The 2nd National Reproductive Health Development Policy and Strategy (2017-2026) on the Promotion of Quality Birth and Growth

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1. Rationale

The population of Thailand has witnessed dramatic changes following the success of the National Family Planning Program as well as the declaration of the country's Population Policy on 17 March 1970. According to the National Statistical Office, the population growth rate declined continuously from 2.7 % in 1970 to 1.1% in 2000 and to only 0.7% in 2010. The total fertility rate (TFR), which was higher than 5 in 1970, has also decreased to only 1.6 in 2014, which is below the replacement level.

The International Conference on Population and Development (ICPD) held in Cairo, Egypt in September 1994 recognized the importance of reproductive health and recommended all countries to provide comprehensive reproductive health services to all age groups. The ICPD Program of Action primarily focused on population development, especially the quality of life of women and children and gender equality through reproductive health, which also encompasses family planning. All countries were requested to give reproductive health high priority and make it accessible throughout the primary health care system.

To show its intention and determination regarding reproductive health, the Ministry of Public Health (MOPH) announced its reproductive health policy on World Population Day, 11 July 1997: "All Thai people, both men and women, must have good reproductive health". Subsequently, the definition of reproductive health was recognized as "a state of complete physical, mental, and social well-being as an outcome of complete reproductive processes and functions in both men and women at every stage of life which brings about social well-being".

Since then, Thailand changed its guidelines for the implementation of reproductive health from focusing on family planning in order to decrease the population growth rate, towards a more comprehensive reproductive health care. The Thai Department of Health, which is responsible for the core elements of reproductive health, has outlined ten components of reproductive health as follows:

1. Family planning,
2. Maternal and child health,
3. Sexuality education,
4. Adolescent reproductive health,
5. HIV/AIDS,
6. Reproductive tract infections,
7. Malignancies of the reproductive tract,
8. Abortion and its related complications,
9. Infertility, and
10. Post-reproductive and care for the elderly.

Since then, Thailand has continuously implemented reproductive health care. On 3 March 2009, the Cabinet passed a resolution to appoint a National Reproductive Health Development Committee to set guidelines as well as to integrate and to coordinate plans among governmental organizations, NGOs, and civil society that work on reproductive health related issues. Thus, all stakeholders will be able to work together more efficiently and

effectively and to adhere to international commitments, conventions, and rules that the government has already adopted.

The National Reproductive Health Development Committee prepared the 1st National Reproductive Health Development Policy and Strategy (2010-2014), which was endorsed by the Cabinet on 14 September 2010. The policy states that "the government has a policy of supporting desired, safe, and quality births by promoting good reproductive health among people of all sexes and ages on a voluntary, equitable, and inclusive basis in order to create a strong and prosperous population for the security of the nation". The lessons learned from the implementation of the 1st policy and strategy are that reproductive health has to be an urgent national agenda item, and cooperation among various agencies has to be integrated in order to reduce overlaps as well as to link the national level with the provincial, district, and sub-district levels. Such an approach also includes continuous monitoring and evaluation of implementation.

Following the end of the 1st National Reproductive Health Development Policy and Strategy in 2014, the 2nd National Reproductive Health Development Policy and Strategy (2017-2026) on the Promotion of Quality Birth and Growth were developed with the aim of continuing reproductive health implementation and revising policies and strategies in accordance with international policies so that they are more suitable for the reproductive health situation in Thailand that is in transition. As the implementation is not the responsibility of any one agency, a mechanism to formulate policy, strategies, and mutual implementation among concerned governmental organizations, NGOs, and civil society is needed. The 2nd policy and strategy was proposed to the Reproductive Health Development Committee and then submitted to the Cabinet for approval.

2. Situation affecting the implementation of the national reproductive health plan in the future

Over 40 years ago, Thailand faced the problem of a rapidly growing population which was impeding the development of the country's basic systems and services for education, health and employment. Therefore, the government declared an official population policy on 17 March 1970 during the 3rd National Economic and Social Development Plan (1972-1976) period which included the following statement: "**The Government has a policy to promote voluntary family planning in order to address problems related to the high population growth rate which threatens to become a major obstacle to economic and social development of the country**". The policy was aimed at decelerating the population growth rate, and Thailand's National Family Planning Program (NFPP) was extremely successful. The contraceptive prevalence rate of married women of reproductive age (15-49 years) increased rapidly from under 15 % before the launch of the NFPP to 60% in 1980 and to about 80 % at present. The success of the NFPP, combined with rapid changes in the socio-economic development profile of the country, has led to significant changes in the lifestyles of the population. More and more, Thai women are attaining higher levels of education which have led to better jobs and higher income. Also, an increasing proportion of people today, both males and females, prefers to remain single or to delay marriage. These phenomena also reduced the fertility rate even more than what NFPP could have achieved. Even among married couples, the tendency is to have fewer children than their parents' generation, and some couples have no children at all. The rapid changing demographic situation led to the 2nd National Reproductive Health Development Policy and Strategy (2017-2026) on the Promotion of Quality Birth and Growth as outlined in the following section.

2.1 Fewer births and low fertility

Similar to other countries that have experienced socio-economic advancement, Thailand is facing a declining birth rate. The number of births in Thailand decreased from about 1 million per year between 1964 and 1983 to about 700,000 births in 2014. During that period, the population growth rate declined steadily from 2.7 % in 1970 to only 0.7 % in 2010. Furthermore, it is estimated that the number of births in Thailand will fall to 600,000 in 2030 and to less than 500,000 in 2040 (NESDB, 2013).

The Declaration of the National Population Policy in 1974 was intended to slow the population growth rate. This policy, along with the continuing implementation of family planning programs across all sectors, resulted in a rapid increase of contraceptive prevalence among married women of reproductive age, from under 15 % before the launch of the NFPP to 60 % in 1980 and to about 80 % at present. In 1964, the TFR (the average number of children a woman has during her reproductive years) was 6, and then the figure declined to 1.6 which is below the replacement level. It is estimated that the TFR will continue to decrease to 1.3 by 2040 (NESDB, 2013).

When considering births based on the mothers' age groups, the 2014 health statistics revealed that fertility declined the most among the working-age group (20-34 years) which is the most suitable period for childbearing while women under the age of 20 have a high fertility rate. It is to note that about 7.2 million women are aged between 20 to 34 years, while 4.2 million women are under the age of 20. According to the Population and Housing Census between 1964 and 2010, the annual number of Thai births peaked in 1970 (1.2 million) and then continuously declined to 776,370 births in 2014. If current trends continue, it is estimated that the number of births will drop to 491,000 in 2040. Therefore, any changes in policies or guidelines to promote births on a voluntary basis have to take into consideration factors affecting fertility.

2.1.1 Factors regarding attitudes and changing lifestyles

In the past, being single during adulthood was quite rare, and all married couples were expected to have children. But for the newer generations, both males and females are more likely to remain single for longer periods and delay childbearing even if they are married. Studies by Pimonpan Isarabhakdi (2014) and Samutachak and Darawuttimaprakorn (2014) and found that most young people still wanted to have children, and the ideal number was two. This is consistent with the average number of children married women aged 15-49 years said they would like to have (1.93 children) (Reproductive Health Survey, 2006). However, their lifestyles influence the decision to have children. Most respondents placed higher education, work, and buying a car and a house as their highest priorities, while having children was among their lowest priorities. These preferences, if acted upon, will certainly have an effect on further reducing Thailand's fertility rate. The reasons given for not wanting to have children include the loss of freedom, concerns about dangers children might face in the future, fears that their child would misbehave in a society ridden with many problems, and the fact that a child would create more financial pressures on the parents to work harder.

2.1.2 Health factors

Although some couples are willing and ready to have children, they have to struggle with infertility. A national survey data of mothers and newborns between 2008 and 2009, conducted by the Surveillance Center in Health and Public Problems, College of Public Health Sciences, Chulalongkorn University in cooperation with the DOH, found that 11 % of

married couples were infertile. According to the 2006 Reproductive Health Survey, 29.1 % of infertile women of reproductive age came for counseling or screening for infertility. Although technology for the treatment of infertility is more advanced at present, the cost of treatment is prohibitively high for most infertile couples, and the National Health Security System does not provide reimbursements for such expenses.

2.1.3 Economic factors

At present, household debt in Thailand is outpacing economic growth. The ratio of household debt to the gross domestic product (GDP) increased from 59.3 % in 2010 to 79.9% in 2014. In addition, the analysis from the National Transfer Accounts in 2011 estimated that the average total cost for parents to raise a child from birth to 20 years is about one million THB (about half of the figure reported in Table 3.3). This figure does not include the portion that the Government has subsidized or supported through other social protection measures, such as healthcare, education, and so on. This means that, on average, parents must invest at least 4,000 THB per month for each child until they reach 20 years of age. This amount is relatively high when considering that it is more than 15 per cent of the average income of a Thai household at 25,194 THB per month (NSO, 2013). If a couple feels financially unprepared, then the decision to have children may be postponed or put aside all together.

2.1.4 Social factors

At present, the proportion of Thai women with advanced degrees or are pursuing an undergraduate degree is higher when compared with the proportion of men with such attributes. Women have more opportunities to work outside the home when compared with women of earlier generations, and many delay marriage or do not want to have a child. The 2015 State of Thailand Population Report showed that the proportion of married couples without children increased threefold between 1987 and 2013. The reasons for this include lack of suitable/quality child care, especially for parents who both work outside the home and have no relatives to take care of their children; lack of daycare services for children under the age of 2 years; lack of childcare support from employers; and gender inequality in the household. The *2009 Survey on Time Use of the Population* indicated that married women devote about twice as much of their time daily than married men to caring for family members and completing domestic tasks. According to the 2009 Reproductive Health Survey, only one-third of pregnant women's husbands participated in a group activity to receive advice and information about maternal and child care from health personnel.

Table 1: Number of childcare facilities type and responsible state organization

Responsible state organization	Type of childcare facility	No. of childcare facilities	No. of teachers/ caretakers	No. of children	Data as of
Ministry of Interior (MoI)	Early childhood development centre (2-5 years old)	19,658	52,362	933,356	October 2015
Ministry of Social Development and	Privately-run nursery (0-5 years old)	1,727	7,241	82,895	August 2015

Human Security (MoSDHS)					
Ministry of Labour (MoL)	Day care centre for employees in the workplace and community (no minimum age limit)	61	190	1,521	September 2015
Bangkok Metropolitan Administration (BMA)	Pre-school childcare centre (2-5 years old)	312	2,089	25,993	September 2015
Total		**21,758**	**61,882**	**1,043,765**	

Source: UNFPA and the National Economic and Social Development Board. *The State of Thailand's Population Report*, 2015.

2.2 Quality of birth

Quality birth means a planned and intended birth for which the parents are completely prepared, leading to a safe labor and a healthy infant who is primed to grow in a quality manner. To analyze quality births in Thailand, the following components are taken into consideration:

2.2.1 Birth from unplanned/unwanted pregnancy

Women with an unplanned/unwanted pregnancy are more likely to terminate their pregnancy or to carry the child to term. Studies from abroad found that unplanned/unwanted pregnancy increases risk to both the mother and the fetus because of delayed antenatal care and premature delivery. Unplanned/unwanted pregnancy also has economic and social impacts. For example, the mother faces a possible loss of opportunity when it comes to her education and her career. In addition, there are increased financial burdens on the government who must take care of these abandoned children. The study also found that children born to mothers who did not want a child were likely to have worse physical and mental health than children of a wanted pregnancy, and they tend to express delinquent or aggressive behavior as they grow up (Logan et al., 2007).

The data from the *2012 Multiple Indicator Cluster Survey* in Thailand found that about one-fourth of women between the ages of 15-49 years who had given birth within two years prior to the interview said that their pregnancy was unwanted. More than 70% said they did not want children anymore, and 30 % wanted to delay childbirth. The survey also was found that the proportion of women with a history of unplanned pregnancy was highest in the age group of 15-19 years and 40-44 years, or 46.9% and 32.2 % respectively. Reasons for unplanned pregnancy include not using contraception and using an ineffective contraceptive method. The survey found that almost 60% of pregnant women who did not want their pregnancy had used temporary methods in the past, such as contraceptive pills, injectable contraceptive, and withdrawal.

The *2014 Report of Abortion Surveillance in Thailand* indicated that the majority (69 %) of abortion patients had their pregnancy terminated due to economic, social, and/or family reasons. One of the social impacts of unwanted pregnancy is abandoned

children. At present, foster homes are available for children under the Ministry of Social Development and Human Security who look after about 6,000 infants annually.

Proper use of highly effective contraceptive methods can help a couple achieve a planned and quality pregnancy. Thus, counseling and providing effective contraceptive services are important in assisting women to have a child when they are ready to do so and to have the number of children they desire.

2.2.2 Unsafe delivery

The maternal mortality ratio and infant mortality rate is an important indicator of unsafe delivery. The data from the Bureau of Health Promotion, Department of Health showed that in 2015, the maternal mortality ratio was 20.0 per 100,000 live births. The causes of deaths were pregnancy risk factors and postpartum hemorrhage. The *2014 Annual Report of the Bureau of Health Promotion* also revealed that 7% of infant mortality was due to congenital anomalies.

Regarding maternal health, the *Report of the 4th Thailand National Health and Examination Survey* (2008 – 2009) found that the prevalence of anemia in women of reproductive age (15 years or over) was 29.8 %. According to the *Bureau of Health Promotion Annual Report* (2014), the prevalence of iron-deficiency anemia in pregnancy was as high as 39.0 %. For infant health, the *Children and Women's Situation Survey* (2010) found that 8% of infants had low birth weights.

2.3 Early childhood development

The *2014 Report of Early Childhood Development Situation* by the Maternal and Child Health Group of the Bureau of Health Promotion found that 27.3 % of children had an insufficient level of development for their age. The risk factors for poor child development include preterm birth, low birth weight (less than 2,500 grams), and neonatal complications. In addition, the rate of exclusive breastfeeding for at least six months was only 23.9 %.

According to the report, young children face the following risks:

- malnutrition (16.8 %),
- stunted growth (8.2 %),
- obesity (10.6 %), and
- asymmetric body shapes (35.3 %).

Children in their early years from the southern region of Thailand had a higher risk of malnutrition and stunted growth than those in other regions, and young children in the southern and central regions had higher risks of obesity than children in other regions. Young children in the northeast region had a higher risk of developing asymmetric body shapes than children in other regions.

The study found that about half (51.1 %) of the children were read to by parents or child caregivers, and 57.3 % were read to three days a week. Regarding the use of electronic media, one-third of parents and caregivers played with their children using technology at least once every day, and nearly all (94.5 %) used it three days a week.

It was also found that maternal factors, e.g., age at pregnancy, educational level, occupation, family income, pregnancy complications, and services received at hospitals which passed the "gold maternal and child health standard" had significant effects on childhood development. For the children, factors affecting childhood development include

birth weight, history of pneumonia, nutritional status, oral health, as well as their experience playing without the use of electronic media. The report of the *7th National Survey of Oral Health Status* (2012) found that young Thai children had a high prevalence of dental caries. Among the 3-year olds, 52.3 % had caries in their primary teeth. Among the 5-year olds, 78.5 % had caries in their primary teeth, and 52.3 % had caries in their permanent teeth.

Moreover, the *2012 Multiple Indicator Cluster Survey* found that 16 % of children aged under 5 years had chronic malnutrition and whose height-for-age was below standard. Almost one-tenth of the children's weight-for-age was below standard, and 7% of these children's weight-for-height was below standard. Children from poorer households had chronic malnutrition and their weight was below standard at a higher rate than those from wealthier families. The survey also found that 93 % of children under the age of 5 years had adults in the household (over age 15) who engaged them in learning activities and helped them prepare for school. However, it was found that fathers had a very low rate of participation in these educational activities. Very poor households and households of parents with less education were less likely to participate in activities to promote child learning when compared to other types of households.

2.4 Demographics and reproductive health data

Population and reproductive health data are essential for planning, monitoring, and evaluating the implementation of strategies. However, at present there are many disparate sources of population and reproductive health data which are not compiled, analyzed, or presented systematically. In addition, population and reproductive health data about minority groups such as the disabled and migrants are not regularly collected. Therefore, many of these datasets will not assist in forecasting directions, and their data will not be of practical use.

In the past, the government had measures to assist and support childbirth and childrearing, both directly and indirectly through laws and policies:

- Free antenatal care and delivery under the Health Security System Scheme,
- Free education for the first 15 years,
- Tax deduction for families with children,
- Maternity and paternity leave rights for government officials,
- Child allowance for social security card holders, and
- Newborn care subsidies for poor families.

The situation of declining births at present indicates that these measures have not been sufficient or may be inappropriate. Thus, if the policies do not change in time, the number of births in Thailand will continue to decrease for an indefinite period.

3. Concepts and principles

The population structure of Thailand is undergoing rapid changes. There are fewer births each year, and more young adults express a reluctance to have children. The younger working age population is more likely to be single, to delay marriage, to delay the age at which they first give birth, and to have one or two children or none at all. Moreover, the population is aging at an accelerating rate. These challenges are the issues that many countries with advanced economic development have faced, not only in Europe but also in Asia such as in Japan, Singapore, and South Korea. The lessons from all these countries is that it is quite difficult to reverse the declining fertility rates, especially when the TFR is ultra-low (below 1.6). Social assistance welfare measures might not be powerful enough to

stimulate an increase in fertility when a society reaches such a low fertility level. Thailand, at present, has a TFR close to that threshold level, yet it still does not have a policy or strategies to promote a higher birth rate. Paradoxically, the country is witnessing an increase in teen pregnancy and childbirth, which is not a desirable reproductive health situation.

Regarding these challenges, Thailand must adapt more skillfully to create a new socio-demographic balance. This implies the need to revise attitudes and concepts to maintain human resource development and to reduce the lifetime disparities among the population from the time of birth. Thailand does not only face the specter of a decreasing population, but also the challenges of increasing the quality of births and childhood development. It can be said that the country is facing a problem of **"fewer births of lower quality"**. Reproductive health is the starting point of the future population and is a vital component in addressing this deficiency. Therefore, the 2nd National Reproductive Health Development Policy and Strategy (2017-2026) on the Promotion of Quality Births and Development will emphasize maintaining the TFR at a level not lower than 1.6 while promoting quality births and development, safe motherhood, as well as growth and age-appropriate growth and development to produce new generations that will act as a productive force in the future of Thailand's national development.

The main concepts behind the 2nd National Reproductive Health Development Policy and Strategy (2017-2026) on the Promotion of Quality Births and Growth are as follows:

1. Develop and promote the population's reproductive health rom pre-reproductive age; reduce marriage at a young age and adolescent pregnancy, especially the childbirth of women younger than 18 years of age; promote semi-permanent contraception to delay an adolescent's next birth until the age of 20 years; support adolescents to continue studying after their pregnancy in order to be more self-reliant; promote knowledge and understanding among the population regarding family planning, not only for correct knowledge and understanding of family planning methods but also counseling and options for both men and women in building a family; increase access to contraceptive services which will help couples decide by themselves to have children when they are ready; and provide counseling to and treatment for infertile couples.

2. Create an environment which contributes to quality family formation and childbearing by arranging a flexible and supportive work environment that is conducive to starting a family life, especially for childless couples who are ready to have children. Also, such an environment will promote a work-life balance as well as gender equality in housework and child care. Creating positive attitudes and a supportive environment for pregnant working women and increasing the coverage and quality of nurseries in the workplace will allow these women to take care of their children without having to leave their jobs.

3. Support the extension of maternity and paternity leave periods for child care.

4. Develop the quality of the country's population from pregnancy to delivery and up to adulthood.

5. Promote equality and sustainable development by not leaving anyone behind which will enable everyone to have options when it comes to their desired number of children without bias against personal social and economic limitations.

In accordance with these principles:

1. To take into consideration human rights, especially in the area of reproductive rights such as the right to receive reproductive health services, right to consent to marriage and marriage equality, right to decide on the number and spacing of births, right to equality and non-discrimination, and right to education and information.

2. To abide by the national development master plan, e.g., the Population Plan in the 11th National Economic and Social Development Plan (2012-2016), the Population Conceptual Framework in the National 20-year Long-term Plan (2016-2035) on the Creation of Well-being of Thai Families, and other related national strategies such as the National Strategic Plan for Child and Youth Development, and the National Strategic Plan for Early Childhood Development.

3. To abide by international treaties, policies, and agreements to which Thailand is signatory, e.g., the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women, the Program of Action on Population and Development, Sustainable Development Goals, unachieved Millennium Development Goals, and other related recommendations and implementation guidelines such as the *Global Strategy for Women's, Children's and Adolescents' Health* (2016-2030).

4. The 2nd National Reproductive Health Development Policy and Strategy (2017-2026) on the Promotion of Quality Birth and Growth

"The Government supports and promotes voluntary births, in which every pregnancy is planned and intended, to ensure that there are sufficient births to replace the population. Having parents who are well-prepared in all aspects will lead to a safe delivery and a healthy newborn who will have a quality upbringing".

5. Target group

5.1 Women and men of reproductive age
5.2 Pregnant women
5.3 Children aged 0-5 years

6. Goals

Quality births will occur when there are plans and comprehensive parental preparedness, and when women are of optimal age when they have a child. To address the adolescent pregnancy issue, the Prevention and Solution of the Adolescent Pregnancy Problem Act, B.E. 2559 (2016) came into force. Therefore, the goals of the 2nd National Reproductive Health Development Policy and Strategy (2017-2026) on the Promotion of Quality Birth and Growth are as follows:

6.1 Maintain the TFR at a level not lower than 1.6.

6.2 Ensure that every pregnancy is planned, with parents who are prepared, starting from before the pregnancy, as well as the provision of fertility assistance to couples wanting to have a child.

6.3 Promote safe motherhood, postpartum care, and childrearing in an environment that is suitable for healthy growth and appropriate development, one which will provide optimal learning and education opportunities for the child.

7. Indicators

7.1 There is an increase in voluntary births to replace the population

7.1.1 The number of births is not fewer than 700,000 per year.

7.1.2 The TFR does not fall below 1.6.

7.1.3 Births to women aged 20-34 years.

7.2 Every birth is well prepared for

7.2.1 Percentage of women aged 20-24 years who started living with their husband/partner when they were under the age of 18

7.2.2 The adolescent birth rate (10-14 years and 15-19 years)

7.2.3 Percentage of women aged 15-49 years who use contraception and are satisfied users of modern contraception

7.2.4 Percentage of pregnancies that are planned

7.3 Healthy newborns and growth with quality

7.3.1 Maternal maternity ratio

7.3.2 Neonatal mortality rate

7.3.3 Percentage of low birth weight infants

7.3.4 Percentage of children aged 0-5 years who have an appropriate level of growth and development for their age

7.3.5 Percentage of children aged 0-5 years who have an appropriate height for their age.

8. Strategies, measures, indicators, goals, and responsible agencies

The 2nd National Reproductive Health Development and Strategy (2017-2026) on the Promotion of Quality Birth and Growth consists of four sub-strategies:

8.1 Improving the relevant legislations, policies, and strategies.

8.2 Improving the health service system and establishing equal access to services.

8.3 Improving the social welfare system.

8.3 Improving the information system and public communication.

Sub-strategy 1
Improving the relevant legislation, policies, and strategies

Objectives

To improve, reform, amend, and advocate for legislation, regulations, rules, policies, and strategies to support quality birth and child growth.

Indicators

Improve, reform, amend, and advocate for relevant legislations, regulations, rules, policies, and strategies.

Measures

1. Improve, reform, amend, and advocate for relevant legislations, regulations, rules, policies, and strategies as follows:

- reform, improve, and enforce laws in order to control the quality, production, distribution, sales promotion, advertisements, and marketing of foods and all products that have an effect on the nutrition of mothers, infants, and children.

2. Promote and support the enforcement of related laws, regulations, rules, policies, and strategies such as the following:

- advocate for key measures to become law, such as the criteria for infant and young childhood food marketing.
- advocate for the implementation of the Prevention and Solution of the Adolescent Pregnancy Problem Act, B.E. 2559 (2016).

3. Enhance knowledge, understanding, and awareness of relevant laws, regulations, rules, policies, and strategies.

4. Advocate for reform and amendment of rights under the three health insurance systems (Civil Servants Welfare System, Social Security System, and Universal Coverage Scheme) to help promote quality birth and childhood growth.

5. Advocate for tax measures to promote quality and safety of food production and related products.

Responsible agencies

The Ministry of Public Health, the Ministry of Labor, the Ministry of Finance, the Ministry of Social Development and Human Security, the Ministry of Justice, the Ministry of Education, the National Health Commission Office of Thailand, the Ministry of Interior, the National Health Security Office, the Thai Health Promotion Foundation, the Ministry of Commerce, and the Ministry of Industry

Sub-strategy 2
Improving the health service system and establishing equal access to services

Objectives

To improve the health service system so that it achieves a standard level and establish equal access to services which will result in safer motherhood.

2.1 Pre-marriage and pre-pregnancy

Indicators

1. Contraceptive prevalence rate
2. Percentage of postpartum women who have an unplanned pregnancy
3. Percentage of couples who receive a health check-up before pregnancy
4. Percentage of both women and men who receive screening for thalassemia before the women’s pregnancy
5. Percentage of women of reproductive age who want to have a child and who receive iron supplement tablets and folic acid 12 weeks before their pregnancy
6. Percentage of women of reproductive age who have anemia
7. Percentage of women of reproductive age who have an appropriate body mass index (BMI)
8. Percentage of unmet needs for contraception
9. Number of couples who are ready for childbearing
10. Number of health facilities that provide services to treat infertility.

Measures

1. Provide family planning, counseling, nutritional assessment, health screening, and health check-ups.

2. Advocate for a policy to provide iron and folic acid supplement tablets to pregnant women of reproductive age and for those who want to have a child.

3. Conduct a campaign on “Have a child only when you’re ready”, and support couples who are ready to have more children.

4. Provide counseling and treatment for infertility.

2.2 During pregnancy

Indicators

1. Percentage of pregnant women who receive their first antenatal care visit before 12 weeks
2. Percentage of pregnant women who receive at least one antenatal care visit
3. Percentage of pregnant women who completed their antenatal care visits (5 times)
4. Percentage of pregnant women who have anemia
5. Percentage of pregnant women who receive iodine, iron, and folic acid supplements
6. Pregnant women with less than 150 microgram/litres of median urine iodine concentration
7. Percentage of pregnant women who are underweight
8. Percentage of pregnant women with a tendency to gain significant weight
9. Percentage of pregnant women who receive screening for thalassemia
10. Percentage of married couples with abnormal thalassemia who receive screening through the Hb Typing Test
11. Percentage of married couples whose infant receive screening for thalassemia before delivery
12. Percentage of pregnant women who receive screening for Down Syndrome
13. Percentage of pregnant women who receive an HIV test
14. Percentage of HIV-infected pregnant women who receive antiretroviral drugs to prevent mother-to-child transmission of HIV
15. Percentage of women younger than 20 years who have a repeat pregnancy
16. Percentage of pregnant women who have an oral health check-up

Measures

1. Improve the maternal and child health service system to reach a set standard and provide equal access to all.
2. Advance pregnant women’s health care through the Maternal and Child Health Development Board at the central level and through regional health services at the provincial and district levels.
3. Promote pregnant women and families to acquire knowledge and skills about self-health care by using the *Maternal and Child Health Handbook* as guidance.
4. Provide services to pregnant women to ensure that their weight is under surveillance so that they achieve standard weight gains and consume a proper diet during their pregnancy.
5. Provide services to pregnant women to ensure that they receive iodine, iron, and folic acid supplement tablets during their pregnancy and until 6 months after they give birth.

2.3 During delivery

Indicators

1. Maternal mortality ratio
2. Neonatal mortality rate
3. Percentage of maternal deaths from preventable causes
4. Percentage of births with congenital anomalies
5. Percentage of birth asphyxia cases
6. Percentage of premature births

7. Percentage of low birth weight infants (less than 2,500 grams)
8. Percentage of quality labor rooms

Measures

1. Implement quality delivery that meets set standards.
2. Implement a referral system for emergency labor.
3. Improve capacity of delivery room personnel.
4. Implement a maternal and infant mortality surveillance system.

2.4 Postpartum period

Indicators

1. Percentage of children aged 0-5 years who have an appropriate level of development.
2. Percentage of children aged 9, 18, 30, and 42 months who receive developmental screenings.
3. Percentage of children aged 0-5 years suspected of developmental delay who receive developmental stimulation.
4. Rate of mothers who breastfeed exclusively for 6 months.
5. Percentage of children aged 6 months – 5 years who receive food appropriate to their age.
6. Percentage of children aged 0-5 years who have an appropriate height.
7. Percentage of children aged 0-5 years have stunted growth.
8. Percentage of children aged 0-5 years who are underweight.
9. Percentage of children aged 0-5 years who are overweight or obese.
10. Percentage of children aged 6 months – 5 years who receive iron supplement tablets.
11. Percentage of children under the age of 5 years who receive the recommended childhood immunizations.
12. Percentage of mothers who nurse for 6 months and who receive iodine, iron, and folic acid supplements
13. Percentage of children aged 0-5 years who receive oral health promotion and dental caries prevention treatment
14. Percentage of fathers, mothers, and/or primary guardians who receive child care education and skills according to the quality parenting preparation school curriculum.
15. Percentage of women under the age of 20 years who have a repeat pregnancy
16. Percentage of women under the age of 20 years who receive modern contraception after a birth or abortion
17. Percentage of postpartum or post-abortion women under the age of 20 years who receive semi-permanent contraception
18. Percentage of health facilities which achieve the standard quality level for their baby clinic
19. Percentage of pregnant women or family members who use the *Maternal and Child Health Handbook* on their own.

Measures

1. Implement a standard child growth and development surveillance system.
2. Provide postpartum care for mothers and children which is up to standard.
3. Promote exclusive breastfeeding for 6 months followed by breastfeeding in combination with age-appropriate food until the child is 2 years of age or older.

4. Promote the importance of an age-appropriate diet at home, at their child care center, and at school among children aged 6 months to 5 years.

5. Provide children aged 6 months to 5 years with liquid iron supplement once a week. In the case of newborns with low birth weight, liquid iron supplement is given daily from 2 to 6 months and then the dosage is reduced to once a week.

6. Provide required immunization for children.

7. Conduct surveillance on child nutrition, oral health, and development by parents or child care givers using the *Maternal and Child Health Handbook* as guidance.

8. Advocate the use of surveillance tools and promote development in all nursing colleges.

9. Provide quality parent preparation training to give knowledge and skills to parents and child care givers in accordance with the quality parent preparation school curriculum.

10. Provide counseling and family planning advice, especially access to a variety of modern contraceptive options after childbirth.

Responsible agencies

The Ministry of Public Health, the National Health Security Office, the Ministry of Labor, the Ministry of Interior, the Ministry of Social Development and Human Security, the Ministry of Education, the Thai Health Promotion Foundation, and the Bangkok Metropolitan Administration.

Sub-strategy 3
Improving the social welfare system

Objectives

To improve and reform the social welfare system to support couples who are ready to have children by taking care of the women from pre-marital and pre- pregnancy periods, during pregnancy, during delivery, and after childbirth, including the provision of other welfare to help new couples raise their child.

Indicators

1. Level of improvement and reform in social welfare according to measures stated in this Policy and Strategies.

2. Percentage of child care centers which pass the national standard for an early childhood care center.

Measures

1. Support married couples to have their own domicile through
   - Tax measures
   - Housing loans

2. Health care from pre-pregnancy until the post-partum period

Advocate for the benefits of Universal Health Security Fund, Social Security Fund and Civil Servants Benefit to cover health care services in every stage of a woman's pregnancy as follows:

2.1 Before marriage and pregnancy

- Premarital and pre-pregnancy counseling
- Provide family planning advice, including access to modern contraception which is safe and highly effective, with the option of semi-permanent contraception such as the IUD and sub-dermal implant.
- Screen for pregnancy risk factors and providing care and treatment

- Provide iron and folic acid supplement tablets during the pre-pregnancy period
- Screen for causes and treatment of infertility

2.2 During Pregnancy

- Provide antenatal care.
- Provide access to safe pregnancy termination if this is in accordance with the law and related regulations.
- Screen for HIV-infected pregnant women and provide antiretroviral drugs to prevent mother-to-child transmission.
- Screen for genetic diseases and congenital anomalies.
- Screen for pregnancy complications and provide appropriate treatment.
- Provide iron, folic acid, and iodine supplements during pregnancy.

2.3 During delivery

- Child delivery
- Care and treatment of complications during delivery
- Neonatal care, including treatment for complications during delivery

2.4 Postpartum period

- Mother and neonatal/infant care
- Provide contraceptive services after delivery.
- Provide child immunization.

3. Support child rearing expenses in the following ways:

- Increase the tax deduction for child expenses.
- Provide a child allowance.
- Promote the right to fundamental education, and provide financial support to cover the expenses of books, school uniforms, and other items which are necessary for school.
- Promote the right to free, routine treatment and care for the child, and assistance if there are medical expenses not covered by that right.

4. Promote working families who want/have children.

- Allow mothers to take a leave with pay for antenatal care without counting that as a leave.
- Expand the right to maternity leave.
- Allow the father and mother to take leave to take care of their children with full pay.
- Establish nurseries supported by the government.
- Promote government and private organizations to have a breastfeeding corner and day care center for their workers' children.
- Promote jobs in the community, especially ones that can be done from home.

5. Take care of pregnant women with no/little readiness to raise their child.

- Support health facilities of both government and the private sector to provide optional counseling for women with unintended pregnancy.
- Provide care and assistance for women with unintended pregnant to continue their pregnancy.
- Provide assistance for accommodations.
- Provide education assistance for pregnant women who are studying.
- Provide assistance for vocational training and career development.
- Provide foster families.

6. Improve child care centers according to guidelines from the National Child Care Center Standard.

Responsible agencies

The Ministry of Social Development and Human Security, the Ministry of Labor, the Ministry of Finance, the Ministry of Education, the Ministry of Public Health, the Ministry of Interior, the Bangkok Metropolitan Administration, and other related public organizations

Sub-strategy 4
Improving the information system and public communication

Objectives

To have up-to-date, reliable, and sufficient information and a body of knowledge that can support decision making when it comes to planning, implementation, monitoring, evaluation, and social communication.

Indicators

1. Existence of a standard central database, information system, and surveillance system for planning, monitoring, and evaluation according to specified measures.
2. A variety of public communication channels.

Measures

1. Appoint a joint working group consisting of relevant agencies to study the data, feasibility, and impact, including advocating for reform, and amendment of laws, regulations, rules, and related benefits.
2. Develop a central database, information and surveillance system, and set standard indicators which have continuity and can be linked at every level.
3. Develop a knowledge management system and conduct research to produce knowledge for social communication through proactive channels for learning. Also, ensure there is timely management of risk at the central, regional, and local levels.
4. Improve the capacity of officers at all levels to enable them to utilize these information systems at an optimal level.
5. Campaign, advocate, and conduct public communication on nutrition in order to promote correct knowledge, beliefs, and values.

Responsible agencies

The Ministry of Public Health, the Ministry of Social Development and Human Security, the National Statistical Office, the Ministry of Education, the Ministry of Digital Economy and Society, the National Research Council of Thailand, the Thai Health Promotion Foundation, the National Health Security Office, the local administration organization, the academic sector, and others

9. Management of policy and strategies for action

To translate the 2nd National Policy and Strategy on Reproductive Health Development (2017-2026) on the Promotion of Quality Birth and Growth into action involves:

9.1 Advocating the 2nd Reproductive Health Policy and Strategy as a national policy by submitting the Policy and Strategy to the Reproductive Health Development Committee for approval, and then presenting the policy to the Cabinet to announce it as an official policy.

9.2 Coordinating policy and strategies at all levels, especially with the Provincial Reproductive Health Development Committee, the Maternal and Child Health Board, and other relevant bodies.

9.3 Preparing an action plan to support the policy and strategies by specifying important developmental issues under the strategies, plans, programs, resource mobilization, and guidelines to ensure there is effective cooperation among all sectors.

9.4 Creating knowledge and understanding among all sectors so that all parties involved realize the importance of the policy and are ready to do their part in advocating the implementation of the policy and strategies. The Department of Health, as the secretariat of the National Reproductive Health Development Committee, will build understanding among all sectors regarding the objectives and goals of the reproductive health policy and strategy through the following process and tools:

9.4.1 Setting guidelines for implementing the policy and strategies at all levels to enable network members to apply guidance effectively through appropriate communication and public relations channels. Doing so, they will be able to reach target groups efficiently through personal channels, local and national mass media, and activities of today's media. Moreover, there is a need to coordinate plans at each level so that every sector can integrate a joint implementation. A document that compiles various mechanisms to advocate the development plans and activities, including documentation of successful cases studies of the implementation of government organizations and other sectors, will be produced. This document will then be disseminated to partner agencies for them to apply as they deem appropriate.

9.4.2 Creating understanding among the political sector regarding goals and guidelines of the policy and strategies and advocating to political parties to integrate essential development issues into their party's and the government's policy preparation.

9.5 Changing the government sector's roles and placing more emphasis on policy setting, monitoring, and evaluating. They should focus more on financial and technical support, and support the private sector, including public benefit organizations and community businesses, as well as local administrative organizations to help them with implementation.

9.6 Building an enabling environment to advocate for the policy and strategies among development networks by encouraging the adaptation of essential tools in research and the use of information technology. They should also create a developmental database which the public can access and utilize. The data should also be updated. Society should be provided channels through which they can express ideas and participate in developmental activities.

9.7 Strengthening the role of all forms of local administrative organizations so that they can implement plans efficiently based on strategies set out by improving the capacity of local organizations.

9.8 Coordinating and advocating mechanisms (outside the government sector) to participate in policy and strategies. Development efforts by the government alone are not sufficient to achieve the goals. Thus, there must be collaboration among the non-public sectors to create a developmental network, comprising of the private sector, academic institutions, professional associations, and independent organizations.

9.9 Advocate academic institutions within the area to participate more in reproductive health development by emphasizing the role of higher education in synthesizing knowledge from studies and research and applying them to strategies. These institutions can also serve as a core to coordinate with other sectors in supporting a comprehensive community development plan.

9.10 Encouraging the private sector to take a leading role in advocating the policy and strategies based on corporate governance, linking business goals with proactive work development and creating innovation together through corporate social responsibility activities by adjusting the mission of private organizations to enable them to work with communities, private development organizations, and academic institutions in the form of alliances. A social responsibility network of business groups should be established to lead these joint social activities.

9.11 Promoting mass media to be a medium for the dissemination of creative information and a channel to promote public good and to present information in professionally ethical ways.

9.12 Promoting the participation of private developmental organizations to work actively with regional and local authorities as well as civil society by supporting or providing opportunities for private developmental organizations to join development activities. This is to tap into the advantage of private development organizations regarding their flexible rules, regulations, work methods, and their proximity to people in the target development areas so that goals can be achieved more efficiently.

9.13 Promoting research and innovation at the national and local levels leading to improvements and amendments of laws, policies, strategies, and measures that support the determination of appropriate benefits, rights, and social welfare.

9.14 Establishing a monitoring and evaluation system for the policy and strategies with a priority to monitor the progress of achievement and the impact of continuing implementation regarding strategic development and the overall outcomes, including lessons learned. The policy and strategies should be reformed to respond promptly to the changing situation and time requirements for each context.