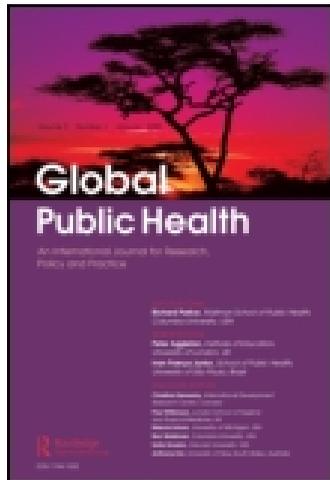


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THEME: SEXUAL AND REPRODUCTIVE HEALTH IN CHANGING HEALTH SYSTEMS

Commentary: Thailand: Sexual and reproductive health before and after universal health coverage in 2002

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Thailand has achieved wide access to health services, including sexual and reproductive health (SRH) services, through two major reforms (Balabanova et al., 2013). Beginning in the early 1980s, physical barriers to care were minimised by increased investment in the health system, particularly nation-wide expansion of well-functioning primary health care (PHC) to all sub-districts, and expansion of financial risk-protection mechanisms. Equity in access to health care, including SRH services, and also in health outcomes, improved significantly (Kongsri, Limwattananon, Sirilak, Prakongsai, & Tangcharoensathien, 2011; Limwattananon, Tangcharoensathien, & Prakongsai, 2007; Teerawattananon & Tangcharoensathien, 2004), though 30% of the population was still uninsured by 2001. A new universal health coverage (UHC) initiative was thus launched in 2002, extending financial risk protection to the remaining population. The UHC benefits package covers almost all relevant SRH services envisioned in the Programme of Action (POA) of the International Conference on Population and Development (ICPD), including treatment of reproductive tract cancers.

Significant progress in SRH was achieved well before the 1994 ICPD and the 2002 UHC initiative. Exemplary achievements include: 80% of pregnant women used prenatal care in 1987 and 92% in 2000. With UHC, utilisation reached 100% in 2012. Likewise, use of skilled birth attendance was 90.8% in 1990, 99.3% in 2000 and 99.7% in 2012.

The contraceptive prevalence rate (CPR) for all methods also increased from 14.8% in 1970, prior to the 1971 launch of the National Family Planning Programme, to 74.5% in 1995, 78.9% in 2000 and 79.3% in 2012 (National Statistical Office, 2009, 2013). During the 1980s, intra-uterine devices (IUDs) and hormonal implants, provided by doctors and trained nurses, were added to widely available contraceptive pills and condoms (Tangcharoensathien, Suthivisessak, Siripornpanich, & Seriratanakorn, 1990). Oral contraceptives, available over the counter, were and remain the most widely used method (32.1% of the CPR), followed by tubal ligation, injectables, condoms and IUDs (National Statistical Office, 2013). All methods, except emergency contraceptive pills, are offered free to the entire target population. The total fertility rate has fallen from 5.9 children per woman in the 1970s to 1.6 in 2011.

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Owing to sustained political commitments and effective programme implementation, HIV was reversed from a generalised to a concentrated epidemic between 1993 and 2006. HIV prevalence in pregnant women declined from a peak of 2.3% in 1995 to 0.51% in 2012. Provision of free breast milk substitutes, beginning in 1995, and investment in preventing mother to child transmission (PMTCT) using azidothymidine (AZT), since 1998, reduced vertical transmission from 30% to 8%. In 2008, the UHC benefit package began to include Nevirapine for PMTCT, and vertical transmission declined further to 3.2% in 2011. By 2011, around 225,000 people living with HIV were receiving free antiretroviral (ART) in 943 health-care facilities, almost all run by the government with costs covered by UHC.

Despite such achievements, certain challenges persist and others have emerged. The adolescent birth rate has sharply increased from 31 per 1000 women aged 15–19 years in 2000 to 53 in 2012. The under-15 pregnancy rate has increased threefold, from 0.5 per 1000 in 2000 to 1.8 in 2012 (UNFPA and National Economic and Social Development Board, 2013). In 2009, 32% of women aged 15–19 years who had given birth reported that their most recent birth was unintended, while only 16% of women aged 15–49 years reported so (National Statistical Office, 2009). Unmet need for contraception is 6.9% higher among women aged 15–19 years (11.6%) than among women aged 45–49 years (8.3%; National Statistical Office, 2013). Pill failure is significant; of women who reported that their most recent birth was unintended, 38% reported forgetting to take their pills (National Statistical Office, 2009). Further, a sharp decline in use of longer acting contraceptives, such as implants and IUDs as well as injection, has occurred during a decade of UHC, due to decentralised management of the family planning programme by the district's health-care provider network (Saejeng, Siraprasiri, Chunin, & Thongtumorong, 2011).

Access to safe abortion is the least addressed SRH service, despite technological advances in abortion care, such as medical abortion (WHO, 2012) and manual vacuum aspiration (Suphanchaimat et al., 2013). Abortion is permitted by law, when conducted by a physician, if the pregnancy threatens a woman's life or health, or is the result of a sexual crime. Official reports suggest that about 30,000 abortions occur each year (including induced, spontaneous and therapeutic), but other estimates go as high as 200,000–300,000 annually, suggesting that abortion is widely practiced.

Many women have experienced intimate partner violence; in 2001, the prevalence of physical violence was 28% (lifetime) and 10% (previous year); while sexual violence was 29% and 16%. Also, 4% of pregnant women reported being beaten by husbands, and such violence is especially high (8%) against pregnant teenagers (Archvanitkul, Kanchanachitra, Im-em, & Lertsrisanthat, 2001). Early marriage (before the legal age of 18 years) also increased from 19.7% in 2005 to 22.1% in 2012 (National Statistical Office, 2013).

Expansion of PHC and universal financial protection has clearly improved utilisation of SRH services and equity in access and health outcomes. A strong example of specific action is the November 2013 announcement by the Ministry of Public Health, of plans to set up community-level, one-stop crisis centres to improve services for child and female victims of violence (Govt to provide more crisis centres, 2013). Other key actions are needed, especially to provide ready access for youth to supportive family planning services, including emergency contraception not yet covered by UHC, and access to safe abortion. Comprehensive sexuality education, including for out-of-school youth, is also urgently needed to reverse the trend of unintended pregnancies among girls, violence against women and an apparent increase in marriage before 18. All these require effective inter-sectoral actions addressing key social determinants.

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