an important role in the process to uphold discipline in school (as in homes). In the past, parents taught their children to behave by quoting this old verse: *"Be careful of that teacher, carrying a rod which if you can avoid is better, many times I had tasted the sticks, how prickly and bruised it still lingers."* Some adults who grew up and had a successful life still remember how the whipping rod shaped who they became. However, due to the change in teaching philosophies, coupled with the wake in child rights, whipping in school and other forms of violent punishment have been banned (per the Ministry of Education's regulation on punishments, 2000). Despite the ban, many teachers still adhere to the rod and use approaches deemed as too harsh by society, as reflected in various news reports in recent years.

Besides whipping by teachers, physical assault and bullying by students are also causes of violence in school. Dr. Sombat Tapanya of Chiang Mai University conducted a survey on violence among students in 2006. Samples were drawn from 3,047 students of grades 9 and 10 and 1,300 teachers from selected schools across the country. The results revealed that almost two out of five (39 percent) of sample students reported violence of various forms by their fellow students in the past two months prior to the survey. In general, violence happened to male students slightly more than their female counterparts. However, looking at violence by grades, both male and female students have equal opportunity to be exposed to violence while primary students have a higher rate of violence than secondary students. The three most frequent forms of violence are ridiculing, insulting and physical assault. At least one-fourth of students admitted having been bullied by their fellow students.

The data on teachers from the same survey reconfirms this. Roughly nine out of ten teachers reported having seen students bullying each other at least once in the past one year. One-fourth of those who had witnessed such violence said they had seen such violence more then ten times. When asked about punishment by whipping, most teachers (72 percent) were of an opinion that such approach was still necessary. Punishments by teachers generally include threatening by showing the whipping rod, whipping and hitting by hand.

All this information indicated how widely bullying among students and whipping by teachers prevailed. However,

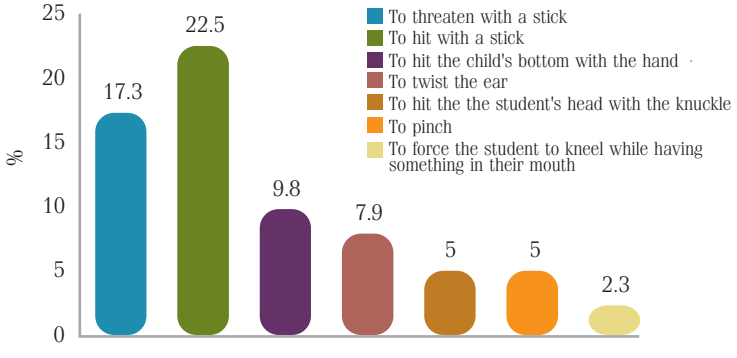
Percentage of grade 4-9 students who reported they were physically assaulted 2-3 times or more in the last two months before being interviewed, 2006



	4	5	6	7	8	9	Grade
Girls	50.5	39.2	50.2	29.3	31.6	23.1	37.4
Boys	46.9	54.9	45.9	36.9	25.9	24.4	40.2
Totals	48.7	47.0	47.9	33.0	29.0	23.7	39.0

Source: Sombat Tapanya, 2006.

Percentage of teachers indicating that they had administered corporal punishment and the type of punishment that they had administered up to 5 times in the past year, 2006



Source: Sombat Tapanya, 2006.

lack of information in such an area has held back the ability to ascertain whether the current situation has improved or worsened when compared to previous years.

Sexual abuse in school seems to be growing by a large extent. Though without systematic data to back this hypothesis, it can be drawn form the media that this form of violence has become serious. Such violence includes the raping of female students by male teachers and when the teachers offer money, objects or better marks in return for sex. This kind of violence often goes unnoticed as students often do not tell their parents. Usually, abnormal signs or indications led the parents to realize something had happened to their child and until only then would they learn what had happened. Some news reports echo this reality.

Sexual abuse among students is not to be overlooked though we are unable to tell the magnitude of the problem. Such problem may prevail in the forms of discrimination, ridiculing, or bullying based on sex rather than direct sexual abuse. This causes the victims (usually girls) to feel upset, embarrassed or stressed. On the other hand, sexual abuse among adolescent students may occur both in and out of school and include sexual intercourse out of curiosity or as a result of rape. This excludes the use of violence in solving love problems in such forms as physical assault, suicide, or killing a partner due to an unresolved conflict. This has made headlines more often these days.

Though violence against children that is embedded in the social and cultural structures is not as obvious as direct violence, it is as threatening. This embedded violence does not affect just one particular child or one family; it also has impact on the future of the children and the nation as a whole in the long run. This structural violence prevails in the forms of consumerism and materialism culture, the number of entertainment establishments and risk venues (pubs, bars, karaoke

Risk factors and indicators of violence:
Comparison of provinces with high risk and provinces with low risk, 2007

	Rayong	Samut Sakorn	Satul	Payao	National
Risk factors					
Number of factories	2,129	4,709	267	435	126,804
Number of entertainment centres and brothels	410	197	52	63	13,833
Internet cafes in cities (per 100,000 people)	50.2	37.8	6.0	34.1	29.2
Number of risky sites in the province (per 100,000 people)	45.0	116.8	16.7	34.1	50.8
Indicators of violence (per 100,000 people)					
Number of attempted suicides among children	74.1	61.4	13.1	46.3	40.2
Number of children from motorbike accidents (per 100,000 people)	2,308.9	3,286.7	334.3	2,644.5	1,669.6
Children 18 and younger who have been sexually abused (per 100,000 people)	4.0	50.02	43.2	63.2	39.2
Number of children sent to detention centre (per 100,000 people)	111.4	106.2	80.9	28.8	64.5
Number of children sent to a drug rehabilitation centre (per 100,000 people)	19.2	78.9	287.3	40.2	111.4

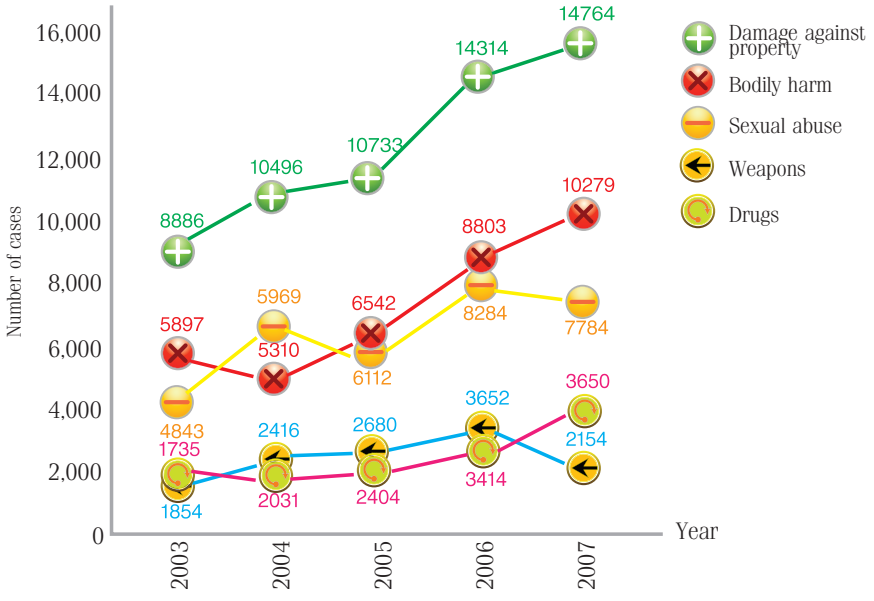
Source: - The number of factories is based on the Industrial Information Centre – Department of Industry (2007).
- Information about the number of entertainment centres and brothels is based on the Department of Communication Disease Control, Ministry of Public health (2005).
- Information about problems faced by children comes from Childwatch (2006-2007).

Note: The risky site is defined in terms of the number of karaoke bars, cocktail lounges, pubs, snooker halls, coffee shops and short-term hotels per 100,000 people.

houses, video game shops, etc.) persuasive and luring media (especially those presenting sexual and violent contents), a competitive, dog-eat-dog society, environmental pollutions and inequality in income generation and distribution. In addition violence against children can result in these children in turn perpetrating acts of violence against others. From a social perspective, this is an issue of concern as it directly impacts the future of the nation.

Evidently, in provinces where a large number of violent factors exist, especially entertainment and risk venues or where fast economic and social changes are taking place, child abuse indicators are also high. These include children trying to commit suicide or being admitted to rehabilitation centres.

Number of convictions against children and youth, 2003-2007



Source: Bureau of Information, Office of Child and Youth Justice, Department of Child Correction and Protection

● Violence by Children

Children are not only victims of violence, but can also be the cause or originator of violence themselves. This has existed for a long time and still a solution for which needs to be identified. This comes in the forms of improper behaviours, fighting, physical assaults, gang violence, crime, sexual misconducts, drug addiction, gambling, motorbikes races and video games.

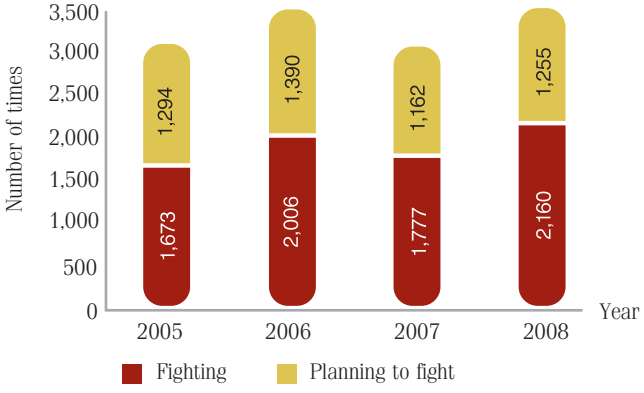
Despite social awareness of the issues, these different forms of violence seem to be increasing both in terms of numbers and complexity. Data on the number of children admitted to rehabilitation centres during 2004 – 2007 confirms an increasing trend in children inflicting violence. Some rapidly increasing forms of violence include charges relating to property and belongings (snatching, robbery and theft), those related to drugs (consumption and dealing) and those relating to life and physical safety (physical injury and killing). Looking at this violence for children by category, the number charges for crimes on property and belongings increased from 8,886 to 14,764 cases in five years (an average increase of 13.2 percent per year), drug charges increased from 5,897 to 10,279 cases (an average of 14.9 percent per year) and physical charges increased from 4,843 to 7,784 cases (an average of 12.1 percent per year), all over the course of five years. It is important to note that this data is only for those who were charged for a crime and does not include those who were not caught or charged.

Another form of child and youth-related violence is students from different schools fighting each other, which has been an issue of concern for the society at large. However, the society has hardly done anything to prevent or reduce the degree of the problem, except posing questions or insulting these violent acts when one incident makes the headline, and requesting those concerned to take actions. As the news fades away, no further actions are taken and the problems remain. As time passes by, these problems develop in new forms which reappear too fast for the society to keep pace with.

Violence by students involves physical assaults as a result of quarrels or personal hatred that is not associated with the school they attend, and violence associated with their educational institution. This latter form of violence reflects the reality that violence has shifted to the level of being institutionalized that passes on from one cohort of students to the next. Behind this violence is somewhat an “institution-crazed cult”.

This institution-crazed cult carries a common belief that everyone shares the same identity and this identity is tightly associated with the institution which they revere

The number of times students caused disturbances and the times they were arrested for doing so in Bangkok, 2005-2008



Source: Bangkok Metropolitan Police Bureau

and highly respect and that no one from any other institution may "touch" or "disrespect". Thus, when someone of the same clan is "violated" by an act of insult, be it physical, verbal, in written form (including on web boards) or by being attacked with weapons in riots, the other clan members will deem it valid to "take revenge", in the name of the institution, against members of the violating institution anywhere, anytime and against anyone. Likewise, this revenge leads to another revenge at a greater degree, and the vicious cycle continues.

Thus violence is being "reproduced" in some vocational colleges, and now it also has been adopted by some secondary schools. A culture of violence has now been established in a number of educational institutions.

In the past 5-6 years there has seen clearly a rising trend in student fights. In 2005, there were 1,673 fights in Bangkok (an average of almost five fights per day), the number which then fluctuated slightly over the subsequent three years (2006 – 2008). Police reports showed that there were 2,160 fights in 2008, an increase of 29 percent or an average of six fights daily, or a fight every four hours. In the same year (2008) the police received 1,255 reports of planned student fights, an average of three incidences per day.

A study to understand the motives of students fighting was conducted in 2004. The results found that the motives consisted at both the macro and micro levels. The macro level involves the education system, social circumstance and the management system of the vocation education, the history that led to the attitude and a "vocational identity" which has been passed on from generation to generation, the origin of which is hard to comprehend. The micro level entails the quality and management system of the school, and the local violence crisis management in different settings, taking into consideration organized events, concerts and provocative writing at public places inciting violence from other parties.

The latest development of violence in schools that has captured attention from the public is female student fights in public. These female students make appointments with their opponent to have a one-to-one fight, as practiced by male students, with friends looking on and cheering with enjoyment. Often, these fights have been captured in video clips and then sent to others via mobile phones or posted on websites to humiliate the defeated party and uphold one's dignity. These female fight clips are easily accessible on certain websites, like the fights of male students.

Motives for female student fights were often to compete for a partner (who many times is of the same sex), or based on dislikes because of various reasons. One important reason for such disliking is to compete over the status of being a gang leader or having more power than others. Some academics explain such incidence as a means of "self release" for female students

Originally, the solution to end a problem by an "appointment in the back of the school" was part of the male students' culture. Female students in this self-releasing era seem to be doing everything that their male counterparts do. These range from dressing to one's liking, drinking, frequenting entertainment venues, having more than one boyfriend at the same time, all the way to "point collection", meaning collecting points for the number of male students they have slept with and competing to see who will get the highest score. Other forms of female students' violence include acting like mafia queens to extort money from those who are weaker than them, going gambling and being involved in drug parties. As such, it is now more difficult to distinguish or differentiate the violent behaviours between male and female students.

The increased complexity and variances of violence caused by children and adults are a reflection of social health. It can be drawn that because the **society is not healthy, the children who are part of or live in that society are inevitably "affected".**

● Violence against the Elderly

Professor Dr. Pramote Prasartkul, a demographer from the Institute for Population and Social Research of Mahidol University describes the sharp rise in the number of the elderly in Thailand as an "elderly explosion".

In the last decade there were about six million elderly in Thailand, constituting 9 percent of the entire population. In 2009 this number may have increased to at least 7.5 million, or 12 percent of the entire 63.4 million. The swift hike in the number of the elderly, coupled with changing family norms and economic and social changes, have put them at risk of violence both from family members, those they associate with, and from the society.

Like child abuse, abuses against the elderly cover a whole range of types of violence that causes physical injury, mental and psychological instability, disrespect or demeanour. This also includes sexual abuse, loss of possessions or property and curtailment of basic human rights.

The fact that the elderly are respected by the young and the society because of a long adopted tradition in Thai society has made people unaware of abuses and violence against them. This unawareness, however, does not stop the violence that is taking place against them. Because of their age they are more susceptible to violence, be it physical, mental, psychological or economical, than those who are younger. Thus, a few mean or ill-expressed words can have paramount violent implications for them.

Aside from the changing physical health and strength, physical abuses against the elderly caused by others are of a minimal extent. Rather, mental and psychological abuses are more common among this population.

In fact, all kinds of inappropriate conducts or behaviours can have an impact on the mental and psychological health of the elderly. Words can hurt, though not spoken intentionally, and so can a lack of care and disrespect. This may include the lack of interaction in their daily life, being excluded from a decision-making process or not being informed of something they should know. Sometimes they are forced to do something that other family members think they should do. All of this can cause stress, distress, loneliness, or depression. These symptoms are detrimental to their health as a whole. Studies have shown that depression and loneliness are important drivers of suicide among the elderly and such efforts to counter these problems among this population can be more successful than for other age groups.

It is difficult to estimate the number of abused elderly due to lack of studies at the national level on this topic. According to the World Health Organization, studies conducted around the 1990s on violence in developed countries such as America, Canada, Finland, the Netherlands and England have shown that 4 – 6 percent of the elderly have experienced domestic violence. The frequency of violence between male and female elderly is different in Canada, the Netherlands and America where the elderly females were twice as likely to suffer from violence compared to their male counterparts.

National statistics on this topic do not exist in Thailand due to lack of studies. However, a few studies have focused on violence against the elderly in a limited number of selected provinces. In 2002, a study conducted in four North Eastern provinces of Thailand by a Khon Kaen University research team found that almost half of the elderly, most of whom were women, (46.4 percent of a sampling of 959 respondents) reported violence in one form or another (the study did not specify time of violence). This finding was similar to that of another study conducted in Chaiyaphum province in the subsequent year. The forms of violence in these two studies are similar and can be categorized by degree of frequency as follows:

(1) Mental and psychological violence, i.e. yelling, threatening, grounding, shouting, cursing, silencing, disrespect, dishonour or condemning.

(2) Abandonment, i.e. being left alone, driven out of house, lack of attention when needed, not provided allowance, or have to take care of grandchildren by themselves.

(3) Being taken advantage of their property, i.e. confiscation, possession, cheating, stealing money, being forced to sell, give or mortgage property without consent.

(4) Physical assault, i.e. injury, not being taken to the hospital when needed or given necessary medicine, and;

(5) Sexual abuses, i.e. forced intercourse, rape or molest.

The number of abused elderly found in these studies above is much higher than that found in developed countries. This may be attributable to different social and cultural structures, or it could be from the way definitions were framed and the duration covered in the studies.

Moreover, violence against the elderly can come from their family members or the elderly themselves. Those causing violence against them often suffer one form of a personality problem or another. This includes being emotional, aggressive, mentally unstable, alcoholic, addicted to drugs or gambling, having economic or relationship problems, all of which lead to stress that translates into undesirable words and acts that are violent to the elderly.

Seniors, themselves also play a role in the violence because of their physical, emotional and psychological changes that take place as they age. Further, they become dependent on others for physical, emotional and financial support, which can create frustrations. These changes can cause the elderly to become moody, sensitive, pernickety, grouchy and self-willed. All these behaviours may cause other family members to lose control, by verbally or physically attacking the elderly. Further, the elderly have more problems with their memory or with some other imperfection, which may cause the children to feel frustrated and bored, leading to neglect or keeping a distance from them, which are forms of violence against the elderly. The elderly are at great risk to be harmed.

Structural violence

Over many years now it can not be denied that Thais have experienced many incidences of structural violence and over time the degree of the violence has become more intense. Part of the structural violence results from unfair development policies and the economic system, which treats people differently. This has been the case since the development of the first National Economic and Social Development Plan in 1957. Another part of the structural violence in Thailand is being played out with the political conflict taking place in the country and the insurgence in the three southern border provinces.

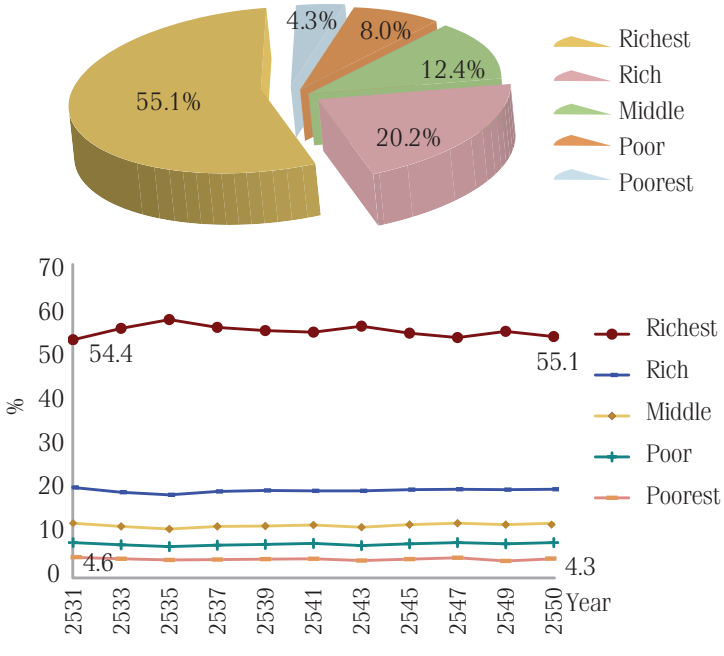
● Unfair development and the economic system

The structural violence that appears in the context of economic development is complex and multi-dimensional and is linked to international developments including globalization. Though complex, it is not difficult to identify the origins of the violence.

The ideals of the New World Order of democracy, free trade, environmental protection and human rights are far from being reality in Thailand. The countries social structures and economic policies, especially capitalism has resulted in great inequality. The problem is that many Thais are unwilling to participate in this new world order. Further, presently many laws and policies support those who are richer and more able to access economic resources. While the poor, the largest group in Thai society, are unable to access these resources. This results in a tremendous gap between the rich and the poor with the rich able to get richer while the poor are unable to gain greater wealth and thus is a root cause of violence.

In 2007, 55 per cent of the country's income was in the hands of 20 per cent of the population (approximately 12.6 million people), the remaining 80 per cent (approximately 50.4 million people) of the population shared only 45 per cent of the country's wealth. The country's poorest 20 per cent shared only 4 per cent of the nation's wealth. This means if 100 baht was divided

Distribution of wealth, by quintile of population, 2007



Source: National Economic and Social Development Board

between 100 people, 20 poorest people would have to share 4 baht among them (on average 0.2 baht per person) while the 20 richest would share 55 baht (an average of 2.75 baht each), and the remaining 41 baht would be shared with the remaining 60 people in the middle. The income gap between the poorest and the richest has changed little during the period of 1988-2007, though those living under the poverty line have decreased significantly.

This different between the rich and the poor is in essence a form of violence that is expressed through the national economy.

Unbalanced and un-sustainable development policies bring about structural violence. For example, economic development that mainly focuses on industry and exports means the agricultural sector receives less attention than it should, even though it supports the majority of people in Thailand. At the same time, promoting industrial growth does not focus enough on sustainability, creating environmental problems and resource shortages (land, forest and water). This has resulted in degradation of the environment creating a serious problem. This is another type of violence, which we could call "a violence against nature, resources and the environment", which will affect the health and livelihoods of people.

All these problems do not come only from poor policies, but also from community members not being able to participate in decisions regarding development projects. Further, law enforcement of issues related to the environment is often neglected, which only goes to make the problem worse. It is the people living on the edge of society – those most connected to the environment who are the ones who suffer the most as environmental problems grow, rather then the people in other sectors of the society.

For those who bear the structural violence, many can cope, however the people who no longer can cope is increasing. Those who are not coping are protesting louder – they have become serious in their protests against the state. Sometimes they are protesting against governmental projects, while other times they are against private ones. These people will protest if a project has or will have an impact on their lives; whether it affects their employment, the environment, their food, their health, their land and their way of life.

Over the last several years, groups of people and organizations that have been affected by the development projects have formed to protest against them. More and more groups have been established throughout the country and their demands have also grown.

A research report titled the "State of Human Rights and the Resource Base in the International Situation" produced by the Office of National Human Rights Committee stated that in the two-year period from 2004-2005, they had received 229 complaints about rights violations connected to the environment; 58 in 2004 and 171 in 2005. Nearly two in three of the complaints concerned the right to manage land and forests.

It can not be refuted that the protesters are reacting to structural violence that exists in the society. Though this is the case, it is painful to see that nearly every time there are protests they are met with direct violence resulting in injuries and at times even deaths, often there are arrests or at least they are attacked verbally by those who oppose them.

● Political violence: Overstepping the rules

In Thailand the most violent political act would be a coup d' etat to topple the government with tanks and guns. But political violence is not limited only to this event; there are other dimensions to the structural violence which can be as severe as a coup d'etat.

In the history of Thai administration, from 1932 with the change from an Absolute Monarchy to a political system based on democratic principles there have been 24 coup d'etats (10 were uprisings). On average one such event took place every 3 years. In some years there have been more than one occurrence, for example, in 1933 it happened twice, 1948 three times, in 1951 twice and in 1977 twice. Though these coup d'etat in recent years have been happening less often, Thailand might be the country in all of Asia, if not the world, that has had the most coup d'etats. No matter if the coup d'etat leads to deaths and the shedding of blood or not it is a form of political violence. These coup d'etat are, indeed, acts of political immaturity.

It is not possible to deny the fact that coup d'etats come from an improper way of using power. Such power (whether we accept it openly or not, has no legitimate ground and thus cannot lead to the right

thing. There is no doubt that after a coup d'etat the same structural violence still remain. These include corruption, cheating, over-use of power by government officials and taking advantage of the economy by political leaders and businessmen closely connected to those in control.

Freedom of expression is needed to develop the intellectual capital and the national economy, but coup d'etats obstruct this freedom. An example is that after the coup d'etat in September 2006, the United States slowed down negotiates for a free trade with Thailand. At the same time, the value of exports to the United States and some other partners declined. Many countries do not want to be in contact with a country that removes an elected government by military force.

Department of Commerce data suggests that in 2004, the growth rate of export value to the United States was 10.16 per cent, in 2005 this figure decreased to 9.3 per cent and in 2006 just before the military take over the rate was 8.9 per cent but by 2007 that rate was contracted to -9.6 per cent (though it must be pointed out that this is the same year that the United States economy was affected by the sub-prime problem).

With an elected government in Thailand in early 2008 this made the country's image improved and the negative rate of export value to the United States decreased to only -0.3 per cent. This is despite the United States experiencing a harder economic crisis than the previous year. Similarly, growth rate of exports to Thailand's other major trading partners such as the European Union, United Kingdom and Japan improved once the government had been elected.

The repeatedly occurring protests over the last three to four years are another representation of the political violence that exists in Thailand. In a politically mature society, peaceful demonstrations where no harm takes places are accepted. But in Thailand the protests use both direct and indirect forms of violence, such as with the protests of the People's Alliance for Democracy (PAD) (the yellow shirts) and the United Front of Democracy against Dictatorship (UDD) (the red shirts).

Percentage of Thai exports to major trading partners, 2003-2008

Year	USA	E.U.	Japan	UK
2003	-2.4	11.4	10.5	4.4
2004	10.2	13.4	14.7	13.7
2005	9.3	3.1	11.3	-7.9
2006	8.9	12.5	3.5	15.5
2007	-9.6	6.6	0.2	-3.5
2008	-0.3	2.3	5.8	4.8

Source: Division of Information, Office of the Permanent Secretary, Ministry of Commerce

The sad truth is that the fuel firing the violence within the protest movement partly comes from the government as it does not govern transparently, it has conflicts of interest and it does not listen to the voices of the people. A second part of the problem is that those involved in the protests are unwilling to listen to the majority of the society expelling all that do not agree with them.

In 2008, the Thai population saw so many incidences of political violence that many people were no longer able to cope. Several times, the protests were severe and unreasonably prolonged. Information from the Erawan Data Centre, a medical emergency centre, indicated that the violent conflicts between protestors and police and between the different colour protestors in Bangkok occurred 12 times (on average once every month). During these incidences 737 people were injured and eight were killed. Further, the Government House and the Suvarnabhumi Airport were taken over by the PAD. These long running protests confused people as they were unsure if they were political protests or acts of terrorism on the economy and the reputation of the country.

The reports above refer to direct violence, but indirect violence which is hidden has the potential to cause damage if not properly dealt with as it can create disharmony and hatred among people. As long as it exists there is the potential that political violence will reappear. Calls by the government for conformity are just only a beautiful phrase, but if there are no changes to policies and programs the call is empty.

The political violence that has occurred over the past year reflects a low level of political maturity of the country, when compared with international standards.

● Violence in the southern border provinces: The fire is still out of control

Five years after the robbery of weapons from the Princess of Narathiwat Army Camp in Cho I-Rong district, Narathiwat province until today, the level of violence resulting in deaths and the destruction of

property has continued, with no sign of peace being established. The number of violent incidents is still high, particularly in 2008, when 1,370 violent acts occurred (3-4 incidents per day). In the same year the number of deaths among the military, the police and civilians was 605 (on average nearly two deaths per day) and the number of injuries was 1,171. Over the last five years there have been up to 3,244 deaths and 5,811 injured people. The loss of state and private property has yet to be estimated. The data indicate that overall the frequency of violent events in the South has lowered, but the severity of the events has increased with more victims being targeted.

Summary of Violent Incidents in the Southern Border Provinces, 2004-2008

Event	2004	2005	2006	2007	2008
Shooting	531	905	1,040	1,308	861
Attacks	53	52	39	41	28
Fires	232	308	281	359	88
Bombs	76	238	327	492	267
Armed robberies to steel electric wires and sim-cards to create bombs	25	140	10	3	0
Protests	2	-	14	45	5
Agitations, such as scattering spikes on roads	33	422	219	214	114
Killed as a result of throat being cut	0	12	3	13	7
Taking hostages	0	1	1	0	0
Total	**952**	**2,078**	**1,934**	**2,475**	**1,370**
Injuries and deaths					
Injuries	314	564	746	1,015	605
Deaths	491	1,105	1,200	1,844	1,171
Total	**805**	**1,669**	**1,946**	**2,859**	**1,776**

Source: Division of Operations, Office of National Police, Yala Province

The above mentioned violence is only part of the problem. It is what can be measured. However, there are impacts of violence which is immeasurable. Violence means people live in fear, suspicion, insecurity, are stressed, have damaged relationships, have despair and lack the spirit to create anything. In the three southern border provinces the violence is clearly affecting the wellbeing of the people in the region.

The violence in the three southern border provinces today does not exist in a vacuum, but has deep roots in history. The problem results form unfair social structures, cultural limitations that discriminate against people, and misunderstandings of the local history all of which have been compounded by poorly developed and implemented centralized policies. The result has been the oppression and the discrimination of others, whether the difference is based on language, religion or culture, creating conflict, suspicion and hatred flaming violence.

Violence in three southern border provinces will continue as long as the measures are unable to resolve the fundamental causes of the violence.

Violent Media: There is social concern, but little can be done

In the world today, there are very few places where the media has not reached. The media is providing a wide range of information whether we like it or not. Every day, from when we awake until we go to bed, we constantly consume news, knowledge and entertainment from television, radio, newspaper, music videos, video games, internet, mobile phones, movies and books.

For television, today, nearly every household has it. In 2003, a survey by the Assumption University in conjunction with the Family Network Foundation, The Foundation for Child Development and the Thai Health Promotion Foundation (ThaiHealth) found that most children spent a large proportion of their time watching TV. From Monday to Friday, children spent on average 3.5 hours per day watching TV, but on the weekend this increased to 5.5 hours. Children are sitting in front of the idiot box longer and longer.

The media brings us good and creative content but also content which is violent. Sometimes we realize that the

content is violent, but other times we do not think that what we are seeing is a form of violence specifically for entertainment programs. For the forms of media that are closest to us, namely television, radio and newspapers there is hardly a day where we do not see, hear or read about violence. This consumption of violence is compounded by all those forms of media which focus on violence, such as movies and computer games.

Analysing the television content of five free TV channels between 16.00 and 22.00 throughout August 2005 found that in every program there were references to sex, violence or was insulting to some group or other. Of particular concern was that the drama before the evening news hour was more violent than the programs in the later hours. On the other hand, programs aiming for education and learning of children are rare despite the government policy to increase them. What we have are certainly less than sufficient, both quantity and quality.

Many parents today, due to demands from paid employment, are unable to spend sufficient time with their children. As a result the influence of television, video and computer games play an increasing role in shaping children's behaviour. Thus there is a growing concern that the violence in the media will impact on the children's thoughts and behaviours. Over the last 50 years there have been numerous studies from the West showing how violence in the media makes children more aggressive.

The violence shown in the media would not be that different from the violence children see in real life. The violence seen by children and adolescents influence their attitudes, emotions, beliefs and behaviours. Research from western countries suggests that violence within the media has a major impact on children in at least three ways: (1) it make them feel that violence is scary (2) it teaches them the different forms of violence and how to create it. This leads them to easily undertaking aggressive behaviours (3) it makes them feel indifferent to violence, so that they see it as something that is common.

The first two impacts may lead to avoidance or acceptance of violence by children depending on the surrounding factors. But it is of great concern that the media is teaching children to be indifferent to violence. This plus the knowledge of how to create violence (point 2) can easily lead children to use violence to solve their problems.

There are past cases of children and adolescents undertaking violent crime being influenced by violent films or computer games that they like. Further, children who have committed or attempted suicide have copied others who were shown on the international news. Further, other children have ended their lives by following the behaviour of their idols, such as pop stars who committed suicide.

The violent media can make people addicted to violence, making them believe it is something that is of no real importance. The packaging of violence in the media is in essence making it part of the cultural values, a means to manage interpersonal relationship. It has also influence on societal values where some acts of violence are no longer perceived as being so. For example, the exploitation of those with limited opportunities, the injuring of opponents, revenge and payback with increased violence and even acts of corruptions have all perceived as normal behaviour to some extent. All of these are aspects of the cultural roots of violence, bringing misery to the society.

Pornography and media presenting sexual references which can incite viewers to have sex, is also a form of violence, as it can influence children's inappropriate sexual behaviour. This type of media can easily be accessible today, especially in the form of television dramas, pornographic VCDs, cartoons, music videos, websites and even advertisements. However, it must be stated that the media is not the only factor to influencing children and adolescents to have inappropriate sexual behaviours, but it is an important factor. An ABAC poll of secondary school students in grade 7 to 12 in February 2009 found that 13 per cent of students had sex and 10 per cent of them said that sexual movies and pornography on the internet and on VCDs had influenced them.

It can be seen from the numerous conferences, seminars, academic papers, and reports on the internet that Thai society for a long time has been worried about the negative consequences of the media. However, little has been achieved to counter the problems. The problem is it is difficult to control the production and presentation of such materials. Further, there is no research showing whether TV classifications have a positive impact or not.

4 Dangers that Threatens Well-being

Well-being is a state in which there is a perfect balance of physical, mental, social and spiritual conditions in a holistic way. But violence hinders, decreases or suppresses these conditions. So we can say that violence is a threat to well-being, both directly and indirectly, for individual, family, community and society at large.

The loss from violence that causes injury or death is tangible. It can be illustrated in terms of disability-adjusted life year (DALY). Public health scientists call the loss to the disability-adjusted life year as the "burden of disease", which is the measure of loss to the overall population. In addition to losses in the form of the burden of disease, public health scientists have been able to measure the loss resulting from violence to the national economy.

The report on "the Loss of Disability-Adjusted Life Year due to Violence in Thailand in 2004" by the International Health Policy Program (published in September 2007) calculated that violence leading to death and injuries reduced the "DALY" by 270,000 years. This loss accounted for 2.7 per cent of all disease burden of that year in Thailand.

Loss from deaths and injuries resulting from violence is greater for males than for females. In 2004, the male population lost approximately 220,000 years from their "DALY" or 3.8 per cent of all losses from all illnesses and deaths. While for the female population the lost was approximately 56,000 years or 1.3 per cent of all injuries and deaths.

Comparing the loss in "DALY" from self inflicted injuries and suicides with harm inflicted on others, the loss from self inflicted injuries is greater.

Injuries and death from violence cause two major losses to the national economy. One is expenses for medical care and the other is a loss of productivity. In 2004 the Health Information System Development Office report indicated:

- Injuries and deaths from self-mutilation and assaults cost 33,000 million baht in economic loss
- More than 90 percent of this economic loss, approximately 31,000 million baht is caused by reductions in productivity. This loss is 4.7 times higher for men than women

Burden of disease

Burden of disease is a holistic health index that combines time lost due to both premature mortality and non-fatal conditions. For a disease or health condition it is calculated as the sum of the years of life lost due to premature mortality (YLL) in the population and the equivalent healthy years lost due to disability (YLD) for incident cases of the health condition.

The loss of healthy life due to non-fatal health conditions requires estimation of the incidence of the health condition (disease or injury) in the specified time period. For each new case, the number of years of healthy life lost is obtained by multiplying the average duration of the condition (to remission or death) by a severity weight that measures the loss of healthy life using an average health state weight.

Source: Based on Burden of Disease and Injuries in Thailand: Priority Setting for Policy. The Thai Working Group on Burden of Disease and Injuries, Ministry of Public Health, November 2002.

- 88 per cent of productivity loss are caused by deaths
- 83 per cent of productivity loss occurs in the population aged between 15-44
- The productivity loss per one death costs 2.3 million baht for men and 2 million baht for women.
- Loss for medical expense costs around 1,900 million baht
- 60 per cent of medical expense loss occurs in the population aged between 15-29

Losses mentioned above are only those that can be estimated as figures. But the threat of violence has a negative impact on people's lives, directly affecting their psychological and social wellbeing.

The point that we need to understand is that violence affects our wellbeing and impacts our heath. For instance, violence from fighting that causes injuries or deaths will affect the minds of all those involved in the event. Fear, distrust, stress, hatred, anger and vindictive revenge can all be created. The impact on the mind can in turn threaten social relationships and consequently leads to the absence of peace.

Another example is political violence due to conflicts of ideas and interests that leads to demonstrations, which can develop into real violence as has happened several times in the past 3-4 years in Thailand. These demonstrations have created social disharmony. During times of protest, many people feel tense and distressed as they believe the country's problems can not be solved. In front of them the country is dividing into different colour groups and those involved in the protests see not only quilt and evil of the opposite group but are convinced that they have the truth on their side.

The most violence incidents that are occurring in the country are taking place in Southern Thailand. This violence is affecting the physical and mental wellbeing of those living in the conflict areas, as well as destroying the local wisdom that had been developed over centuries. It is impossible to predict how this conflict will end, but as long as the killings continue the wellbeing of the people in the south will continue to deteriorate.

If we do not want our wellbeing to be threatened we need to reduce the degree of violence within the society. However, this mission will be challenging.

Disability-adjusted life years (DALYs) caused by violence within the Thai population, 2004

Cause/violence	Males		Females		Total	
	Years of life lost (YLL)	% of years lost from all causes of violence	Years of life lost (YLL)	% of years lost from all causes of violence	Years of life lost (YLL)	% of years lost from all causes of violence
Deaths/injuries/disabilities	5,716,465	100	4228,613	100	9,945,078	100
From all types of violence	215,732	3.8	55,937	1.3	271,669	2.7
Cases caused by the person him/herself	107,206	1.9	37,092	0.9	144,298	1.5
Cases caused by others	108,367	1.9	18,845	0.4	127,212	1.3
War	156	0.0	0	0.0	159	0.0

Source: Based on the Office of International Health Policy and Program 2007.

5 Stopping Violence: Challenging but Feasible

Violence does not occur by instinct but is man-made. Although biological disorders and psychological defects may create the risk of violent actions, the influence of these factors could be decreased under the properly managed environment. As such, we can ensure that violence can be avoided, stopped or reduced, though to do is challenging.

Due to the complexity of violence, it is impossible to solve this problem with only one strategy, a one-fit-all system. The potential solution should be holistic strategies that give priority to intervention that can bring about changes at the individual level, within relationships, for the community and for the society simultaneously.

At the Individual level

For individuals there should be at least two factors to reduce violence. The primary objective should be to cultivate nonviolent attitudes and behaviours among children and adolescents, so they can be peaceful to both themselves and others and have skills to avoid violence. A secondary objective should be to change attitudes and behaviours of those who are at risk of violence in both children and adults, especially, those who are likely to be associated with violence such as violent perpetrators or victims. Those involved in violence prevention programs must have knowledge and awareness of events leading to violence and should be able to identify risk factors that can cause violence in children, adolescents, family, elderly, and mobs. They should know who is at risk and be able to initiate appropriate non-violent solutions.

There are many approaches that can be undertaken at the individual level. For example non-violent education in schools or with special training sessions for children can be provided so that they can learn about conflict resolution. Projects to reduce violence in schools can help children and adolescents manage their anger and emotions instead of expressing them in violent ways. There should be organizations to provide those most at risk group (for example persons with aggressive behaviour or those with a tendency to commit suicide) to provide activities, counseling and treatment if needed.

At the Relationship Level

Conflicts within relationships are an important cause of violence. To reduce this type of violence there is a need to build and manage relationships, especially with family members, fellow students and those in the workplace.

Though people are aware to an extent that domestic violence attributes to fragile relationships, there are only a limited number of projects aiming to build good relationships in the family. Therefore, the media and organizations dedicating to promoting families should pay more attention to this issue. Certain activities, such as counseling, are of benefit not only to a couple frequently experiencing relationship problems but also to those who do not have problems as problems can arise at any time. Those suffering a prolonged problem may need therapy, hence the necessity for projects that build family relationships. This will entail human resources and facilities to implement.

Measures at the social level should foster a violent-free society. This would require interventions at three levels; namely, knowledge, policy and society. This triangular approach may be called a "mountain shifting strategy".

Educating parents on how to care for children at different ages is important, especially these days when parents have less time for their children. These activities are crucial for public education and are something different media can contribute to. To maximize the impact, they can be conducted along the campaigns to refrain from drinking, drug abuse and gambling as many studies have indicated these are factors that lead to domestic violence.

At the Community Level

Measures to prevent violence in the community should raise awareness of the perils of violence. Activities should include media campaigns to educate community members about factors that foster or lead to violence. These may include the reduction in entertainment venues, casinos and other places of vice, while increasing good spaces such as parks, libraries and sports centres.

There should also be a warning system for community members, plus the provision of sufficient lighting on streets and corners. Importantly, there should also be conflict management mechanisms. In summary, these measures shall aim at create a better community.

At the Social Level

Measures at the social level should foster a violent-free society. This would require interventions at three levels; namely, knowledge, policy and society. This triangular approach may be called a "mountain shifting strategy".

- Changing Knowledge

Violence is a complex social problem, hence the need for an informed, evidence-based and reliable solution. This requires the building and the management of clear knowledge of what causes violence within Thai society, the magnitude of the problems, who are at risk, trends, stimulants and possible solutions. This approach would also entail knowing how to mobilize and make use of the existing body of knowledge and approaches influenced by the society and culture.

However, as expressed in this chapter, a large gap in the knowledge of violence in the Thai society exists. Existing information is scattered and not managed systematically, causing difficulty in translating that information into activities that drive change. Thus, a national "institute of knowledge on violence management" needs to be established. Should such an institute be established, it should be independent and active.

Development of a data system must occur with a well-defined and measurable goal. Taking suicide as an example, officials should set a target rate that should not be exceeded. Society at large and policy-makers could use such a database to shift practices to ensure that violence is reduced.

A number of existing agencies may play a pivotal role in this shifting. These may include university research teams, the national research council and the office of research promotion fund. The Thai Health Promotion Foundation may also play a role in knowledge management as a health promotion organization.

- Changing Policy

Changing policy involves two important steps, one being the strategy-driven policy that is informed and evidence-based, and the other is the law that is a tool and mechanism to implement the policy. Thailand has the laws needed to protect and take care of the welfare of the population, i.e. the Labour Protection Act 1998, the National Elderly Act 2003, the Child Protection act 2003, and the latest being the Domestic Violence Victim Protection Act 2007. These acts help the victims of violence, but they do not prevent the violence; thus there needs to be better strategy-driven policies for prevention.

Some preventive policies that should be reinforced include income distribution policies, the social security development policy and the national harmony policy. These policies need to be developed and implemented in collaboration with all stakeholders. Clearly, they include not only the government and the political body but the entire society, and require different available mechanisms such as those involved with health, community leader councils, social and economic advisory councils, local administrative authorities and the parliament. In sum, it must be a participatory public policy process.

- Changing Society

To challenge violence, the society and the culture must be challenged, as the roots of violence are deeply embedded within social and cultural structures. To change society there needs to be strategies that confront the violence while fostering equality and harmony.

This change can take place through the education system, the mass media, campaigns and social mechanisms that range from family, religious groups, local community groups and other organizations throughout the country. A society that understands the problem and shares the same goals can shift policy effectively.

Violence does not subside or stop at a request but by actual implementation that is well-informed, evidence-based, and politically sound. Only a concerted and harmonious collaboration can stop violence. Though this is a challenging task, it is not impossible to achieve.

Appendixes

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4 for notable Thai contributions to the health of Thais

1. Yasothon Hospital won the UN Public Service Award for Improving the Delivery of Services

- "เปิด 7 กลยุทธ์โรงพยาบาลยโสธร...เพื่อประชาชน สู่ความภาคภูมิใจกับรางวัลด้านบริการระดับโลก". Daily News (24 July 2008).

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3."The community nurse"–A new movement for health care in the community, by the community, for the community

- The Thai Health Promotion Foundation (http://www.thaiheslth.or.th)
- The Thai Nursing Council (http://www.thainoc.net)

4. The seventh year when 99 percent of Thais have access to the universal health insurance coverage

- คนไทยกว่า 99 เข้าถึงและรักษาโรคได้ครอบคลุมในระบบหลักประกันสุขภาพ. Komchadluek. (19 November 2008).
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The Process of Writing the Thai Health Report 2009

10 Health Indicators

The process

Select interesting and important issues to be included in the health indicators through a series of meetings of the Steering Committee

Search for and contact experts, then hold meetings to plan each section

Assign an expert to each approved section to prepare a draft

Brain storm the draft papers, considering suitability, content, coverage, data quality, and possible overlaps

Meetings with experts responsible for each section, to review the draft papers and outline key message for each section

Broad review of the draft papers by experts, followed by revisions of the papers

Guidelines for health indicator contents

Find a key message for each section to shape its contents

Find relevant statistics, particularly annual statistics and recent surveys to reflect recent developments

Emphasize formats, contents and language suitable for diverse readers

10 Health Issues and 4 for Notable Thai Contributions to the Health of Thais

Criteria for selecting the health issues

- Occurred in 2008
- Have a significant impact on health, safety, and security, broadly defined
- Include public policies with effects on health during 2008
- Are the new or emerging
- Recurred during the year

Health showcases are success stories in innovation, advances in health technologies, and new findings that positively affected health in general.

Procedure for ranking the issues

A survey was conducted using a questionnaire listing significant issues in 2008 before the survey date. The situations obtained from the survey were ranked using a Likert scale with three levels: high (3 points), medium (2 points), and low (1 point).

The ranking data were analyzed using the SPSS statistics package. Issues with high mean scores were given high priority.

The final decisions on what to include were made by consensus among members of the Steering Committee for the Thai Health Report Project.

The special topic

There are two types of special topic: target group oriented and issue oriented. The types alternate each year. The topic is sometimes selected from the 10 health issues.

Important criteria in selecting the topic special include:

- Political significance
- Importance to public
- The existence of diverse views and dimensions

Working process

1. The Steering Committee met to select the topic
2. The working group outlined a conceptual framework for the report
3. Experts were acted to act academic advisors
4. The working group compiled and synthesized the contents. The contents were thoroughly checked for accuracy by academics and experts.
5. The report was revised in line with reviewers' suggestions.

Steering Committee 2009

Dr. Suwit Wibulpolprasert	Office of Permanent Secretary, Ministry of Public health	Committee Chair
Dr. Vichai Chokevivat	Institute for the Development of Human Resource Protections	Committee
Dr. Ampol Jindawattana	National Health Commission Office	Committee
Dr. Pongpisut Jongudomsuk	Health Systems Research Institute	Committee
Dr. Pinit Faramnuayphol	National Health information System Developing Office	Committee
Dr. Narong Kasitpradith	Bureau of Policy and Strategy, Ministry of Public health	Committee
Dr. Chuchai Supawong	The National Human Rights Commission of Thailand	Committee
Apinya Wechayachai	Faculty of Social Administration, Thammasat University	Committee
Suttilak Samitasiri	Institute of Nutrition, Mahidol University	Committee
Uvadee Katkanklai	National Health Foundation	Committee
Parichat Siwaraksa	Researcher	Committee
Benjaporn Chatrakul Na Ayuthaya	National Statistical Office	Committee
Warunya Teokul	-	Committee
Pipop Thongchai	Foundation for Children	Committee
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Benjamaporn Chantrapat	Thai Health Foundation Promotion	Committee
Churnrurtai Kanchanachitra	Institute for Population and Social Research, Mahidol University	Committee and Associate Secretary
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Chai Podhisita	Institute for Population and Social Research, Mahidol University	Committee and Associate Secretary
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Experts 2009		
1. Dr. Suwit Wibulpolprasert	Office of Permanent Secretary, Ministry of Public health	Whole Report
2. Dr. Vichai Chokevivat	Institute for the Development of Human Resource Protections	Whole Report
3. Parichat Siwaraksa	Researcher	Whole Report
4. Dr. Viroj Tangcharoensathien	International Health Policy Program (IHPP)	Health Indicators

Experts Health Indicators: Health Care Systems	
1. Dr. Viroj Tangcharoensathien	International Health Policy Program (IHPP)
2. Dr. Phusit Prakongsai	International Health Policy Program (IHPP)
3. Dr. Thinakorn Noree	International Health Policy Program (IHPP)
4. Walaiporn Pacharanarumol	International Health Policy Program (IHPP)
5. Dr. Pinit Faramnuayphol	Health Information System Development Office (HISO)

Special Advisor: Violence	
1. Phra Paisan Visalo	Wat Paa Sukhato Tambol Bann Tamafaiwan, Amphoe Kangkro, Chaiyaphum province
2. Sulak Siwaraksa	Bangkok
3. Gothom Arya	Mahidol University's Research Center for Peace Building
4. Korawin Vorasuk	Association for the Promotion of the Status of Women

The Thai Health Report Team	
1. Churnrurtai Kanchanachitra	Main Editor
2. Chai Podhisita	Editor "Stop violence for well-being of mankind"
3. Kritaya Archavanichkul	Editor "10 Health issues and 4 for notable Thai contributions to the health of Thais
4. Umaporn Pattaravanich	Editor "10 How our health care systems perform? indicators"
5. Kullawee Siriratmongkhon	Research assistant
6. Parnnachat Seangdung	Research assistant
7. Suporn Jaratsit	Research assistant

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We are grateful to the writers of the 10 Health Issues for contributing well-written articles of interest to a wide audience.

Lastly, thank you to all members of the working group for their dedication towards continually improving the quality of the report. We thank the support staff including Kullawee Siriratmonghon, Parnnachat Seangdung, and Suporn Jaratsit for their hard work, making sure the report is released on time.

With thanks from the Thai Health Working Group

Feedback form for the Thai Health Report

The Thai Health Working Group would be grateful if you could fill out the following questionnaire. Your responses will be used to improve the quality of the report.

Please tick ✓ in the boxes provided ☐

Part 1 General information

1. Sex ☐ Male ☐ Female

2. Age ..... years

3. Highest level of education

☐ less than lower secondary ☐ lower secondary ☐ upper secondary secondary/vocational
☐ other (specify)..... ☐ diploma ☐ bachelors degree ☐ higher than bachelors

4. Occupation ☐ researcher ☐ executive ☐ teacher/lecturer ☐ student
☐ trade/business ☐ personnel/worker ☐ media ☐ other (specify).....

5. Which of the following Thai Health Report have you read?

☐ Thai Health 2003 Youth and Health
☐ Thai Health 2005 Free Trade and Access to Drugs
☐ Thai Health 2006 Facing the Challenges of Bird Flu?
☐ Thai Health 2007 "The Scent of the Landuan Flower" Preparing for an Aging Society
☐ Thai Health 2008 Global Warming Threats from the Hand of Human Beings

Part 2 Satisfaction with "Thai Health"

Item	Degree of satisfaction				
	Highly satisfied	Satisfied	Moderate	Unsatisfied	Highly unsatisfied
1. format and layout					
2. accuracy and completeness of data					
3. contents					
4. presentation					

Part 3 The use of "Thai Health"

To what extent is the Thai Health Report useful?

Section	Highly useful	Very useful	Moderately useful	Slightly useful	Not useful
1. Health indicators					
2. Health issues					
3. Special topic					
4. Overall					

In what way do you use "Thai Health"?

Section	Teaching	Reports or presentations	Advocacy	Expanding knowledge	Other
1. Health indicators					
2. Health issues					
3. Special topic					
4. Overall					

Additional comments/suggestions

Thank you very much for your kind cooperation

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