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National Report on Violence and Health
Thailand



WHO Kobe Centre

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Preface from the WHO Centre for Health Development



Violence, defined 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 high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation”, pervades the lives of many people around the world and is a crucial public health issue globally, nationally and locally.

In 1996, the Forty-Ninth World Health Assembly adopted Resolution WHA49.25 citing violence as a major and growing public health problem. In this resolution, the Assembly drew attention to the serious consequences of violence and stressed the damaging effects of violence on health. Member States were urged “to assess the problem of violence on their own territory and to communicate to WHO their information about this problem and their approach to it.”

The World Report on Violence and Health provided for the first time in 2002 a global overview of what was known about the magnitude, causes and risk factors for violence and violence-related deaths and injuries; the scope and effectiveness of strategies for preventing different forms of violence, and the scope and effectiveness of services to mitigate the effects of violence for victims. The report made a huge impact to our understanding of violence and its effects highlighting the simple message that violence can be prevented using a public health approach. A key recommendation and next important step then was to call on countries to develop national reports on violence and health.

In response to global efforts on violence and health and consistent with its mandate to address broad determinants of health, violence as a public health problem has been high on the research and policy advocacy agenda of the WHO Kobe Centre. In 1999, the Centre published a Global Atlas on Violence and Health illustrating the form, magnitude, associations and spatial distribution of violence and associated indicators globally.

In 2005, in collaboration with the WHO Department of Injuries and Violence Prevention in Geneva, respective WHO Regional Offices and Country Offices, the WHO Kobe Centre lent support to five Member States to develop national reports on violence and health. These Member States are Malaysia, Mongolia, Nepal, Sri Lanka and Thailand.

These five national reports on violence and health provide important information bolstering the case for policy and action to improve health. Moreover, the relationships and partnerships that were built in the process of developing the reports have paved the way for continuing collaboration in addressing violence as a public health problem that needs our urgent attention.

Dr Soichiro Iwao
Director
WHO Kobe Centre

Foreword from the World Health Organization



When the *World report on violence and health* was published in 2002, it provided a first global overview of what was known about the magnitude, causes and risk factors for violence and violence-related deaths and injuries; the scope and effectiveness of strategies for preventing different forms of violence, and the scope and effectiveness of services to mitigate the effects of violence for victims. The report's launch was widely covered by media in all regions, and drew attention as never before to the many violence prevention opportunities awaiting government and non-government agencies willing to take up the challenges of extending a public health approach to such seemingly intractable problems as child maltreatment, youth violence, intimate partner violence, sexual violence, elder abuse, self-directed violence and war. As a consequence, the handful of health and other government ministers that in 2001 appreciated the links between health and violence had by early 2006 increased by many orders of magnitude, with nearly 100 WHO Member States having officially appointed health ministry focal points for the prevention of violence.

A key recommendation of the World Health Assembly Resolution 56.24 *Implementing the recommendations of the World report on violence and health* calls on countries to develop national reports on violence and health. As the *World report* created awareness at the international, regional and country levels about how much more can be done to prevent violence, so country reports can draw attention on the part of ministries, non-governmental agencies and civil society groups at central, regional and local government levels. Like the *World report*, country reports are an opportunity for taking stock - of what's known about the problem; of the adequacy of information systems for monitoring the problem; of the nature and effectiveness of existing prevention programmes, and of the nature and effectiveness of existing victim services. Like the *World report*, country reports are an opportunity for looking ahead, and for allocating prevention roles and responsibilities to agencies on the basis of their mandate and capacity. Unlike the *World report on violence and health*, national reports are able to be much more specific and by addressing particular local realities can serve as the basis for national plans of action.

WHO's Global Campaign for Violence Prevention works to promote and support national- and local-level violence prevention initiatives. The WHO Kobe Centre for Health and Development played an important role in the Campaign by supporting this set of national violence and health reports from countries in the WHO South East Asian and Western Pacific regions. While violence is prevalent in rural and urban settings alike, the evidence points to it occurring with greater frequency and higher severity in urban settings, which in the years ahead are set to be a focus of the WHO Kobe Centre's project to optimize the impact of social determinants of health on exposed populations, and therefore a continuing opportunity to deepen and expand public health programmes for the prevention of violence. I hope that the reports will serve as a stimulus to initiate violence prevention activities and a solid basis from which to develop national plans of action.

Etienne Krug
Director, Department of Injuries and Violence Prevention
WHO, Geneva, Switzerland

Foreword from the Department of Diseases Control, Ministry of Public Health, Thailand



Violence is a health problem that affects everybody's life. It is an important cause of death, injuries, and damaged health in every country and has long-lasting consequences.

The Thai Constitution protects children, youth and the family, using the principles of human rights and protection of liberty without discrimination. There are national policies, targets and lead agencies for prevention and control of self-harm, and violence against women and children. The government is also very responsive to related international treaties and proposals. Several national information systems include self-harm and assaults. Legal procedures for child and women victims of violence have been improved. The services for child and woman victims from violence are available countrywide. Several government and NGOs provide related services and conduct research to prevent and control violence. In spite of our various responses to violence, Thailand still has the problem of violence.

I welcome this first *National report on violence and health*. This report makes a major contribution to our understanding of violence and its impact on societies. It illuminates the different faces of violence. It advances our analysis of the factors that lead to violence, and the possible responses of different sectors of society. And in doing so, it reminds us that safety and security don't just happen: they are the result of collective consensus and public investment.

The report describes and makes recommendations for action at the local and the national levels. It will be valuable tool for policy-makers, researchers, practitioners, advocates and volunteers involved in violence prevention. While violence traditionally has been the domain of the criminal justice system, the report strongly makes the case for involving all sectors of society in prevention efforts, including health sectors.

Public health has made some remarkable achievements in recent decades, particularly with regard to reducing rates of many childhood diseases. However, saving our children from these diseases would only let them fall victim to violence and injuries unless appropriate actions done in a concerted manner.

Public health does play roles in the prevention of violence worldwide. This report contributes to shaping the response to violence and to making our country a safer and healthier place for all. I invite you to read the report carefully, and to join hands with many violence prevention experts in the country and from around the world in implementing its vital call for action.

A handwritten signature in black ink, appearing to read 'T. Santrajarn'.

Thawat Santrajarn
Director General

Department of Diseases Control, Ministry of Public Health, Thailand

Acknowledgements

The WHO Centre for Health Development (WHO Kobe Centre/WKC) would like to acknowledge with special thanks the Principal Investigator, Ms Chamaiparn Santikarn, MD. MPH. We also would like to express our gratitude for the assistance of Co-Investigators Ms Siriwan Santijarakul, M.Sc (Epidemiology), Ms Siriluck Jittrabiab, M.Sc (Behavioural Science)

Executive Summary

Rationale

Violence is an important health problem in Thailand. Suicide was the 11th and homicide as the 12th leading cause of disability adjusted life years, according to the Burden of Diseases and Injuries, Thailand 1999.

In 2003, the World Health Assembly resolution (WHA56.24) urged all governments to implement the recommendations of the World Report on Violence and Health. However, little information was available in Western Pacific and South-East Asia Regions, thus WHO Kobe Centre organized a meeting with seven countries in the two regions to discuss and endorse a working protocol for developing national reports on violence and health. The Ministry of Public Health (MoPH) Thailand assigned the Department of Disease Control to develop the report.

Objectives

1. To review the extent of violence, using the most recent information.
2. To present a situation analysis of the country's capacity to understand and prevent violence.
3. To provide recommendations for strengthening the organizations, mechanisms, systems in preventing violence, and victim services.
4. To increase political commitment and investment in systematic and science-based efforts to prevent violence and provide services for victims and perpetrators.

Methodology

1. Content analysis of existing official documents, reports, publications, legislation, policy and programme descriptions.
2. Structure and organizations related to violence prevention and services for victims and related people, including outstanding NGOs, were listed and compared in order to realize the potential of violence prevention network.
3. A research committee from concerned organizations and experts was set up to give advice and review the report, including the recommendations.

Results

Violence Situations In 2004, self-harm and assault were the second and fourth leading cause of injury deaths in Thailand with the death rate of 6.9 and 4.9 per 100 000 people. Geographically, self-harm is always more prevalent in the north, and assaults more prevalent in the south of Thailand.

Self harm During 1998–2004, there were 4200–6900 deaths annually due to self-harm, with a decreasing trend. In 2004, there were 4296 suicide deaths (12 deaths per day; 2–3 children under 15 die from suicide each month). Males had a higher death rate (11–13.2 per 100 000) than female (1.8–3.8). The age group of 25–34 years had the highest age-specific death rate (10.1), and elderly (65 years and over) was second, with the rate 9.6 per 100 000. In 2000–2004, Thailand had 16 000–19 000 severely injured by self-harm annually (about 54 per day), a 17% increase from the previous five years. In 2004, most of the severely injured were 15–19 and 20–24 years of age; each was about 23% of total cases. Labourers were occupation

most likely to harm themselves. The event occurred most on Mondays (16.8%), in March and April, and the time occurred were mostly in the evening (19.00–21.59). The home was the most common place (84%). The method used most for the severely injured was pesticide ingestion (23-29%); analgesic/antipyretic drugs were second (14-20%). For the dead, the most common methods were ingesting pesticides (39-48%) and hanging (30-33%). Twenty percent drank alcohol drinking before committing suicide, an increase from 2000-2003 (15%–18%). The most common causes of self-harm were conflicts with family members or lovers.

Interpersonal violence During 2000–2004, deaths from assaults were about 3000–5000 persons and severely injured were 30 000–50 000 persons annually, about 82–137 victims per day, a heavy burden for the health care system. The deaths peaked in 2003 (4829 deaths) and were at their lowest in 2004 (3044 deaths). The male death rate was 9–13 per 100 000 while female mortality was 1.6–2 per 100 000. In 2004, the highest age-specific death rate was found in 15–19 year olds at 8.3 per 100 000 populations followed with 35–54 year-old at 6.5. The trend of the severely injured cases was similar to the deaths. In 2004, most of severely injured from assaults were 20–24 years of age followed with 15–19 and 25–29. These three groups alone already accounted for 62% of total reported cases. The male-to-female ratio was 7.3:1.

Labourers were the most common occupation for suffering injury and death. Events occurred most often on a Sunday, followed with Saturday and Friday day, in the evening until after midnight (7 pm–3 am). The severely injured cases peaked in April, with a lower peak in November. The most common location of occurrence was home 39% (most often a victim's own house), streets and highway (25%), and restaurants (20%). Most of the severely injured was assaulted by sharp objects 38.3% (knives were the most common, followed by broken glass bottles), blunt objects (21.9%) and guns (17.6%). The deaths were caused most often by guns (45%). Alcohol, from the national injury surveillance, was reported to be detected for 48.3% of the injured in 2000, and increased to 56% in 2004.

For perpetrators, a study in an eastern province found 67.6% drinking, while 51.9 % was found in the victims. This risk factor was particularly highest in the north, northeast and the eastern region. The trend is rising dangerously. Most of the circumstances leading to assaults were related to skills in assessing situations, coping and controlling emotion and behaviours such as quarrelling (20%), sexual harassment (18%) and uncontrolled anger (11%). Victims and perpetrators of severe violence had the same demographic characteristics. In most of the cases, the victim and perpetrator were acquaintances, friends, family members, relatives or lovers.

Violence against children and women Approximately one child died every week from assaults during 1998–2004. In 2004, 1146 children were severely injured from assaults. On average, 12–15 women died or were severely injured each day by assault. The trends increased since 2000.

Response The Thai Constitution of 1997 protected children, youth and family, based on the principles of human rights and liberty protection without discrimination. There are national policy, planning, targets and a lead agency for prevention and control of self-harm and violence against children, women. The government is very responsive to related international treaties and proposals. Several national information systems have self-harm and assaults in their database; the variables included are sufficient for monitoring and evaluation.

The academia, organizations and NGOs concerned have increasing evidence for continuous movement. Legal procedures for child and women victims of violence have a social worker and psychologist present in the process. The services for child and woman victims of violence are available countrywide. Several government and NGOs provide related services and conduct research to prevent and control violence. **Population-wide prevention projects** such as **a life skills curriculum** for students and “**Kanjanapisek Home**”, a new model being piloted in the Juvenile Delinquency Institute which focuses on developing the positive potential of youth and preparing them for returning to the society have been initiated.

Recommendations

1. Strengthen the existing information systems urgently, and systematically support research and knowledge management.
2. Evaluate pilot curriculum/model/activities for building life skills, gender equity in children and family, and the “Kanjanapisek Home” and disseminate the reports for further discussion and adjustment or expanding the model countrywide to create a sustainable non-violent society.
3. The Ministry of Public Health should take the role as lead agency to collaborate the development of national policy and planning for prevention and control of violence for the whole population, including the male population which is the most affected, aiming at population-wide strategies for sustainable results.
4. Establish a national mechanism, with budget attached, for monitoring and evaluating national programmes/projects on violence against women and children.
5. Support capacity-building in police, health personnel and researchers concerned with violence victims for the required attitude, skills and sensitivity.
6. Amend laws contradicting the constitution and gender equity.
7. The Consumer Protection Agency should mandate and enforce standardized volume and design of packages of products which are frequently used for self-harm (pesticides, analgesic, cold tablets) and in assaults (glasses and bottles used to serve alcohol and soda).
8. Seriously enforce and enhance restriction of access to alcohol beverages and firearms.
9. Review and amend the national budgeting and financing system to be supportive to multi-sectoral collaborative work and financing among ministries and disciplines.
10. Expand the One-stop service crisis centers to cover all district hospitals and include the comprehensive rehabilitation services for the child and women victims. Collaboration, linkages, and technical support to concerned organizations should be enhanced.
11. Equity should be promoted by peaceful means to prevent violence between men and women and among those of different ethnicity, religions and beliefs.
12. The Ministry of Public Health and concerned agencies should communicate continuously with the media to create understanding that reiterating gender differences in TV programmes and the use of violence as topic for comedians or part of TV commercials can cultivate acceptance of violence in children and society.
13. Communicate to the public the risks to the self and to family members associated with the possession or availability of firearms in households and society.
14. Strengthen the legal system by using scientific evidence to obtain social justice.

Introduction

Background information on Thailand

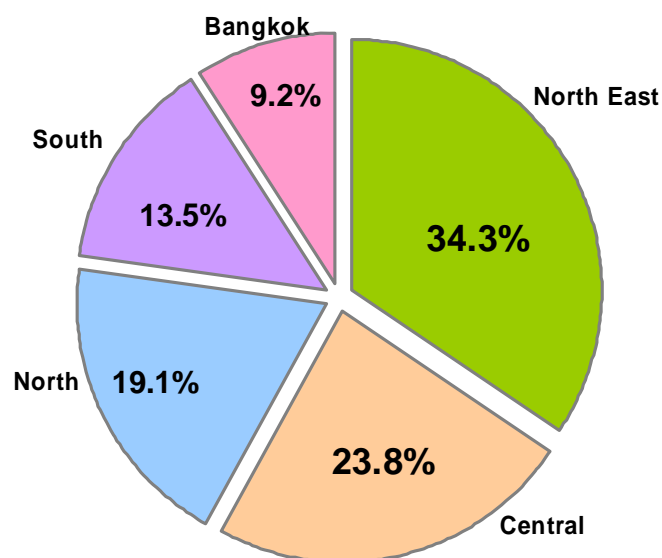
Location

Thailand is located at the heart of the Southeast Asia region, with Myanmar at the west and northern border, Lao P.D.R. at the north and northeast, Cambodia at the southeast and Malaysia at the southern border.

Area

Thailand covers the area of 513 118 sq. km. It is divided administratively into 76 provinces. The largest province is Nakorn Rajsima (20 494 sq. km.); the second largest is Chiang Mai (20 107 sq. km). Bangkok, the capital city, is the third (1568.7 sq. km). The smallest province is Samut Songkhram (416.7 sq. km) and Phuket (543 sq. km) ¹

**Figure 1 Proportion of midyear population by region
Thailand, 2004 (pop. 62 625 693)**



Source: Public Health Statistics 2004, Bureau of Health Policy and Strategy, Ministry of Public Health ²

Population

The total population is 62 526 693 as of 2004 (females 50.5%, males 49.5%) . The northeast has the biggest portion of the population (34.3%). The next is Central (Bangkok excluded) with 23.8%, the North (19.1%), the South (13.5%) and Bangkok (9.2%). Bangkok is the province with highest population (5 739 370); the second is Nakhon Ratchasima (2 565 197) and Ubon Ratchathani (1 784 192). The smallest province, in terms of the population, is Ranong (169 904) and Samut Songkhram (199 608).

Table 1 Number of live births, birth rates, number of deaths, death rates, Thailand 1995–2004

Year	No. of live births	Birth rates per 1000	No. of deaths	Death rates per 1000	Mid-year population
1995	963 678	16.2	324 842	5.5	59 277 900
1996	994 118	15.8	342 643	5.7	59 788 284
1997	897 604	14.8	300 323	5.0	60 466 243
1998	897 201	14.7	310 534	5.1	61 155 888
1999	754 685	12.3	362 607	5.9	61 563 980
2000	773 009	12.5	365 741	5.9	61 770 259
2001	790 425	12.7	369 493	6.0	62 093 855
2002	782 911	12.5	380 364	6.1	62 554 380
2003	742 183	11.8	384 131	6.1	62 939 819
2004	813 069	13.0	393 592	6.3	62 526 693

Source: Health Information Section, Bureau of Health Policy and Strategy, Ministry of Public Health²

Crude birth rate:	13.0 per 1000
Crude death rate:	6.3 per 1000
Religion:	Buddhist 94.2%
	Christian 4.6%
	Islam 0.8%

Life expectancy at birth:

2000–2005 Female 74.9 years, Male 67.9 years

2005–2010 Female 76.2 years, Male 69.6 years

2010–2015 Female 77.5 years, Male 71.3 years

(Office of the National Economic and Social Development Board, 2003)¹

Infant Mortality Rate: In 2002, the infant mortality rate in Thailand was 24/1000 live births, compared to 7/1000 live births in high income countries, 30/1000 live births in middle income countries and 55/1000 live births in low income countries. Infant mortality rates in Southeast Asian countries are as follows (rate per 1000 live births)¹:

Singapore	3	Vietnam	28	Bangladesh	48
Japan	5	Philippines	29	Nepal	62
Malaysia	8	Indonesia	32	India	65
Sri Lanka	16	North Korea	42	Myanmar	77

1. Rationale and objectives of the study

Violence is a health problem that pervades everybody's life, at every age, and is an important cause of death, injuries, and damaged health in every country. It also has long-term consequences.

In the study of the burden of disease and injuries in Thailand in 1999⁴, K Bundhamcharoen et al demonstrated that violence (suicide, homicide) was the 11th and 12th leading cause of disease burden (disability adjusted life years, DALYs*). Homicide was at the 8th and suicide was at the 9th rank among males, and accounted for 3% of total loss, each. For females, it was not listed in the top ten. (Table 2, 3)

Table 2 Ten leading causes of disease burden (DALYs), Thailand 1999

Disease categories	Percent of total loss
1. HIV/AIDS	14
2. Traffic accidents	7
3. Stroke	6
4. Diabetes mellitus	5
5. Liver cancer	4
6. Cardiovascular diseases	3
7. COPD (emphysema)	3
8. Depression	3
9. Osteoarthritis	2
10. Anemia	2
11. Suicide	2
12. Homicide and violence	2

Source: Burden of Disease and Injuries in Thailand, 1999⁴

*One DALY is one lost year of healthy life

Table 3 Ten leading causes of disease burden (DALYs) by sex, Thailand, 1999

Disease categories		%	Disease categories		%
Rank	Male		Rank	Female	
1.	HIV/AIDS	17	1.	HIV/AIDS	9
2.	Traffic accidents	9	2.	Stroke	7
3.	Stroke	5	3.	Diabetes	7
4.	Liver cancer	4	4.	Depression	4
5.	Diabetes	3	5.	Liver cancer	3
6.	Ischemic heart disease	3	6.	Osteoarthritis	3
7.	COPD (emphysema)	3	7.	Traffic accidents	3
8.	Homicide and violence	3	8.	Anemia	3
9.	Suicide	3	9.	Ischemic heart disease	3
10.	Mental disorders	2	10.	Cataracts	2

Source: Burden of Disease and Injuries in Thailand, 1999⁴

*One DALY is one lost year of healthy life

The 49th World Health Assembly (WHA 49.25) in 1988, declared that violence is a worldwide public health problem, and that violence prevention should be given priority in public health concerns. It also called for WHO action to prevent this problem. As a

consequence, the World Report on Violence and Health (WRVH), by Krug E, et al. (2002) was published and distributed to member countries.⁵

The World Report on Violence and Health had touched upon violence among young people, tribes, sexual violence, self-directed violence, violence among intimate partners, and deprivation and negligence of elderly and children. The World Health Statistics showed that violence was the third cause of death, second to tuberculosis and AIDS. In 2000, there were 815 000 deaths from suicides, 520 000 deaths from homicide and 310 000 deaths from war. Interpersonal violence was very high in South Africa, South America, Eastern Europe and Russia. Most violence occurred among males, 15–59 years of age, and the rates increased with age. The goal of the report was to raise awareness about the problem of violence globally and to emphasize the point that violence is preventable. The public health sector has a crucial role to play in addressing its causes and consequences. It is emphasized that investment in preventive strategies using multisectoral and collaborative efforts is found to be effective and this is confirmed by scientific, economic, political and social approaches. It also provides increasing evidence for efforts to implement primary prevention of violence, focusing on its causes and determinants of interpersonal violence. The report suggests a national agenda for violence prevention:

1. create, implement and monitor a national action plan for violence prevention;
2. enhance capacity for collecting data on violence;
3. define priorities for, and support research on, the causes, consequences, costs and prevention of violence;
4. promote primary prevention responses;
5. strengthen responses for victims of violence;
6. integrate violence prevention into social and educational policies, and thereby promote gender and social equality;
7. increase collaboration and exchange of information on violence prevention;
8. promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights;
9. seek practical, internationally agreed responses to the global drugs and arms trade.⁵

In 2003, a World Health Assembly resolution (WHA56.24) urged all governments to implement the recommendations of the World Report on Violence and Health to enhance human security and safety. However, little information for planning is available in Western Pacific and South-East Asia Regions, thus the WHO Kobe Centre organized a consultation with seven countries in the Asia-Pacific region for the development of a national report on violence and health of each country in close collaboration with WHO Headquarters and Regional Offices for the Western Pacific and South-East Asia. A review of international and national experiences, resources and capacities in preparation for the development of national reports on violence and health and to implement selected recommendations of the World Report on Violence and Health were made and a working protocol, including a strategic plan of action for the development of national reports, was discussed and endorsed.

Thailand is one among the seven countries which participated in the consultative meeting. The Ministry of Public Health, Thailand, expressed its concern over the issue of violence and agreed to collaborate on developing the national report in order to facilitate the implementation of violence prevention in the country and the exchange of crucial information for the whole region.

1.1 Objectives

1. To review the extent of the violence problem, using the most recent available information.
2. To present a situation analysis of the country's capacity to understand and prevent violence.
3. To provide recommendations for strengthening the organizations, mechanisms and systems needed to prevent violence and improve victim services.
4. To increase political commitment and investment in systematic and science-based efforts to prevent violence and provide services for victims and perpetrators.

1.2 Target audiences

1. National policy- and decision-makers in the Ministry of Public Health, Ministry of Internal Affairs, Ministry of Justice, Ministry of Social Development and Human Security and Ministry of Culture
2. Experts from various agencies (public and private)
3. International donors, UN agencies

1.3 Expected outcomes

1. Development of policy, plans and projects on violence prevention and services to be provided to violence victims, based on evidence and scientific knowledge.
2. Political commitment to support programmes on violence prevention, allocating resources and related plans and actions.

Materials

Existing official documents, databases, scientific publications, legislation, policies and programme descriptions, World Report on Violence and Health and WHA resolutions.

1.4 Methodology

1. Content analysis of existing official documents, database, survey and surveillance reports, publications, legislation, policy and programme me descriptions.
2. Structures and organizations related to violence prevention and services for victims and related people, including outstanding NGOs were listed and compared in order to realize the potential of violence prevention network.
3. A research committee comprising representatives of concerned organizations and experts on violence was set up to give advice and review the research report, including the recommendations.

1.5 Definitions

Violence is defined in the World Report on Violence and Health as:⁶

"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 high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation."

(<http://www.who.int/violenceprevention/approach/definition/en/>)

This definition involves the term “power”, apart from physical force, in the improper acts against others. Therefore, the scope of violent acts is broadened and covers the consequences of action originating from using power over the others, including threaten and intimidating. The use of power includes the negligence or refraining from one’s duty that results in negative impacts on physical, psychological, sexual health; as well as suicide and self-directed injuries.

It should be noted that, by this definition, violence covers psychological effects that could create poor physical and psychological development, injuries and death as well. It reflects the interest in the impact on the health and welfare of individual, family and community. It also covers long-term effects that may occur later in life after the first violent attack.

1.6 Typology of violence

The *World Report* also presents a typology of violence that, while not uniformly accepted, can be a useful way to understand the contexts in which violence occurs and the interactions between types of violence. This typology divides the general definition of violence into three sub-types according to the victim-perpetrator relationship.

1. **Self-directed violence** refers to violence in which the perpetrator and the victim are the same individual and is subdivided into self-abuse and suicide.
2. **Interpersonal violence** refers to violence between individuals, and is subdivided into family and intimate partner violence and community violence. The former category includes child maltreatment; intimate partner violence; and elder abuse, while the latter is broken down into acquaintance and stranger violence and includes youth violence; assault by strangers; violence related to property crimes; and violence in workplaces and other institutions.
3. **Collective violence** refers to violence committed by larger groups of individuals and can be subdivided into social, political and economic violence.

This typology distinguishes four modes in which violence may be inflicted:

1. physical,
2. sexual,
3. psychological,
4. deprivation or negligence.

Diagram 1 Typology of Violence

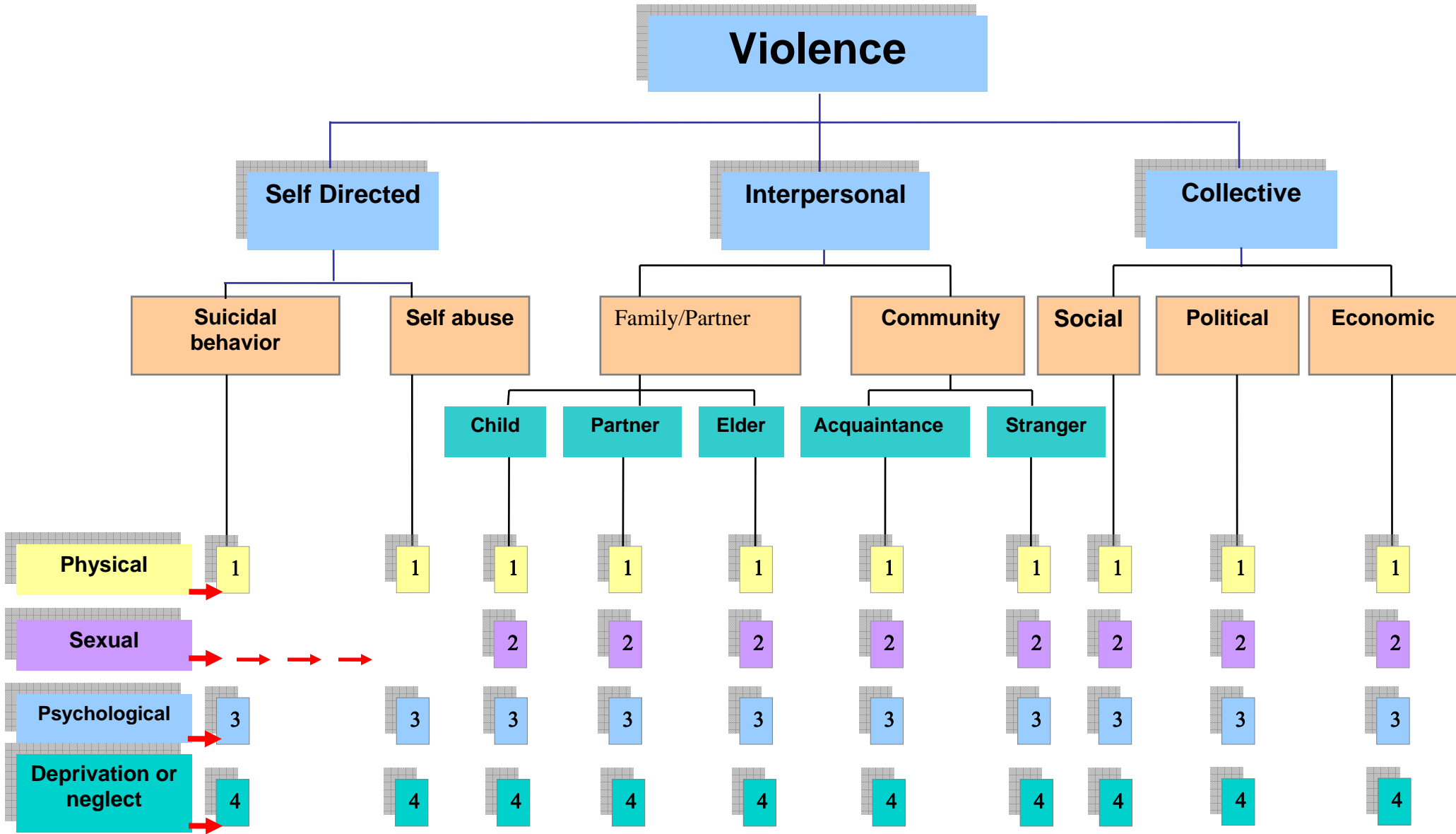
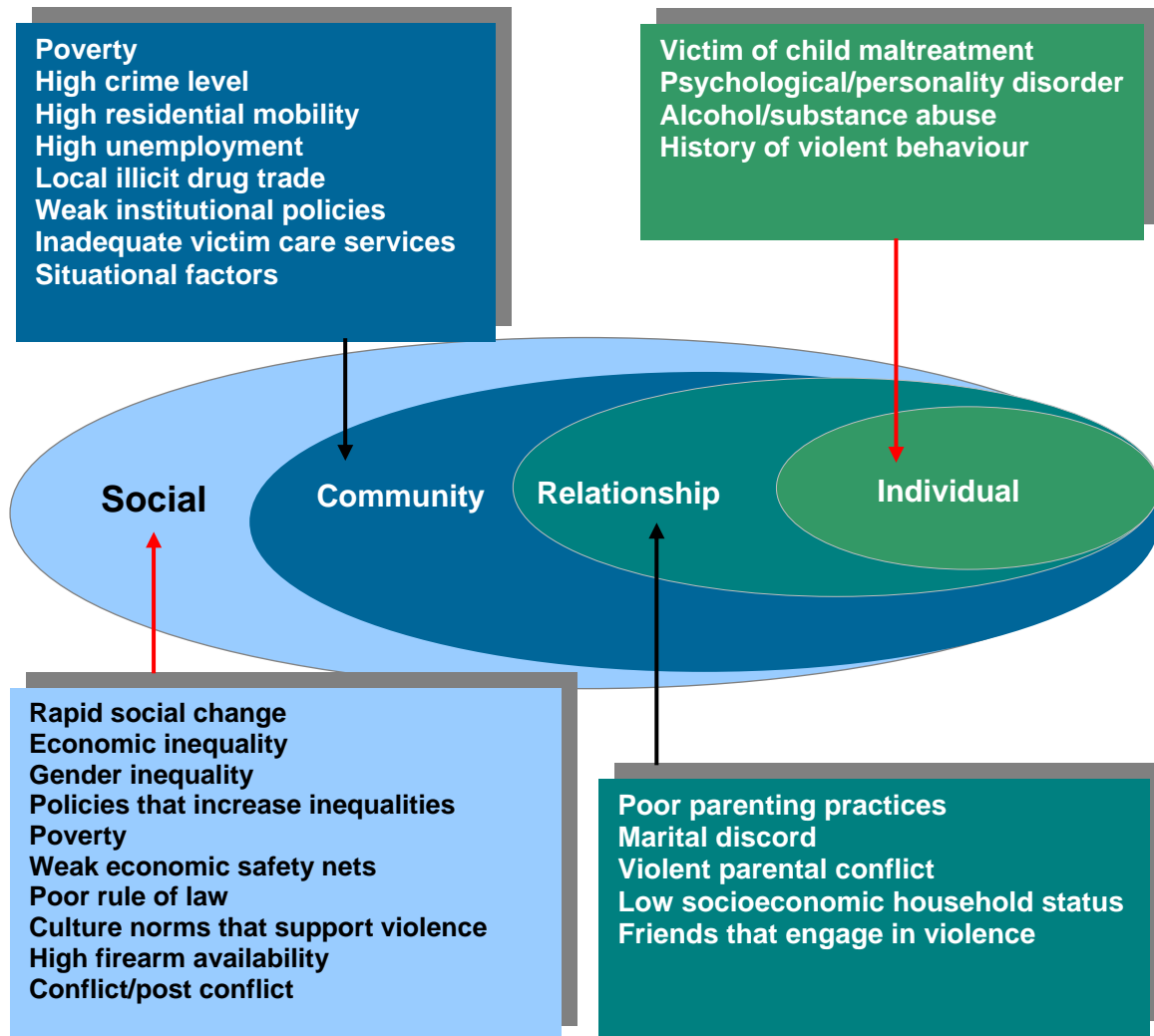


Diagram 2 Ecological model showing shared risk factors for sub-type of interpersonal violence ⁶



Source: Buchart et al (2004: 4) ⁶

1.7 Nature of violence and interactions of risk factors

In its report, WHO has proposed theories on the roots of violence in humans positing that there is no single factor fully responsible for the occurrence of violence. There is no single factor to explain why one person and not another behaves in a violent manner, nor why one community will be torn apart by violence while a neighboring community lives in peace. Violence is an extremely complex phenomenon that has its roots in the interaction of many factors: biological, social, cultural, economic and political. ⁶

The *World Report on Violence and Health* uses an ecological model to try to understand the multifaceted nature of violence. The model assists in examining factors that influence behaviour, or which increase the risk of committing or being a victim of violence, by dividing them into four levels.

Individual level

The first level identifies biological and personal history factors that influence how an individual behaves and increases their likelihood of becoming a victim or perpetrator of violence. Examples of factors that can be measured or traced include demographic characteristics (age, education, income), psychological or personality disorders, substance abuse, and a history of behaving aggressive or experiencing some kinds of abuse.

Relationships

The second level looks at close relationships such as those with family, friends, intimate partners and peers, and explores how these relationships increase the risk of being a victim or perpetrator of violence. In youth violence, for example, having friends who engage in or encourage violence may increase a young person's risk of being a victim or perpetrator of violence.

Community

The third level explores the community contexts in which social relationships occur, such as schools, workplaces and neighborhoods, and seeks to identify the characteristics of these settings that increase the risk of violence. Risk at this level may be influenced by factors such as residential mobility (for example, whether people in a neighborhood tend to stay for a long time or move frequently), population density, high level of unemployment, or the existence of a local drug trade.

Frequent moves, different social characteristics, lack of social binding, widespread social isolation, and lack of communication within a neighborhood and community are all factors that increase the likelihood of violent acts.

Society

The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These social and cultural norms include:

- those that give priority to parental rights over child welfare;
- those that regard suicide as a matter of individual choice instead of a preventable act of violence;
- those that entrench male dominance over women and children;
- those that support the use of excessive force by police against citizens, and
- those that support political conflict.

Larger societal factors also include the health, economic, educational and social policies that help to maintain economic or social inequality between groups in society.⁶

Complex linkages

While some risk factors may relate to some specific violence acts, other groups of risk factors may interact with one another to create violence, such as some sociocultural factors, poverty, social differentials, substance abuse and access to firearms. Therefore, those prone to be perpetrators of violence may have several experiences with different types of violence acts, for example a man who tends to hurt his intimate partners is at a higher risk of sexual

violence. Conversely, the modification of one factor may result in a decrease of more than one type of violence.

2. Data sources

2.1 Sources of data used in this study

The five databases that were used in this study were national statistics from various concerned organizations. These databases were as follows:

2.1.1 Mortality Notification System

This system covers all deaths which occurred in Thailand's territory. It is mandated that a known death must be reported to the authorities within 24 hours. This system is the responsibility of the Ministry of Interior. A deceased person's relative must report to health workers, community doctor, sub-district leader or village headman. Either of them would then issue a letter on the assumed cause of death, and the relative of the deceased person brings this letter to a district office to obtain official death certificate. The death information is recorded into a database which is an online system and links to central information center in the Ministry of Interior in Bangkok. This information is also sent to Ministry of Public Health (MoPH) in form of electronic files. The causes of death would be entered as text-file and sent to MoPH to assign the codes according to ICD-10 system.

The causes of death from death certificates are meant for prevention and control of the underlying causes of death, and would be employed in preparing the Public Health Statistics of Thailand. Public health plans for improving the health of the Thai population are based on this statistics. It is important to understand that the use of the causes of death recorded in this system is different from those recorded in the autopsy report or the legal document, which is issued in the case of non-natural death (deaths which do not occurred from diseases) such as lightning strike, suicide or homicide. The cause of death report in the autopsy and legal document is generally the direct (or immediate) cause of death, such as the attack from mechanical force with blunt material, broken skull, bleeding in abdomen, etc., which offers information only on the immediate cause, but not the underlying cause of death, hence it is not as useful for prevention.

2.1.2 National Injury Surveillance (IS) System, Ministry of Public Health⁷

This is the national, sentinel surveillance system for injuries in Thailand. The system started in 1995, covering all injury cases presented to ER as reported by five largest general hospitals in five selected provinces. It represents a modification of the trauma registry to accommodate all types of injuries, and major risk factors. Due to the flexibility of the system, it can be used either for monitoring and evaluation of trauma care from pre-hospital, inter-hospital and intra-hospital, or for planning and monitoring injury prevention or both. The system expanded steadily before the reporting criteria was changed to include only severe injuries (death, observed in hospital or admitted) in 2001. This change was intended for cost containment and better data quality. In 2005, the system had 26 regional hospitals and two general hospitals in Bangkok under the MoPH as its sentinel sites. These were general hospitals with more than 400 beds each. Every nurse in the ER is trained to record the required information about the injured except the final diagnosis, for which the hospital medical records personnel, specifically trained for the IS system, would copy all the doctor's diagnosis (including important investigation finding) and also provide ICD-10 coding for

both external causes and the injuries as well as the AIS score for severity. This system covers the injured of all external causes except injuries from complication of medical and surgical care. This system is under a continuous, systematic, routine supervision and quality assessment. The completeness of reporting compared to the reporting criteria was 77-86 % and 88.6% of the variables evaluated were filled correctly and matched the medical records.

2.1.3 Crime statistics (Bureau of Royal Thai Police)⁸

It is a statistical database of criminal cases in Thailand carried out by Police Information Technology Center, Office of Planning and Budget, Bureau of Royal Thai Police. It used to be reported annually. But from the year 2000 onwards, there was no further publication of this annual report due to lack of manpower and computers.⁸

The criminal prosecution statistics database in Thailand is maintained by Bureau of Royal Thai Police and is used for analyzing, planning, and prescribing strategies in preventing and solving crimes in area under responsibility of each station, as well as for academic use. The database is processed from the data reported from all units under the Bureau of Royal Thai Police. Reported cases are classified into five categories, as follows:

1) Severe violence crimes

This consists of intentional murder, robbery, gang-robbery, kidnapping, and committing arson.

2) Crimes against life, body, and sex

This includes intentional murder, unintentional manslaughter, negligent manslaughter, attempted murder, assaults and rape.

3) Violence against property

This includes theft, snatching, blackmail, extortion, robbery, gang-robbery, possession of stolen goods, and vandalism.

4) Robbery

This consists of motorcycle theft, car theft, cattle theft, theft of agriculture tools, public transport vehicle robbery, cheating and fraud, and misappropriation of property.

5) Crimes against state

This includes crimes against the Drug Abuse Act, the Prostitution Engagement Act, the Gambling Act, the Firearms Act and the Pornography Act.

A police officer responsible for this statistical database stated that the categories above are not mutually exclusive, which means that one type of crime can be put into more than one category, depending on the characteristic of the crime.

2.1.4 Behavioural Risk Factors Surveillance System, BRFSS⁹

This is an active surveillance system which is designed according to epidemiologic and statistical approaches in conducting surveys for specific health risk behaviours. The system employs periodical surveys with good quality control and covers many aspects of health of the population including general health status, health behaviours and the practice of using health screening services for health problems. It covers noncommunicable diseases and

important risk behaviours. It started in 2003 in 12 provinces and was expanded to 41 provinces in 2004 and 76 provinces (the whole country) in 2005.

The survey covers the population of 15 years of age and over registered in each province. It divides the population into three age groups (15-39, 40-59, 60+ years). The sampling design is stratified two-stage sampling, in which each province is divided into municipal and non-municipal areas. The sample areas are randomly selected in each stratum, and the sample subjects are randomly selected according to the age scheme. The questionnaire consists of 14 parts and it is developed from the BRFSS questionnaire of CDC/WHO. It also covers information on injuries due to violence.

2.1.5 Research database on violence in Thai society¹⁰

This research database on violence in Thailand is set up to be a resource for literature searches and reviews on violence in Thai society, with support from the Health System Research Institute, MoPH. The methodology includes integrative research review, proposed by Cooper (1982), and principles of content analysis (Polit & Hungler, 2001). All research in this database has been audited for completeness and validity. A total of 190 research papers are included in the database. Thirty-one studies were published during 1981-1990 and 159 from 1991-2001.

For analysis and quality control, the researcher who set up the violence research database checked for the completeness of the all materials. The uncompleted photocopies were rechecked. Research reports which had no relevant information or were conducted before 1981 were deleted. The rest were carefully examined on the objectives, samples, research methods, results and recommendations. The basic characteristics of each study were entered into a pre-designed table used as a log book. Important information was summarized and put into summary tables.

2.2. Strengths and Weaknesses of data sources

2.2.1 Mortality notification

Strengths

- It covers most of the victims of most severe violence.
- Its coverage of all deaths which occurred in the country was about 95%.

Weaknesses

This system has a chronic problem with “ill-defined condition” as causes of deaths, which were approximately 30-40% of total deaths. Another important problem is that the system lacks manpower. At present, only two technical officers are assigned to take care of the system for the whole country.

Recently, doctors have been reluctant to specify the underlying cause of death. This was because other agencies concerned, such as insurance company, attorney or relatives, usually take this information as evidence in court, although it is clearly written in the death certificate that the information is used for public health planning only. As the consequence of the court process, doctors avoid recording underlying causes of death, so that they would not have to argue the causes of deaths before the court. Therefore doctors would record only immediate

cause of death, such as intracranial hemorrhage, asphyxia, contact with blunt objects, etc. instead of suicides or homicides.

2.2.2 National Injury Surveillance System

Strengths

This system includes 75 variables on each injury observed, so it covers sufficient details of the violence victims. The system is timely and can be expedited to report as frequent as everyday if more in-service staff are assigned to look after the system. This system covers approximately one third of injuries in the country.

It is the only information system of the MoPH that has continuous, systematic, routine supervision (every year on data providers) and system and data quality assessment including utilization of data (every 2-3 years).

It covers victims of violence from various types, such as assaults by different methods (ICD-10 Code X85 – Y09), intentional self-harm (ICD-10 Code X60 – X84), legal intervention and operation of war (ICD-10 code Y35 – Y36). These three groups can be sub-classified to more details according to Chapter 20 of ICD-10.¹¹ Moreover, this system covers related risk behaviours of the injured, such as alcohol consumption before or while the injury event happened, non-helmet use, etc.

Weaknesses

The biggest problem is the lack of manpower. The number of permanent staff, responsible for complete processes in operational epidemiology for injuries (surveillance, investigation, and epidemiological research); training, supervision providers; data editing and generating surveillance report was reduced from six to two persons in 2005.

2.2.3 Crime statistics

Strengths

This database covers both victims and perpetrators. It has 100% coverage of criminal cases which gets the police attention and records. The details of the crime cases are sufficient for violence prevention planning.

Weaknesses

There have been problems with definitions which can vary according to the understanding of reporters. Even though the police use the wording of the law to define the terms, many terms still do not have definition in the law or are defined differently in different laws. Moreover, those definitions have no document to refer to. The police officers involved have to make phone calls to ask the police in charge of the system or make their own judgment in recording.

The quality of the report is important problem and is growing, both in timeliness and in completeness of the report, due to lack of resources to support.

Recently, a computerized recording system was set up for criminal data but the budget is not enough to put computers at every station, so there is still a problem.

The latest document report we could obtain from the system was an annual report in 2000, and no further publication has been issued. There is some report on the website but not in as much detail as the report document and not sufficient for preventive planning.

2.2.4 Behavioural Risk Factors Surveillance System (BRFSS)

Strengths

It is planned to be a routine population-based survey that covers all 76 provinces of the country and has good quality control.

Weakness

It covers only persons between 15-60 years of age; therefore people of other ages are left out and new risk groups cannot be detected, especially children.

The interview techniques used in the survey may cause some errors in the data and the variables about violence are insufficient.

Not as timely, hence not being used for planning and monitoring of injuries and violence.

Quite costly when compare with hospital-based injury surveillance.

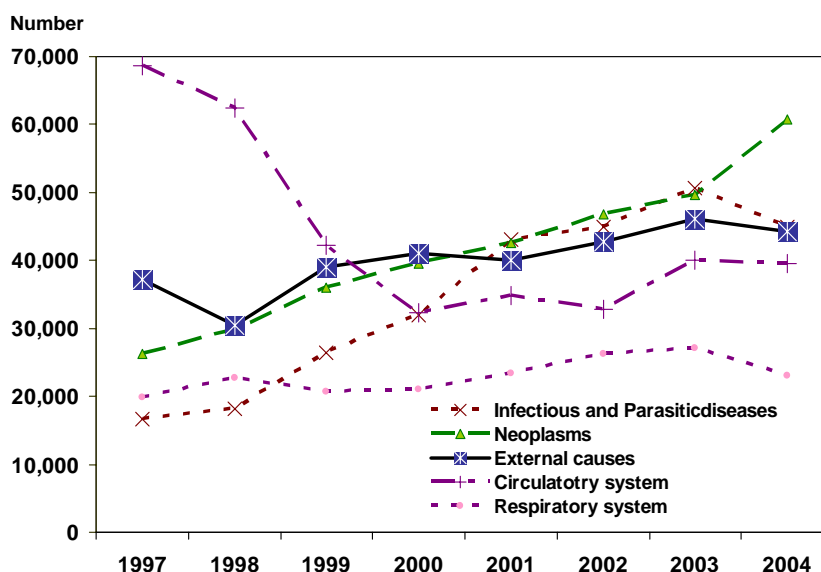
3. Results

3.1 Current situation of violence problem in Thailand

From 2001-2004, external causes of morbidity and mortality (all causes of injury including intentional and unintentional injuries) were the third leading cause of death in Thailand with a slightly increasing trend.² (Figure 2)

Assaults and self-harm, which are important indicators for violence, are the 2nd and 4th leading cause among all external causes of morbidity and mortality in Thailand, while the first is traffic accidents. (Figure 3) In 2000, the self-inflicted injury rate was 8.4 per 100 000 populations and slowly declined to 6.9 per 100 000 populations in 2004. The death rate due to assault was 5 per 100 000 and increased rapidly to the peak in 2003 and declined in 2004 to 4.9 per 100 000. In 2004, the peak death rate from assaults was found in a younger age group (20-24 year-olds) than the peak of death rate from suicide, which was 30-34 year-olds.³

Figure 2 Cause of death in Thailand, 1997-2004



Sources: Public Health Statistic 1997-2004, Bureau of Health Policy and Strategy,

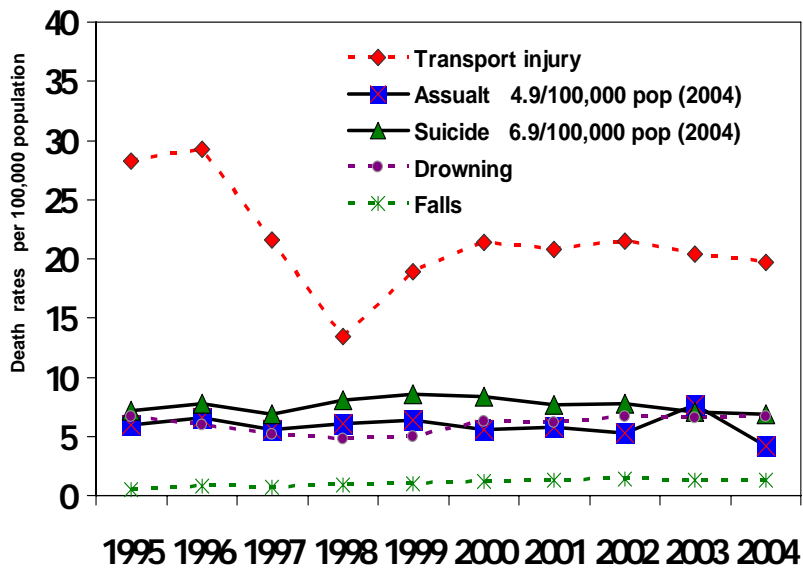
3.1.1 Self-inflicted violence (suicide and intentional self-harm) Situation, descriptive epidemiology and related factors

3.1.1.1 Mortality Notification

Situation and trend

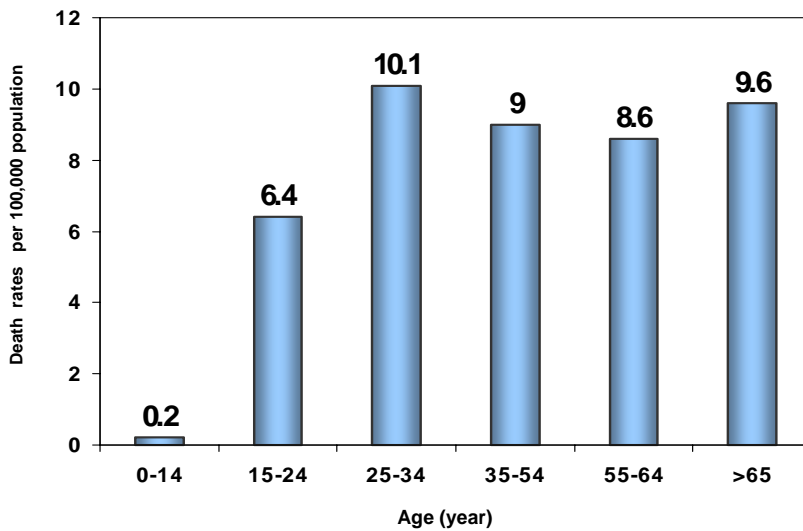
During 1998-2004, there were 4200–6900 suicides each year. In 2004, there were 4296 suicides (12 deaths per day), and 2-3 children under 15 who committed suicide each month. The suicide rate was 6.87 per 100 000, making it the 2nd cause of death. In 2004, the 25-34 age group had the highest suicide rate with age-specific rate of 10.1, and elderly (65 and over) ranked second with 9.6 per 100 000.⁹ (Figure 3, 4) From 1998-2004 there was a declining trend in deaths from suicide.^{2,3}

**Figure 3 Mortality rates by external causes of death
Thailand, 1995-2004**



Sources: Public Health Statistic 1995-2004, Bureau of Health Policy and Strategy, Ministry of Public Health 3

**Figure 4 Mortality rates of suicide by age groups,
Thailand, 2004**



Sources: Public Health Statistics 2004, Bureau of Health Policy and Strategy, Ministry of Public Health

Geographically, the Northern region has the highest rate of self-inflicted injury deaths, especially in Lamphun, Chiang Mai, Chiang Rai, and Phrae. The suicide rates were 15.5-20.6 per 100 000; while the lowest rate was found in the south, such as Narathiwat, Pattani and Satun province with suicide rates of 0.6, 1.3 and 2.6 per 100 000 respectively. Another group

of provinces with high rate of suicide was on the eastern coast, such as Chantaburi Rayong, and Chonburi. (Table 3)

Males had higher rate of suicide than females (death rates 11–13.2 and 1.8–3.8 per 100 000 respectively).^{2,3} (Table 4)

Table 3 Suicide rate, highest and lowest rate groups, by province, Thailand, 2004 (rate per 100 000)

Highest rate group			Lowest rate group		
1	Lamphun	20.6	1	Narathiwat	0.6
2	Chiang Mai	19.5	2	Pattani	1.3
3	Chiang Rai	16.7	3	Satun	2.6
4	Phrae	15.5	4	Yala	2.8
5	Chantaburi	14.9	5	Ubon Ratchathani	3.1
6	Phayao	12.7	6	Udon Thani	3.3
7	Rayong	12.5	7	Nong Khai	3.4
8	Chonburi	11.7	8	Sakon Nakhon and Mukdahan	3.6
9	Ang Thong	10.1	9	Bangkok	3.9
10	Mae Hong Son	10.0	10	Nakhon Phanom and Nong Bua Lamphu	4.0

Source: Public Health Statistics, Bureau of Health Policy and Strategy, Ministry of Public Health, 2004
<http://www.moph.go.th/stat1.php>^{2,3}

Table 4 Number of deaths and mortality rates per 100 000 from suicides by region and sex, Thailand, 2000-2004

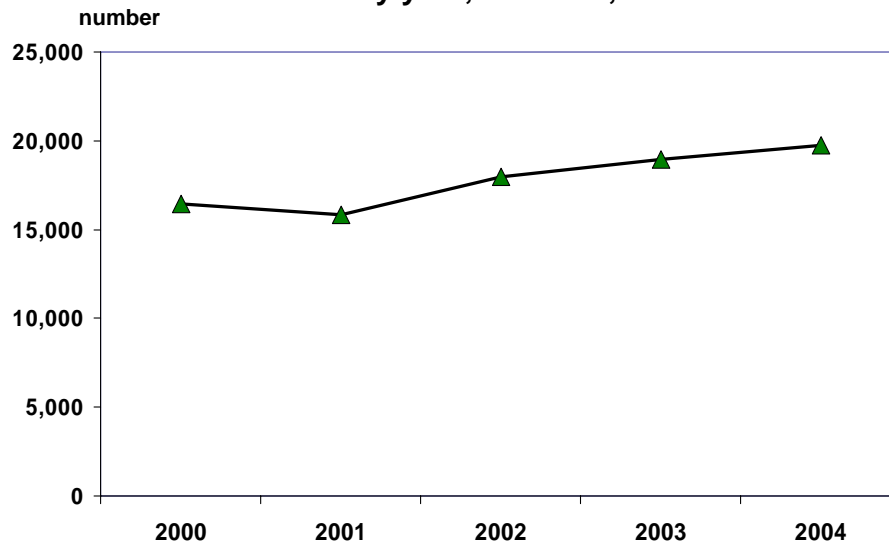
Year	2000		2001		2002		2003		2004	
	No	Rate	No	Rate	No	Rate	No	Rate	No	Rate
Whole Kingdom	5189	8.4	4803	5.8	4905	7.8	4486	7.1	4296	6.9
Male	4038	13.2	3666	9.9	3715	12.0	3426	11.0	3253	10.5
Female	1151	3.7	1137	1.8	1190	3.8	1060	3.3	1043	3.3

Sources: Public Health Statistics, 2000–2004, Bureau of Health Policy and Strategy, Ministry of Public Health
<http://www.moph.go.th/stat1.php>^{2,3}

3.1.1.2 Intentional self-harm cases in Injury Surveillance System

The information in this system was from 19 hospitals. These hospitals reported all severe injury cases (all injury dead cases, cases observed at ER or admitted). There was 16 000–19 000 severe injury cases from intentional self-harm reported each year (54 per day on average). This amount had increased approximately 17% as compared to the previous five years. (Figure 5)¹²

Figure 5 Number of severe injuries from intentional self-harm by year, Thailand, 2000-2004

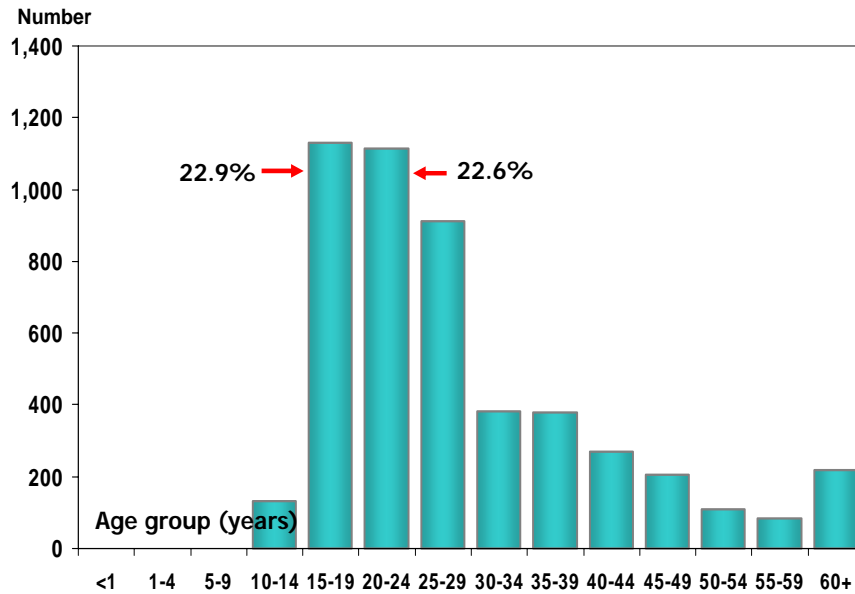


Sources : Estimated from 19 sentinel hospitals, National Injury Surveillance, Bureau of Epidemiology, Ministry of Public Health, Thailand ¹²

In 2004, most of severe intentional self-harm cases were 15–19 and 20–24 years of age, each group accounted for 23% of total reported cases (Fig. 6). Females had a slightly higher proportion than males (57.7%) in the intentional self-harm severe injury group, but males accounted for 72.1% of completed suicides. Hence the female case fatality rate (4.8 %) was lower than for males (case fatality rate 17.5%) (Fig. 7).¹²

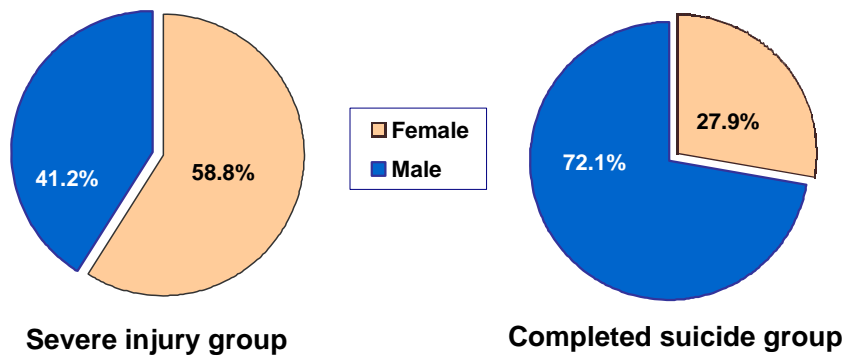
Labourers were the occupation which accounted for the highest proportion (41.3%) among all intentional self-harm severe injury cases and the second was students (20.2%). Among those intentional self-harmers who died, the most-represented occupational group was also labourers (37.8%), but the second biggest group was agriculturists (16.2%).

Figure 6 Number of intentional self-harm severe injuries by age group, Thailand, 2004



Source : 19 sentinel hospitals, National injury surveillance system, Epidemiology Bureau, Ministry of Public Health, Thailand¹²

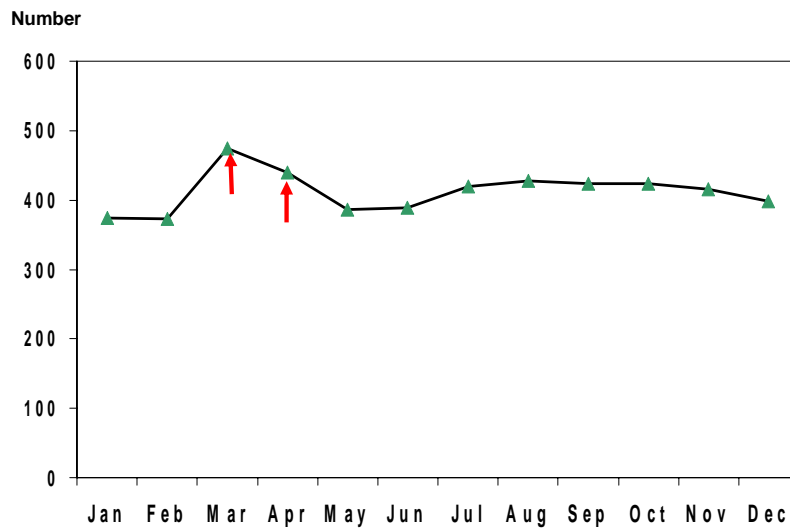
Figure 7 Severe injuries and completed suicides from intentional self-harm, by sex, Thailand, 2004



Source : 19 sentinel hospitals, National injury surveillance system, Epidemiology Bureau, Ministry of Public Health, Thailand¹²

The most likely day of the event was Monday (16.8%), the least Sunday (12.1%). March and April had the highest rate of this cause of injuries (Figure 8), and the event mostly occurred at night (7.00–9.59 pm). Eighty percent of events occurred at home.¹²

**Figure 8 Intentional self harm (severe injuries) by month
Thailand, 2004**



Source : 19 sentinel hospitals, National injury surveillance system, Epidemiology Bureau, Ministry of Public Health, Thailand¹²

Methods of self-harm

Rujivipat V, analyzed the data from national injury surveillance system in 2000–2004¹¹ and found that:

Committed suicide group (fatal cases only)

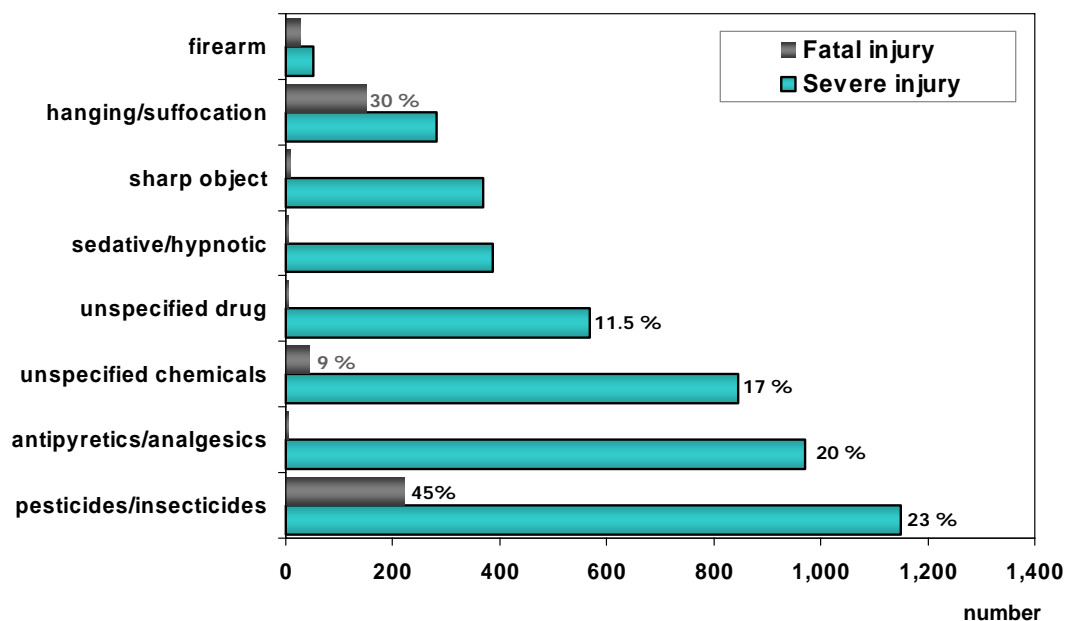
- 39–48% ingested insecticides or pesticides;
- 30–33% hung themselves or caused asphyxia.

Severe injured cases of self-harm (including fatal cases)

- 23–29% ingested insecticides or pesticides;
- 14–20% ingested analgesic or antipyretics drugs (ICD10 code X60, most were paracetamol). (Fig. 9)

For the abuse of analgesic or antipyretics drugs, the proportion increased from 13.7% in 2000 to 19.6% in 2004.

Figure 9 Proportion of severe injury from intentional self-harm by method, Thailand, 2004



Sources : 19 sentinel hospitals, National Injury Surveillance, Bureau of Epidemiology, Ministry of Public Health, Thailand ¹²

3.1.1.3 Related factors from various sources

Personal and family characteristics

- **Conflicts within family and/or with parents**

In the Lortrakul M et al's study¹³ among attempted suicide cases aged 14–40 years attending Chiang Rai hospital (northern Thailand), it was shown that, among females, the chief cause of self-harm was quarrelling with boyfriend or husband. Among males, the cause was quarrelling with relatives or partners. Lertpanich M¹⁴ studied the factors related to attempted suicides admitted into governmental hospitals, and found that 56.9% of attempted suicide cases lived with both parents, and 43.1% lived with either father or mother. A Suan Dusit poll surveyed suicide among adolescents and adults¹⁵ and found that 31% of adolescents who attempted suicide had been quarrelling with parents, while 22.8% were due to problems in school. In adults, the causes usually were problems in family, self-disappointment (26.1%) and problems in married life (13.8%).

- **Family history (psychological disorders, attempted suicide and committed suicide)**

1.5% of cases had family members who had committed suicide. In a survey carried out in 2003¹⁶ involving review of 12 000 medical records in Khon Kaen Psychiatric Hospital (Rajanakharin Khon Kaen Psychiatric Hospital) (northeast), Suan Saranrom hospital (south) and Somdej Chao Phraya Psychiatric Institute (Bangkok), it was found that 0.6% had family members who committed suicide, while 4.5% had attempted suicide. In 91.2% of cases it was the first attempt.

- **Stress and disappointment in work and life**

26.1% were unhappy with their professional lives and 13.8% had problems in married life.¹³

- **Drug and alcohol abuse**

Among persons with severe self-harm injury reported by injury surveillance report, Thailand in 2003, 20% had drunk alcoholic beverages before committing self-harm. This was higher than had been reported in the year 2000–2003. (15%–18%).¹² Lortrakul M et al¹³ found that self-harming males often drank alcohol before the action. In the survey among patients at psychiatric hospitals¹⁷, it was shown that 37.2% used alcohol, 13.5% used drugs and 7.5% used marijuana.

- **Environment and community**

Sanghatthit M et al¹⁸ conducted an in-depth interview on community participation in preventing and helping people with high risk or who had previously attempted suicide in Sri Sa Ket province in 2000. It was found that communities at high risk of suicide often lacked local authority preparedness, care organizations, transportation, communication and education quality. Factors among local people in such communities were drug addiction, HIV/AIDS and family conflict. Lortrakul M et al¹³ studied patients admitted to Chiang Rai hospital for attempted suicide, between 14–40 years of age. The study showed that the most commonly used chemicals were insecticides, herbicides, sleeping pills and analgesic drugs. These were commonly used for suicide because they were already available in households and/or easy to buy.

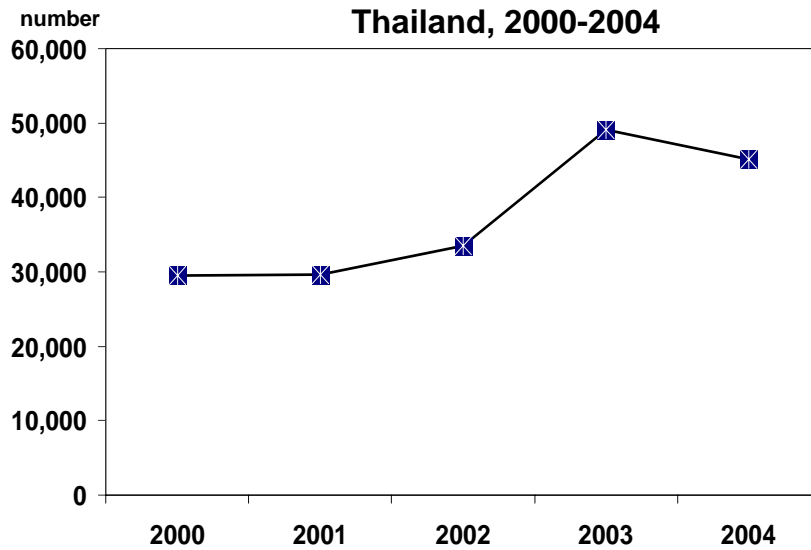
3.1.2 Interpersonal violence

3.1.2.1 Assault data from Mortality Notification

Deaths due to assaults were approximately 3000-4000 persons annually from 2000-2004. The highest was in 2003 with 4829 deaths and the lowest were in 2004, with 3044 deaths and the rate of 4.9 per 100 000.^{2,3} The trends of severe injuries and deaths from assaults, both were increasing from 2000 and reached the highest number in 2003 and decreased in 2004 as mentioned previously.¹⁹ (Figure 3, 10)

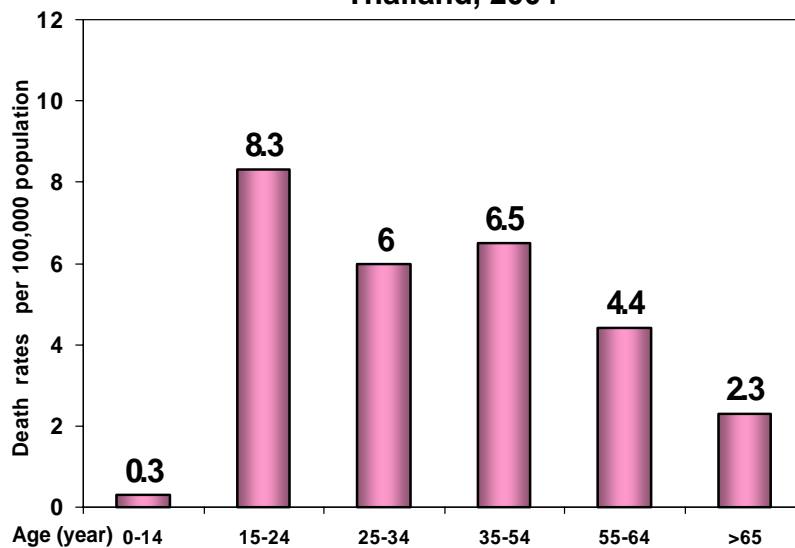
The age group with the highest age-specific rate in 2004 was 15-19 year-olds at 8.3 per 100 000 populations, followed with 35-54 year-olds at 6.5 per 100 000 (Fig. 11).²

Figure 10 Number of severe injuries from assault by year



Sources : Estimated from 19 sentinel hospitals, National Injury Surveillance, Bureau of Epidemiology, Ministry of Public Health, Thailand ¹⁹

Figure 11 Mortality rates of assault by age group Thailand, 2004



Sources: Public Health Statistic 2004, Bureau of Health Policy and Strategy, Ministry of Public Health ³

According to the “Injuries and Deaths from Assaults in Thailand” (Santikarn C and Rujivipat V, 2001)²⁰. Deaths from assaults according to the 1998 death certificate database of the Ministry of Interior which transferred to MoPH to process and report, most of them (86.6%) with regard to deaths by sex, more cases were found in males than in females – the ratio of males to females was 6:1. The sex disparities were evident for the group aged 15 years and above, and particularly different for 20–49 year-olds. Regarding geographical distribution, the highest rate of deaths due to assaults was highest in the South 11.1, followed by that of the North 6.7 and the Central 5.1 per 100 000. The provinces with top three highest rates,

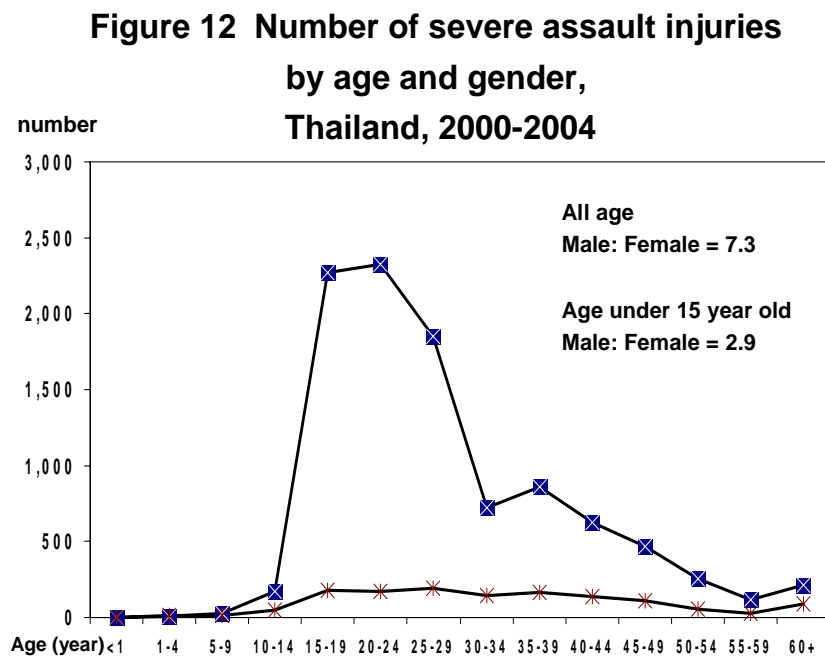
from highest to lowest, were all in the south – Phatthalung, Surat Thani and Chumphon. In 1998, according to the death certificate database, the most common method used for assaults was firearm shooting (60.4% of all deaths) followed by use of sharp objects (9.2%). It was noteworthy that no causes of death were recorded for 25.1% of all the deaths in the deaths notification database.

3.1.2.2 Assault cases in the Injury Surveillance System

The information in this system was from 19 hospitals (which could follow the trend from 2000-2004). All were severe injury cases (deaths, cases observed at ER or admitted). From the reported cases, it was estimated that 29 548–49 060 persons per year were assaulted, resulting in severe injuries.

The trend increased steadily from 2001 then rapidly increased to a peak in 2003 before decreasing slightly in 2004.¹⁹ (Fig. 10)

In 2004, most of severely injured from assaults were 20–24 years of age followed by the 15–19 and 25–29 age groups. These three groups alone accounted for 62% of total reported cases. The male to female ratio was 7.3: 1. (Fig. 12)

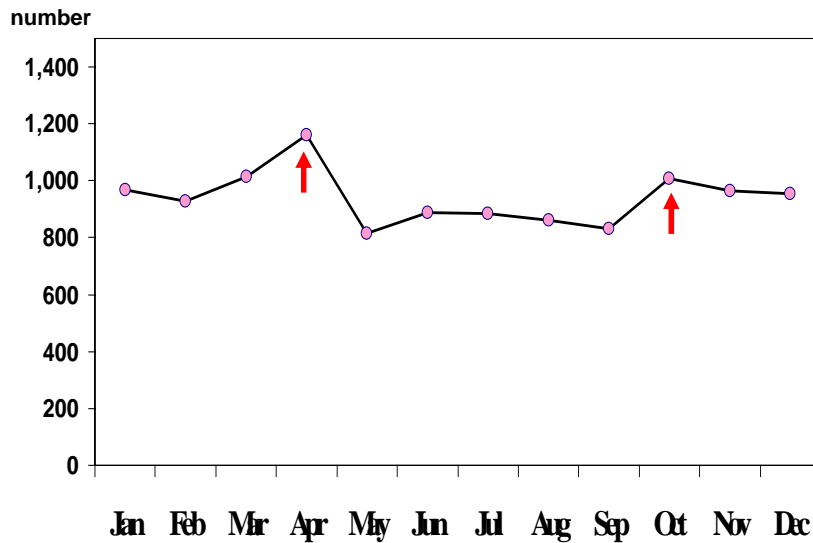


Sources : 19 sentinel hospitals, National Injury Surveillance,
Bureau of Epidemiology, Ministry of Public Health, Thailand¹⁹

Labourers were the occupation which accounted for the highest proportion of injuries (50.4%) followed by students (14.3%) and farmers (11.6%). The same rank and order was found for fatal and non-fatal cases.

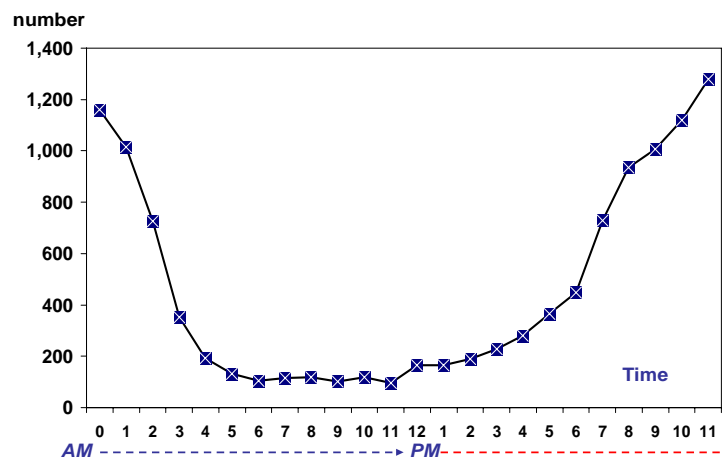
The events occurred mostly on Sunday, followed with Saturday and Friday. For the severely injured, the number peaked in April with a second lower peak in November. The event mostly occurred at later night time from (17.00 – 03.00). (Figures 13,14)¹⁹.

Figure 13 Number of severe injury assaults by month, Thailand, 2000-2004



Sources : 19 sentinel hospitals, National Injury Surveillance, Bureau of Epidemiology, Ministry of Public Health, Thailand ¹⁹

Figure 14 Number of fatal injuries from assault by time injury occurred, Thailand, 2000-2004



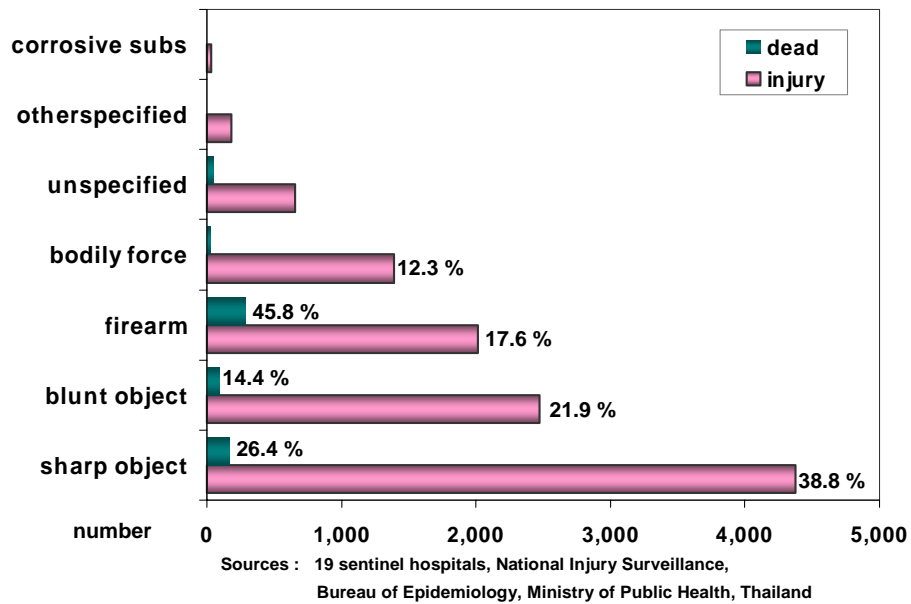
Sources : 19 sentinel hospitals, National Injury Surveillance, Bureau of Epidemiology, Ministry of Public Health, Thailand ¹⁹

Home and vicinity was the most common place, accounting for 39% of assault injuries, followed with streets and highways (25%), and trade and services areas (20%). The same rank and order was found in the deaths from severe injury from assaults with little difference in proportion.

Method of assault

Most of the severely injured were assaulted by sharp objects (38.3%), blunt objects (21.9%) guns (17.6%). In the severely injured who died, most of the severely injured was assaulted by guns (45%) and by sharp objects and blunt objects in equal proportion (26.4%), (Figure 15)

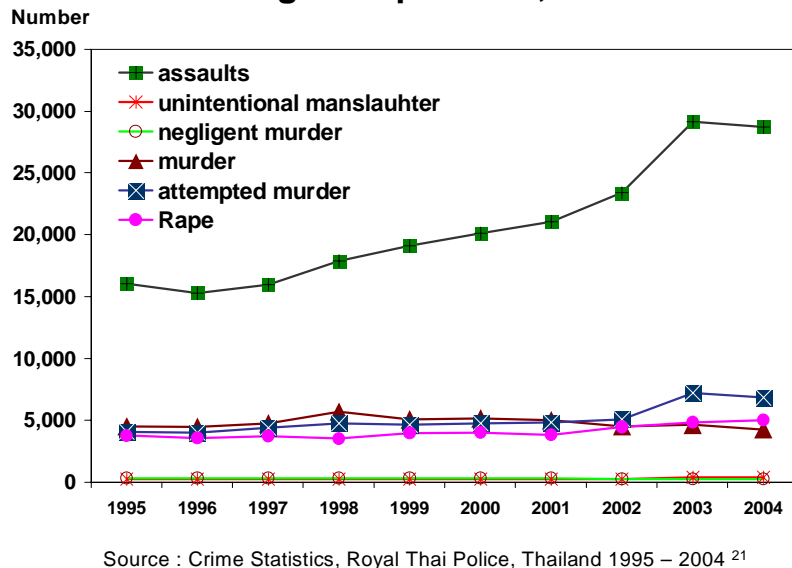
Figure 15 Proportion of severe injuries from assault by method/object of injured, Thailand, 2000-2004



3.1.2.3 Assaults cases according to Royal Thai Police Statistics

This research studied crimes report which covers the most of violent events and analyzed the trend of cases recorded in Royal Thai Police database from 1995 to 2004 as follows:²¹

Figure 16 Reported “crimes against person”, 1995-2004



Crimes against life, body, and sex (figure 16)²¹

1) Assaults

In 1995, there were 16 053 reported cases of assault. This decreased in 1996-1997 and then increased continuously to 23 412 records in the year 2002. Assaults spiked in 2003-2004 (29 166 records in 2003 and 28 714 records in 2004). A remarkable upwards trend was seen from 1995 to 2004.

2) Unintentional manslaughter

This type of case involves intentional harm to other people, but the act is not meant to kill (considering from the characters of assault), however, the victims lost their lives as a consequence of the injury events.

In 1995, there were 241 cases, decreasing to 238 in 1996. In 1997-2002, there were 230–277 cases per year. Then it increased to 346 in 2003 and 351 in 2004, meaning an increasing trend from 1995 to 2004.

3) Negligent manslaughter

This type of case is an injury event without intention to harm, or so-called “accidents”, in which epidemiologic approach and ICD-10 11 do not include in intentional injury, therefore this group was not taken into account for this report.

4) Murder

In 1995, there were 4542 murders recorded. This decreased to 4474 in 1996. A marked increase was found in 1998 and decrease to 5020–5140 over 1999-2001. There was a decrease in 2002 and then increase to 4634 cases in 2003 and then a fallback to 4278 cases in 2004. Murder had slight decreasing trend from 1995 to 2004.

5) Attempted murder

This type of case, some may be only the planning for action and may not have direct impact as injury or deaths but can indicate violence in society.

There were approximately 4000 cases of attempted murder in 1995. The number decreased in 1996 but increased gradually until reaching a peak in 2003, before falling to 6845 cases in 2004. An increasing trend was seen from 1995 to 2004 with an abnormal peak in 2003–04.

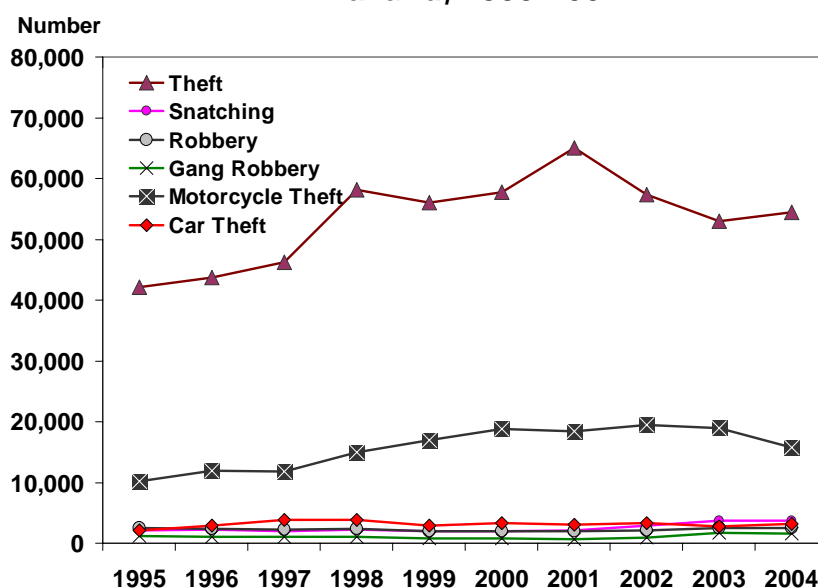
6) Rape

In 1995, there were 3756 incidents of rape, plateauing between 3516 to 4020 rapes from 1996–2001 and then rapidly increasing to 4435, 4811 and 5041 in 2002–2004. An increasing trend was seen from 1995 to 2004, with a peak in 2003–04.

Crimes against property ²¹

This includes theft, snatching, robbery and gang-robbery. There were 58 653 cases in 1995, and increased to 68 569 cases in 1997, 68 906 cases in 2002 and 68 665 cases in 2004. An increasing trend was seen from 1995 to 2004. Car and motorcycle theft were higher than others and also increased from 1995 to 2004 (Figure 17) ²¹

Figure 17 Reported property crimes in Thailand, 1995-2004



Source : Crimes Statistics, Royal Thai Police, Thailand 1995 – 2004 ²¹

*Victimless crimes*²¹

These includes crimes against the Drug Abuse Act, the Prostitution Engagement Act, the Gambling Act, the Firearms Act and the Pornography Act, crimes associated with possession of offensive weapons. (Figure 18)²¹

1) Offensive weapons

There were 14 102 cases in 1995, with a peak of 24 334 cases in 2003 dropping back to 19 160 in 2004.

2) Gambling

There were 103 982 cases in 1995, stabilizing at between 102 722 and 107 482 cases/year up to 1998, then decreased to 81 527–91 367 cases/year from 1999-2003 and decreased to 77 866 cases/year in 2004.

3) Narcotics

There were 149 452 cases in 1995, increasing in the following year and abruptly decreasing again in 1997 (69 963 cases). There was an increase from 1998 (225 252 cases/year) before further decrease in 2003 (123 786 cases) and 2004 (74 121 cases).

4) Prostitution

There were 7833 cases in 1995, and the number of cases fluctuated, but there was a very high number in 1997 (176 307 cases), 26 897 cases in 2004 and 25 559 cases in 2003.²¹ (Figure 18)

Characteristics of Crimes^{8, 20, 22}

The Bureau of Royal Thai Police analyzed the crime characteristics in order to know the gender of the victims and perpetrators of the violence, time and place of violence, and weapons used for the planning of violence prevention.²²

1) Assault

In 2000, there were 20 360 cases, a 10% increase from 1999. The rate was 33/100 000 population. There were 14 640 arrest cases. (71.9%). It should be noted that the proportion of female victims increased from 9% in 1998, as well as the proportion of the accused females, from 4% in 1998.⁸

Victim	Percent	Accused person	Percent
Male	73	Male	86
Female	25	Female	9
Children and Youth	4	Children and Youth	10

Time of event: the most common time of crimes (37%) was 18-24 hr., and 12-18 hr, (25%). There were 18% and 17% from 0-6 and 6-12 hr, respectively.^{8, 22}

Scene of crime: the most common places (29%) were at home. Entertainment places and government offices were approximately equal in proportions (2%). However, the biggest category (64%) was unidentified place, which was higher than 49% in 1998.

Method of assault: the biggest proportion was assault by physical force (38%), followed by use of objects (17%) and opportunistic assault (8%). Data was missing for 40% of the cases.²⁰

Object used in assault: 82% did not specify the object used. Knife was the biggest proportion among the known category (7%), and followed by blunt objects. (4%).²⁰

Cause: Quarrelling was the biggest category of cause of assault (34%), followed by uncontrollable anger (9%), vengeance (3%) and affairs (1%). Unidentified cause accounted for 45% of the reports.^{8, 22}

2) Murder

In 2000, there were 8258 cases, an 11.6 % increase from 1999. The murder rate was 13.4/100 000 population. The number of arrested perpetrators was 2043.⁸

The characteristics of the crimes were:

Victim	Percent	Accused person	Percent
Male	75.3	Male	92.8
Female	23.5	Female	4.7
Children and youth	1.2	Children and youth	3.1

Scene of murder: 37% of homicides occurred at home, 2.7% were in abandoned places or buildings. Unidentified places took accounted for 54% of the reports, which was higher than in 1998 (43%).^{8, 22}

Method of murder: most of them were killed by some kinds of objects (36%), opportunistic murder (14%) and physical power (5%). Missing data on the method was 44% of cases.^{8, 22}

Object used in murder: 39% used gun or firearms, and 9% used knife. The rest were sharp or blunt objects, 3% each. Unidentified objects took accounted for 40% of the reports, 2% increase from 1998.^{8, 22}

Cause: Quarrelling was the biggest category of cause of murder (13%), vengeance (6%), uncontrollable anger (5.6%), conflict of interest (4%), adultery (3%), and drunk (1.4%). Other causes were induced by other people, and drug abuse. Unidentified cause took accounted for 66% of the reports, 2% increase from 1998.^{8, 22}

3) Rape

In 2000, there were 4037 cases of rape, a 0.9% increase from 1999. The rate was 6.54 /100 000 population. The number of arrested perpetrators was 2625. The characteristics of the crimes were as follows:

Victim	Percent	Accused person	Percent
Male	0	Male	90
Female	91	Female	0.8
Children and youth	9	Children and youth	9

Time of occurrence: the most common time of crimes was 1800-2400 (34%), and for the hours of 600-1200 and 1200-1800, there were approximately 20% each. The lowest number of events was during 000-600 hr (18%).^{8, 22}

Scene of crime: 55% occurred at home, 10% were in a government office. Abandoned places or buildings, entertainment places, and public places represented about 3-5%.

Methods: opportunistic event (38%), using physical power (6%). Missing data on the method was 55.9% of cases.²⁰

Causes: “Affair” was the biggest category of cause of rape (36%). Two percent were “induced by others” while “drunkenness” was to blame for 1%. Unidentified causes accounted for 61% of the reports.

4) Rape and murder

In 2000, there were only two reports of rape and murder, a big drop from 1998 when 24 cases were recorded. The rate was 0.003/100 000. Owing to very few cases in 2000, the characteristics of cases were drawn from the 1998 data.⁸

Victim	Percent	Accused person	Percent
Female	92	Male	92
Children and youth	8	Children and youth	8

Time of occurrence: the most common time of crimes was 12-18 hr (44%), and 18-24 hr (22%). Other periods were found equally (11% each).^{8, 22}

Scene of crime: 70% occurred at abandoned places or buildings, 13% were at home, 8% were entertainment places, 5% were at government buildings and 4% at public places.^{8, 22}

Method: most of cases used physical power (44%), using weapons, such as blunt objects, sharp objects and knife was 11% each. Missing data on the method was 44% of cases.²⁰

Cause: The majority of rape-murders took place in order to cover-up the event (56%), affairs (33%), and intoxication (11%).²⁰

5) Gang robbery

In 2000, there were 790 reports of gang robbery, which was 8% reduction from the number in 1999; the rate was 1.3/100 000. The arrest case rate was 8%.⁸

Victim	Percent	Accused persons	Percent
Male	70	Male	90
Female	27	Female	6
Children and youth	3	Children and youth	3

Time of occurrence: the most common time of crimes (35%) was 000-600 and 1800-2400 (31%). 16% of cases took place from 1200-1800.

Place of occurrence: 29% occurred at home. Religious places and public places were about 2% each.

Methods: most of cases used weapons (19%), opportunistic occurrence (16%), and physical power (12%). Missing data on the method was 41% of cases.⁸

6) Snatching

In 2000, there were 2032 reports of snatching, which was 3% increase from the number in 1999; the rate was 3.3/ 100 000. The number of arrests was 1100.⁸

Victim	Percent	Accused persons	Percent
Male	52	Male	92
Female	46	Female	4
Children and youth	3	Children and youth	4

Time of occurrence: the most common time of crimes (26% each) was 1200-1800 and 1800-2400. 25% of cases took place during 600-1200.^{8, 22}

Places of occurrence: 25% occurred at home. Public places accounted for about 2%. Data was missing in 69% of cases.^{8, 22}

Methods: most of the known cases used weapons (18%), opportunistic occurrence (15%), and physical power (12%). Missing data on the method was 44% of cases.^{8, 22}

7) Robbery

In 2000, there were 68 334 reports of robbery, which was 4% increase from the number in 1999. The rate was 110.8/100 000. There were 29 024 arrests.⁸

Victim	Percent	Accused persons	Percent
Male	74.71	Male	75.55
Female	24.95	Female	14.83
Children and youth	0.34	Children and youth	9.62

Time of occurrence: the most common time for occurrence of crimes were 600-1200 (36%). 34% were between 1200-1800 and 14% during 1800-2400. 9% of cases happened between 000 and 600.^{8, 22}

Place of occurrence: 93% occurred at home, 3% in government offices and 2% in a religious place.^{8, 22}

Methods: most of cases were opportunistic (53%), followed by invasion through doors (5%). Data was missing in 42% of cases.^{8, 22}

3.1.2.4 Assault data from the Behavioural Risk Factors Surveillance System⁹

There was a survey in 2004 covering 10 provinces in the north, 11 central provinces, 10 provinces in the northeast, 10 provinces in the south and with 59 109 subjects.

<i>Age group</i>	Municipality area			Outside municipality area		
	male	female	total	male	female	total
15-39	4,896	4,917	9,813	4,917	4,937	9,854
40-59	4,969	4,997	9,966	4,958	4,969	9,927
60 +	4,912	4,975	9,887	4,785	4,874	9,659
Total	14,777	14,889	29,666	14,660	14,783	29,443

In terms of the severity of assaults, it was found that males were more prone to be hurt physically than females in every age group. Young people were more likely to be hurt physically than older people.

The prevalence of injury among 15-39 years old was 11.22%, among 40-59 years old 8.03% and among 60 years and older, 7.94%. 9.35% of population over 15 years of age reported that they had ever been assaulted. The highest prevalence rate was observed in Phatthalung (29.89%) which is in the south, Yasothon (14.84%) which is in the northeast and Ranong (14.63%)

10.85-74.15% of victims observed that their perpetrators were drunk. 2.20%-46.72% went to seek medical care after the occurrence. Most of perpetrators were friends, acquaintances, lovers, relatives and parents. Only a few were hurt by strangers.

3.1.2.5 Related factors from various sources

Victims and perpetrators

Their characteristics were almost the same, such as age between 15-24 years, had primary school education, married and were labourers or agriculturists. 37% of the cases, victim and perpetrator were acquaintances, 10% were friends, family members, relatives or lovers. This was quite similar to a report in the USA in 1980.²⁰

Causes and risk factors

Except the use of alcohol in the injured which is well monitored by the Thai IS, these could be described in more detail in the research results.

Alcohol

Alcohol was the major risk factor found in both the injured and perpetrators in a study in Chantaburi province. Use of alcohol was reported to be at 51.9% among the assault victims and 67.6% in their perpetrators. This risk factor was reported in a smaller proportion in the severely injured reports in 2000 (48.3%) and 56% of severely injured persons in 2004 according to national injury surveillance data.²³ The proportions of alcohol use in the severely injured were particularly high in the northern, northeastern and eastern regions.²⁰

Circumstances

The circumstances which led to assaults were quarrelling (20%), sexual harassment (18%) and uncontrolled anger (11%). All of these related to ability or skills to assess situations, coping with strong emotions and control of own behaviours.²⁴

Most of the injured were assaulted while resting (70%).²⁰

Place of occurrence

Many of the assault events occurred at home²⁰ (approximately 30%-40%) but most of the database does not contain the information on whose home it was. This could be obtained only from research. It was found in a study in Nakhon Sri Thammarat province in the south of Thailand that most house assaults occurred in the house of the victim. This was from a police report that found a total of 33% of assaults took place in houses, 18% of which were the victim's house, 5% at the perpetrator's house and 10% in other houses.

A study in Chantaburi Province in the east confirmed the finding again recently with 37.5% of the injuries from assaults (all ER and admitted cases) occurring in a home. Of these, 57.1% occurred at the injured person's home, 14.3% at the house of the victim's friend.²⁴

The second most common place of occurrence was streets (19.6%) and restaurant (16%).²⁴

According to geographic location, the assault rate was highest in the southern part of Thailand.²²

Methods of assaults

According to the study in Chantaburi Province, the most common method of assault was the use of human force (kicking or punching) 42%, followed by use of glass bottles of water or wine (26%).²³

Generally, the fatal cases assaults were usually injured by more harmful methods such as guns or knife and the less severe cases were injured by a knee, elbow, head, fist or foot of the perpetrator, blunt objects, glass bottles or glasses.²³

The observed trends from different databases only show the change in situations of violence in Thai society. These differences may be due to the changes in reporting and recording system, or the changes in social conditions or changes in political constraints.

A review of violence in Thailand and its characteristics, together with the potential of the country to prevent and control violence, would assist administrators and academics to understand more clearly and be able to systematically and scientifically plan for injury and violence prevention. It should be emphasized that violence is preventable, and avoidable, via the creation of proper policy, plans, and community participation.

3.1.3 Violence towards subgroups of population

3.1.3.1 Children

In the past five years, number and proportion of children under 15 years of age has reduced, from 2000 with 15 874 957 (25.7% of the population) to 13 770 137 in 2004 (20.0%). (Table 6) Southern Thailand has the largest proportion of children to its total population (25.2%), followed by the Northeast (22.7%). The North has the least (20.2%). (Table 5)

Table 5 Number and percentages of children under 15 years of age, midyear population, 2000-2004²

Midyear population	2000	2001	2002	2003	2004
All ages	61 770 259	62 093 855	62 554 380	62 939 819	62 526 693
>15 years old	15 874 957	15 833 933	14 074 736	14 035 580	13 770 137
Column %	25.7	25.5	22.7	22.3	20.0

Sources: Public Health Statistics 2004, Bureau of Health Policy and Strategy, MOPH²

Table 6 Number of children under 15 years, midyear population 2004, by region

Population	Bangkok					
	Country	Central	Northeast	North	South	
All ages	62 526 693	5 739 369	14 892 055	21 463 562	11 965 435	8 466 272
>15 years old	13 770 137	1 165 345	3 171 104	4 878 639	2 420 248	2 134 801
Column %	22.0	20.3	21.3	22.7	20.2	25.2

Sources: Public Health Statistics 2004, Bureau of Health Policy and Strategy, MOPH²

In 2004, the number of children was 13 770 137 or 22.0% of total population. The Northeast has the largest number of children (4 878 639) and largest proportion of total number of children of the whole country (35.4%), followed by Central (3 171 104 or 23.0%), North (2 420 248 or 17.6%), South (2 134 801 or 13.5%) and Bangkok (1 165 345 or 8.5%).² (Figure 19)

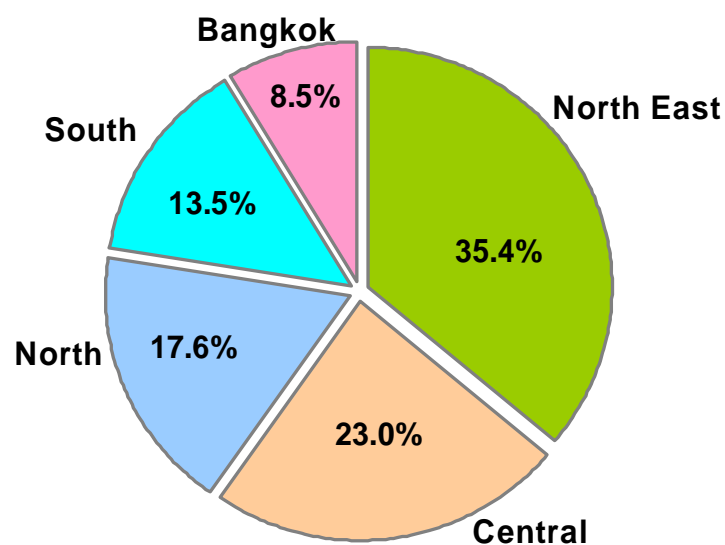
Leading causes of death among children less than 15 years

From mortality data, drowning is the major cause of death in children under 15 years of age, at 1000–1400 per year (death rate 4.8-10.7 per 100 000). The second rank was traffic accidents (death rate 5.5 per 100 000).²⁵ The study on causes of mortality in Thailand in 2000 using verbal autopsy found that drowning was also the major cause of death among children aged 1-4 years old.²⁶

The deaths due to assaults and intentional self-harm were sixth and seventh-most prevalent (death rate 0.3–0.2 per 100 000 respectively). The number of deaths in children due to these two causes was 70-80 persons per year, which accounted for 1.1% and 0.8% of all deaths among children respectively.²⁷

From *National Injury Surveillance*, reporting from 26 sentinel hospitals in 2004, it was estimated that approximately 1200 Thai children suffered severe injury from assaults annually (2% of severely injured children from all causes of injuries at this age). Intentional self-harm seriously injured 600 children per year (1% of injuries for the age group). (Table 8)²⁷

Figure 19 Proportion of children population by region Thailand, 2004 (Total 13, 770, 137 pop.)



Source : Public Health Statistic 2004, Bureau of Health Policy and Strategy, Ministry of Public Health ²

Table 7 Ten leading causes of DALYS in children under 15 years of age, by sex, 1999

Cause (Male)	%	Cause (Female)	%
1. Low birth weight	12	1. Low birth weight	13
2. Birth trauma and asphyxia	8	2. Birth trauma and asphyxia	9
3. HIV/AIDS	6	3. Lower respiratory tract infections	7
4. Drowning	5	4. Congenital heart disease	6
5. Lower respiratory tract infections	5	5. HIV/AIDS	6
6. Traffic accidents	5	6. Anemia	6
7. Asthma	4	7. Asthma	4
8. Congenital heart disease	4	8. Drowning	4
9. Anemia	4	9. Diarrhea	3
10. Deafness	2	10. Traffic accidents	3

Source: The study on Burden of Diseases and Injuries in Thailand, 1999
Bureau of Health Policy and Strategy, MOPH⁴

Table 8 Causes of severe injury among children under 15 years of age, 2003–2004

Causes of severe injury	2003		2004		Whole country Estimated no. injuries(deaths)
	26 hospitals		26 hospitals		
	n	%	n	%	
1. Transport	8123	38.6	8273	38.2	24 183 (953)
2. Falls	5856	27.8	6047	27.9	17 676 (53)
3. Inanimate mechanical forces	3529	16.8	3642	16.8	13 840 (82)
4. Animated mechanical forces	743	3.5	780	3.6	2280 (6)
5. Drowning and submersion*	325	1.5	352	1.6	1029 (488)
6. Other accidental threats to breathing	53	0.3	36	0.2	105 (3)
7. Electric current, radiation and extreme	114	0.5	129	0.6	377 (32)
8. Smoke, fire and flames	100	0.5	115	0.5	336 (20)
9. Heat and hot substances	355	1.7	386	1.8	1128 (12)
10. Venomous animals and plants	711	3.4	736	3.4	2151 (32)
11. Forces of nature	4	0.0	19	0.1	56 (6)
12. Poisoning by exposure to noxious substances	380	1.8	383	1.8	1120 (12)
13. Overexertion, travel and privation	29	0.1	27	0.1	79 (0)
14. Other and unspecified factors	16	0.1	24	0.1	70 (3)
15. Intentional self-harm	151	0.7	200	0.9	585 (12)
16. Assaults	421	2.0	392	1.8	1146 (41)
17. Event of undetermined intent	52	0.2	53	0.2	155 (15)
18. Legal intervention and operations of war	0	0.0	0	0.0	0(0)
19. Unspecified event and unspecified intent	89	0.4	53	0.2	155 (23)
Total	21 051	100.0	21 647	100.0	63 276 (1792)

Source: National Injury Surveillance System, Thailand 2003–2004 (26 sentinel hospitals)²⁷

Note: *Drowning has a lower rank than in mortality reports in the death certificate system because bodies are often taken straight to the temple for funeral purposes.

Table 9 Number of children under 15 years of age severely injured by assaults

Assaults	1998	1999	2000	2001	2002	2003	2004
	Number						
Severe injuries	722	739	1,031	1000	945	1276	1151
Fatal injuries	33	43	65	38	27	27	33

Source: Estimated from National Injury Surveillance System, Thailand 1998-2004
(14 sentinel hospitals)

Note: Severely injured cases means persons who got injuries not more than seven days before coming to hospital, attending emergency room and were kept under hospital observation, were admitted into wards, or died due to the event.

Violence against children and child negligence

The classification of age for children in Thailand was formerly defined by health personnel, considering the stage of puberty. More recently, the Child Protection Act 2003 states that the term “children” refers to persons under 18 years old which is in accordance with Agreement on Children’s Rights proposed by Humanity Commission of the United Nations which enacted since 26 April 2002.²⁸ Therefore, in this report, the term “children” refers to either the age 15 years and under or 18 years and under, depending on the references cited.^{28,29}

The Mortality Report 1999-2004, revealed that there were 3044–4829 deaths due to homicide, 1.3% of which were children under 15 years. The highest number of children deaths and injuries were found in 2003.²⁵

*Report from the National Injury Surveillance System in 2003*³⁰ showed that the number of severely injured children increased by 37% as compared to 1998. This finding was the same as mortality report and police report, where the highest number was also recorded in 2003.(Table 9) The majority of severely injured children were between 10 and 14 years of age (78.0%). 78.0% were male. The summary data classified by sex was as follows:

- girls assaulted:
 - sexually 44%
 - by physical force 21%
 - by blunt objects 18%
- boys assaulted:
 - by blunt objects 28%
 - by physical force 27%
 - by sharp objects 22%
 - by firearms 13%

From *Khon Kaen Hospital report 2001-2004*³¹, it was found that the majority of assault cases involved victims under 19 years old (85.7%). 57.5% were primary school students, 22.4% were secondary school students. Most of them were assaulted by acquaintances, such as father, mother, friend, boyfriend and relatives. Only 7.1% were assaulted by strangers.

The Department of Health Service Support, Ministry of Public Health³², analyzed the reports from 72 One Stop Crisis Centers (OSCC), a new service set up in government provincial hospitals to support women and children who have been victims of violence. The cases and some characteristics of the cases seen by OSCCs all over the country during October 2003-September 2004 were as follows:

There were 132 abandoned persons (4.2%), 65.9% of whom were children under 15 years. 34% of assault victims were under 15 and the types of assaults were:

- sexual abuse 68%
- physical abuse 21%
- psychological abuse 8%
- neglect 3%

Most of the cases (71%) occurred at the child's house. 13% occurred in deserted buildings.

A report from a One Stop Crisis Center in Khon Kaen Province in January-December 2004 showed the characteristics of victims as follows:

- 85.5% were female, age 1-60 years
- 58.5% single, 34.6% married
- 54.2% were labourers/agriculturists/fishermen
- 34.4% were students
- 54.7% had primary education, 22.8% completed junior high schools.

From the report of Children's Rights Protection Center³³ the number of 4465 victims supported from 1981 to 2003 was. They were:

- sexually abused 32%
- child prostitutes 30%
- physically abused 12%

A study at the Police Hospital in Bangkok³⁴ on the users of child services (less than 15 years old) and female victims from violence over 15 years of age during 2000-2002, recorded 783 assaulted children. Almost all (97.2%) were girls. In 2002, the number of assaulted children which came for the services was almost double that of 2000. 72.6% were in schools and 7.3% were preschool children. Half of them stayed with both parents (49.8%). 43.9% lived with single parents (father or mother), of which 59.8% lived with either father or mother.

The Association for the Promotion of the Status of Women (under the Royal Patronage of HRH Princess Soam Sawali)³⁵ reviewed the documents of police records and estimated that, on average, two children (under 15) were raped each day. It also reported that the number of rape cases that were brought to court in 2002 doubled when compared to 1992. It also reported on children (<19 year old) and women who got support from the association after being assaulted (physically harm, rape, unwanted pregnancy) between August 2000 and April 2005 as follows:

- Number of victims supported: 47 379
- <19 years old 47%
- <9 years old 21%

From the report of Sri Thanya Psychiatric Hospital in 2000-2004³⁶, the number of assaulted children admitted to hospital increased gradually and increased six-fold from 2000, and accounted for 81.1% of severely injured children hospitalized there.

The Emergency Home (Association for the Promotion of the Status of Women)³⁷ reported that there was at least one abandoned child each day.

- The perpetrators were boyfriend/friend (36%), family member (16%), stranger (12%), and father of the victim (4%).
- 56% were labourers
- Circumstances and other related factors:
 - victim's house 67-71%
 - opportunistic event 52%
 - deserted place 14.3%
 - pornography-related 13%
 - drug-related 4%

From the same study in the Police Hospital in Bangkok, the incidence of pregnancy and HIV infection among physically-abused children admitted was:³⁴

- pregnancy 5%
- HIV infection 1%

Perpetrator

The national injury surveillance system, though providing timely information sufficiently on the victims, does not contain the information on perpetrator.

The Police database contains most of the information on perpetrators and has been stated previously. The following offender information is from other databases, of which the OSCC is the largest:³²

- OSCC reported that in 44.9% of cases, perpetrators were lovers or friends, 13.3% were acquaintance or friends.
- 55.5% were labourers/agriculturists/ fishermen,
- 9.7% were students.
- 82.2% were 23-25 years of age, and most of them often entertained themselves with pornography.
- Assaults were done with curiosity, with pornography and friends as catalyst.
- 36% were lovers/friends of their victims, 16% were family members, 12% were strangers and 4% were the victim's father.
- Children who were in family with violence were psychologically affected and might be perpetrators when they grew up. 90% of violence in family appeared in front of a child.²⁸

Children as perpetrators

The Department of Juvenile Observation and Protection, Ministry of Justice³⁸ reported the number of children (<18 years old) in juvenile delinquency homes, classified by act committed; crimes related to narcotics are the biggest category, followed by sex-related acts. (Table 10)

Table 10 Number of children in juvenile delinquency home, by act

	2001	2002	2003	2004
- Sex-related	1026	1479	1735	2417
Sexual harassment	244	299	289	360
Rape	3	543	630	942
Attempted rape	42	49	41	82
Kidnap	314	474	585	778
Gang rape	437	108	184	239
Attempted sexual wrongdoing	6	5	6	16
- Narcotics	16 563	16 732	8597	5310
- Guns and bombs	933	1380	1957	2424
- Gambling	847	1155	1393	1844

Source: Department of Juvenile Observation and Protection, Ministry of Justice³⁸
(<http://www.moj.go.th>)

3.1.3.2 Violence against women, in the family and married life

Most of the cases of violence against women were studied and reported together with family violence as domestic violence.

The Office of Women and Family Affairs, Ministry of Social Development and Human Security³⁹ has defined violence in family as “the behaviour of forcing, brutalizing, compelling, offending, bodily and psychologically harm, etc, by family members”. This could be manifested in many forms, and most of the victims were women, children and elderly. Several forms of violence were:

Bodily harm: Punching, slapping, kicking, pushing, shaking, and using weapons

Psychological harm: forcing, threatening, emotional oppression, using rude words, cursing, humiliation, etc.

Sexual abuse: rape, obscene, sexually harassment (verbal or physical).

Social blockage: prohibition of social communication with friends, relatives, in order to keep someone away from outside world.

Monetary control: prohibition of spending and monopolizing of decisions on expenditure for herself/himself and for the family.³⁰

Situation and trends

The National Injury Surveillance Report 2000-2004 from the Bureau of Epidemiology, Ministry of Public Health¹⁹ showed that the number of severely injured women peaked in 2003. (Table 11)

Table 11 Estimated total of severely injured cases seen at hospital ERs, Thailand

Year	2000	2001	2002	2003	2004
Total	29 548	29 660	33 452	49 060	45 104
Male	24 936	25 136	28 692	43 452	39 692
Female	4612	4524	4760	5608	5412

Source: Estimated data from 19 sentinel hospitals, National Injury Surveillance Network, Bureau of Epidemiology, Ministry of Public Health¹⁹

On the average, 12-15 injured women die or are severely injured by assaults each day. A comparative study by the Institute for Population and Social Research, Mahidol University, in

cooperation with Women Foundation, conducted a survey of 3000 women aged 15-49 years in Bangkok and another province.²⁸ It found that:

- 23% of women in Bangkok and 34% of women in the province were assaulted physically by her intimate partner.
- about half of women in both provinces had experienced physical and/or sexual violence (41% in Bangkok and 47% in that province). The estimated number for the whole country was 5.4 million, and of those, 500 000 were women who were sexually abused before the age of 15.
- about half of the injured women in both provinces were assaulted more than once in their lives. The proportion of women sexually abused by non-family members was almost double in Bangkok compared to the other province (14% compared to 8%).
- one third of physically, severely injured women did not seek medical care, even though they suffered both physical and psychological injury. They also did not seek medical care when they were abused during childhood.
- women had very few choices in responding to the violence problem. In Thai culture and social values, violence in the family is considered a personal or family matter which should not let be disclosed to others. So most injured women stay quiet and seek no consultation.
- injured women had no information on resources for assistance, either governmental or private. Health care access is also a problem. Moreover, these agencies are usually available at provincial level only.
- women who have children tend to keep quiet because they do not want to leave their children.
- injured women who seek medical care do not always tell the truth about the cause of injury to doctors.³⁹

Risk groups and risk factors

Research results revealed clearly the connection between violence, attitude, social values and the relationship between men and women in society, which is rooted in communication in family, school and mass media.³⁹

- Perpetrators and victims usually came from families with violence. This has made violence socially acceptable from their point of view.
- There is a common attitude in society that men have power and rights over women.
- A study in 2003 revealed that injured women seeking medical care at seven government hospitals in every region including Bangkok were mostly of 15-24 years of age (26%); the next largest group was 35-44 years (26%). 63% attended the outpatient department. The perpetrators were husband or lover (62%), live-in intimate partner (57%), of whom 17% were legally married, and 7% were intimate partners not living together. The other perpetrators were relatives (13%), ex-husband or ex-lover (9%) and acquaintances (9%). The time of event were mostly in the evening, 1800-2400 (43%).³⁷
- The causes of violence were jealousy, the perpetrator's flirting behaviour, unmanageable separation (36%), economic or debt problems (18%) and violence provoked by the victim (10%).³⁷

- For family violence caused by a husband, 26% were in the first four years of marriage, 22% had been married for less than a year, and others were at the 5-9 years and 10-19 year stage of marriage (17% each). 31% of the victims were labourers, 20% were students, 12% had no occupation or were housewives, 42% had primary education, 17% had secondary education, and 10% had no formal education.³⁷
- 39% of perpetrators were drunk at the time. 18% of victims were drunk. However 59% of victims were sober, 36% were occasional drinkers and 4% were routine drinkers.³⁷
- The biggest proportion of victims had a quiet personality (30%), or grumbled (25%). Some ridiculed the attacker (19%) or were aggressive (17%).³⁷
- The biggest proportion of injured persons aged under 15 years were in the south (10%) and in the central (10%), the second biggest were in the northeastern.³⁷

Method of assaults The reports from Siriraj Hospital and Vachira Hospital revealed that the injured women were kicked, punched, or pushed (72%).⁴⁰ Data from the injury surveillance system; Bureau of Epidemiology reported that the injured women were assaulted by physical force (33%), blunt materials (23%) and sharp materials (16%). Among the deaths, 54% were assaulted by gun, 10% were assaulted by blunt materials, and another 10% were assaulted by sharp materials.¹⁹

3.1.3.3 Sexual violence

In March 2004, a report on rape by the Office of Women's Affairs and Family Institution stated that there were 12 rape cases per day. Four percent of the victims were under 15 years of age. Most of perpetrators were boyfriends, friends or acquaintances. Only a low percentage were assaulted by strangers. However, whenever rape occurs, social attitudes say that it occurs because the woman herself had dressed provocatively and provoked sexual feelings.⁴¹

In 2004, the number of rape cases were 5041, 25% higher than 2003 (4020 cases). Police could arrest only one third of perpetrators in these cases. Statistics on the number of cases that passed through the court and the perpetrators got their final verdicts are not available.

The data from injury surveillance system in 2003 revealed that sexual violence accounted for 8% of severely injured women. The highest proportion was in the northeast (12.2%), then the central and the south. There was no such report from the 2 large hospitals in Bangkok.

Among children under 15 years old, proportion of sexual violence that resulted in severe injuries accounted for 43.9% of all severe injuries. The highest rate was also in the northeast (56.7%), south (56.0%) and central (43.0%).³⁰

Risk groups and risk factors^{39, 42, 43}

Among 225 female victims of violence that seek medical attention at seven hospitals, 37.3% had been sexually abused, of which 88.1% were raped. 8% of them got pregnant as the consequence. The majority of victims (66.7%) were between 15-19 years of age, and 20-24 years (22.6%).⁴²

In order of occupation, the offenders were labourers (28.6%); unknown occupation (28.6%), students (19.0%), unemployed (14.3%), and government service (3.6%). In terms of the

relationship, 77.4% were acquaintances, 8.0% were boyfriends or ex-boyfriends, 7.7% were relatives, while strangers accounted for 22.6% of sex crimes.

The scene of the crime was abandoned buildings/spaces (32.15%), victim's house (23.8%), perpetrator's house (21.4%), perpetrator's friend's house (11.9%), hotel or bungalow (10.7%).⁴²

Time of the event was between 1801-2400 (42.9%), 0001-0600 (29.8%) and 1201-1800 (14.3%). 54.8% of victims arrived at ER within 24 hours, 22.6% within 1-7 days, 9.5% between 1-4 weeks later, and 10.7% delayed for more than one month. Six percent of the victims had been raped before.⁴²

90.5% of the victims reported to the police, the rest did not. 9.5% were impregnated.³⁹

It was reported from Juvenile Observation and Protection Department that sexual violence was increasing. A member of the senate stated that some youths probably think that rape is an acceptable action in his group, or among his peers. The penalty by the law is minimal, particularly if the perpetrator is under 18 years old. He also suggested that this law should be revised and that rapists should be punished severely, especially in the case of planned rape. Perpetrators who were between 14-18 years old should be sent to normal jurisdiction process in criminal court, not Youth and Family Court.⁴⁰

3.1.3.4 Violence against the elderly

The data from injury surveillance system stated that violence victims over 60 years of age accounted for approximately 3% of all injured persons. There was only one research report on neglected disabled elderly.¹²

3.1.3.5 Violence in the workplace

Few reports exist on violence in the workplace in Thailand.

- 1) A survey in the nursing profession revealed that the rate of physical violence in the workplace was 4.5–40%.^{41, 44}
- 2) Sexual harassment, either verbally or physically, was found to be present in 23–40% of workplaces. Perpetrators were colleagues and persons in superior positions. A hotline centre found that 70% of complaints on sexual harassment came from the government sector.^{41, 43}

3.1.3.6 Collective violence (riots, terrorism, legal intervention and operation of war)

Violence among youth groups

Violence among youth groups such as fights between vocational school students, within or outside their schools, was found to be mostly a male problem.

Most research results revealed that this violence was due to delinquent behaviour among students, troubles and quarrels caused in sports competitions, use of addictive substances, lack of family strength and immature personality.

A study of juvenile delinquency homes reported that violent youngsters living in such facilities had problems of personality, adaptation, poor economic status and poor family relationships. Among those who exhibited self-directed harm such as use of narcotic drugs or other addictive substances, it was found that problems in the family had an important adverse effect on children, particularly concerning drug use.

Violence among vocational school students was mainly related to lack of communication in family, and school principals did not pay enough attention and effort to stop the problem. Fights usually originated from group extra-curriculum activities, hatred of the other, lack of values assigned to study classes and grades, seeing that fighting is normal for men, and valuing of physical force in problem-solving.

Most of the research made recommendations that family had a major role in solving problems of violence in society. The application of knowledge gained from research is still not fully done because solving such problems requires cooperation among various sectors of the society. Governmental sectors are the main organizations in issuing school policy, laws on carrying guns and policy on suppression of violence in society. This includes research on the teenagers values.¹⁰

Violence in legal intervention and operation of war

V Rujivipat⁴⁵ analyzed data on injuries due to legal intervention and operations of war (ICD-10 code Y35-36) in 2002-2004 and the first half of 2005, for the whole country. She found that the highest number of events took place in 2004, and that 86.5% of the injured were male, aged 25–30 years (24%). In the fatalities group, the peak was seen in 2003, all male. The data in 2005 showed that labourers were the most likely to be injured (32.5%); the second biggest was military and police officers (25.4%).

In the fatalities group, the biggest group was also labourers (38.9%), the second biggest was military and police officers (16.7%) and the third was students (11.1%). The injury events mostly occurred on roads (49.2%). The second most common place was markets and entertainment venues (18.3%). Fatal events mostly occurred on roads (66.7%) and at home (11.1%). In 2005, 18.3% of injured persons used alcohol before the event. The figure in 2003 was 38.7% and in 2004 was 34.3%.

Violence due to civil unrest in the southern Thailand

Violence in the south of Thailand started in 2003, although its roots had been fostered for several decades. The main force behind the upsurge was presumed to be separatists connected to Muslim terrorists in other countries. Southern headquarters police reported 919 violent crimes in 2004, and 496 of them (53%) related to separatists and riots. The provinces experiencing the worst of the violence were Narathiwat province (455 events), Pattani province (276 events) and Yala province (183 events).⁴⁶

A report from Prince of Songkhla University stated that in 2004 alone, the number of violent incidents was 1.7 times higher over the previous decade. The violence continued on daily basis (mostly involving the shooting of innocent local people and border police), punctuated by the disastrous event at Grue-sae Mosque, an ancient mosque in Pattani in April 2004: a riot and a battle between 200 protestors and police. One hundred and eight protestors died, most of them in the mosque.⁴⁶

In October, there was a riot in Narathiwat where 85 protestors died, mostly during transportation on military trucks to a military station which was 80 km away.⁴⁶

Trends of injuries from several attacks during 2002-2004, using injury surveillance data of Yala regional hospital which is the sentinel site of national injury surveillance, were as seen in the following tables.⁴⁷

Table 12 Number of injuries from civil attack, 2002-2004 and male-female ratio

	2002	2003	2004
Injured persons	160	270	248
Death	15	23	28
Male : Female	11.3: 1	10.3: 1	8.2:1

Source: Injury Surveillance System, Yala regional hospital, 2002-2004⁴⁷

Table 13 Percentages (and rank*) of injured persons 2002-2004, by age group

Age group	2002	2003	2004
0-4	0	0	0.4
5-9	0	0	0
10-14	0.6	3.3	1.6
15-19	28.1***	23.8***	10.9
20-24	18.8**	21.2**	9.7
25-29	15.6*	14.9*	11.7*
30-34	10	9.7	14.5**
35-39	6.9	7.8	15.3***
40-44	5.6	7.1	14.5**
45-49	5	4.8	10.1
50-54	3.8	4.1	4.8
55-59	0.6	0.4	2
60+	5	3	4.4
Total	100	100	100

Source: Injury Surveillance System, Yala regional hospital, 2002-2004⁴⁷

Table 14 Percentages (and rank*) of injured persons 2002-2004, by occupation

Occupation	2002	2003	2004
Unskilled labourers	32.5 ***	37 ***	23.8*
Agriculturists	19.4*	13.3	11.7
Students	18.8	19.6 *	12.1
Police/Soldiers	0	0	24.6**
Other	29.3**	30**	27.8***

Source: Injury Surveillance System, Yala regional hospital, 2002-2004⁴⁷

Table 15 Percentages (and rank*) of injured persons 2002-2004, by time of event

Time of event (hr)	2002	2003	2004
0100-0300	7.5	15	3.6
0400-0600	1.2	3.9	11.2
0700-0900	2.4	19	14.*
1000-1200	1.8	6	7.2
1300-1500	9.2	8	6
1600-1800	14*	14*	14*
1900-2100	32***	23**	28.4***
2200-2400	32***	29***	14.4**

Source: Injury Surveillance System, Yala regional hospital, 2002-2004⁴⁷

Table 16 Percentages (and rank*) of injured persons 2002-2004, by place

Place	2002	2003	2004
Home/ home garden/garage	37.5***	37.4***	27.4**
Street/highway	33.1**	31.9**	41.9***
Trade/service area	15.0*	19.6*	11.3*
Other	14.4	11.1	19.4

Source: Injury Surveillance System, Yala regional hospital, 2002-2004⁵²

Table 17 Percentages (and rank*) of injured persons 2002-2004, by method

Method of assault	2002	2003	2004
Sharp object	50.0***	42.6***	25.0**
Firearm	25.6**	20.0*	40.3***
Blunt object	17.5*	23.7**	14.5*
Other	69.	13.7	20.2

Source: Injury Surveillance System, Yala regional hospital, 2002-2004⁴⁷

From the data, it was obvious that there was an increase in injury and deaths in 2003-04. There was major change in male to female ratio (more female injuries and deaths), and a shift of the most affected age group to 30-44 year olds. The occupation most commonly injured which had been labourers in 2002-03 changed to “other” in 2004. The police and military became the second most commonly-injured occupation in 2004. The most common method of assault, which was sharp objects in 2002-03, became firearms in 2004.

In 2005, S Musikarangsee and S Laoma⁴⁷ compared the severe injury data of the sentinel provinces of national injury surveillance: 1) Yala province, which was plagued by civil unrest and 2) Trang province and Songkhla province, adjacent to the south.

For Yala, the male to female ratio was higher than the other two. The age group suffering the most severe injuries in Yala was 35-44 years (29.8%), and in Songkhla and Trang was 15-24 years (42.0%). In Yala, was mostly likely time for an event was 2200–2400, but in the other two provinces the peak time was 1800-200. Alcohol drinking by the injured before injury event in Yala was 14.1% but in Songkhla and Trang was 55.7%.⁴⁷

3.2 The prevention and control of violence in Thai society

Thai law states clearly that death due to self-inflicted injury and interpersonal violence is considered a non-natural death and must undergo investigation by a medical doctor, and the case will be brought to court attention if it is a homicide. This serves as a preventative measure against violence in Thai society.

Thailand also has clear policies and plans on violence prevention and control. These include the central role and responsibility that the Ministry of Health has for prevention and control of self-harm and the role of the Ministry of Social Development and Human Security, which is responsible for prevention and control of violence against women and children, including protection.

3.2.1 Addressing prevention and control of self-harm: policy, plan and projects

The Department of Mental Health, Ministry of Public Health, is the organization responsible for prevention and control of self-harm and coordination among various concerned agencies. The government also established goals on self-harm in the National Socioeconomic and

Social Development Plan (9th period). The following outcomes were targeted by the end of the plan in 2006:⁴⁸

	Indicators	Goals
1	Reduction of mental illnesses among Thai population	Incidence of mental illnesses is reduced from 1.8% to 1.7%
2	Reduction in mental retardation among Thai population	Incidence is reduced from 1.3% to 1.2%
3	Reduction of problems due to stress	Incidence of stress is reduced from 57.8% to less than 50%
4	Reduction of attempted suicide and suicide	Incidence of attempted suicide and suicide is reduced from 35.2 per 100 000 to not more than 33.52 per 100 000
5	Reduction of drug abuse	Incidence of drug addictions is reduced from 5.6% to not more than 5.3%
6	People live happily in Thai society	At least 80% of population are happy with their lives in Thai society
7	Health care centres provide mental health care according to its qualification criteria	Health care centres provide mental health care according to their qualification criteria as follows: 1) In every province, there is at least one health care center (hospital) which provides OPD and IPD services on mental health 2) In every district, at least 50% of health care centers (hospitals and health centers) provide services on mental health according to its qualification criteria
8	Research results and body of knowledge and technology in mental health are applicable and are used fruitfully by health care workers and the public	80% of research results and body of knowledge and technology in mental health are applicable and are used fruitfully by health care workers and the public
9	Number of research papers, body of knowledge, technology on mental health	29 research papers, body of knowledge, technology on mental health are produced

10	Mentally ill persons and/or persons who have mental health problems can access care	1) Proportion of mentally ill persons and/or persons who have mental health problems who have access to care increases from 23% to 30%. 2) Proportion of mentally retarded persons who have access to care increases from 4% to 10%. 3) Proportion of persons with depression who have access to care increases from 1.7% to 5%. 4) Proportion of persons with anxiety that have access to care increases from 17.38% to 40%.
11	Increase referral rate of outpatients with mental health problems	Referral rate of outpatients with mental health problems increases to 5% of all patients attending OPD psychiatric clinic.

3.2.1.1 Suicide prevention project

Suicide is a major mental health problem in Thailand. It is considered a preventable problem, if the signs are detected early enough and mental health crisis intervention and a high-risk group surveillance system exists. The Department of Mental Health has set a target of reducing the suicide rate in the Thai population to not more than 7.7 per 100 000 by the end of FY2006.

Activities

1 Development of services and databases

1.1 Health care service system in all areas

- There are screening and surveillance systems (EP 506 DS form), including treatments and assistance in prevention and control of suicide in every health care centre all over the country.

1.2 Health care service system in high risk areas

- There is an integrative system of health promotion, suicide prevention, treatment and rehabilitation, which covers both governmental and non-governmental health services, working together with the community.
- There are surveillance systems (EP 506 DS form), and routine investigation of each suicide case.

2. Development of network potential

- 2.1 A network of resource persons for depression prevention and treatment has been developed in 37 provinces, as well as management of high risk groups. This project could be expanded to cover all provinces.

3. Technology development

- 3.1 Development and printing of learning materials in regular classes and specific training on depression prevention and treatment, as well as management of high risk groups.

- Development and printing of operational manuals on depression prevention and treatment, as well as management of high risk groups.
- Production of screening form for depression and high risk of suicide to support activities in each locality.
- Production of surveillance form (EP 506 DS).

4. Research and evaluation

- 4.1 Conducting research and publishing evaluation result from projects on suicide prevention and management of people with depression and at high risk of suicide.
- 4.2 Conducting research and publishing results on the epidemiology of suicide and self-harm behaviour.

5. Public relations and campaigns

- 5.1 Running campaigns and sharing knowledge with people in order to prevent suicide via television and radio broadcasting.

Recommendations for further activities

1. Every province administrative office must make an integrative plan for suicide prevention and control by health care services at every level.
2. Implementing the developed plan and strategies in prevention and control of suicide in a pilot area with high incidence.
3. Development of technology, surveillance forms and investigation forms for high risk groups.
4. Development of a network of resource persons to support suicide prevention and control.
5. Campaign and public relations in terms of knowledge about mental health in suicide prevention via mass media on a permanent basis.

3.2.1.2 Mental health projects in Primary Care Unit (PCU)

The Primary Care Unit (PCU) is the front-line health service facility set up under the national health insurance programme. Its main objectives are to develop health care services in Thailand to be more efficient, considering rights, freedom and equity in health care access. Moreover, PCUs are intended to be familiar with people's lifestyles and to have social contacts in the community in its responsible area. The service provides a holistic approach in health care; that is, taking care of physical health, mental health, social and spiritual well-being. In terms of health promotion, treatments and rehabilitation, it covers care at individual, family and community level, and aims at increasing community participation and self-reliance. The Department of Mental Health has integrated mental health care activities into PCUs as well.

Activities

All 29 PCUs conduct pilot projects on mental health care. Mental health care methods available in PCUs include:

- operating manuals for mental health care

- counseling on mental health

3.2.1.3 Prevention and treatment for people with depression and high-risk group for suicide project

Goals

- Reduce suicide rate to under 7/100 000.
- 75% of attempted suicide cases get continuous help to reduce the risk.
- 10% reduction of people repeatedly attempting suicide visiting health care facilities and harmonizing with others in their community.

Strategies

- Educate people in order to make them recognize those who have attempted suicide and ensure that everybody is able to get help from health care facilities.
- Improve the capacity to take care of these people and increase the number of mental health service units.
- Make continuous improvements in knowledge management.

3.2.2 Prevention and control of violence against women and children, and child negligence

Thailand is the same as many countries around the globe, the problem of violence towards women is still hidden. Mainly it is because the victims choose to endure the sufferings and do not make any complaints where the severity of the violence is lower. Therefore the perpetrator does not face legal consequences.

The first time that violence against women surfaced in the awareness of Thai society was in 1980 when health care workers and NGO officers observed that in every case of violence towards children, there always was violence towards woman also in families, then mass media started to focus on the problem and NGOs concerning women health started campaigns to reduce violence towards women. However, most violence occurring in families is still not reported. The extent and the scope of the problem is not so clear, due to the lack of information on incidence and severity. The government policy to cope with the problem was put on hold because of a lack of supportive information.

A lot of conditions are underlying causes of violence in family, including personal characteristics, social values, culture, infrastructure and environment. During years of economic crisis in Thailand, in most families, incomes were reduced, there was more unemployment and higher stress in families. In some families, quarrelling and violence increased.¹⁰ It could clearly be seen that solving and preventing violence in women and children is a single challenge. Although the proposal made by working groups on stopping violence towards women to the Cabinet did not mention violence against children, the Cabinet responded regarding both violence against women and children.

3.2.2.1 Legislation

*The 1997 Thai constitution*²⁸

The Thai constitution promulgated in 1997 was called “the people’s constitution” because it was the product of the “political reform” which started in 1992. It covers the protection of human rights, human dignity and individual rights. Slavery, adults or children, is absolutely

forbidden and using human subjects in clinical trials are not allowed unless the proposal gets full approval from certified ethical committees.

In the constitution, there are several chapters and sections that cover the protection of children, youth and family, using the principles of human rights and liberty protection without discrimination. This was due to the continuous movement by several organizations since 1980, as mentioned previously.

A special commission was set up to take care of legislation for children rights and safety. The committee includes not only the government sector but also the nongovernment sector and youth associations. Moreover, the constitution states that a National Human Rights Committee must be established, as well as Parliamentary inspectors for children, youth and family.

Sections of the constitution that directly concern violence towards children and youth are Sections 4, 5, 31 and 53.²⁸

At the international level, Thailand has signed up to many international conventions, as follows:²⁸

- Convention on the Rights of the Child (1989)
- Convention on the Elimination of All Forms of Discrimination Against Woman (1979)
- ILO Convention 182 on the Worst Forms of Child Labor (1999)
- UN Convention against Transnational Organized Crime (2001)
- UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Woman and Children (2000)
- Supplementing the UN Convention against Transnational Organized Crimes (2000)
- International Covenant on Economic, Social and Cultural Rights (1976)
- International Convention on Elimination of All Forms of Racial Discrimination (1969)
- ILO Convention 129 on Compulsory Labor Force
- ILO Convention 137 on Minimal Required Age of Children at Work

Government activities for international coordination on violence against children

- Thai government representatives attended meetings on violence control at the sub-regional, regional, and global level. These were specific group meetings with entities such as EU, ASEM, ASEAN to set the framework for assistance, welfare and law enforcement in violence victim protection, such as the Yokohama Congress, MINCON, and the Coordinated Mekong Ministerial Initiative against Trafficking (COMMIT).
- The Thai government coordinates with various agencies in prevention and control of violence against children, participates in bilateral and multilateral agreements, collaborates on research and academic issues, attends training and organizes international training courses such as CRC Sensitization in the Asia-Pacific region, in collaboration with Interpol.
- Thailand has been providing academic assistance to neighboring countries in the Mekong and Asia-Pacific region, such as organizing international conferences to sensitize other countries on children's rights violation, setting up networks with

neighboring countries and creating mechanisms and skills in evacuation, rehabilitation, and returning violence victims to their homes.

Thai legislation concerning violence in all its forms, such as physical and psychological violence and neglect include:²⁸

Laws that directly relate to violence against children:

- Thai Criminal Code
- Child Protection Act 2003

Laws that directly related to violence against children in some specific forms:

- Labor Protection Act 1998
- Prevention and Control of Prostitution Act 1996
- Prevention and Control of Women and Child Trafficking Act 1997
- Act for Prevention and Control of Money Laundering 1999
- Boxing Act 1999

Other laws that cover child protection in their legal processes:

- Criminal Procedure Code (20th issue) 1999
- Juvenile and Family Court Code, Juvenile and Family Procedure Code 1991

*Laws that have sections on child rearing and protection:*²⁸

- Guardian's duty and child rearing:
 - Child Protection Act, section 23, 25, 28;
- Negligence:
 - Criminal Procedure Act, section 306,
 - Child Protection Act, section 61;
- Child protection:
 - Child Protection Act, section 24, 26
- Sexual Abuse and Child Prostitution:
 - Criminal Procedure Code, section 276, 278, 279, 282, 283, 286;
 - Prevention and Control of Prostitution Act, section 10
- Life:
 - Criminal Procedure Act, section 288, 293, 295
- Physical and mental harm:
 - Criminal Procedure Act, section 295
- Liberty:
 - Criminal Procedure Act, section 309, 310, 312, 313, 317, 320
- Child rights in crime investigation:
 - Criminal procedure act, section 134
- Working duties and conditions:
 - Labor Protection Act, section 49, 50
- Sport competition:
 - Child Protection Act, section 26,
 - Boxing Act, section 29.
- Compensation for violence victims:

- Civil and Commerce Act, section 420
- Criminal Procedure Code
- Labor Protection Act
- MOU on bilateral cooperation for eliminating trafficking in children and woman and assisting victims of trafficking
- On punishment of juvenile delinquency:
 - Juvenile and Family Court Act, section 104;
 - Criminal Code section 76
- On protection against intimidation:
 - Child Protection Act, section 63.

Laws on rehabilitation and integrative measures for rehabilitation of victims²⁸

Child Protection Act: section 37, 40, 41, 42, 43, 44

- Crime Procedure Act: set up One Stop Services Crisis Center (OSCC)
- Prevention and Control Of Prostitution Act: vocational training of arrested women, section 14, 34
- Juvenile and Family Court Act: physical and mental rehabilitation, education and vocational training, section 55, 46
- MOU on bilateral cooperation for eliminating trafficking in children and woman and assisting victims of trafficking.

Complaints procedures

The Criminal Code states that police must take records of complaints on violence, investigate and send a complete report to prosecutors. Prosecutors would take the case to the court after careful examination of evidence. The police must take the accused person to court for further examination. If the defendant pleads guilty, the court issues its verdict. If the defendant denies the act, the court calls for witnesses on both sides before issuing the final judgment and verdicts.

- Complaints to the National Human Rights Commission

Complaints about violations of children's rights can be sent to the National Human Rights Commission. It is the Commission's duty to examine and propose remedial measures for acts which violate human rights and which are not being litigated in the court or upon which the court has already passed a final order or judgment. The complaints could be either submitted in person or by registered mail to the Office of the National Human Rights Commission or to any of its members or via a private organization. Upon receiving the complaint, the Office of the National Human Rights Commission shall, without delay, notify the petitioner or the representative. The notification shall be made no later than three days after the date the complaint is received.

- Complaints to nongovernmental organizations

The cases of violence against children can be sent to NGOs which have notification centres such as the Center for the Protection of Children's Rights Foundation, Foundation for Child Development and the Child Protection Foundation. These organizations collaborate with the concerned agencies for further assistance.

In the national plan on prevention and control of prostitution, there are several plans for evaluation of violence control. A report called “Thailand Progress Report on the Status of Implementation of the EAP Regional Commitment and Action Plan against CSEC” was presented at the Post-Yokohama Mid-term Review in November 2003.

In the national plan on human trafficking, there are action plans which give details on mechanisms for monitoring and evaluation. The national plan on prevention of violence among youths also bears action plans on mechanisms for monitoring and evaluation. Monitoring and evaluation are conducted by the Office of Welfare Promotion, Protection and Empowerment of Vulnerable groups and National Promotion and Collaboration on Youths Commission.

*Problems concerning existing laws and limitations*⁴⁹

1. Failure of Police to record cases of domestic violence

In the process of filing for divorce, a woman has to show evidence of violence, according to police and medical records. Often, such written evidence is not available, either because she did not go to hospital, or because police did not write down such events for police daily records because they are considered as a “family matter”. They almost always instruct women to return home and tend not even to converse with the husband.

It is the fact that most women did not want to send their husband to jail. What they want was to have the police to warn their husband not to do it again. But, generally, police officers do not bother with this matter.

2. The law itself makes it difficult to obtain a court filing for sexual harassment

Because procedure has to follow the criminal code, a woman must take sexual harassment complaint to the police, then the police officer gathers all evidence for court filing. These long and difficult (and embarrassing) processes make women reluctant to file.

3. Thai law still takes the wife as husband’s property

According to the criminal code, section 276, rape case applies only to *women who are not the man’s wife*. The phrase of “*is not his wife*” contradicts the government policy of “respect of woman’s rights to her body and decisions”. This is also not compliant with the constitution.

The Civil and Commercial Act, section 1445 states a man can call for compensation from another man who has sex with his wife or his fiancée. But a woman cannot make the same claim of a woman who had sex with her husband or her fiancé.

This indicates the unequal rights between male and female, and treats the wife as her husband’s property rather than as another human being.

4. Laws related to prevention of violence against women and children are not enforced seriously

Laws related to violence against children and woman which have not been strictly enforced or supported by the society include the Prevention and Control on Women and Child Trafficking Act which mentions punishment of such activities, either during preparation or during the process of trading sex or labour, both inside or outside the country. For example, if

a man has sex with a girl between 13-15 years of age, even without forcing her, this is illegal. However, later the court can allow them to marry during the imprisonment period, and the man is usually out of jail by then.

Such loopholes have allowed defendants to escape punishment and have proven to be harmful to the girl in later life. The attitude of police, who mostly see domestic violence as a family matter which should be solved without help from the authorities, has meant that police have tried to negotiate for both sides even in rape cases. This makes the problem more difficult to solve.

5. Imprisonment is a controversial remedy for family violence and rape in Thai society

An appeal court judge stated that sending a husband or rapist to jail will not help improve the situation of family relationship and would not benefit any of the parties. Husband and wife will have poor relationship after imprisonment because of sorrow and anger. Moreover, Thai society places value on beating children with sticks as good practice in case of “need”. There is a fine line between hitting with love and hitting with hatred and violence.

The long-term experience of a lawyer who works for the cases assisted by women’s foundations, Ms Yaowaluk Anupandh, indicates that police attitude and the values of Thai society that the main role of a wife is to maintain peace in the family and that she has to endure all suffering in order to keep the family together, have led to an increasing number of women giving up the belief in the system’s ability to help her to change her husband and remedy the family. They are also afraid that her children will not love her because their father would go to jail, and afraid of being a loser in family life.

6. Most police are never trained to question these sensitive and complicated cases. Those who have been trained still do not recognize the important history of family violence, and hold on to old social practices

Because most police are never trained, they usually question the victims in open area of police station, often surrounded by other police and their clients, who obviously show interest in the story being told (or, sometimes, even make fun out of it). This embarrasses the victims. A training course for policewomen to perform this duty was held but at present, the total number trained is only 39. A master thesis conducted by a police officer studying criminology stated that the environment in a police station is not friendly to the victims of such violence. Most of the women subjects in his thesis stated that policemen asked questions impolitely or in an inappropriate manner. The victims often felt as if they were insulted sexually and verbally by the police, and were treated unfairly.

Plan for legal reform

The law section of the Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups has reviewed all the existing laws related to violence and proposed a protocol for the next revision as follows:²⁸

1. A draft revision of the Criminal procedure code on the process of questioning child-witnesses (awaiting Cabinet approval).
2. A draft revision of the Criminal procedure code on the prevention and control of advertising, producing and trading pornography and sexual materials (awaiting comments from the Ministry of Interior).

3. A draft revision of the Criminal procedure code on increasing the minimum age of juvenile delinquency subject to legal punishment (from 7 to 12 years old and over), increasing the maximum age of juvenile delinquency eligible for reduced sentences as a child (one-half or one-third reduction in terms of punishment) from 14 to 15 years old, and increasing the age that a juvenile is sentenced as an adult, from 17 to 18 years old (awaiting Cabinet approval).
4. A draft law for prevention and control of human trafficking, especially women and children to increase law enforcement of human trafficking, and protection and exemption from legal procedures for illegal-alien victims.
5. The establishment of a Juvenile and Family Court. It is set up to process the cases in which the defendants are children (7–14 years of age) or youths (over 14 years old and less than 18 years old), and to process civil court cases which concern the welfare of children and youth in families.

Other measures at national level to protect children and youth from improper and harmful information:

- Anybody who finds evidence of law violations, evidence of any crimes, websites or chat rooms related to pornography, commercial sex, child sexual abuse, gambling and libel should notify the authorities by emailing feedback@police.go.th
- Measures on scrutinizing and screening pornographic websites.
- Measures on investigating websites regarding illegal property, drugs, sex and libel of national image.
- Measures on controlling on-line games. Every company that provides on-line game entertainment must have the registration process for the age of players. Players who are under 18 should play on-line games between 0600-2200 only, and not for more than three hours per session. Gambling, lotteries and trading of game equipment are forbidden. Internet service shops should be registered and under surveillance regarding the types of games installed.
- Web guard software should be developed and sold at a moderate price for parental use in computers in the home.
- Special clinics for “game addiction therapy” should be set up at the Youth Mental Health Institute, Ministry of Public Health. The institute provides services for parents and children who are addicted to computer games.
- Many other measures regarding taxing and pricing are recommended to reduce the online computer game addiction in children.

It was also suggested that the Ministry of Culture should establish a bureau for cultural surveillance (according to the Cabinet resolution) to control inappropriate and violent media including all types of games.⁴⁹

3.2.2.2 Policy, planning and programmes/projects for prevention and control of violence against children and women

Thailand has strong policies, projects and plans in this area. The initiative was from the proposal of the Working Group for Terminating Violence Against Women, Office of the Prime Minister which resulted in the Cabinet resolution of 29 June 1999 on measures to prevent and control violence against children and women. Key policies were as follows:

Table 18 Measures to resolve the problem of violence against children and women⁵⁰

Proposal of the Working group for Terminating Violence Against Women	Resolutions of the National Committee for Women Promotion and Coordination	
	Recommendations	Responsible agencies
1. Critical centres should be set up in the Emergency Department of every government hospital to help women in need. It must be a 24-hour service where women can get help from doctors, psychologists, social scientists, representatives of NGOs and police, and is referred to appropriate agencies for further assistance.	Request for emergency and critical centres in every governmental hospital to assist women in need, and have a team of personnel to give the service on 24-hour basis. These personnel should be trained properly for managing victims of violence.	1. Hospitals under <ul style="list-style-type: none"> • Ministry of Public Health • Ministry of Defense • Bangkok Metropolis Administration • Bureau of University Affairs • Bureau of Royal Thai Police • Bureau of Supreme Prosecutors • Department of Public Welfare • Concerned nongovernmental agencies • Concerned specialized agencies
2. Improvement of investigative procedures and laws. Promote the victims to get help and protect their rights. Educate governmental officers such as police, prosecutors, and lawyers. Provide appropriate and private rooms at police station for questioning on sexual harassment and rape. Protect victims from being photographed or having their personal information appear in the media.	Request for training course for officers concerned on investigative and court processes. Provide a list of psychologists, social welfare officers, and instructors to provide basic information to them and the police for further assistance.	1. Office of Promotion and Coordination on Women Issue Committee 2. Ministry of Justice 3. Bureau of Royal Thai Police 4. Bureau of Supreme Prosecutors 5. Office of the Council of State 6. Department of Public Welfare 7. Universities 8. Concerned non-governmental agencies 9. Concerned professional associations
3. Provide a safe home for women and provide economic assistance for those in need.	Request for renovation of emergency homes, either governmental or private, both on number of rooms and housing conditions. Request for governmental budget to assist the improvement of private emergency homes for women.	1. Department of Public Welfare 2. Non governmental agencies that could provide emergency homes.

4. Provide 24-hour police surveillance on roads and improving roadsides conditions.	Request for police patrol forces to work throughout the nights and cover all areas under responsibility	Bureau of Royal Thai Police
5. Provide telephones lines for emergency consultations, free of charge.	Request for agencies concerned to provide 24-hour service on telephone consultation.	1. Department of Public Welfare 2. Department of Mental Health 3. Universities 4. Non governmental organizations which provide consultation on phones. 5. Concerned professional associations
6. Provide village volunteers to do surveillance for violence on women and children.	Request for agencies that already has village volunteers to assist the surveillance. Local authority administration should provide resources for this activity.	1. Ministry of Interior 2. Ministry of Public Health 3. Department of Public Welfare 4. Bangkok Metropolis Administration 5. Local (sub district) authority administration 6. Non governmental agencies concerned
7. Control and suppress the production of pornography and all types of sexual media.	Request for agencies concerned to inspect newspaper and mass media on presenting information on violence, including amendments of Press and Mass Media Act	1. Office of Promotion and Coordination on Women Issue Committee 2. Office of Promotion and Coordination on Youth Activities 3. Office of Supreme Prosecutors 4. Office of the Council of State 5. Bureau of Royal Thai Police 6. Department of Public Relations 7. Press and Mass Communication Association 8. Press and mass communication agencies 9. Concerned NGOs
8. Improving the content of sex education at every level, including respect for personal and human rights, both in formal and informal education curriculum.	Request for sex education programme, both in formal and non-formal education, including programmes on self-defense for youths and	1. Ministry of Education 2. Ministry of Public Health 3. Bureau of University Affairs 4. Concerned NGOs

The cabinet meeting on 29 June 1999 agreed that:⁵⁰

1. The Government approves the measures in the proposal of the Working Group for Terminating Violence Against Women and recommends that the measures also

include children. The concerned agencies must follow these proposed measures. The Office of the National Committee for Women's Promotion and Coordination will monitor and evaluate the project.

As a result, the Bureau of Royal Thai Police was also obliged to:

- organize training courses for investigative police on proper questioning processes, educate all officers concerned to have good knowledge and understanding, and make investigations more proper and efficient.
 - strengthen the prevention and control of child prostitution.
2. The Government also announced that November would be the month for an annual campaign on "Ending Violence Against Children and Women".

Following the Cabinet resolutions, the Office of the National Committee for Women's Promotion and Coordination coordinated the drafting of policy and plans for preventing and controlling violence against children and women, including public and private agencies and professionals. The Cabinet has approved the national policy and plan for use as a framework for agencies working for the prevention and control of violence against women and children as follows:

1. National-level policy

Government policy to prevent and control violence against women and children is as follows:

1.1 The government will take action seriously, and continuously, on protection and prevention of children and women from all kinds of violence, both in family and in society. It will also emphasize human, family and social development towards peace and equity between men and women, including amendments of the relevant laws.

1.2 The Government will take care of women and children affected by violence and support all agencies, governmental or nongovernmental, which provide physical and mental care, rehabilitation and temporary shelters. The government will pursue lawsuits for negligence.

1.3 The Government will promote and support the role of women in violence prevention and control, at local and national level.

1.4 The Government will promote and support knowledge development, personnel development and the development of information technology in order to foster good family conditions and to prevent domestic violence.

1.5 The Government will promote the integration of plans, projects and budgets of various agencies for more efficient prevention of violence.

1.6 The Government will try to reduce risk factors for violence against women and children.

1.7 The Government will provide knowledge, understanding and public awareness of women's and children's rights, and human rights, giving a helping hand for the prevention of violence.

Master plan

Policy and plans for the elimination of violence against women and children are divided into six main plans, which are (1) prevention and awareness-raising through legislation (2) protection and welfare, (3) research, (4) development of coordination mechanism, (5) monitoring and evaluation, and (6) information systems.

Plans and policies at national level:

- Plans for helping children in crisis (2002–2006) which comprise of (1) development of family and community strength, (2) development of protection, prevention, treatment and rehabilitation, (3) improvement of social services, (4) development of administration and management mechanism, and (5) legislative measures.
- National policy and plans to prevent and eliminate prostitution, followed by a national policy and plan for the elimination of trafficking in women and children.
- National policy and plan for family development.
- National policy and plan for family counseling projects.
- (Draft) national policy and strategies on a “Suitable world for children” which covers violence.
- Measures to prevent and solve violence among youths which aims at promotion of collaborative efforts to prevent violence among youths. The main targets of the measures are vocational students.
- Effort to end violence against children and women (2004) ²⁸

One-stop Service Crisis Center (OSCC) ⁵¹

The Cabinet meeting on 29 June 1999 agreed to set up services for women and children in crisis in every hospital, both governmental and private. The total number of centres around the country is 104. OSCCs are equipped with a health team trained to give proper care for violence victims and are open 24 hours a day.

Objectives

1. Giving care to violence victims who are assaulted physically, mentally or sexually.
2. Acting as notification centers for violence against women and children, to collect information and coordinate with concerned agencies.
3. Building up a network and resources to assist violence victims.

These centres provide medical, psychological care to violence victims on a 24-hour basis. A team comprised of doctors, nurses, psychologists and social welfare workers is available at the centres. They work in collaboration with police, prosecutors, lawyers and NGOs to provide further assistance. There is five-year strategic plan for violence victim assistance, which covers (1) setting up OSCCs in all provincial and community hospitals, (2) setting up a fund for short-term economic support before referral of victims to a multidisciplinary assistance team, (3) assisting the legal process for the victim, (4) motivating and helping the community to take participation in violence prevention and set up a pilot project in each village.

Limited ability of government agencies to help violence victims ⁵¹

- OSCCs have only been set up in provincial hospitals, not yet in community hospitals, hence access is still inconvenient.

- Lack of effective coordination between concerned agencies, particularly during non-official hours.
- The proposed plan is suffering budget shortages because the budget has to be set up and managed by the Ministry of Social Development and Human Security but the activities are performed by hospitals under the Ministry of Public Health. The existing government financial rules, regulations and system make the transferring of budget to support the service very complicated and non-timely.

3.2.2.3 Available monetary resources²⁸

Within Thailand

- The Child Protection Fund, which got seed budget from the government of 30 million baht (38 baht = US\$ 1 at the reporting time) is now waiting for national committee selection.
- The Ministry of Public Health requests 69 million baht (budget to set up OSCC in 104 hospitals), but still struggles with the problem of the budgeting and transfers from the Ministry of Social Development and Human Security.
- The government allocates 250 million baht for anti-trafficking integrative plans (2005-2007).
- The government allocates budget to build homes for abandoned children through the Division of Social Development and has a budget for hiring personnel working on child protection in each province.
- The government allocates 20 million baht to Bangkok Metropolis Administration every year to run projects on children and families.

The ThaiHealth Promotion Foundation (ThaiHealth) is an office under the Prime Minister which was established in 2001. ThaiHealth seeks to enhance the physical, mental, and social health of Thai people. It receives 2% of the excise taxes on tobacco and alcohol, which provides revenues of about US\$ 55 million baht per year and supports various activities in health promotion. Promoting and strengthening family is one of its key advocacy issues.

International financial resources

Organizations in Thailand, both governmental and nongovernmental, receive international financial support for conducting activities, organizing conferences, developing manuals and academic materials. This aid includes visits of foreign experts. The resource comes from UNICEF, ILO-IPEC, IOM, UNDP and WHO. Moreover, Thailand gets support from governments of various countries in Europe, America, Asia-Pacific as well as foreign NGOs.

3.2.2.4 Monitoring and evaluation of the national plan to prevent violence against women and children

Most of the national plan covers broad areas of work, hence it is difficult to monitor and evaluate. Moreover, there is no designated mechanism for monitoring and evaluation in these matters.

For a specific issue such as prostitution, there was a “Thailand Progress Report on the Status of Implementation of the EAP Regional Commitment and Action Plan against CSEC”, presented at the meeting of Post-Yokohama Mid-term Review in November 2004.

For human trafficking, there was a plan of action with a mechanism for monitoring. This took the form of a mid-plan review meeting as well as a meeting of the subcommittee.

For the plan to prevent child and youth violence, the Ministry of Social Development and Human Security is designated to conduct evaluation.

3.2.2.5 Major institutions for violence prevention and control, including services and care for violence victims

1. Parliament

The Thai parliament has provided several committees, both in the Senate and the House of Representatives.²⁸

The Senate

A Committee on Women, Youth and Elderly has the main role in the activities to stop violence against children. Apart from this, the Senate also has other committees similar to the House of Representatives, such as Committee on Justice and Human Rights and the Committee on Labor and Social Security. The difference between the Senate and the House of Representatives is that the Senate has the authority to screen the law and high-rank officials including the executives of the national autonomous offices, but cannot terminate a law or position.

House of Representatives

There are several committees which are working on control of violence, including:

1. The Committee on Children, Youth, Women and Elderly conducts fact-finding on any crisis involving children, youths, women, and elderly, and collaborates with other concerned organizations, locally or internationally, to seek cooperation in solving profound problems among these vulnerable groups.
2. Committee on Justice and Human Rights conducts fact-finding on any problem in jurisdiction process and human rights.
3. The Committee on Labour conducts fact-finding on any problem regarding labour, local and abroad.
4. The Committee on Social Security conducts fact-finding and follow-up on poverty resolution projects, improving the quality of life of Thai people, social security, accident prevention, rehabilitation of the disabled and projects for the poor and under-privileged groups.

2. The National Human Rights Commission

The National Human Rights Commission was established in 1999, in accordance with the Thai Constitution (1997) section 15. Its roles and functions are:

- (1) to promote respect and compliance with human rights principles at domestic and international level;
- (2) to examine and report the committing or omitting of acts which violate human rights or which do not comply with obligations under international treaties relating to human rights, to which Thailand is a party; and to propose appropriate remedial measures to the person or agency committing or omitting such acts. In the case where it appears that

- no action has been taken as proposed, the Commission shall report to the National Assembly for further action;
- (3) to propose to the National Assembly and the Council of Ministers policies and recommendations with regard to the revision of laws, rules or regulations for the purpose of promoting and protecting human rights;
 - (4) to promote education, research and the dissemination of knowledge on human rights;
 - (5) to promote cooperation and coordination among government agencies, private organizations, and other organizations in the field of human rights;
 - (6) to prepare an annual report for the appraisal of the situation in the sphere of human rights in the country, submit it to the National Assembly and the Council of Ministers and disclose it to the public;
 - (7) to assess and prepare an annual report of the performance of the Commission and submit it to the National Assembly;
 - (8) to propose opinions to the Council of Ministers and the National Assembly in the case where Thailand is to be a party to a treaty concerning the promotion and protection of human rights;
 - (9) to appoint a subcommittee to perform the tasks as entrusted by the Commission;
 - (10) to perform other acts under the provisions of this act or as the law prescribes the powers and duties of the Commission.

The National Human Rights Commission has appointed a committee on child, youth and family to examine and report on violation of children's rights on any petition.

In 2002, Thai Health Foundation, together with Committee on Child, Youth and Family and the Office of the National Human Rights Commission organized a brainstorming meeting, together with a review of existing research, policy, plans and projects, in order to ascertain crucial points regarding child, youth and family problems that need urgent solutions. It was demonstrated that the problems that need urgent attention are: (1) children involved in criminal court cases, (2) violence against children, (3) child labour, (4) stateless children and (5) promotion of safety and accident prevention in children and (6) mass media and children. This information led to plans for promotion, support, and protection of health and rights of children, youths and family (2003–2007).

3. Ministry of Social Development and Human Security⁵²

The Thai Constitution states that the government has the duty to ensure the proper welfare of the population so that people can live with human dignity. Therefore, the Thai government has set up a Department of Social Development and Welfare to provide social welfare to the underprivileged, homeless people and people in crisis. They provide shelters, send people to concerned agencies and support communities in setting up their own social welfare for those in need.

Office of Women and Family Affairs

The Office of Women and Family Affairs is aimed at women development, promotion of equal rights of men and women and promotion of family ties. It provides policy, measures, mechanisms, and collaboration between governmental and non governmental sectors to work accordingly to increase potential of human, men and women alike, in community and social development.

Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups

The Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups take care of children, youths, under privilege people, disables and elderly. Their main task is to protect the right and promote skill development of these vulnerable people to be able to live with good quality of life and security.

National Child Protection Commission

This organization is chaired by Minister of Social Development and Human Security, and representatives of concerned agencies and specialists are members of the committee. Under this there are:

Children Protection Committee of the Bangkok Metropolis and the Provincial Children Protection Committee

This committee is chaired by the governor and consists of representatives of concerned agencies, specialists from various professions (medical doctors, psychologists, lawyer, social workers, etc.), NGO representatives and experts on child welfare.

4. Ministry of Public Health

The Ministry of Public Health has several departments responsible for violence:

Office of Permanent Secretary, Bureau of Health Policy and Strategy

The office is responsible for policy, strategic planning, monitoring and evaluation of all important public health problems including violence.

The Department of Disease Control

It is responsible for disease prevention and control. The organizations within this department have different functions in violence prevention as follows:

- The Epidemiology Bureau is responsible for national injury surveillance which includes severe injuries from all types of violence.
- The Non Communicable Disease Bureau is the focal point for coordinating prevention and control of all types of violence.
- The Bureau of AIDS, TB and STIs is responsible for care and services for rape victims. It recently coordinated a number of relevant agencies in producing a guideline for the service.
- The Department of Health Service Support, Bureau of Health Service System Development is responsible the establishment of One-stop Service Crisis Centers (OSCC) in provincial and regional hospitals all over the country.
- The Department of Mental Health is responsible for prevention and control of self-harm and suicide, including the transfer of technical guidelines and practice for care of self-harm patients to all hospitals. It also started to develop life skills in students in collaboration with the Ministry of Education.
- The Department of Health, Reproductive Health Division is responsible for gender equity promotion.

5. Bureau of Royal Thai Police

The Bureau of Royal Thai Police is responsible for crime control and information. It also recently established the Children and Women Protection Center, which acts as violence notification center on 24-hour basis. Its tasks are:

- prevention and control of prostitution and commercial sex;
- prevention and control of sexual harassment;
- prevention and control of illegal labour, brutality and violence in the labour force;
- prevention and control of human trafficking, locally and trans-nationally;
- prevention and control of gambling and casinos;
- prevention and control of wrongdoing among women and children involving drugs and crime.

6. Departments under the Ministry of Justice^{53,54}

Department of Rights and Liberties Protection

This department is concerned with the promotion and development of human rights and liberty protection, conflict management, witness protection, setting up measures to help violence victims and operating action plans for human rights protection.

Department Of Probation

This department conducts investigation, observation and monitoring of the behaviour of perpetrators until the legal process finishes. Its tasks include rehabilitation and supportive measures for people to return to the community after trial.

Department of Juvenile Observation and Protection

This department concerns the protection of children and youths who are accused as wrong-doers, promotion of stability of family and community. It would choose alternative justice and conciliation procedures rather than the criminal code. The department takes care of criminal cases involving children and youth, family court cases, monitoring home conditions, and evaluation of children and youth behaviours after trial. A significant initiative of the Department of Juvenile Observation and Protection, “Kanjanapisek Home”, or the Center for Training of Children and Youth, is a new model being piloted at the Juvenile Delinquency Institute focusing on developing the positive potential of the youth and preparing them for returning to the community. Kanjanapisek Home employs methods to develop the positive potential of juvenile delinquents and applies discipline without violence (See box, “Kanjanapisek Home”).

Central Institute of Forensic Sciences

This institute is an administrative office of the Committee on Forensic Sciences Standards and Procedures. It appoints and withdraws forensic science assistants and workers, acts as a notification center for complaints from the victims of misconduct in forensic medicine, searches and certification of individual identity.

Kanjanapisek Home⁵⁵

A case study for developing the potential of juvenile delinquents and disciplining without violence

Kanjanapisek Home is new model being piloted in the Juvenile Delinquency Institute which focuses on developing the positive potential of youth and preparing them for returning to the community. Hence:

Kanjanapisek Home is not a “prison”

Teenagers are not “criminals” or “murderers”

Officers are not “prison wardens”

But Kanjanapisek Home is a temporary substitute home for teenagers who have made a mistake in life.

The home welcomes teenagers and youth (15-23 year olds) judged in court as guilty of robbery, assaults, murder, attempted murder or rape. First, they are greeted as nephews, starting from the tying of a sacred white thread onto their wrists to bring back their hearts and souls. There is no body search for weapons, no head counting, no tight control and definitely no physical punishment. Most important, there is no silence. All opinions are listened to for consideration, always.

On July 25, 2005 this home admitted a new group of 50 juvenile delinquents finally judged as guilty, in addition to the other group of 112 who had already observed there. Yai, the son of a victim, met Lek, the young man who had taken his father’s life. Lek informed Aunt Mol that perhaps he would have to pay back what he had done. Yai asked Aunt Mol, with frustration, why Lek, who had killed his father, was allowed to live in the “Victory Heart Cottage” (a lodging where youths who can take responsibility for themselves live peacefully together with good reasoning and patience without the presence of controlling officers; as a special reward they can take leave every weekend with their families). Yai inquired about weapons but the reply from the young man he asked was that there was no violence in this home.

The next step was to take turns going out for “BBQ pork” outside the home. After five days, all of the new entrants had been out for a meal, and Aunt Mol held an open room talk to them.

She thanked the new entrants for not escaping – even though there was no locked door, for going back into own lodgings punctually at 9pm, for making phone calls as agreed and for participating diligently in assigned activities. She talked about building up or adding “self capital” in order to receive special privileges in the home. She consulted the newcomers on whether they could accept her belief that the mistakes teenagers made were not due to their origin but because the teenage years are the most difficult period in a human’s life, hence they are prone to be out of step and to all types of failing. She asked if they could accept the youth who had been out of step, even if that youth had harmed them.

On August 16 2005, Aunt Mol received the news that Yai had given up on his plan to seek revenge. He said, “It’s over. No more bad things.” He wrote in his diary: “I will do only good things every day, otherwise the evilness will drive away my goodness.” For Aunt Mol, this was a day of great victory for the hearts of all the youths in Kanjanapisek Home and should be shared with everyone in the Home to give them pride, celebrating it as a day of victory of all youths who had once been out of step.

Victory of the heart is the victory that lasts.....

Aunt Mol: Ms. Ticha Na Nakorn,
Director of Center for Training of Children and Youth
(Kanjanapisek Home)
Department of Juvenile Observation and Protection

www.thaingo.org2prboard_1/view.php?id=3980⁵⁵

There is not yet an evaluation report of the model.

Table 19 The Ministry of Justice and violence victims: Structure, organizations, plans and obstacles

Items	Concerned organization	Roles and functions	Plans	Obstacles
Self-directed violence and suicide in prison	Department of Correction	<ul style="list-style-type: none"> - Determine criteria and operative instructions, monitor, control and evaluate medical and public health works, such as sanitation and environmental hygiene in prison. - Conduct research and analyze factors on health promotion, treatment, and rehabilitation of prisoners. 	<p>Mental health promotion and prevention of violence. The target groups are:</p> <p><i>1. Officers working in jail</i></p> <ul style="list-style-type: none"> - Create operating manuals to prevent suicide among inmates. - Organize training courses on mental health promotion and counseling for officers. After training, these officers are designated as mental health counsellors for those in need. - 20 May each year is designated to be mental health day in every prison. There are activities to promote mental health and prevent mental health problems among inmates. - Set up anti-anxiety clinic - Construct questionnaires and recording forms to evaluate the mental health condition of Thai inmates (PMGQ-Thai) - Conduct evaluation of risk of repeat sexual offenders in jail. - Conduct training courses on negotiation with inmates who are on crisis or on the verge of mental disorders. 	<ul style="list-style-type: none"> - The improper ratio of officers to prisoners (1:16 in Nov 2003) - Lack of budget - Lack of psychiatric nurses

Table 19 The Ministry of Justice and violence victims: Structure, organizations, plans and obstacles (cont.)

Items	Concerned organization	Roles and functions	Plans	Obstacles
			<ul style="list-style-type: none"> - Produce educational booklets on mental health, such as a diary for good mental health, five minutes for happy life, to distribute to officers and inmates who need them. - Set up anti-suicide programme for inmates, which covers four aspects: personnel development, inmate training on mental health assistance, prevention of mental health breakdown and manuals on primary care of mental health disorders. <p>2. <i>Inmates</i></p> <ul style="list-style-type: none"> - Sending a letter on “Smiling friends” to inmates who are under stress or anxiety and who are at risk of suicide. - Because of a personnel shortage, there is a programme to select some inmates to help with mental health promotion in prison. - In case of psychiatric disorders, the patient will be sent to see doctors outside prison; staff will take care of the medication schedule of inmates. (Psychiatric disorders are a cause of self-directed violence). 	

Table 19 The Ministry of Justice and violence victims: Structure, organizations, plans and obstacles (cont.)

Items	Concerned organization	Roles and functions	Plans	Obstacles
	Department of Juvenile Observation and Protection	<ul style="list-style-type: none"> - Imparting knowledge to children and youth on mental health to prevent mental health problems. - Care, observation and surveillance of children and youths to prevent self-directed harm and suicide. - Giving first aid and referring to a hospital for proper treatment in case of mental health problems. 		<ul style="list-style-type: none"> - Most officers do not have knowledge or skill in detection and surveillance of children and youth with mental health problems. - The improper ratio of officers to inmates.

Table 19 The Ministry of Justice and violence victims: Structure, organizations, plans and obstacles (cont.)

Items	Concerned organization	Roles and functions	Plans	Obstacles
<p>Interpersonal violence in family, including violence against children, women and elderly</p>	<p>Department of Correction</p>	<ul style="list-style-type: none"> - Determine patterns and standards for treatment, rehabilitation, and behaviour modification of inmates. <p>Development of quality of life of inmates and children of inmates who were born in prison. Set up proper education, both vocational and high school level for inmates.</p>	<ul style="list-style-type: none"> - Behavioural modification programme for interpersonal violence that is used as standard protocol at Dhonburi Prison - Behavioural modification programme for family violence that is used as standard protocol at Klong Prem Prison - Behavioural modification programme for sexual violence that is used as standard protocol at Nakhorn Pathom Prison <p>- The process is selection of target groups, discipline practice, characterization, history taking, personality identification, modification on attitudes and behaviours, and preparation of release process (before and after release).</p>	<ul style="list-style-type: none"> - Lack of budget - Lack of personnel who have knowledge on specific fields (psychologist, social welfare scientist, etc.)

Table 19 The Ministry of Justice and violence victims: Structure, organizations, plans and obstacles (cont.)

Items	Concerned organization	Roles and functions	Plans	Obstacles
	Department of Juvenile Observation and Protection	<ul style="list-style-type: none"> - Set plan for agricultural training and vocational training of inmates, including monitoring and evaluation of the programme. - Collaborate with concerned agencies on drug control activities. <p>Establish instruction for officers to cope with youth violence, without resorting to force.</p>	<ul style="list-style-type: none"> - Specific programmes for the elderly, giving information on health, lifestyles, exercises, eyesight examination and recreation. 	

Table 19 The Ministry of Justice and violence victims: Structure, organizations, plans and obstacles (cont.)

Items	Concerned organization	Roles and functions	Plans	Obstacles
	Department of Probation	<ul style="list-style-type: none"> - Assisting children who are affected by violence in family, evaluating the impact of such violence on children, giving treatment, rehabilitating, and reporting to judges to assist their decisions, and collaborating with concerned agencies when the child is released. - Collaborating with concerned agencies such as health workers, police, social scientists and psychologists to help in the process of family reconciliation. - Conducting focus groups in the process of family reconciliation. - Rehabilitating offenders and keeping track of their behaviour. 	<ul style="list-style-type: none"> - Pilot project on reconciliation among family members to solve family violence. 	<ul style="list-style-type: none"> - The activities depend on the voluntary participation of the family and offenders only. There is no specific law on these activities.

Table 19 The Ministry of Justice and violence victims: Structure, organizations, plans and obstacles (cont.)

Items	Concerned organization	Roles and functions	Plans	Obstacles
Collective violence	Department of Rights and Liberties Protection	<ul style="list-style-type: none"> - Collaborating with concerned agencies such as health workers, police, social scientists and psychologists that would help in the process of family reconciliation. - Conducting focus groups in the process of family reconciliation. - Rehabilitating offenders and keeping track of their behaviour. - Pursuing compensation and expense reimbursement for victims and offenders. 	<ul style="list-style-type: none"> - Pilot project on reconciliation among family members to solve family violence. - Project on compensation and expense reimbursement for victims and offenders 	<ul style="list-style-type: none"> - The activities depend on the voluntary participation of the family and offenders only. There is no specific law on these activities. - Lack of manpower while the number of cases requested for reimbursement increases rapidly. The waiting list and the time required in the process are unnecessarily long.

Table 19 The Ministry of Justice and violence victims: Structure, organizations, plans and obstacles (cont.)

Items	Concerned organization	Roles and functions	Plans	Obstacles
	Department of Special Investigation (DSI)	<ul style="list-style-type: none"> - Prevention and control of specific crimes which cause widespread damage to economic, social, and security conditions of the country, including crimes committed by unlawful organizations such as narcotics smuggling, human trafficking, gambling, hired killing, etc. 	<ul style="list-style-type: none"> - Projects on data collection for prevention and control of human trafficking. - Projects on coordination of international concerned agencies in prevention and control of transnational crimes. - Integrative projects on prevention and control of human trafficking. 	<ul style="list-style-type: none"> - There is no specific law on transnational crime control and law concerned with criminal organizations. Criminal organizations have wide networks in different types of criminal activity, therefore the prevention and control of these activities is difficult if integrative measures are not applied at full scale and in time. - Lack of budget and manpower.

7. Ministry of Culture²⁸

The National Culture Committee announced its agenda of stopping violence against women and children in 2003, and worked with concerned agencies, governmental, nongovernmental and international organizations to draft a proposal on “Measures on cultural aspects in policy and plans for a “Cultural Environment Suitable for Children”. In that proposal, there are proposals to increase the potential to publish cultural news for children and youth, and to impose penalties on people who produce and publicize pornography and violence-promoting articles and photos. The Ministry held a conference on “Network and participatory approaches on culture: a case study from pornography” together with Office of University Affairs, Ministry of Education. It also organized several activities to build up herd immunity, such as training courses on art and culture, training courses on musical bands for children, Thai classical dance and Thai traditional music bands, as well as activities to bolster good social values such as the Cultural Center of Thailand and Great Artist Hall.

8. Bangkok Metropolis Administration²⁸

The city has had a clear policy on violence against children and women since the present deputy governor was appointed in 2005. The division for the welfare of vulnerable groups (children, women, the elderly, disabled and underprivileged persons) takes care of those in need who reside in Bangkok area. It has focused on the use of alcohol and adolescents.

9. NGOs²⁸

Thai nongovernmental organizations are actively campaigning to solve major social problems of health, society, culture, politics and human rights. Most of their actions are challenging and gathering new ideas to solve these problems, and questioning existing systems and structures not functioning well for people’s rights and welfare. NGOs have important roles in stirring up wide public interest in specific problems and initiate many activities which have an impact on policies and social development.

The Office of the Promotion and Protection of Vulnerable Groups, in collaboration with the Faculty of Humanities, Mahidol University, collected data on organizations involved in helping children in trouble in 2005. There are 580 organizations, 229 of which are governmental while 331 are private organizations.

Because governmental organizations find it difficult to reach children in trouble all over the country, NGOs put their effort into assisting and helping them with more flexible structures and mechanisms. They are:

- **Children whose rights are violated:** children in the commercial sex industry, human trafficking, child labour, rape victims, and victims of brutality and torture.
- **Abandoned children:** wandering children, young beggars, orphans, children in congested communities.
- **Children with inappropriate practices:** drug addicts, pregnant girls, children involved in crimes and jurisdiction, children involved in the sex industry.
- **Mentally retarded children:** children with psychosis, attempted suicide cases, children with uncontrollable tempers.
- **Underprivileged children:** very poor children, uneducated children, children of the unemployed, stateless children and children of aliens.

- **Children affected by HIV/AIDS:** children infected with HIV, children whose parents got HIV/AIDS, orphans.

NGOs' focus on protection of children's rights according to the Children's Rights Act, including promotion of community organizations and support for family development, increased participation by children and networking. The functions include:

- Keeping track of the situation and finding facts on children's conditions.
- Investigating and reporting the violation of children's rights.
- Helping children whose rights are violated.
- Publicizing and distributing knowledge on children's rights and the works of international organizations.
- Assembling all people concerned with children's rights and promoting proper policies.
- Recommending and extending help to children to claim their rights.

Several NGOs working on violence against women and children normally take care of other vulnerable groups too. Major NGOs in violence prevention and protection of vulnerable groups are:

1. *Hotline Center Foundation* which was founded by Ms. Orn-anong Intarajit. It started from the fact that most Thai women need support, mentally and spiritually, in order to face and solve problems in life. Consultation with governmental authority might not be practical, because these women do not want to disclose their identity and do not want to reveal their painful experience to others face-to-face. Moreover, there is a traditional social stigma of people who seek consultation with psychiatrists, with the implication that any client must have severe psychiatric problems such as neurosis. Therefore, an anonymous telephone consultation service can provide good suggestions to reduce emotional stress and information that might solve their problems. After a certain period of time, users of the service come to trust the hotline personnel and dare to share the underlying truth of their situation, making them ready for individual and open counseling later. Apart from telephone counseling, Hotline Center Foundation organizes training courses for consultants from various organizations on the HIV/AIDS issue. It runs campaigns on various issues via newspaper, magazine, radio and television in order to reach other sectors of population as well. The president of the foundation estimates that the Center provides services to at least 30 000 cases annually. Approximately 65% of its clients were women.

2. *Women's Friend Foundation* has been working hard to promote awareness of the unfair treatment of women. It collaborates with many agencies to improve the social conditions of women, provides legal consultation for women in cases such as rape, harassment, unwanted pregnancy and discrimination towards women. It offers training courses to sensitize those who are on duty related to violence (such as female police) to the presence of gender inequality.

3. *The Association for the Promotion of the Status of Women under the Royal Patronage of HRH Princess Soam Sawali* has been the largest NGO providing emergency homes for women and children for more than 20 years. It has reached out to more than 40 000 people suffering from violence, HIV infection, AIDS and unwanted pregnancy. In addition to food, shelter and the necessities of survival, the Association provides consultation and vocational training, as well as courses for youths and nurseries for preschool children. Director Dr

Sutheera Thompson points to its strong information system management. The Association's success also arises from the fact that it has good connections with local communities and networks at the grassroots level. This is proven by the large number of people who walk in by themselves because they have received information on the Association's activities via friends, neighbors, press and mass media.

4. *The Foundation for Women (FFW)* provides information, support, referral and emergency assistance to individual women affected by gender-based violence, particularly domestic and sexual violence. It cooperates with organizations in countries of destination in assisting women and children and preventing human trafficking. It also provides social and legal assistance to Thai and non-Thai women and children who are victims of national and cross-border trafficking. FFW advocates for the rights of trafficked women and children, and cooperates with other organizations to defend their rights such as the right to compensation and civil remedies. And FFW has a special interest in the plight of migrant women and children from other countries as they are vulnerable to trafficking and being made to work in exploitative conditions. In order to access to these women and children, FFW works in the Immigration Detention Centre and the Public Welfare Home.

5. *Education Means Protection of Women Engaged in Recreation or EMPOWER* is an organization that works with women in the entertainment sector. Their staff teaches them to know and protect their basic rights, to have other vocational skills and to attend academic classes. The main objectives are to train commercial sex workers (CSWs) to protect themselves, to be self-reliant, and to have more strength inside in order to be able to make their own decisions in solving various problems. CSWs on Patpong Street in Bangkok are able to attend language classes: English, Japanese or German, are able to negotiate with customers on safe sex and on prices. EMPOWER also works on prevention of HIV/AIDS and distributes condoms, free of charge, to its members. It offers mobile classes at night on Thai and foreign language, and other professional skills. These CSWs are easy targets for offenders because police can turn around and accuse them of prostitution and put them into jail (instead of chasing the offender).

Another challenge that NGOs have to manage is family rape. Wives that were raped by their husbands could not seek help from authorities because there is no law to protect them. NGOs are now calling for an amendment to family law to stop such domestic violence.

6. *Paveena Foundation for children and women* was established in 1999 to help children and women in crisis. The founder is Ms Paveena Hongsakul, a former Member of Parliament. Its objectives are:

1. To help children and women who are victims of crime or have experienced cruelty of different types, and to provide rehabilitation programmes both physically and spiritually;
2. To help children and women who have no shelter and protection to be able to stay by themselves;
3. To develop professional skills among poor and underprivileged children;
4. To promote Thai traditional activities .

From the work of Paveena Foundation during the past six years, it is now well-recognized by the public and mass media. All other sectors also give good coordination with the Foundation. Thousands of people in trouble have contacted the foundation for help regarding cheating, being deceived into prostitution, rape, brutality, etc.

Other civil society

- *Business sectors* support governmental and nongovernmental organizations working on children welfare in monetary terms, publicizing and producing mass media communication to stop violence.
- *Professional council and associations* such as the Lawyers Council which provides legal aid to represent the poor in court. The weekly meeting of the Committee on Children's and Women's Rights continues to be conducted. There are volunteers to observe child and youth behaviour after the legal process. A committee on child and youth welfare provides comfort and professional training for children during court trials.
- *Religion-related organizations*, such as temples which provide buildings for nurseries and daycare centres.
- *Volunteers on children's rights protection*: networks of community organizations in Bangkok and other provinces are ready to be notification centres on children's crises, surveillance, giving advice to families, checking out information received, coordinating with concerned agencies, giving physical and spiritual care and providing short-term financial support.

Governmental support to civil society

- *Legislation:*²⁹ The Child Protection Act states that the private sector must be involved on Child Protection Committees at national, provincial and district levels. The Prevention and Control of Prostitution Act states that at least five specialists from the private sector must be included in the Protection and Skill Development Committee. The Criminal Procedure Code states that there must be psychologists, social welfare scientists or other relevant professionals involved in the investigation of children involved in any crime. Private sector personnel should be included in several government plans to create interdisciplinary collaboration.
- *Policy*: Government gives the opportunity for private sector representatives to get involved in policy-making committees such as Committee on Protection of Child's Rights, Commission on Prevention and Control of Human Trafficking, etc.
- *Memoranda*: used to authorize private sector professionals to work with the same status as government personnel, such as memoranda on the roles of NGOs in prevention and control of human trafficking and in approaching target groups together with government officers.
- *Budget*: The Child Protection Act has set up the Child Protection Fund and provides budget to local administrative authorities to create activities for children and youths in their area of responsibility. There is a supporting fund, managed by the Ministry of Social Development and Human Security, to be allocated to private organizations to work for the welfare of children, youth and women.
- *Academic*: State universities and professional associations such as physicians and lawyers give academic support to private organizations on research and plans.
- *Personnel*: Personnel in the government sector collaborate with private sector professionals in terms of organizing training courses and work in various multidisciplinary projects.

3.2.3 Violence prevention and care

3.2.3.1 Elderly

The Ministry of Social Development and Human Security has projects for:

1. Care of elderly who have been tortured.
2. Care of elderly who are illegally exploited.
3. Care of abandoned elderly.
4. Care of elderly in family crisis.

3.3.3.2 Victims of workplace sexual harassment

Stories about sexual harassment in the workplace, whether it be government, state enterprises or private organizations, appear on newspaper pages and other mass media occasionally. However, most harassment cases do not reach the police and are not reported to workplace superiors. This is understandable, because most victims feel ashamed and afraid that the news will spoil their reputation. Moreover, even if she brings up the case, the offender receives a paltry penalty. Meanwhile, the victim may be adversely affected by defamation or threats to encourage withdrawal of the filing. Some victims decide to quit their jobs or get psychological treatment in order to restore good mental health.⁴¹

The Office of Women and Family Affairs is a government office which is responsible for protection of women, women's rights and elimination of violence against women, is aware of the seriousness of this problem. Therefore it set up an **Anti-Sexual Harassment in Workplace Center** aimed at providing consultation by telephone and advocacy services and sought coordination with other concerned agencies in pursuing further cases. In the near future, it has plans for a campaign for specific legislation in this area. The activities of the Center include:

1. A hotline (1300) for victims of harassment for consultation and filing of reports.
2. If the victim wants to pursue a filing and court judgment, the office will coordinate with the secretariat office of Anti-Sexual Harassment in Workplace Center under the Office of Women and Family Affairs in order to make an official filing to the police and prosecutors, and will collaborate with other agencies as needed.
3. Follow-up support is offered for any problems that might obstruct the process in each case.
4. Collection of statistics and writing of summary reports.⁴²

3.3 Research on violence 28

This part summarizes research on violence and activities related to research, which might be useful in explaining, planning and proposing policy for prevention and control of violence against children in Thailand.

Examples:

- A case study of children joining in a pilot project to assist other children who have been abused, using a multidisciplinary approach in Thammasat Chalermprakiet Hospital
- Factors relating to the aggressive behaviour of primary caregivers toward a child
- Girl prostitutes in Nakorn Panom Municipality

- Lives and lifestyles of young workers at gasoline stations in Khon Kaen Municipality
- Project on mobile legitimate streets drama for children, youth and women.

The Health System Research Institute has supported many research projects on violence on women and children such as:

- The potential of society to manage violence against women and children
- Evaluation of social security programmes for child violence victims
- Documentary study on child perpetrators: rationale and management

The Thailand Research Fund has supported much research on violence on women and children including:

- A research project on development of social roles for children, situation analysis and determination of process of solving problems concerning children and youth
- Collaborative project on “Development of Protection System for Children in Thai Society”
- A study of knowledge, attitudes, beliefs and practices on sexuality among youth in Thailand
- A review and synthesis of research on “Children in trouble in Thailand”
- A review and synthesis of research on “Role of mass media toward children, youth and family improvement”
- Report on “Violence among youths: the case of violent conflicts among vocational Students”
- Management of security fund for children in trouble: a case study in Uttaradit province.
- The development of cooperative networks among various organizations in helping wandering and under-privileged children, Chiang Mai province
- Situation analysis of children and youth in each province
- Development of baseline mechanism at community level for child development and solving problems concerning children and youth.

Research plan of Mahidol University – National Center for Violence Outreach and Risk Reduction (MU-N-CVORR), supported by the National Research Council of Thailand consists of:

- Outreach on violence and risk reduction among schoolchildren, preschool children, and undergraduate students
- Outreach on violence and risk reduction among youths in jail

Projects on knowledge building by Thai National Health Foundation

The Thai National Health Foundation, together with the Commission on Children, Youth and Family under the Office of National Commission on Human Rights and the Thai Health Promotion Foundation, has established an agenda for setting up research projects on health development and children’s rights over a three-year period (2004–2007) and has prepared a proposal covering the following fields:

Children in the legal system

- A study to develop alternative justice processes by local communities

- A study on the situation of children and youths under the Juvenile Observation and Protection Programme
- A study on the situation of pregnant girls and their babies under the Juvenile Observation and Protection Programme
- A study of children of inmates staying in jail and pregnant women in jail
- A study of patterns, models and practice toward children in the legal system
- A study to develop patterns, models and practices in returning qualified children to society

Violence among children

- A study to develop patterns, models and practices in sustainable prevention of violence among children and youths
- A study to develop patterns, models and practices of systematic and complete aid to child violence victims

Child labour

- A study to develop patterns, surveillance models and aid concerning child labour

Stateless children

- A study to develop patterns, models and measures to reduce the impact and address stateless status among children in Thailand

Children and mass media

- A study on the development of standards, patterns, law amendments and social campaigns to promote good mass media approaches and eliminating bad ones on the following topics: (1) children and computer games, (2) children and television programmes and movies, (3) children and radio broadcasting programmes, (4) children and the press and (5) children and the internet.
- A study on examination of practices with regard to the Agreement on Children's Rights. This focuses on obstacles, problems and recommendations regarding the Agreement on Children's Rights, of which Thailand is a signatory.

*Research projects and improvement of Thai mass media has and its impact on the health and rights of children, youths and family*²⁸

This research project is supported by Professor Kanuang Luachai Foundation and the Thai National Health Foundation. It studies social problems faced by children and youth through the Thai mass media and studies four types of mass media (press, radio broadcasts, television programmes and the internet) during May 2004-April 2005, in the following aspects:

1. Sex education in mass media
2. Problems among youth and computer games
3. Problems of child deception on the internet
4. Using mass media to promote and protect the health and rights of children, youth and family.

Research projects by the National Commission for Promotion and Collaboration on Youths (1983-2003)

- Juvenile delinquency prevention and control in Thailand
- The influence of mass media on children and youth in Bangkok
- Security and development of child labour in the manufacturing industry
- A study on gambling concepts and behaviours among children and youth
- A survey on abandoned children in governmental hospitals
- Relationship between attitude to violence and behaviour among children and television programme preference: a case study on junior high school students
- A study on conditions and magnitudes of problems on children whose rights are violated and abandoned children: case studies in Chiang Mai, Prae, Cholburi, Trad, Udon Thani, and Sri Saket province
- A study on neglected children: ways and measures to prevent and solve the problems for the government and private sector
- A survey on child boxing in Thailand
- Violence and its impact on students in primary schools in Bangkok

Research collected by the Office of Welfare Promotion, Protection and Empowerment of Vulnerable groups

- News about children and youths on the front pages of daily newspapers
- Knowledge and attitudes toward drug addiction and behaviour related to juvenile delinquency in confinement
- Satisfaction of children on first admittance status in Pakkret Juvenile Delinquency Home
- Perception of communication patterns in family among children and youths with and without criminal actions in Bangkok
- Protection of children and youths as a victim in criminal cases: a study on power and duty of police officers under the Juvenile and Family Court
- Child and youth development in Juvenile Observation and Protection Home, Ministry of Justice.
- Behaviour surveillance by Department of Probation for youths judged not guilty by court.
- Child Welfare Organization, collaboration between government and NGOs.
- Social deviation behaviour, intelligence quotient of children and youths, child performance on first admission into Northern Juvenile Observation and Protection Home.

Collection of research on child abuse by Pairojkul S, Faculty of Medicine, Khon Kaen University

- A case study of children attending a pilot project in Thammasat Chalermprakiet Hospital to assist children who have been abused using a multidisciplinary approach
- Factors relating to the aggressive behaviour of the primary caregiver toward the child
- Sexual abuse in children: Case series of 16 patients
- Sexual abuse in children: Impact on family and adaptation mechanism
- Child abuse and negligence in northeastern Thailand

4. Discussion

4.1 Self-inflicted violence

4.1.1 Strengths/opportunities

1. *Body of knowledge/perspective/information systems and expertise*

- A significant body of knowledge has been accumulated in the country in various specialty areas. There are also many research results and experts in most disciplines.
- Buddhism, which is the national religion, considers suicide as a sin. This is supportive to prevention of self-harm and can be used for social mobilization if strategically planned and applied.
- There are several national information systems which include self-harm in their database. These cover all age groups, several levels of severity, legal aspects, time, place of occurrence and risk factors including methods and objects/products used in self-harm.

2. *Policy, legislation, the justice system and other governmental measures*

- There are policies, plans, targets and lead agencies for prevention and control of self-harm at the national level.
- Death from self-harm is considered “unnatural death” and by law has to be reported to the police for cause of death investigation and forensic evidence for justice.
- A population-wide prevention project which does not aim to screen for high-risk groups, such as life skills curriculum on dealing with controlling emotions and behaviours and appropriate communication among family members. This would avoid stigmatization or provocation and would not only prevent self-harm but also interpersonal violence and promote community mental health, if wisely planned and supported.

3. *NGOs/civil society*

- There are strong NGOs providing services such as the “Samaritan hotline”.

4. *Mass media and the public*

- Due to continuous communication to the mass media since the Department of Mental Health was identified as the lead agency, mass media are getting more cautious in reporting the suicide cases and avoiding to create fashions or copy-cat acts by teenagers.
- There is strong public interest in the issue of suicide.

4.1.2 Weaknesses/problems/obstacles/development needs

1. *Body of knowledge/perspective/information systems and expertise*

- A Western-influenced approach of not blaming victims of self-harm would need to be adapted and harmonized with the Buddhism perspective in preventing self-harm.

- The result of the evaluation of the intervention model to increase life skills and mental strength among children and families against violence have not yet been reported or disseminated to related disciplines and public.

2. Policy, legislation, the justice system, programmes, projects and other government measures

- The integration of prevention, control and services for self-harm victims into non-psychiatric hospitals is hindered due to the excessive workload of psychiatrists at provincial hospitals and the knowledge and skills of community hospital doctors (general practitioners).
- Most of the national programmes and projects focus on screening for high-risk groups more than building up mental health immunity regarding self-control over emotion and behaviours.

4.2 Interpersonal violence

4.2.1 Strengths/opportunities

1. Body of knowledge/perspective/information systems and expertise

- A Western-influenced approach of not blaming victims of self-harm would need to be adapted and harmonized with the Buddhism perspective on preventing self-harm.
- There is significant body of knowledge concerning violence against women and children in various specialties. The academia and the organizations concerned have engaged in a strong and continuous movement for change.
- Buddhism has the principle of avoiding all types of interpersonal violence. This should be supportive to the prevention of self-harm and can be used for social mobilization if strategically planned and applied.
- Several national information systems include assaults in their databases and cover all age groups, several levels of severity, legal aspects, time, place of occurrence and risk factors including methods and objects/products being used in self-harm. The system has existed for more than 10 years and includes the important risk factor of alcohol drinking. This should serve very well for planning, monitoring and evaluation.
- Regarding violence against women and children, there are large data recording systems all over the country, ready to be managed and computerized and made use of for research and intervention programme planning and evaluation.
- There are sufficient research results regarding demography and the personal histories of youth perpetrators, the roles and attitudes of the educational institutes involved with youth violence, awaiting application to intervention and management on a larger scale.

2. Policy, legislation, the justice system, programmes, projects and governmental measures

- The Thai government has been very responsive to international treaties and proposals for collaboration to prevent violence against children.
- There are policies, plans, targets and a lead agency for prevention and control of violence against children and women at the national level.

- Death from assault is considered “unnatural death” and is law requires that it be reported to police for cause of death investigation and forensic evidence for the justice system.
- Services for children and women who are victims of violence are available all over the country.
- The legal procedures for child and women victims of violence have been very much improved. A Social worker and psychologist are present in the process.

3. *NGOs/civil society*

- There are strong NGOs providing the services, research and advocacy in order to solve the problem of violence against children and women.

4. *Mass media and the public*

- Society is willing to support problem-solving concerning violence against children. Social norms, values and culture do not contradict moves against such violence.
- Mass media have done well in promoting the “Stop violence against children and women” campaign, both on reporting the activities and coordinating the proposal of policy.

4.2.2 Weaknesses/problems/obstacles/development needs

1. *Body of knowledge/perspective/information systems and expertise*

- There is very little research regarding appropriate services and rehabilitation for children who are victims of violence in Thailand.
- Lack of knowledge regarding the root of violence in relation to the Thai theoretical framework on society, culture, history, politics and norms that can appropriately explain the geographical difference in the types of violence prevalent in the north and the south of Thailand.
- Lack of multidisciplinary coordination and resources in conducting research on violence.
- Existing national information systems need support for exchanging of technology, experience and cross-checking between databases. This problem is urgent, especially for the police database, which also needs support to develop a manual for data recording (definitions and interpretation).
- There is severe resources crisis in all relevant national database systems, both in human and financial terms, as well as for computer hardware for the police system at the district level.
- Social structures and norms of Thai society that have cultivated the privilege of males over females is one of the obstacles to solving violence between genders.
- Lack of information on public awareness, attitudes and perceived risks of assaults among men, domestic violence and its relationship to social structures, which is important for policy and planning of population-wide intervention.
- Lack of information on public awareness, attitudes and perceived risks to self and family members associated with the possession and availability of firearms in households and in society.
- Lack of effective intervention research in solving the problem of domestic violence and also harmonizing with the Thai culture.

- Information on domestic violence perpetrators is lacking.
- Lack of knowledge regarding the impact on family function from the change of family structure (from extended to nuclear family, single parent and rearing by grandparents only) and indicators of a safe, sound and warm, efficient and resilient families.
- Insufficient studies on rape perpetrators who are not prisoners. These are normally people with higher status in society.
- More researchers of sexual violence who do not adhere to old ways of thinking (blaming the victim) are needed.

2. *Policy, legislation, the justice system and government measures*

- There is no formally assigned lead agency for national policy and planning for prevention and control of violence in an integrated way for the whole population (male, female children and elderly), aiming for sustainable results.
- There is no formally assigned lead agency to be responsible for comprehensive (physical, mental and societal) rehabilitation services for children who are victims of violence.
- The Child Protection Act, B.E. 2546 (2006) is not yet well known to officials and the public, hence enforcement is not yet seen by the public. Moreover, the responsible organization is not acquainted with law enforcement.
- Services provided to child victims are still passive. There are still problems in collaborative work among the concerned units which is less effective or efficient than it could be.
- Police officials still need to learn more techniques and skills to obtain adequate information without condemning, embarrassing, or stigmatizing the victims, especially in the cases of sexual and domestic violence. Physicians and nurses need to be skilled enough to detect hidden cases of domestic violence.
- Some police officials need to change their attitude to be able to work with the victims in a more sensitive and understanding manner.
- Lack of evaluation of pilot projects initiated, hence, no scale-up is possible or effective.
- There is inequity between genders in family law (between husband and wife regarding rape and adultery), in contravention of the Constitution.
- Inadequate official action in standardizing or controlling the volume and design of packages at high risk of being used for self-harm (e.g. enforcing limits on the amount of paracetamol allowed for over-the-counter sale, packaging of pesticides to be difficult for ingestion); and for assaults (e.g. ensuring that drinks sold in pubs or nightclubs are served in plastic, not glasses, so that they cannot be used as weapons).
- There are still obstacles regarding the budget system in working collaboratively among different ministries against violence, especially OSCC.

3. *NGOs/civil society*

- The promotion of gender equity to prevent violence is not yet well advanced. Appropriate techniques have to be developed in order to obtain better cooperation.
- NGOs providing services to violence victims are mostly situated in Bangkok and vicinity. Most of them still cannot collect and analyse their data in a systematic way.

4. *Mass media and the public*

- Several movies and soap operas still reiterate the inequity between genders and treat women characters as inferior to men.
- TV comedians or commercials still use violence as a topic without realizing that they are cultivating values in using power over others among young audiences. The concerned government agency is unable to control content effectively.
- Most Thai people are not concerned to participate in preventing violence, simply leaving it to the police or the judicial system. Creating an environment without violence is not yet adopted as everyone's responsibility in society.

5. Recommendations of the National Report on Violence and Health

1. Strengthen the existing information systems urgently, and systematically support research and knowledge management.

- Support technical development of the police information system (including a manual for data recording, data definitions and interpretation) and computer hardware by providing a specific budget that is exclusive from general budget of the police department to ensure implementation.
- Urgently strengthen death statistics, death certificate and injury surveillance and support exchange of technology, experience and cross-checking between each database; set up an investigation system to respond to abnormal events or discrepancies detected by the systems in order to obtain more knowledge about violence.
- Support the standardization and computerization of the OSCC database and link with other agencies providing services to victims in order to obtain more in-depth information on victims and data on offenders.
- Support for a the conduct of a national report on the trends of each type of violence, rotating among the major types each year. This should be provided as a five- or ten-year research grant to obtain comparable indicators and reliable trends. This reporting should also be used as a mentoring and training opportunity for young researchers under the supervision of senior experts who would at the same time utilize the report for advocacy in violence prevention.
- Support for a study to assess the national economic loss from assaults and the cost effectiveness of national programmes and projects to stimulate public awareness, along with appropriate allocation of budget.
- Assign a national multidisciplinary research plan with budget attached and with high priority, as research that contributes to economic development, to generate knowledge regarding:
 - 1) Family change: changes in family structure, roles of family members, and the relationship between the changes and strength of family mechanisms for early detection and prevention of risks, remedial measures for families whose members have been victims of violence.
 - 2) Techniques and models to control emotions and behaviour, disciplining without violence, living together peacefully in spite of differences in concepts, norms and beliefs.
 - 3) The root of violent behaviours in relation to the Thai theoretical framework on society, culture, history, politics and norms that can explain the geographical

difference in the types of violence prevalent in the north and the south of Thailand.

- 4) Cultural and societal studies to understand the conditions which foster violence in society and how constructive change may be achieved.
 - 5) The feasibility of adapting and harmonizing a Western-style intervention for self-harm of “not blaming the victim” with the Buddhism perspective on preventing self-harm.
2. Evaluate pilot curriculum/models/activities for building life skills and gender equity in children and family, the “Kanjanapisek Home” model and disseminate the resulting reports for further discussion and application to expanding the model in primary schools countrywide to create a sustainable non-violent society.
 3. The Ministry of Public Health should take the role as lead agency to coordinate the development of national policy and planning for prevention and control of violence for the whole population, with particular focus on the male population, the most affected, though aiming at population-wide strategies for sustainable results. The Ministry would have the most capacity to take this role in light of the health sector’s experience in epidemiology, advocacy and research on high-risk and population-wide approaches to violence prevention.
 4. Establish national measures, with budget attached, for monitoring and evaluating national programmes/projects on violence against women and children.
 5. Support capacity-building among police, health personnel and researchers concerned with violence victims for the required attitude, skills and sensitivity.
 6. Amend the laws contradicting the Constitution or gender equity.
 7. The Consumer Protection Agency should mandate and enforce standardized volumes and designs of packages of products which are frequently used for self-harm (pesticides, analgesic-paracetamol, cold tablets) and in assaults (drinks sold at pubs or nightclubs should be served in plastic, not glasses).
 8. Enhance and strictly enforce restriction of access to alcohol beverages and firearms.
 9. Review and amend the national budgeting and financing system to be supportive of multi-sectoral collaborative work and finance among ministries and disciplines.
 10. Expand One-stop Service Crisis Centers to cover all district hospitals and include comprehensive rehabilitation services for child and women victims. Collaboration, linkages and technical support to concerned organizations should be enhanced.
 11. Equity should be promoted as a peaceful means to prevent gender violence as well as violence between those of different ethnicity, religion and beliefs.
 12. The Ministry of Public Health and concerned agencies should communicate continuously with the media to create understanding that reiterating gender inequity in TV series and using violence as topic for comedians or in TV commercials can cultivate acceptance of violence in children and society.

13. Communicate to the public the risks to self and family members associated with the possession or availability of firearms in households and society.
14. Strengthen the system by using scientific evidence as a peaceful means of obtaining social justice.

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List of organizations working in violence prevention, 2005

	Agency	E-mail address	Data/emergency call
1	Office of the Prime Minister	http://www.opm.go.th Tel :662-280-3000	
	<i>The National Reconciliation Commission</i>	http://www.nrc.or.th/th/	Youth violence, Collective violence
2	Bureau of Royal Thai Police (NOT UNDER OPM OR MINISTRIES)	http://www.police.go.th	
	<i>Police Information System Center</i>	http://www.police.go.th/new/index1.php	National report (<i>Statistics crimes</i>) Reported crimes of Thailand
	<i>The Metropolitan Police command</i>	http://www.metro.police.go.th/ Tel : 662-280 3206 to 7-228	
	<i>Police Center for child and youth welfare</i>	http://www.korkorsordor.com/ Tel : 662-282 3892 Fax: 662-281 1449	
3	Ministry of Interior	http://www.moi.go.th Tel : 662-222-1141 to 55	24-hour hotline Tel: 1646 and 662-241-4170
	<i>Police general hospital</i>	http://hospital.police.go.th/ Tel: 662-252 8111 to 25	
	<i>Bangkok Metropolitan Administration</i>	http://www.bma.go.th/ccwed/ Tel : 662-245 4748 ext 53, Fax: 662-245 4748	24-hour hotline Tel: 1555
	Bureau of Gender Equality Promotion	http://www.women-family.go.th/women2/home.html	

4	Ministry of Social Development and Human Security	http://www.m-society.go.th	24-hour hotline Tel: 1300 and Post mail 108 Bangkok Hotline 1507, 1578
	<i>Office of Welfare Promotion Protection and Empowerment of Vulnerable group</i>	www.opp.go.th	
	<i>Women's Affairs and Family Development</i>	www.women-family.go.th/th/ http://www.women-family.go.th/home.htm http://www.women-family.go.th/women2/home.html	
	<i>Bureau of Gender Equality Promotion</i>	tml	
5	Ministry of Justice	http://www.moj.go.th	
	<i>1.Information and Communication Technology Center (ICT)</i>	Tel : 662-502 8051 to 8 Fax : 662-502 8059	
	<i>2. Deputy Permanent Secretary (Controlling and Behaviour Development).</i>	Tel : 662-412 1306 to 7, 662-411 2485 to 9, Fax : 662-411 1869	Call Center 662-419 0099
	<i>3.Department of Corrections</i>	http://www.correct.go.th/eng/eng.htm	Call Center 662-967 2222
	<i>4.Department of Juvenile Observation and Protection</i>	http://www.djop.moj.go.th/ Tel : 662-502 8004 , 662-502 8011 Tel : 662-502 8022 Fax: 662-502 8013	National report
6	Ministry of Labor	http://www.mol.go.th Tel : 662-321 1421 to 22	Call Center 1111
	<i>Department of Labor Protection and welfare</i>	http://www.labour.go.th/ Tel : 662-245 1000	24-hour hotline 1546
	<i>Social Security Office</i>	http://www.sso.go.th/ Tel : 662-956 2345	Call Center 1506
7	Ministry of Public Health	www.moph.go.th Tel : 662-590 1000	
	<i>1.Office of Secretary Bureau of Health Policy and Strategy</i>	http://hss.moph.go.th/	National report (death certificate) Death Rate

<i>2. Department of Health service Support</i>		Diagnostic Related Groupings (DRGs) and One-stop crisis center for women suffering violence (OSCC)
<i>3 Bureau of Health Service System Development</i>	http://203.157.3.250/	
<i>3. Department of Disease Control</i>	http://www-ddc.moph.go.th/ Tel : 662-590 3000	
<i>Bureau of Epidemiology</i>	http://epid.moph.go.th/ Tel : 662-590 1827, 1723 662-590 3337 Fax: 662-590 1784	National injury surveillance system : sever injury
<i>Bureau of Communicable Disease</i>	Tel : 662-590 3968 Fax: 662-951 0272	National Survey Behavioural Risk Factors Surveillance System (BRFSS)
<i>Bureau of AIDS, TB and STIs</i>	http://www.batsthai.org/main/index.php	
<i>4. Department of Mental Health</i>	http://www.dmh.go.th/ Tel: 662-951 1300 to 29	Hot line 24 hours Tel: 1667 and 1323
<i><u>Construction & Design Division</u></i>	http://www.dmh.go.th/plan/	
<i>5. Department of Health</i>	http://www.anamai.moph.go.th/ Tel: 662-590 4000	Hot line Tel: 1675
<i>Reproductive Health Division</i>	http://rh.anamai.moph.go.th/	
<i>6. Thailand Nursing Council</i>	http://www.tnc.or.th/ Tel : 662-951 1045 to 51	
<i>7. The Nursing Association of Thailand</i>	http://www.tnc.or.th/ Tel : 662-247 4463 to 4 Fax: 662- 247 4470	
<i>8. Health System Research Institute(สวรส)</i>	http://www.hsri.or.th/	

8 Ministry of Education

Mahidol University ศูนย์พิทักษ์สิทธิเด็กและครอบครัว กระทรวงศึกษา	www@mahidol.ac.th	Hotline 24 hours Tel: 1579
<i>Faculty of Social Sciences and Humanities</i>	http://www.sh.mahidol.ac.th/ Tel: 662-800 2840-70 Fax: 662-441 9738	

Institute for Population and Social Research <http://www.mahidol.ac.th/mueng/faculties/faculties.html>
E-mail : directpr@mahidol.ac.th
Tel: 662-441 0201 ext 113, 114
Fax: 662-441 9333

Thammasat University <http://www.tu.ac.th>

Faculty of Sociology and Anthropology <http://socio.tu.ac.th/>
Tel: 662-696 5800
Fax: 662-696 5812

Faculty of Political Science <http://polsci.tu.ac.th/en/index.php>
webadmin@polsci.tu.ac.th
Tel: 662-613 3333

Assumption University of Thailand www.nurse.au.edu
. *Faculty of Nursing*

9 **Bangkok Metropolitan Administration** <http://www.bma.go.th>
Tel: 662-221 2141 to 69

Friends of Woman Foundation <http://www.freindsofwoman.net/>
Tel: 662-513 1001
Fax: 662-513 1929

Paveena Foundation <http://www.paveena.thai.com/main.html>
Tel: 662-972 5489 to 90

Office of The National Human Rights Commission of Thailand <http://203.146.201.34/>
Tel: 662-219 2980
Fax: 662-219 2940
Hot line 24 hours
Tel: 1377

* The Women's Health Advocacy Foundation www.violence.au.edu
<http://www.whaf.or.th/>
Tel: 662-591 1224 to 5
Fax: 662-591 1099
Violence research database

Association for the Promotion of the Status of Women <i>(under the Royal Patronage of HRH Princess Soam Sawali)</i>	www.apsw-thailand.org Tel:02 929 2301 to 07	Hot line 24 hours Rape Crisis Center (Kanittha Naree Center) Tel: 662-929 2222 or E-mail : admin@apsw-thailand.org
1. <i>The Emergency Home</i>	http://www.apsw-thailand.org/Eemergency01.html	Hot line 24 hours Tel: 662-241 4170
2. <i>Woman's Education and Training Center</i>	http://www.apsw-thailand.org/Eeducate.html	
3. <i>Youth Center</i>	http://www.apsw-thailand.org/EYouth%20Center.html	
4. Gender and development research	http://www.apsw-thailand.org/Egdri.html	
5. <u><i>WE-TRAIN International House</i></u>	http://we-train.co.th/	
6. The Women's Health Advocacy Foundation	www.violence.au.edu http://www.whaf.or.th/ Tel: 662-591 1224-5 Fax: 662-591 1099	Violence research, database and Shelter and Counseling Resources 29 resources
7. ABAC School of Nursing Science, Assumption University of Thailand	http://www.violence.au.edu/c_shelter.html	

10 UNICEF Thailand	http://www.unicef.org/infobycountry/Thailand_1022.html e mail: eapro@unicef.org Tel: 662-356 9499, Fax: 662-280 3563 to 4
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