



Thai
Health
2026

Thai Health 2026



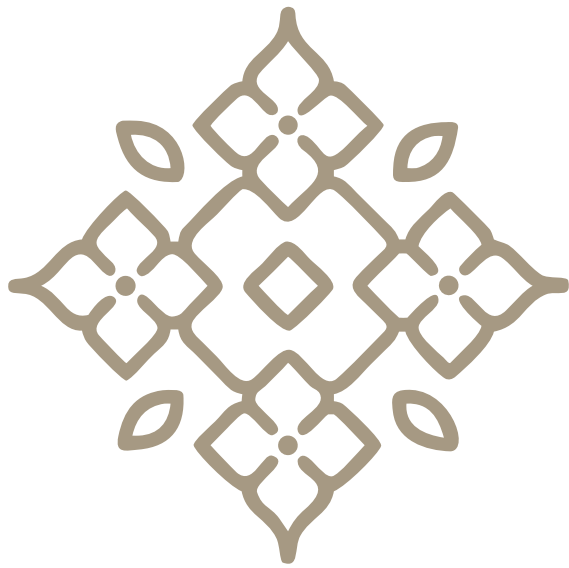
Health Literacy and the Role of Digital Communication



10 Indicators “Population Change and Thai Health”

10 Outstanding Health Situations

4 Outstanding Achievements for Health



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Preface

The 2026 Edition of the Annual Thai Health Report presents a special feature titled “Her Majesty Queen Sirikit The Queen Mother and the Health of the Thai People,” which conveys the royal initiatives and compassion of Her Majesty Queen Sirikit, who continuously devoted herself to the health and well-being of the Thai people throughout her life. Her work has ranged from visiting people in remote areas and providing relief during times of crisis, to promoting hygiene and improving the population's quality of life. The article invites readers to reflect on the role of our “Mother of the Nation” as a source of moral support and inspiration for the well-being of Thai society over many decades.

The Health Indicators section presents “Changes in Population Structure and the Health of the Thai People,” offering data on the health indicators of Thais within the context of rapidly changing demographic structures. These include declining birth rates, an aging society, and evolving family patterns, all of which affect health, lifestyles, healthcare systems, and public policy. This section encourages readers to understand the key challenges facing Thai society and to consider sustainable responses for the future.

The Key Health Situations of 2026 compiles important news and events, presented through in-depth analytical articles that closely follow ongoing developments related to the following areas: 1) Non-communicable Diseases (NCDs): A Thai Health Challenge 2) Social Security: It Is Time for Reform - Before a Crisis Hits 3) US Policy and Its Impact on the Health of the Thai People 4) From Call Center Gangs to Cross-Border Human Trafficking 5) Borderless Education: Transnational Students and Thai Society 6) Earthquakes: A Disaster That Should Not Be Overlooked 7) A Toxic Transboundary River: Contamination in the Kok, Sai, Ruak, and Mekong River Basins 8) Breath of the Border – On the Day the Gunfire Has Not Yet Ceased 9) Equal Marriage: Social Acceptance of Sexual Diversity 10) From “Welfare” to the Protection and Promotion of the Livelihoods and Rights of Ethnic Groups.

Section 4, “Outstanding Achievements for Health,” highlights achievements in medicine and public health: 1) Thailand Produces Imcranib 100: A Major Step Forward in Targeted Cancer Therapy 2) Siriraj Produces Titanium Hip Sockets Using 3D Printing Innovation 3) Model Healthy Communities: Scaling Up Toward Sustainable Well-being 4) Thailand Bans Plastic Waste Imports in 2025: Toward Environmental Sustainability and the Well-being of the Thai People.

The Special Topic feature of the 2026 edition presents the article “Health Literacy and the Role of Digital Communication” This section invites readers to understand health literacy in the digital age, analyzing both the opportunities and challenges of accessing health information through online media-from health news and influencers to digital medical services. It also reflects that, although Thai people have greater access to information, appropriate health decisions and behaviors do not always follow. Accordingly, the article proposes concepts and policy directions to develop health literacy so that people can “think critically, make informed choices, and take proper care of their health” in everyday life.

The Thai Health Report 2026 Working Group would like to thank our readers for their continued support and for utilizing the Thai Health Report in areas such as research, planning, policymaking, and field operations. This support serves as an important source of encouragement for the working group to further improve the report.

For more information and additional interesting articles, please visit:
www.thaihealthreport.com

Thai Health Report Team

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Her Majesty Queen Sirikit, the Queen Mother of Thailand



and
the Health of the Thai People

Dr. Vichai Chokevivat



Introduction

Just one day after the anniversary of the passing of King Chulalongkorn (Rama V), Her Majesty Queen Sirikit, the Queen Mother, passed away on 24 October 2025, at 9:21 p.m. at King Chulalongkorn Memorial Hospital. On the following day, a royal ceremony was held to transfer her royal remains to the Dusit Maha Prasat Throne Hall in the Grand Palace.

At the time of King Chulalongkorn's death, it was the first instance in the Rattanakosin era that a monarch passed away far from the place where the royal remains would be enshrined. The royal remains were carried by bearers along Ratchadamnoen Road on a royal palanquin adorned with a nine-tiered white umbrella. This required the cutting of overhead electrical wires, as the palanquin and umbrella could not pass beneath them. The procession took place in the evening, leaving the route without electric lighting. Along both sides of Ratchadamnoen Road, men and women sat in rows, lighting incense and candles in homage. One could see rows of candlelight, but people appeared only as dim silhouettes—or not at all—while the sound of weeping filled the air.

That day, rain clouds had gathered since late afternoon. Lightning flashed intermittently across the sky. The golden royal urn, decorated with finials, hanging tassels, and ornamental motifs around its midsection, was adorned with silver thread that sparkled like diamonds when it caught the light. Strong winds and stormy weather persisted throughout the route.

Those walking in the procession expected to be drenched at any moment, yet along the entire route there was only thunder and strong wind. Only after the royal remains had entered the Dusit Maha Prasat Throne Hall did a heavy downpour finally begin.



Rain, as if commanded by the heavens, bidding farewell to the Fifth Reign as he returned to the celestial realm.⁽¹⁾

King Chulalongkorn, the Great Beloved King, reigned for 42 years—longer than any previous monarch. He contributed immeasurably to the nation and its people and was deeply loved by his subjects. Thus, when his royal remains were transferred from Dusit Palace to the Dusit Maha Prasat Throne Hall in the Grand Palace, people gathered in rows to weep and bid him farewell, despite the darkness, the threatening rain, the strong winds, and the thunder.

Her Majesty Queen Sirikit, though not a reigning monarch, was the Queen Consort and the cherished partner in virtue and merit of His Majesty King Bhumibol Adulyadej the Great. For nearly seven decades, she devoted herself to serving the Thai people, as well as those from neighboring countries who sought refuge under her benevolence. Her contributions have been recognized worldwide. It is difficult to find any queen in world history who could equal her—both in her role as consort to a great monarch and in the royal initiatives she personally conceived and carried out.



Birth of Her Majesty

Her Majesty Queen Sirikit is the eldest daughter of His Serene Highness Prince Nakkhatra Mangala, the Prince of Chanthaburi Suranath, and Mom Luang Bua Kitiyakara. She was born on 12 August 1932. She was given the name “Sirikit” by Queen Rambai Barni, consort of King Prajadhipok (Rama VII), which means

The Glory of the Kitiyakara family

She has siblings of the same lineage, including her elder brothers Mom Rajawongse Kalyanakiti and Mom Rajawongse Adulkiti, and her younger sister Mom Rajawongse Busba.

At the age of five, around 1937, she began her kindergarten education at Rajini School, where she was assigned student number 2414. According to her teacher’s report, she studied happily without crying or fussing like other students and enjoyed performing classical dance. Later, in 1940, she continued her primary and secondary education at Saint Francis Xavier Convent School on Samsen Road, not far from her residence, allowing her to walk to school herself.⁽²⁾



The reason for transferring to Saint Francis Xavier Convent School was that her mother believed that, during the period of World War II, the family’s financial situation was not very strong. Therefore, the children—especially the daughters—should be able to support themselves. One suitable profession, in her mother’s view, was becoming a piano teacher. Hence, she was enrolled in a school that offered piano instruction. At that time, a popular game was “wing piaw” (a traditional Thai running game), which she considered her favorite sport, and she served as the team leader. It was also recalled that she would secretly eat snacks in the classroom—usually gooseberries—passing them around among classmates in the afternoon.

“We would secretly eat during the afternoon, because after Thai language class it made us sleepy, so we had a little snack. Her Majesty joined in as well.”⁽³⁾

In 1946, she accompanied her father, who had been appointed by the government as Ambassador Extraordinary and Plenipotentiary to the Court of St. James’s in the United Kingdom, and subsequently to the Kingdom of Denmark and the French Republic.



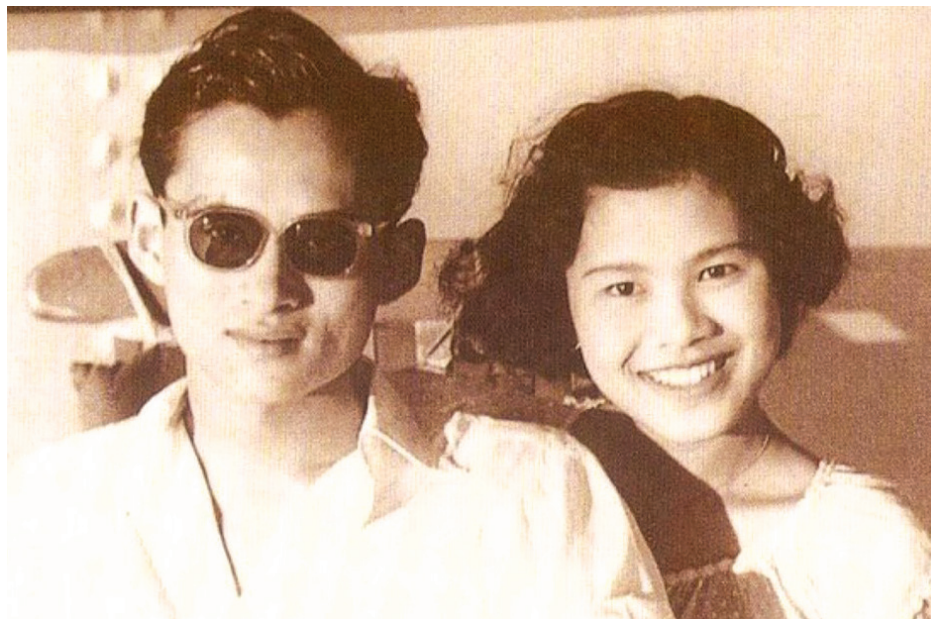
The Royal Consort

While Her Majesty Queen Sirikit was residing in Paris, France, in 1946, His Majesty King Bhumibol Adulyadej the Great was living in Lausanne, Switzerland. The two countries share a border, with a distance of approximately 350 kilometers between them. The Princess Mother (Somdet Phra Srinagarindra) spoke to her son about the two daughters of Mom Chao Nakkhatra Mangala, saying:

“Take a look and see if they are beautiful and charming. Mom Chao Nakkhatra Mangala is no ordinary person—he is a direct grandson of Somdet Ya (Queen Savang Vadhana), and a good man. Mom Luang Bua is the daughter of Chao Phraya Wongsa as well, and she is also virtuous and honest.”

She further instructed, “Once you arrive in Paris, call me.”

When His Majesty the King arrived in Paris, he telephoned his mother and reported what he had seen of Mom Chao Nakkhatra Mangala's daughters, saying, "I've seen them... very charming indeed."⁽⁴⁾



¹ Image: The Fine Arts Department (2022)

Their first meeting took place in 1948. At that time, His Majesty King Bhumibol Adulyadej the Great was 21 years old and had already ascended the throne, while Her Majesty Queen Sirikit was 16 years old. During their stay in Lausanne, the government provided an annual allowance of 100,000 baht, so all members of the royal household had to spend frugally. On that occasion, the royal car was old and in poor condition; it broke down and ran out of fuel, requiring considerable time to fix before they could arrive. Those waiting to receive them "changed from cheerful smiles to pouting expressions," even to the point of "walking about restlessly with frowns, waiting to offer their formal greeting." The reason given by those receiving them

was that "they had to frown because only the adults were allowed to join the royal dining table, while the children were sent off to eat elsewhere."⁽⁵⁾ And no one knew that the incident would become "love at first sight."

On that occasion, His Majesty took a photograph of Mom Rajawongse Sirikit for the first time. "It was a group photo of those in attendance at the embassy, and Mom Rajawongse Sirikit was standing at the very back, her face not clearly visible. So he said, 'Yoo-hoo, the person in the back, please show your face a little.' Later, he had the photograph enlarged and cropped to keep only her face, which he carried with him in his pocket."⁽⁶⁾

Later, on 4 October 1948, His Majesty King Bhumibol Adulyadej the Great, together with Khun Aram—the husband of Her Royal Highness Princess Galyani Vadhana, the Princess of Naradhiwas Rajanagarindra—was driving to Geneva to listen to jazz music. A serious accident occurred when their car crashed into the back of a truck, leaving both of them severely injured.⁽⁷⁾

He was admitted for treatment at a private hospital in Lausanne. The Princess Mother, Her Royal Highness Princess Srinagarindra, went to visit him. “The first thing he did upon regaining consciousness was to take out the photograph of Mom Rajawongse Sirikit from his pocket and present it to his mother, saying, ‘Mother, please call Sirikit to come.’”⁽⁸⁾ When the family of Her Majesty Queen Sirikit went to visit him, “upon arrival, he held everyone’s hand in greeting. But when it came to Her Majesty (then Mom Rajawongse Sirikit), he did not let go. She was very startled, not

understanding why he kept holding her hand. They went to visit him every day, and each time it was her turn, he would hold her hand for a long time. He also asked her to read stories to him—One Thousand and One Nights in Thai. At the time, she did not think anything of it...”⁽⁹⁾

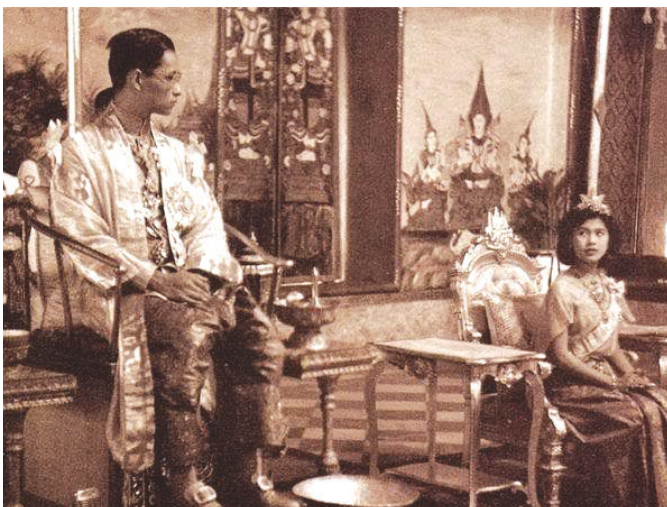
At last, the Princess Mother, Her Royal Highness Princess Srinagarindra, requested the hand of Mom Rajawongse Sirikit from Mom Chao Nakkhatra Mangala. A private engagement ceremony was held on 19 July 1949, during which a ring was given as the engagement token. This ring was the very same one that Prince Mahidol Adulyadej had given to the Princess Mother.

The engagement was publicly announced to the Thai people on 12 August 1949. On that occasion, His Majesty graciously permitted a simple celebratory reception to be held at the Thai Embassy in London, United Kingdom.

Subsequently, the royal wedding ceremony took place at Sra Pathum Palace on 28 April 1950. Her Majesty Queen Savang Vadhana, the Queen Grandmother, presided over the ceremony, bestowing holy water, sacred blessings, and anointing both of them.

Later, when His Majesty King Bhumibol Adulyadej the Great held the Royal Coronation Ceremony at the Phra Thinang Phaisan Thaksin in the Grand Palace on 5 May 1950, he formally proclaimed Her Majesty Queen Sirikit as Queen of Thailand.⁽¹⁰⁾

At that time, she was only 17 years, 8 months, and 24 days old. From that moment on, she faithfully carried out her role as the Queen Consort for more than 66 years.

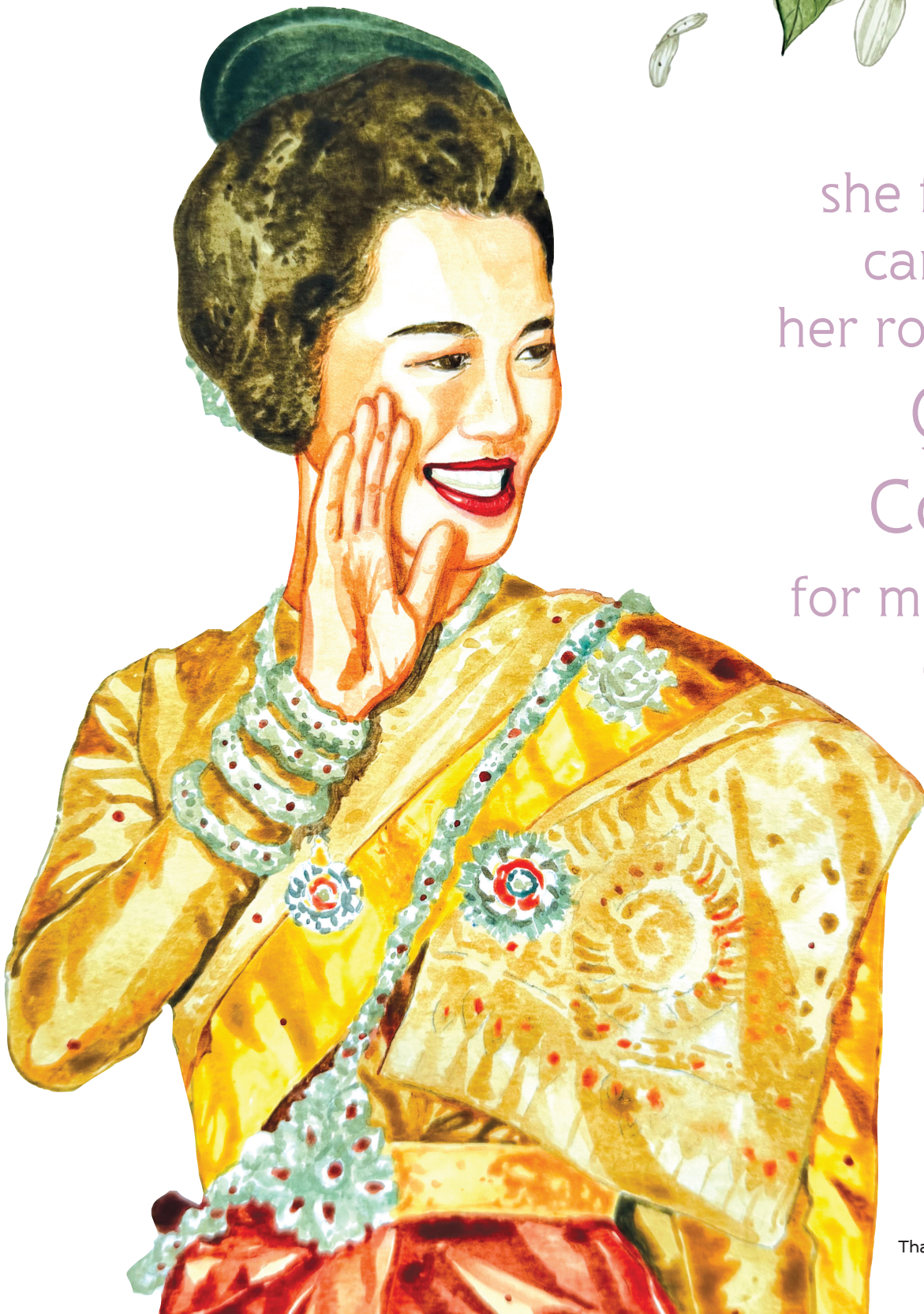


²Image: The Public Relations Department (2025)





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**Queen
Consort**
for more than
66 years.





The Spiritual Center of the Thai People



The Thai people have long maintained a deep bond with the monarchy. When King Prajadhipok (Rama VII) abdicated the throne, the government and parliament invited King Ananda Mahidol to ascend the throne. However, he was still very young and not in strong health, and was also studying abroad. The government made repeated efforts to invite him to return to the capital to reassure the people, but it took several years before he could do so—and even then, his visits were brief. After his second return following World War II, the country was in turmoil from the effects of the war, and only a few days before his departure, a tragic event occurred.

Afterward, when His Majesty King Bhumibol Adulyadej the Great ascended the throne, he soon had to return abroad to continue his studies, leaving the people in deep sorrow and concern that he might “abandon” them. Therefore, when he returned and held the Royal Coronation Ceremony, along with the royal wedding and the proclamation of the Queen, it brought immense joy to the people.

On that auspicious occasion, Their Majesties appeared on the balcony of the Suthaisawan Prasat Throne Hall, graciously granting the public audience to offer their blessings.

“...Wherever Her Majesty the Queen looked, she saw vast crowds of people stretching as far as the eye could see. It filled her with warmth and deep emotion. Though still very young, she realized within herself a sense of strength and confidence drawn from the heartfelt support of the people. She resolved to follow in the footsteps of His Majesty the King and to share in the joys and sorrows of the people as if they were her own.”⁽¹¹⁾

She carried out her role as the “Queen Consort” with the utmost grace and excellence, despite her young age. As she once said:

“At age 17, when I became Queen, I knew almost nothing. It was through the grace of His Majesty the King that I was constantly guided and taught what should and should not be done. He taught me how a Queen of Thailand should conduct herself and what her duties were. Most importantly, he instructed that I must be someone in whom the people could place their trust—that they would feel close enough to confide their hardships. His Majesty also set an example through his own conduct, showing me how to be close to the people. For instance, when he conversed with them—sometimes for hours—he did not like to stand. He observed the Thai custom of not standing over elders; instead, he would sit down to speak with the people, even under the blazing midday sun. I have witnessed this conduct since the beginning of his reign...”⁽¹²⁾

Her Majesty the Queen Mother

After the royal wedding ceremony, Her Majesty Queen Sirikit gave birth to her first child, a daughter—

Her Royal Highness Princess Ubolratana Rajakanya Sirivadhana Barnavadi—at Montreux Clinic in Lausanne, Switzerland, on 5 April 1951.

She later gave birth to a son, His Majesty King Maha Vajiralongkorn (Rama X), at Amphorn Sathan Residential Hall, Dusit Palace, on 28 July 1952.

Her second daughter, Her Royal Highness Princess Maha Chakri Sirindhorn, was born at Amphorn Sathan Residential Hall, Dusit Palace, on 2 April 1955.

Her youngest child, a daughter—Her Royal Highness Princess Chulabhorn Walailak—was born at Amphorn Sathan Residential Hall, Dusit Palace, on 4 July 1957.



Photographs Through the Lens of
His Majesty King Bhumibol Adulyadej

³ Image: rama9art (2017)



Throughout the period of raising all four of her children, Her Majesty Queen Sirikit accompanied His Majesty King Bhumibol Adulyadej the Great on visits to people across the country, as well as on state visits abroad to foster international relations. She devoted her heart and physical strength to their upbringing, placing the highest importance on their health and education.⁽¹³⁾



Compassion
and kindness
cannot be
commanded
by anyone

On 9 September 1954, a fire broke out at the market in Ban Pong District, Ratchaburi Province, covering an area of over 100,000 square wah. A total of 832 houses were destroyed, at least three people were killed, and 5,904 people were affected. The damage was estimated at 61,542,255 baht.

On 13 September at around 9:00 a.m., His Majesty King Bhumibol Adulyadej the Great personally drove, accompanied by Her Majesty Queen Sirikit, departing from Amphorn Sathan Residential Hall. Security officials were initially unaware and only realized after they had been gone for some time. The royal escort later caught up with the royal vehicle in Nakhon Pathom. They stopped for lunch at Chali Mongkol Asana Hall in Sanam Chandra Palace before continuing on to Ban Pong.

Upon arrival, Their Majesties toured the fire-damaged area, inquiring about the well-being of those affected. They distributed clothing, food, and medicine, and donated 100,000 baht from their personal funds to relieve the suffering of the people. This act brought great joy not only to those affected in Ban Pong, but also became major news throughout the kingdom.⁽¹⁴⁾

Visits to the People

It is clear that Their Majesties' visit to provide relief to the victims of the great fire in Ban Pong was like a gentle, nourishing rain bringing much-needed comfort to those in distress. From then on, they regarded visiting the people as an important royal duty, believing that the happiness and suffering of the people were their own.

The Northeast

The first region they chose to visit was the Northeast, the most remote and underdeveloped area at the time. It should be remembered that, in those days, Mittraphap Road—the main gateway to the Northeast—had not yet been built. Their journey to the Northeast, from 2–20 November 1955, began with a special train departing from Chitralada Station at 7:40 a.m. to Nakhon Ratchasima. From there, they continued by royal car to Chaiyaphum, Khon Kaen, Loei, Udon Thani, Nong Khai,

Sakon Nakhon, Nakhon Phanom, Kalasin, Maha Sarakham, Roi Et, Ubon Ratchathani, Si Sa Ket, Surin, and Buri Ram.

At that time, most of the travel routes were extremely difficult—remote, long, and arduous. Yet they were determined to go, whether by train, car, airplane, rowboat, motorboat, elephant, or horse. Most often, they traveled by jeep. Roads were not yet paved; in some places, they had to drive through water and climb up muddy banks.

During these visits, Their Majesties rarely took meals. Sometimes they worked until late at night—one or two in the morning—continuing tirelessly and with great dedication. Eating was of little importance. They were able to work anywhere, at any time, even writing without the need for a formal desk or chair, preferring instead to sit on the ground for long periods, fully focused on their work.

They would inquire closely into the well-being of the people. In those days, no one dared inform them that it was time to return, as they would not agree—they wished to help the people as much as possible. They never thought of themselves, but cared more for the people. For them, the people always came first...⁽¹⁵⁾

During the period of visiting the people in the Northeast, Her Majesty Queen Sirikit was just over 23 years old and already had three children. At that time, Her Royal Highness Princess Maha Chakri Sirindhorn was 7 months old.

The North

The North was the second region Their Majesties visited, from 27 February to 17 March 1958. Traveling by train, they visited 10 provinces, beginning with Phitsanulok and continuing through Sukhothai, Tak, Lampang, Lamphun, Chiang Mai, Chiang Rai, Phrae, Nan, and Uttaradit.

The South

The South was the third region they visited, from 6 to 26 March 1959. They traveled to 14 provinces, starting from Chumphon and continuing through Ranong, Phang Nga, Phuket, Krabi, Nakhon Si Thammarat, Trang, Phatthalung, Songkhla, Satun, Yala, Pattani, Narathiwat, and finally returning to Surat Thani as the last province.

In many southern provinces, the population is Muslim. This visit to the South was a significant moment that led Their Majesties to deeply realize the strong loyalty of the people in the region. As Thanphuying Kenlong Snitvongs Na Ayudhya recounted: “People, whether Thai Buddhists or Muslims, showed the same love and loyalty. Thai Buddhists would raise the royal hand to their heads as a sign of reverence, while Thai Muslims expressed respect by kissing the royal hand. Some even rushed forward to prostrate at the royal feet inside the mosque, where there was a seat similar to a pulpit in a Thai temple. They respectfully invited His Majesty the King to sit there for auspiciousness, even though normally they would not allow those of other religions to enter. This truly reflected a shared sense of being Thai.”⁽¹⁶⁾

The Central Region

As for the Central Region, which is not far from Bangkok, His Majesty King Bhumibol Adulyadej the Great made visits to the people periodically. In some provinces, he visited many times—for example, Nakhon Nayok Province, which he visited a dozen times. In addition to being like life-giving rain that nourished the hearts of the people, numerous royal initiative projects followed. In Nakhon Nayok, in particular, he demonstrated a true model of “understanding, reaching out, and development.” This led to the successful construction of the Khun Dan Prakan Chon Dam, along with seven reservoirs under royal initiatives: Sai Thong Reservoir, Khlong Bod Reservoir, Huai Prue Reservoir,



⁴ Image: The Public Relations Department (2025)

Khlong Si Siet Reservoir, Ban Wang Muang Reservoir, Ban Rim Bon (Khlong Yang) Reservoir, and Khlong Klang Reservoir. These projects effectively addressed both drought and flooding problems for the people on a wide scale.⁽¹⁷⁾

In addition to the hardships caused by poverty and remoteness, when ideological conflicts later intensified, Their Majesties did not fear the dangers involved. As recalled by Her Royal Highness Princess Vibhavadi Rangsit:

“...Since 1967, His Majesty the King and Her Majesty the Queen no longer traveled abroad. Instead, they devoted themselves to visiting soldiers, police, and the people across various regions—especially in areas under threat or affected by natural disasters. I still remember when they went to visit troops and villagers in a remote area at Ban Pon, Thung Chang District, Nan Province. Just before their visit, the unit there had been violently attacked, resulting in several casualties. When Bangkok learned of this, there were requests for them to cancel the visit, but they refused, as the schedule had already been set—they did not wish to let anyone wait in vain.

When they arrived, they carried out the entire program as planned. Along the route, fresh bomb

fragments were still scattered everywhere, and unexploded ordnance had not yet been cleared. Yet wherever His Majesty went, Her Majesty always accompanied him, no matter how dangerous the situation, never showing any hesitation. They never had days off like others; they worked every day, at every opportunity. In my view, the two of them were the hardest-working individuals in Thailand...”⁽¹⁸⁾

Serious incidents occurred frequently, one of the most severe being the bombing in Yala on 22 September 1977. On that day, His Majesty King Bhumibol Adulyadej the Great and Her Majesty Queen Sirikit together with Her Royal Highness Princess Maha Chakri Sirindhorn and Her Royal Highness Princess Chulabhorn Walailak, traveled to present awards to Islamic religious teachers in the South and to bestow flags upon Village Scouts at the White Elephant Ground in Yala Municipality Park.

During the ceremony, the PULO insurgent group planted two bombs near the venue. The first exploded just 55 meters from the royal pavilion, and the second 110 meters away. A total of 47 people were injured, 11 of them seriously. Panic broke out as people fled in all directions. However, His Majesty the King remained remarkably composed. After the initial chaos subsided, the ceremony was briefly paused, and the injured were sent to the hospital. He then resumed the ceremony and addressed those in attendance:

“May everyone remain strong and not be shaken by the situation. Keep your eyes and ears open, and such dangers can be overcome. Thai people, no matter where they are, share the same spirit—to preserve peace. If anyone creates unrest, we must defend against it. I commend the Village Scouts for conducting themselves well according to their training. May everyone remain strong, safe, and successful in all endeavors.”

After the ceremony, royal security officers respectfully advised returning to Thaksin Ratchaniwes Palace for safety. However, His Majesty requested to visit the injured at the hospital. The officers urged, “Please do not go—it is dangerous. The return route will be even more dangerous after dark; there could even be rocket attacks. It would be best to return immediately while it is still daylight.” But His Majesty insisted:

That won't do.
They came here and
were injured because
we came. They came
to see us—we must
go to visit them.

Her Majesty Queen Sirikit gave an interview to a group of female journalists about the incident:

“There were reports saying that the injuries were not serious. I can assure you—we were told they were only minor scratches, that a bit of antiseptic would be applied and they could go home. I think that in some countries, monarchies have collapsed because of situations like this—because they believed what they were told.

His Majesty said that if they were only scratches, he would go and see for himself. But they would not allow it and ordered the royal car to return to the residence. As the car was driving back, His Majesty ordered it to turn around immediately—‘I am going to the hospital.’

The driver was afraid and took another route toward the hospital. When we arrived, we were shocked—there was blood everywhere. There was a young girl, about 17 to 19 years old, struggling to breathe, one lung collapsed. If we had not gone, she would have died. Another child was at risk of losing her sight. People were lying everywhere—there was nothing but blood.

When we went in, the young girl saw us and began to cry, saying, ‘Your Majesty, I am in so much pain. I can’t breathe. I’m hurting. My parents are not here—please help me...’⁽¹⁹⁾

Her willingness to face hardship and danger—traveling to remote areas to visit the people, and going to the front lines to see soldiers and police—was because: “...His Majesty the King taught all his children, and first taught me, that when people honor and revere us as their leaders, we must feel that we have to work harder than anyone else. We must have responsibility and make sacrifices. Foreign journalists have asked why His Majesty must constantly go out to help with development, seeing how tired he becomes and that he never seems to rest. I explained that the reason he must keep going is that he cannot afford to be tired—we cannot afford to be tired—because our country still has so many people who are poor and in need of help.”⁽²¹⁾

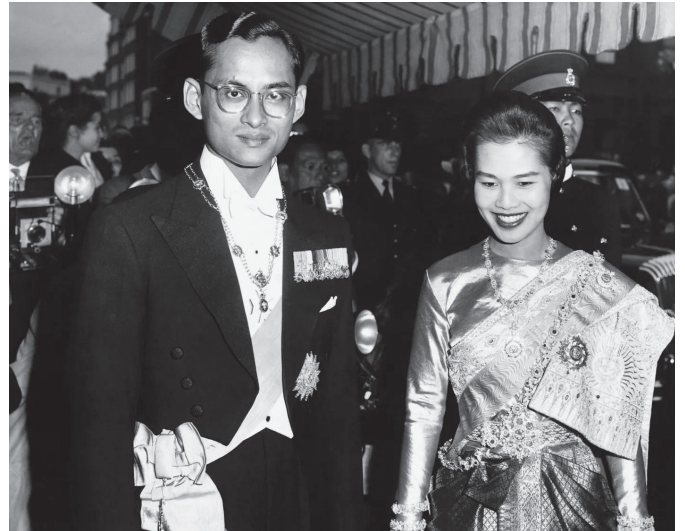


⁵ Image: Sanook (2025)



Formally proclaimed as Her Majesty the Queen

During the period when His Majesty King Bhumibol Adulyadej The Great was ordained as a monk, from 22 October to 5 November 1956, for a total of 15 days, a royal command was issued appointing Her Majesty Queen Sirikit to serve as Regent. At the same time, she was elevated to the title of “Her Majesty Queen Sirikit, the Queen.” She thus became the second Queen Regent of the Rattanakosin era, following Queen Saovabha Phongsri, the Queen Mother, consort of King Chulalongkorn, who had been graciously elevated to the title of ‘Queen’ during His first royal visit to Europe in 1897. In her capacity as Regent, Her Majesty Queen Sirikit performed her duties by taking the oath of office before the National Assembly at the Ananta Samakhom Throne Hall. She also attended Privy Council meetings and affixed her royal signature to certain laws.”⁽²⁰⁾



⁶ Image: VOGUE Thailand (2025)

International State Visits

After visiting people in all regions of the country, it was time for state visits abroad, totaling 27 countries. Beginning with neighboring nations, the first official visit was to the Republic of Vietnam from 18–21 December 1960. This was followed by a visit to the Republic of Indonesia from 8–16 February 1960, during which the royal couple paid homage at Borobudur, the renowned Buddhist monument. Subsequently, they visited the Union of Burma from 2–5 March 1960, where they also paid homage at the Shwedagon Pagoda.



The United States

After that, they made an extended visit to the United States for over one month, from 14 June to 15 July 1960. This period marked a true international recognition of Siam, as they clearly demonstrated their commitment to democratic ideals to the world and further strengthened diplomatic relations with allied nations.

Both were received with the highest honors. As reflected in a message from Dwight D. Eisenhower to His Majesty King Bhumibol Adulyadej The Great, one passage stated:

“This visit to the United States by Your Majesty and Her Majesty the Queen is not merely a ‘return to your birthplace,’ but also a new symbol reflecting the long-standing friendship in the history between our two peoples. It further demonstrates the deep admiration and warm regard that Americans everywhere hold for Your Majesty, Her Majesty the Queen, and the people of Thailand...”⁽²²⁾



⁷ Image: Thai PBS (2025)

The United Kingdom

After that, they paid a state visit to the United Kingdom from 19–23 July 1960, where Queen Elizabeth II graciously welcomed them with full royal honors at Victoria Station. Her Majesty Queen Sirikit The Queen Mother later recounted:

“I personally felt that every time His Majesty met Queen Elizabeth, they spoke with great familiarity, even though they had only met for the first time just a few days earlier. Especially that evening, there was a great deal of playful teasing between them, which made all of us at the dinner table equally delighted and amused. This was likely because their destinies seemed well matched, and their ages were very close...”⁽²³⁾



⁸ Image: THE STANDARD (2017)

The Federal Republic of Germany

The next country they officially visited was the Federal Republic of Germany, from 25 July to 2 August 1960. Her Majesty Queen Sirikit The Queen Mother later recounted:

“...During that visit to Germany, I remember that we learned a valuable lesson. The German authorities had requested that the Thai ambassador in Bonn send a very detailed schedule of the visit for His Majesty to review while we were still in America...

When we saw the full nine-day itinerary for Germany, we were quite overwhelmed. We felt it was extremely demanding, as we were already exhausted from

our time in America—sleep-deprived, constantly attending receptions, and flying almost every day throughout that month... There was no time to rest and regain our strength.

I therefore asked His Majesty to have the Royal Secretary contact the Thai ambassador in Bonn to privately inquire whether it might be possible to remove some of the less essential items from the schedule. The response we received, in summary, was that it would not be appropriate to cut any items, because for an official state visit such as this, the host country should be given the full opportunity to extend their hospitality. If parts were removed, they would feel they had not been able to fully welcome us. I immediately realized that this was true. On that trip, the two of us should not have been thinking of our own comfort. When we travel in our capacity as heads of state, it is not appropriate to feel sorry for ourselves for being tired from previous visits and then try to negotiate reductions with a country that had nothing to do with our fatigue. That would not be fair to them. So, we agreed to accept the entire program arranged by the German government without any changes...”⁽²⁴⁾

From Germany, they continued their visits to various countries in succession, including Portugal, Switzerland, Denmark, Norway, Sweden, Italy, Vatican City, Belgium, France, Luxembourg, the Netherlands, Spain, Pakistan, the Federation of Malaya, New Zealand, and Australia. The journey was extremely demanding, as Her Majesty recounted:

“...His Majesty began to suffer from a cold while we were in Belgium. If he had been able to rest for even one or two days, his condition might not have worsened. But instead, he had to attend engagements from morning until night without pause, traveling from city to city. The weather was

quite cold, and it rained every day, so he was constantly exposed to cold rain. By the second day, he developed a fever. The royal physician administered medicine every four hours, which made him drowsy and sluggish, yet the fever did not subside.

Even so, he forced himself to remain energetic and attended every engagement without exception. No one except those of us close to him knew how ill he truly was. He would speak French at one moment, English at another. Each day, he must have shaken hands with nearly a thousand people. I felt deeply concerned for him. If I had been that ill, I am not sure I could have endured it. Seeing his face pale and his eyes heavy with fever only increased my anxiety, yet I could do nothing to help.

I knew well that he would persevere to the very end—there would never be a day when he would give in. When I think of the phrase foreigners like to say, ‘As happy as a king,’ I feel like laughing out loud in both irony and bitterness...”⁽²⁵⁾

While in the Islamic Republic of Pakistan, Her Majesty recounted:

Factory workers were excited by the royal visit of the King of Thailand. In every department that was visited, they presented garlands to place around his neck and cheered ‘Zindabad’ (‘Long live!’), as they admired how unpretentious and approachable the Thai King was with the workers...”⁽²⁶⁾



⁹ Image: The Public Relations Department (2025)

During the visit to New Zealand, Her Majesty Queen Sirikit The Queen Mother fell ill. She recounted:

“...One evening, we arrived at our accommodation later than scheduled because people had been waiting to see us along the entire route, forcing the car to move slowly and causing delays. As soon as we arrived, we had to prepare immediately for a large buffet reception.

My cold worsened significantly, and I developed a fever. I therefore asked His Majesty for permission to excuse myself from attending the event that evening, as it was a buffet rather than a formal seated dinner as usual. His Majesty saw that I had a severe cold and a high fever, and he sympathized, granting my request.

However, when the officials were informed, they pleaded with me to attend, even briefly, saying that many people would be disappointed. I could not refuse their earnest request, so I decided to go, taking a full dose of cold medicine beforehand.

It turned out that my endurance on that occasion was not in vain—it was truly worthwhile. Everyone at the event came to thank me for making the effort to attend despite being unwell. They showed great sympathy and seemed especially appreciative.

That day, I learned a valuable lesson: A person in a position such as mine must possess both physical and mental endurance. And this was a lesson I had to apply very much in the countries we visited afterward...”⁽²⁷⁾

Australia

Not only did they have to endure physical hardship; in Australia, during the visit from 26 August to 12 September 1959, they also had to face an awkward situation. While His Majesty King Bhumibol Adulyadej The Great attended a ceremony to receive an honorary Doctor of Laws degree from the University of Melbourne, Her Majesty recounted the following:

“...When we entered the hall, it was nearly full. There were students, professors, prominent figures of Melbourne, and members of the press. I was seated with the entourage in the front row among the audience, while His Majesty ascended the stage with the Chancellor, deans, and members of the university council.

As the ceremony began, the Chancellor stood to read a tribute in honor of His Majesty before conferring the degree. At that moment, I suddenly heard a commotion outside—jeering mixed with laughter—from a group of ‘intellectuals’ standing in rather improper postures, such as resting their feet against trees or standing with legs spread and hands on hips. Their noise was loud enough to disrupt the Chancellor’s speech.

I felt a surge of anger and could hardly restrain myself. Looking up at the stage, I saw the professors and council members sitting there looking pale and visibly uneasy, embarrassed by the situation. If those people had been children, an adult might have gone out and disciplined them to teach proper manners as hosts. But these were adults—so-called ‘intellectuals’—making inappropriate noise at the most improper time.

I glanced at our group and saw that we were all sitting stiffly. When the Chancellor finished reading the tribute, the degree was conferred. Then it was time for His Majesty to deliver his remarks at the microphone in the center of the stage. Before anything could begin, the jeering and laughter from that group outside started again.

My hands turned cold, and my heart felt unsteady. I felt such sympathy for His Majesty that I did not know what to do. I did not even dare to look up at his face. Finally, I forced myself to look up in order to offer him moral support—but instead, I was the one who regained my strength. As I watched him walk to the center of the stage, his expression was calm and composed.

At that moment, everyone inside the hall burst into thunderous applause, as if to encourage him. When the applause subsided, I looked up again and saw His Majesty open the academic hood of his gown, then turn and bow gracefully toward the group making the noise outside. There was a slight smile on his face, with a faint hint of irony in his eyes, yet his voice remained perfectly even as he said:

Thank you very
much for the
warm and
courteous
welcome you
have shown
to your guest.



¹⁰ Image: HELLO Thailand (2021)

With just those words, he defused any tension in the audience, and turned to address those inside the hall.

“At that moment, I felt like laughing out loud with satisfaction, because the jeering stopped instantly—as if someone had switched it off—and from then on, there was no more disturbance. Everyone, both outside and inside, sat quietly listening to the speech, appearing thoughtful.

I felt that His Majesty’s speech that day was excellent. He spoke extemporaneously, without any notes. He spoke about Thailand’s long-standing culture—that we have maintained our independence, that we have our own language and our own script, which we created ourselves. We established our own systems of governance and laws, and have granted rights and freedoms to our people for more than 700 years.

At this point, I could hardly contain my amusement, because after saying ‘more than 700 years,’ he paused as if something had just occurred to him, gave a slight start, and then bowed politely as he said, ‘Excuse me... I forgot... at that time, there was not yet an Australia.’ He then continued, saying that the Thai people have long been generous and open-minded, always willing

to give others a chance and to listen to differing opinions. We tend to think things through carefully and consider reasons before making judgments, rather than making rash decisions without reason.

After the ceremony, the Chancellor invited His Majesty and me to a reception room, where refreshments were served and a small reception was held, allowing professors and invited guests to meet us. Everyone came to praise His Majesty’s speech. Some professors, looking rather embarrassed, hurried over to explain that the earlier disturbance had merely been a quarrel among some youths and had nothing to do with the degree ceremony.

In truth, I did not blame anyone at all. Both the country and the university had shown the utmost respect to His Majesty and to me. The inappropriate behavior of some students—so much so that even their own professors felt compelled to refer to them as ‘children’ rather than students—was likely because they believed they had the freedom to express their opinions as they wished, without considering whether those opinions were reasonable or appropriate to the occasion. They seemed to remember only that being students meant having freedom, and so they exercised that freedom to the fullest on that day.

“After the reception, as we made our way back to the royal car, we had to pass by that same group again. They were still standing there watching us, but their demeanor had completely changed. Some looked subdued and avoided eye contact, no longer staring in that strange manner. Others, however, showed good sportsmanship—they smiled, waved, and applauded us all the way to where the car was waiting.”⁽²⁷⁾



During the state visit to Australia, Her Majesty received an exceptionally warm welcome from the moment of arrival at the airport and on many subsequent occasions. Nevertheless, throughout the 17-day visit as a royal guest, Her Majesty graciously carried out her royal duties with compassion and benevolence, in a manner of dignity and elegance, thereby strengthening and sustaining the enduring friendship between Thailand and Australia.

Thereafter, Her Majesty Queen Sirikit The Queen Mother continued to accompany His Majesty on visits to several other countries during the years 1963–1967, including Japan, the Republic of China, the Republic of the Philippines, the Republic of Austria, the Islamic Republic of Iran, the United States, and Canada. Later, from 16–31 October 2000, she paid an official visit to the People’s Republic of China together with Her Royal Highness Princess Maha Chakri Sirindhorn. During this visit, they traveled to various cities including Beijing, Xi’an, Shanghai, Suzhou, Henan Province, and Guilin. The People’s Republic of China accorded her a reception befitting her royal status, marked by warmth and hospitality at every place visited.

In 2007, Her Majesty also served as the royal representative of His Majesty King Bhumibol Adulyadej The Great and paid an official visit to the Russian Federation at the invitation of President Vladimir Putin from 2–11 July 2007, on the occasion of the 110th anniversary of diplomatic relations between Thailand and Russia. In addition to the official reception accorded by the Russian government, a university in Saint Petersburg also presented her with an honorary doctoral degree in Eastern Languages and Culture.⁽²⁸⁾

Undertaking visits to numerous foreign countries required great physical exertion. Nevertheless, Her Majesty faithfully carried out her royal duties even while unwell, beginning at a time when her daughters



¹¹ Image: VOGUE Thailand (2025)

and sons were still very young. She also faced situations in certain countries where there were negative attitudes toward her. Yet, as always, she fulfilled her royal responsibilities with remarkable success and grace, as reflected in the words respectfully submitted by the Thai Ambassador in Paris:

“The royal visit has enabled hundreds of millions of people abroad to come to know Thailand and Her Majesty—certainly in the best possible way, and quite different from what they had previously known. They have witnessed her remarkable intellect in her eloquent exchanges, and have come to understand the exemplary royal duties She has carried out. In every country, people have fully beheld the royal prestige of both Their Majesties. As for Her Majesty the Queen, news and portraits of her have spread across the world, and it is widely acknowledged that she is one of the most beautiful queens in the world.”⁽²⁹⁾



President of the Thai Red Cross Society

The Thai Red Cross Society is a charitable organization dedicated to providing humanitarian assistance to people of all backgrounds, regardless of race or religion. It was established in line with international practice during the reign of King Chulalongkorn (Rama V) on 26 April 1893. At its founding, King Chulalongkorn served as its royal patron (“Thanamayu Pathamphok”), and graciously appointed Queen Saovabha Phongsri as the first President (“Saphanayika”). Queen Savang Vadhana, the Queen Grandmother, initially held the position of “Saphachonni” (Maternal Patron) and later became the second President until her passing.





One of her most memorable humanitarian missions in connection with the Red Cross, deeply impressed upon people around the world, was her assistance to Cambodian refugees fleeing war into Thailand in 1979:

“...Cambodian people fleeing for their lives crossed into Thailand along the border. In Trat Province alone, in May 1979, nearly one hundred thousand refugees arrived. It was beyond the capacity of the province to adequately relieve their suffering. The condition of the refugees at that time was profoundly distressing to all who witnessed it. Each person was emaciated, starving, and severely malnourished—some reduced to little more than skin and bones, like living corpses. Many were ill, lying scattered on the ground. Most of the refugees were women and the elderly, while children were left orphaned, their parents having died along the way. Numerous young children lay waiting for death due to lack of food and care. Some infants were abandoned, left alone, slowly fading away on muddy ground contaminated with waste. The sheer number of refugees, all suffering from hunger, illness, and exhaustion, far exceeded the host province’s ability to provide assistance...”

Subsequently, King Bhumibol Adulyadej The Great graciously appointed Her Majesty Queen Sirikit as President of the Thai Red Cross Society on 12 August 1956. Since then, she has continuously carried out royal duties to support and strengthen the organization. She presided over committee meetings, visited various Red Cross units, led fundraising efforts, and, under her royal initiative, the annual Red Cross Fair was established to generate income. She regularly attended the fair each year. She also promoted blood donation activities and personally presented pins and tokens of appreciation to donors over many decades, encouraging widespread participation from government agencies, organizations, and the general public.

When the matter came to the knowledge of Her Majesty Queen Sirikit, in her capacity as President of the Thai Red Cross Society, she made a personal decision without regard for her own safety, placing humanitarian concerns above all else. Thus, on 26 May 1979, Her Majesty Queen Sirikit, as President of the Thai Red Cross Society, undertook an urgent visit to Cambodian refugees who had gathered at Ban Khao Lan, Mai Rut Subdistrict, Khlong Yai District, Trat Province. She departed from Klai Kangwon Palace in Hua Hin District, Prachuap Khiri Khan Province.



¹² Image: The Thai Red Cross Society (2025)

Upon learning of her impending visit to the refugees at Ban Khao Lan, officials, concerned for her safety, attempted to gather a group of refugees who were in relatively better condition and brought them to Ban Mai Rut School in Mueang District, Trat Province, to receive her. However, when Her Majesty observed the situation, she found that it did not correspond with the report given by Mr. Panya Rukurai, the Governor of Trat Province. She therefore ordered that the facts be verified. It was concluded that the location was not where the Cambodian refugees had actually gathered; the real site was another place called Khao Lan, not far from Ban Mai Rut School.

She then questioned Mr. Panya Rukurai in detail and gave instructions regarding the establishment of a Thai Red Cross relief center so that assistance to the Cambodian refugees could begin immediately that very day. She also addressed Dr. Mom Luang Kaset Snidvongs, Secretary-General of the Thai Red Cross Society, who was present at the time, saying, “Uncle, please go and inspect the site for the relief center at Mai Rut.” Next, she told Mr. Panya Rukurai,

I think I would like to go
and see it myself, so that
we can plan the assistance properly.

I also wish to see those who are
suffering. I will go to inspect the site of
the Thai Red Cross relief center
at Khao Lan myself.

In the words of Her Majesty:

“...I still remember it clearly... In May 1979, His Majesty the King was residing in Hua Hin. The Governor of Trat Province reported that Cambodian refugees were pouring into Thai territory at Khao Lan, Khlong Yai District, Trat Province, crossing

through the Banthat mountain range in numbers exceeding 200,000 souls. They were in a state of extreme suffering; many children were seriously ill due to lack of food. The sheer number of these unfortunate people far exceeded the province’s capacity to provide assistance. As President of the Red Cross, I flew there myself to see the situation.

I found that the area from Khao Lan down to the seashore was densely crowded with Cambodian refugees. It was almost unbelievable that in such a large area, constantly swept by sea breezes, the stench of feces and urine could be so overwhelming. The sight of these displaced Cambodians before me is something that will remain in my memory forever. They lay on damp ground under the blazing sun. With every step I took while inspecting the conditions, I had to be careful not to step on people who were sitting and lying about in disarray. The food supplies they had brought with them were small fish laid out to dry in the sun, mixed among piles of excrement, along with sacks of rice they carried. In some places, the ground formed puddles where rainwater collected—and that was the water they used for drinking. The condition of these deeply pitiable people was unlike anything I had ever seen. I so wished that those living comfortably in big cities could witness the plight of people who have lost their nation and their homeland like this...”

Upon returning before nightfall on 26 May 1979, Her Majesty graciously commanded that Thanphuying Supraphada Kasemsan, Khunying Jarungjit Thikhara, and Khun Chavali Amatayakul, who had accompanied her from Hua Hin, remain there to continue the work. The Thai national flag and the Red Cross flag flew side by side atop the pole at the Thai Red Cross center at Ban Khao Lan, which had been established under her royal initiative as a central hub for providing humanitarian assistance to the refugees—without discrimination.⁽³⁰⁾

Medical Care and Public Health



The medical and public health work of Her Majesty Queen Sirikit The Queen Mother began with Her visits to the people, during which she personally encountered those who were ill. She consistently paid close attention, recording the names and details of the illnesses of the people she visited herself.⁽³¹⁾ Many patients were taken under Her royal patronage, receiving genuine assistance to relieve their hardship, as reflected in one part of Her royal address:

“Providing assistance to people who are ill is one area of work that I have carried out in service of His Majesty the King for a long time. During royal visits to the people, His Majesty would often focus on agricultural work and water resource development for cultivation, which require considerable time and careful judgment. I therefore volunteered to take responsibility for matters concerning the well-being and health of the people, as well as the provision of supplementary occupations, in order to help ease His burden...

“I consider health and hygiene to be of great importance, as they are the foundation of all living beings. As the saying goes, ‘A sound mind resides in a sound body.’ If people are in good health and free from illness, they will have the capacity to learn, to pursue rightful occupations, and to contribute to the development of the nation. Therefore, it would not be wrong to say that strong citizens are capable of building a strong nation.”⁽³²⁾

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living beings.

Royal Mobile Medical Unit

This mobile medical unit was established by the gracious initiative of His Majesty King Bhumibol Adulyadej The Great in 1969 to provide medical assistance to people living in remote, underserved, and impoverished areas lacking medical personnel and facilities. Later, Her Majesty Queen Sirikit The Queen Mother took personal responsibility for overseeing, monitoring, and supporting the Royal Mobile Medical Unit, and continued in that role over time. The unit comprises doctors, nurses, and various professional staff from multiple agencies, who provide medical care to the public whenever accompanying royal visits or serving communities in remote areas. Everyone involved in the program devotes themselves to fulfilling the royal mission, as recounted by a pediatric infectious disease specialist reflecting on their experience:



¹³ Image: The Public Relations Department (2025)

“Sometimes when we travel to a unit, we aren’t even sure whether the vehicle will reach the destination. Sometimes, when there was no more road to follow, we would continue by helicopter. We see patients from around 12:30 p.m. until about 6 or 7 p.m., and sometimes follow up with additional patients who bring their handicrafts to present to Her Majesty the Queen. Then we examine patients with eye problems, sometimes until 8 p.m. And it’s not just physical health we address, but mental health as well, especially issues related to HIV and AIDS...

“One woman’s husband died of AIDS, and everyone in the community knew about it. At that time, because of the societal stigma about HIV, the woman couldn’t get a job anywhere, even though she was healthy and not a danger to anyone. Even when her neighbors were hired for group work, she would be left out. She struggled to cover expenses, and her children couldn’t attend school. I asked her if she knew how to weave and whether she was interested in handicraft work. Her eyes welled up with tears... she wanted this opportunity.”



Health Centers to Commemorate Her Majesty the Queen’s 60th Birthday Anniversary

On the occasion of Her Majesty Queen Sirikit The Queen Mother’s 60th birthday in 1992, the Ministry of Public Health initiated a project to honor Her Majesty while promoting the health of rural communities. This included the “Decade of Health Center Development Project” (1992–2001) to enhance services by constructing large health centers—both upgrading existing centers and building new ones—totaling 1,576 centers. The Cabinet approved the project on 3 September 1992.

Her Majesty graciously bestowed the name “Her Majesty the Queen’s 60th Birthday Anniversary Health Center”, abbreviated HMQ-60, on 21 January 1993, for 80 of the large health centers.



¹⁴ Image: Bureau of the Royal Household (2025)



After completing construction of the 80 HMQ-60 centers, there remained 8,620,787.32 baht donated by the public. The Ministry of Public Health proposed establishing a foundation with these funds, which was authorized by Bangkok Metropolitan Administration on 25 July 1994. Later, Princess Soamsawali, Krom Muen Suddhanarinatha, became the Honorary President, and Her Majesty Queen Sirikit granted permission to use the emblem of the Royal Birthday Ceremony of 12 August 1992, later shaped as a teardrop and placed above the entrance of each HMQ-60 center, serving as both a symbol of auspiciousness and a distinctive mark.

Subsequently, additional HMQ-60 centers were established across various districts and provinces, including those dedicated in honor of His Majesty King Bhumibol Adulyadej The Great and other members of the royal family

Health Zone # 1

1. HMQ-60 Health Center, Doi Tung, Mae Fa Luang Subdistrict, Mae Fa Luang District, Chiang Rai Province
2. Royally-Granted HMQ Health Center, Mae Chan District, Chiang Rai Province
3. HMQ-60 Health Center, Ban Pang Ma O, Bo Kaeo Subdistrict, Samoeng District, Chiang Mai Province
4. HMQ-60 Health Center, Santhan Subdistrict, Na Noi District, Nan Province
5. HMQ-60 Health Center, Mae Puem Subdistrict, Mueang District, Phayao Province
6. HMQ-60 Health Center, Analayo, Mueang District, Phayao Province
7. HMQ-60 Health Center, Mae Chua, Den Chai District, Phrae Province
8. HMQ-60 Health Center, Ban Pong Sa, Pai District, Mae Hong Son Province
9. HMQ-60 Health Center, Ban Thung Klui, Ban Uam Subdistrict, Mueang District, Lampang Province
10. HMQ-60 Health Center, Pa Sang, Pa Sang District, Lamphun Province

Health Zone # 2

1. HMQ-60 Health Center, Mae Ja Rao, Mae Ramat District, Tak Province
2. HMQ-60 Health Center, Ban Klang, Wang Thong District, Phitsanulok Province
3. HMQ Health Center, Ban Ngiu Ngam, Lom Sak District, Phetchabun Province
4. HMQ Health Center (Eubjit Yossunthorn Uthit)
5. HMQ Health Center 1987, Ban Nam Lat, Phetchabun Province
6. HMQ-60 Health Center, Mueang Kao Subdistrict, Mueang District, Sukhothai Province
7. HMQ-60 Health Center, Ngiu Ngam, Mueang District, Uttaradit Province

Health Zone # 3

1. HMQ-60 Health Center, Ban Trai Trueng, Trai Trueng Subdistrict, Mueang District, Kamphaeng Phet Province
2. HMQ-60 Health Center, Huai Krot, Sankhaburi District, Chai Nat Province
3. HMQ-60 Health Center, Ban Nong Ben, Mueang District, Nakhon Sawan Province
4. HMQ-60 Health Center, Samnak Khun Naen, Dong Charoen District, Phichit Province
5. HMQ-60 Health Center, Ban Pradu Yuen, Pradu Yuen Subdistrict, Lan Sak District, Uthai Thani Province

Health Zone # 4

1. HMQ-60 Health Center, Sarika, Sarika Subdistrict, Mueang District, Nakhon Nayok Province
2. HMQ-60 Health Center, Sai Mun Subdistrict, Nakhon Nayok Province
3. HMQ-60 Health Center, Khlong Ma Song, Sai Noi District, Nonthaburi Province
4. HMQ-60 Health Center (Wat Prayoon), Khu Khot Subdistrict, Pathum Thani Province
5. Princess Mother – 84 Health Center, Bueng Nam Rak Subdistrict, Thanyaburi District, Pathum Thani Province
6. HMQ-60 Health Center, Bo Ngoen Subdistrict, Pathum Thani Province
7. HMQ-60 Health Center, Ban Klang, Mueang District, Pathum Thani Province
8. HMQ-60 Health Center, Nakhon Luang, Nakhon Luang District, Phra Nakhon Si Ayutthaya Province
9. HMQ-60 Health Center, Khok Salung Subdistrict, Phatthana Nikhom District, Lopburi Province
10. HMQ-60 Health Center, Lam Phaya Klang, Muak Lek District, Saraburi Province
11. HMQ-60 Health Center, Phikun Thong, Tha Chang District, Singburi Province
12. HMQ-60 Health Center, Ban Thung Klap Noi, Phak Than Subdistrict, Bang Rachan District, Singburi Province
13. HMQ-60 Health Center, Ban Yang Sai, Pho Thong District, Ang Thong Province

Health Zone # 5

1. HMQ-60 Health Center, Wang Sala Subdistrict, Tha Muang District, Kanchanaburi Province
2. HMQ-60 Health Center, Huai Muang Subdistrict, Kamphaeng Saen District, Nakhon Pathom Province
3. HMQ-60 Health Center, Ban Nikom, Km. 5, Mueang District, Prachuap Khiri Khan Province
4. HMQ-60 Health Center, Ban Ruam Jai Phatthana, Kaeng Krachan District, Phetchaburi Province
5. HMQ-60 Health Center, Khu Bua Subdistrict, Mueang District, Ratchaburi Province
6. HMQ-60 Health Center, Bang Khan Taek, Mueang District, Samut Songkhram Province
7. HMQ-60 Health Center, Ban Khok Krabue, Mueang District, Samut Sakhon Province
8. HMQ-60 Health Center, Ban Don Rai, Sam Chuk District, Suphanburi Province
9. HMQ-60 Health Center, Bo Suphan, Song Phi Nong District, Suphanburi Province

Health Zone # 6

1. HMQ-60 Health Center, Khlong Phlu, Khao Khitchakut District, Chanthaburi Province
2. HMQ-60 Health Center, Don Chim Phli, Bang Nam Prioa District, Chachoengsao Province
3. King's 50th Anniversary Health Center, Ban Mab Lam Bid, Ban Bueng District, Chonburi Province
4. HMQ-60 Health Center, Khao Khansong, Si Racha District, Chonburi Province
5. HMQ-60 Health Center, Nong Bon Subdistrict, Bo Rai District, Trat Province
6. HMQ-60 Health Center, Ban Rabopai, Si Maha Phot District, Prachinburi Province
7. Princess Chulabhorn Anniversary Health Center, Prachinburi Province
8. HMQ-60 Health Center, Ban Nam Sai, Khao Chamao District, Rayong Province
9. HMQ-60 Health Center, Ban Khlong Bang Ping, Mueang District, Samut Prakan Province
10. HMQ-60 Health Center, Branch at Wat Bang Ping, Mueang District, Samut Prakan Province
11. HMQ-60 Health Center, Wang Sombun, Wang Sombun District, Sa Kaeo Province

Health Zone # 7

1. HMQ-60 Health Center, Phon Ngam, Kamalasai District, Kalasin Province
2. HMQ-60 Health Center, Ban Mueang Mai, Wiang Kao District, Khon Kaen Province
3. HMQ-60 Health Center, Ban Krabak, Chuen Chom District, Maha Sarakham Province
4. 4.HMQ-60 Health Center, Ban Si Kaeo, Mueang Roi Et District, Roi Et Province

Health Zone # 8

1. HMQ-60 Health Center, Ban Natom, Nakhon Phanom Province
2. HMQ-60 Health Center, Nong Hin, Nong Hin District, Loei Province
3. HMQ-60 Health Center, Ban Kham, Sawang Daen Din District, Sakon Nakhon Province
4. HMQ-60 Health Center, Ban Khok Saeng, Wanorn Niwat District, Sakon Nakhon Province
5. HMQ-60 Health Center, Fao Rai, Fao Rai District, Nong Khai Province
6. HMQ-60 Health Center, Thung Prong, Mueang District, Nong Bua Lamphu Province
7. HMQ-60 Health Center, Na Muang, Prachak Silpakhom District, Udon Thani Province

Health Zone # 9

1. HMQ-60 Health Center, Nong Bua Khok, Chaturat District, Chaiyaphum Province
2. HMQ-60 Health Center, Lam Takhong Settlement, Pak Chong District, Nakhon Ratchasima Province
3. HMQ-60 Health Center, Ban Nong Yai, Satuek District, Buriram Province
4. HMQ-60 Health Center, Rom Pho, Mueang Fang Subdistrict, Mueang District, Buriram Province
5. 5. HMQ-60 Health Center, Ban Run, Bak Dai Subdistrict, Phanom Dong Rak District, Surin Province

Health Zone # 10

1. HMQ-60 Health Center, Ban Na Sok, Mueang Mukdahan District, Mukdahan Province
2. Ban Huai Ta Puea Chalerm Phra Kiët Health Center, Ban Ao Subdistrict, Kham Sa-EE District, Mukdahan Province
3. HMQ-60 Health Center, Ban Daeng, Kut Chum District, Yasothorn Province
4. HMQ-60 Health Center, Phum Sa Ron, Kantharalak District, Sisaket Province
5. HMQ-60 Health Center, Pla Khao, Mueang Amnat Charoen District, Amnat Charoen Province
6. HMQ-60 Health Center, Rai Tai, Phibun Mangsahan District, Ubon Ratchathani Province
7. HMQ-60 Health Center, Ban Yang Noi, Ko Ae Subdistrict, Khueang Nai District, Ubon Ratchathani Province

Health Zone # 11

1. HMQ-60 Health Center, Ban Khlong Phon, Khlong Phon Subdistrict, Khlong Thom District, Krabi Province
2. HMQ-60 Health Center, Ban Hat Yai, Lang Suan District, Chumphon Province
3. HMQ-60 Health Center, Ban Hua Khlong Laem, Laem Subdistrict, Hua Sai District, Nakhon Si Thammarat Province
4. HMQ-60 Health Center, Bang Muang, Bang Muang Subdistrict, Takua Pa District, Phang Nga Province
5. HMQ-60 Health Center, Chalong Subdistrict, Mueang District, Phuket Province
6. HMQ-60 Health Center, Kam Phuan, Suksamran District, Ranong Province
7. HMQ-60 Health Center, Ban Khuan Yung, Mueang Surat Thani District, Surat Thani Province

Health Zone # 12

1. HMQ-60 Health Center, Khuan Mao Subdistrict, Ratsada District, Trang Province
2. HMQ-60 Health Center, Aipa Jo, Phu Khao Thong Subdistrict, Sukhirin District, Narathiwat Province
3. HMQ-60 Health Center, Puyud Subdistrict, Mueang District, Pattani Province
4. HMQ-60 Health Center, Ban Khuan Pom, Khok Sai Subdistrict, Pa Bon District, Phatthalung Province
5. HMQ-60 Health Center, Cholong, Pu Rong Subdistrict, Krong Pinang District, Yala Province
6. HMQ-60 Health Center, Phatong Subdistrict, Hat Yai District, Songkhla Province
7. HMQ-60 Health Center, Nikom Phatthana, Manang District, Satun Province

Currently, health centers across the country, including the HMQ-60 Health Centers, have been upgraded to Subdistrict Health Promoting Hospitals (SHPH). They now have an increased number of public health professionals from various fields providing services, which allows communities nationwide to access healthcare conveniently near their homes, with significantly improved quality.

Queen Sirikit National Institute of Child Health

The Queen Sirikit National Institute of Child Health was established in 1951 as the pediatric department of the Women's Hospital, which initially focused on maternal and child health. Later, the Women's Hospital in Bangkok developed into a general hospital, and the pediatric department gradually expanded. In 1954, it was organized as a hospital within the Women's Hospital, and later, during the Ministry of Public Health's structural reforms in 1974, it became an independent children's hospital under the Department of Medical Services. The Children's Hospital specialized in treating children with complex diseases referred from hospitals nationwide, most of whom came from disadvantaged backgrounds.

Queen Sirikit visited the community personally and took many pediatric patients under her royal patronage. The hospital had the opportunity to support her royal initiatives and was continuously entrusted with caring for children with complex conditions under her patronage.

On 4 October 1996, the hospital received the royal grace of Her Majesty Queen Sirikit, and was officially renamed the Queen Sirikit National Institute of Child Health. It became a central hub for admitting and transferring critically ill pediatric patients from both public and private hospitals across the country, conducting pediatric disease research, and training pediatric specialists, following the Queen Mother's example of providing care without discrimination.



¹⁵ Image: Queen Sirikit National Institute of Child Health (2019)

In 2010, the Institute received a budget to construct a specialized pediatric medical center with 27 floors and 1 basement. Queen Sirikit graciously bestowed the name "Queen Sirikit 80th Anniversary Commemorative Building (Specialized Pediatric Medical Center)" in honor of her 80th birthday on 12 August 2012. She also personally presided over the foundation-laying ceremony on Friday, 29 June 2012.

During this occasion, besides laying the foundation stone and presenting commemorative gifts to donors who contributed to the building's construction, she granted audiences to various individuals, such as:

Lt. Danai Komkai, a former refugee who had stayed at the Thai Red Cross Refugee Center at Khao Lan at age three and later resettled in the United States with his mother.

Ms. Supisara Lukkanasirorat, a student from Sattharachinee School in Trang Province, who had a heart condition and was under Royal Patronage. She presented her cumulative GPA of 3.14 for the Queen Mother to see.

Many other pediatric patients under royal patronage at the time also had audiences with Her Majesty, during which she inquired about their health, condition, and offered encouragement and moral support.⁽³⁶⁾



¹⁶ Image: Bureau of the Royal Household (2025)



¹⁷ Image: Bureau of the Royal Household (2025)

Royal Patronage Patient Residence

Children patients placed under the royal patronage of Her Majesty Queen Sirikit for treatment at the Queen Sirikit National Institute of Child Health—back when it was still the Children’s Hospital—benefited from Her Majesty’s gracious initiative to establish a residence in Bangkok, on Sukandharam Alley, Dusit District. This residence serves patients waiting for treatment, those returning for follow-up visits, and their relatives or guardians who accompany them during their care, all free of charge.

The facility allows families to stay close to the patients and provide full support during treatment. This clearly demonstrates Her Majesty Queen Sirikit, The Queen Mother’s deep concern and heartfelt care for children’s health and medical treatment. Children traveling from other provinces to receive treatment in Bangkok must be accompanied by parents or guardians, and without such accommodation, both the caregivers and the child patients would face significant hardships.⁽³⁷⁾



Promotion of Handicraft Occupations

Accompanying His Majesty King Bhumibol Adulyadej The Great on visits to rural and remote communities across the kingdom since 1955 (B.E. 2498) allowed Her Majesty Queen Sirikit to observe the potential of rural residents. She recognized that, in addition to their primarily agricultural livelihoods, villagers possessed traditional craftsmanship skills, producing clothing and household items, which could also be developed as supplementary occupations to earn income.

In response, Her Majesty initiated the first special handicraft project in 1965 (B.E. 2508), encouraging women from Khao Tao, Hua Hin District, Prachuap Khiri Khan Province, to learn weaving as an additional source of income. Later, she officially established a silk Ikat ('mutt mee') weaving project in Nakhon Phanom Province, marking the first formal handicraft project. This initiative improved the livelihoods of local people, and on 21 July 1976 (B.E. 2519), Her Majesty graciously authorized the creation of the Foundation for the Promotion of Supplementary Handicrafts under Royal Patronage, which was later renamed the Queen Sirikit Promotion of Handicrafts Foundation.

Two years later, in 1978 (B.E. 2521), Her Majesty founded the Chitralada Handicraft Training Center, expanding the program across Thailand. She selected impoverished residents from all regions of the country to develop their skills, producing artisans capable of high-quality traditional craftsmanship. Throughout, she upheld her

royal initiative to improve the lives of citizens while preserving and advancing Thailand's artistic heritage.

Subsequently, on 21 September 2010 (B.E. 2553), the government elevated the Chitralada Handicraft Training Center to "Queen Sirikit Institute" in honor of Her Majesty's 80th birthday in 2012 (B.E. 2555). Her Majesty delivered a speech regarding this occasion, emphasizing the importance of promoting handicrafts and supporting livelihoods.

"...In truth, I happened to come across it (i.e. Ikat woven material). The people who came to pay their respects were extremely poor. I saw the skirt they were wearing, just a little peeking out from the new skirt they wore when receiving me. The inner skirt was so beautiful, with an old traditional pattern. So I asked them, quietly, one-on-one, whether this pattern—the one you wore inside—could be woven for the Queen. The women replied, 'Why would you want it? If I can weave it, I can, but why take it? Only people in Bangkok wear fabric like this; no one else wears it.' I said, 'I promise, I promise that if you weave it for me, I will wear it. I will wear it to events and functions to show everyone how exquisitely beautiful the Isan handwoven fabric is.' They said, 'Well then, agreed...'"

Their grandparents had taught them, and they wove it to sell in the local markets. But the merchants underpriced it so much that, speaking of it, they cried. They didn't understand why they had to stay up all night weaving. So they decided to abandon this art. I assured them that if they wove it for the Queen, and the Queen wore it, I would fulfill my promise. And wherever I went in the world, I always wore the handwoven fabric..."⁽³⁹⁾



...These people are the children of very poor farmers.

I chose them specially, selecting from the poorest families, the ones with the most children who could not support themselves.

I brought them to reside in the old buildings of the Grand Palace, which originally housed many nobles. I had them live there and then come to train at Chitralada...



The Royal Crafts Project of Her Majesty Queen Sirikit has led to the creation of exquisite royal-level arts and crafts across 23 disciplines, including: royal goldsmithing; silver and gold inlay; traditional gilding; cloisonné enamel; silk weaving (Thai native silk, squirrel-tail silk, tortoise-scale silk, glass-bead patterned silk, patterned silk, pha khao ma, and handwoven mutt mee silk); Praewa weaving; Jok weaving; brocade and Khid-pattern weaving; wood carving; soapstone carving; traditional Nang Talung leather carving; Li Pao reed weaving; bamboo weaving with Khid patterns; carpentry and rattan craft; palace-style doll making; painting with beetle wing decoration and mother-of-pearl inlay; embroidery; artificial flowers; garment and packaging production.

These works have gained recognition and popularity worldwide. Later, Her Majesty selected the most exquisite pieces to exhibit for public viewing at Phra Thinang Anantasamakhom starting in 1992 under the exhibition name “Silp Paendin” (Arts of the Land). In 2008, His Majesty King Bhumibol Adulyadej graciously granted royal permission to use Phra Thinang Anantasamakhom as the “Silp Paendin Museum.”

Her Majesty also addressed visitors who came to pay their respects on the occasion of her birthday at Sala Dusit Palace, Chitralada Garden, on 11 August 2007, saying: “...These people are the children of very poor farmers. I chose them specially, selecting from the poorest families, the ones with the most children who could not support themselves. I brought them to reside in the old buildings of the Grand Palace, which originally housed many nobles. I had them live there and then come to train at Chitralada...”⁽³⁹⁾



Promotion of Thai Arts and Culture



¹⁸ Image: Thai PBS World (2025)

Her Majesty Queen Sirikit has continuously promoted Thai arts and culture, both as a precious national heritage and to elevate Thai cultural achievements to international recognition. She once said:

“...If we reflect on the age of the Thai nation, which has existed for thousands of years, we can see that our ancestors created things that are good, beautiful, and beneficial for us, their descendants, and even for the world. This is our culture itself. Everyone should take pride in the Thai lineage and our ancient culture, and recognize it as our direct duty to preserve it forever...”

Her Majesty combined the foundations of Thai identity with the meticulous craftsmanship of Thai textiles, adapting them to international tastes. This resulted in Thai national costumes shining across Thailand and worldwide, including the Boromphiman, Ruean Ton, Chitralada, Amarin, Chakri, Dusit, Chakraphat, and Siwalai ensembles.

Later, she obtained royal permission from His Majesty King Bhumibol Adulyadej to use the Hor Ratsadakorn Pipat building within the Grand Palace to establish the Queen Sirikit Museum of Textiles, which officially opened on 9 May 2012.⁽⁴¹⁾

Royal-Granted Khon Performances



On 27 November 2003, the Fine Arts Department presented the Khon performance Niew Phet (Diamond Finger), followed by Rama Battles Tosakanth, for Her Majesty Queen Sirikit to privately watch at Phu Phan Ratchaniwet Palace in Sakon Nakhon Province. Her Majesty graciously allowed the performers to meet privately with her, and remarked on her concern regarding the Khon costumes, which had become very different from the traditional style.

Subsequently, a committee was established to carry out Khon-related work in accordance with her guidance. They collected and studied materials from ancient documents and consulted experts in fine arts and

traditional costumes to create authentic Khon costumes, accessories, and masks. Teachers in the fields of dance and classical music were then brought together to stage Khon performances, beginning with the set Phrommas, which premiered on the auspicious occasion of His Majesty King Bhumibol Adulyadej's 80th birthday and Her Majesty Queen Sirikit's 75th birthday in 2007. The performances received widespread public acclaim, and Her Majesty expressed her delight, saying:

“...This Khon performance is not only successful in showcasing the high art of Thai performance, but it also brings added value: we have nurtured a new generation of skilled artisans—young people who truly understand the art of creating Khon costumes and witness the close social bonds of traditional Thai society, with children accompanying parents and grandparents to watch the performance...”

Following this success, Her Majesty encouraged Khon performances to continue annually, becoming widely known as the “Royal-Granted Khon.”

Notable performances include Nang Loi (2010), The Battle of Maiyarap (2011), Chong Thanon (2012), The Battle of Kumbhakarna: Mokkahasak (2013), The Battle of Indrajit: Nakphat (2014), and The Battle of Indrajit: Phrommas (2015), among others.⁽⁴²⁾ The most recent performance was Satyapali, staged after the passing of Her Majesty Queen Sirikit and held from 6 November to 8 December 2025.



National Resources Conservation



Her Majesty Queen Sirikit through her visits to the people in remote and underdeveloped areas across Thailand, became deeply aware of the vital importance of nature as the foundation for the sustainable existence of all life. Conservation of natural resources—including soil, water, forests, plant species, and animal species—has therefore been one of her most important royal initiatives. She once said:

“...We call this land ‘Mother Land’ because it has been the birthplace and nurturer of the Thai people for over 700 years. It is our duty to maintain the fertility of the land. If we merely exploit it for our own benefit—cutting down trees until the forests disappear, using pesticides and herbicides until the soil is ruined, or dumping waste into rivers and canals without regard for the land—if we commit such acts of cruelty toward the land without awareness of its value, one day Mother Land may die and never return to us. Only barren land will remain, unable to support cultivation, with dust blowing everywhere, as if the land were soulless and meaningless to life on earth. Right now, we still have the time and opportunity to restore and protect Mother Land...”



¹⁹ Image: The Public Relations Department (2025)

Throughout her life, Her Majesty Queen Sirikit has initiated numerous projects, including the forest conservation project “allowing forests to coexist with people, and people to coexist with forests, without destroying one another,” the “Love Water, Love Forests” Project, the “Small Homes in the Big Forest” Project, and coastal resource restoration projects inspired by royal initiatives, which include mangrove forest conservation, sea turtle species protection, and the conservation of marine natural resources in accordance with the royal initiatives of His Majesty King Bhumibol Adulyadej and Her Majesty Queen Sirikit during the reign of King Rama IX.⁽⁴⁰⁾ Although these projects cannot fully resist the worldwide forces of environmental destruction, they have helped slow the problems and provided a vital source of encouragement and determination for individuals and organizations to continue their efforts in conserving the Earth and the land of Thailand.



Prestigious International Honors

In addition to the contributions mentioned above, Her Majesty Queen Sirikit carried out numerous royal duties, earning widespread international recognition and many distinguished awards, including:



Ceres Medal

The Ceres Medal, presented by the Director-General of the Food and Agriculture Organization of the United Nations (FAO) on 11 May 1979 at Chakri Maha Prasat Throne Hall, in recognition of her dedication to promoting livelihoods, agriculture, social welfare, and assistance to orphans. The inscription on the reverse reads: “TO GIVE WITHOUT DISCRIMINATION.”

First Distinguished Service Award

The First Distinguished Service Award, presented by the Save the Children Federation on 9 November 1981 in New York, USA, in recognition of her compassionate assistance to Cambodian refugees at Khao Lan in Trat Province, especially children.

Humanitarian Award

The Humanitarian Award, presented by Mr. Robert B. Oxnam, President of the Asia Society, on 14 March 1985 in New York, USA, in recognition of her humanitarian work with refugees, promotion of Thai arts and crafts, foresight, and leadership.

Certificate of Recognition as an Outstanding Conservationist in Forestry and Wildlife

A Certificate of Recognition as an Outstanding Conservationist in Forestry and Wildlife, presented by Mr. Russell Train, Chairman of the World Wildlife Fund, on 19 November 1986 at Chitralada Villa, Dusit Palace, in recognition of her outstanding contributions to forest and wildlife conservation.



²¹ Image: Queen Sirikit Museum of Textiles (2025)



²⁰ Image: Queen Sirikit Museum of Textiles (2025)

The Honorary Fellowship

Honorary Fellowship, conferred by the Royal College of Physicians of London on 1 May 1988 at Chakri Maha Prasat Throne Hall, in recognition of her assistance to the sick and her support for the advancement of medicine and public health in Thailand

1990 Refugee Assistance Award The Center for Migration Studies Immigration and Refugee Policy Award 1990

Presented by the Center for Migration Studies (CMS) in recognition of Her Majesty Queen Sirikit as an outstanding humanitarian leader in assisting refugees from Indochinese countries who arrived in Thailand, providing them shelter and fostering understanding and compassion for refugees among Thai citizens. On this occasion, Her Majesty graciously appointed Her Royal Highness Princess Chulabhorn Walailak, Princess Srisavangavadhana Worakhattiya Naree, to represent her in receiving the award in Washington, D.C., USA, on 29 March 1990.

First International Humanitarian Award

Presented by the Friends of the Capital Children's Museum, Washington, D.C., through Mrs. Esther Coopersmith, Chairperson, in recognition of Her Majesty's lifelong dedication to activities benefiting humanity. The award ceremony took place on 1 November 1991. On this occasion, the Mayor of Washington, D.C., proclaimed 1 November of every year as Queen Sirikit Day.



Borobudur Gold Medal

Presented by Mr. Federico Mayor, Director-General of UNESCO, in recognition of Her Majesty's development of arts and crafts projects that provide sustainable income for the people, at Chiang Mai University on 30 January 1992.



²² Image: Queen Sirikit Museum of Textiles (2025)

The UNICEF Special Recognition Award

Presented by Mrs. Karin Shampoo, Vice President of UNICEF, in honor of Her Majesty's benevolent contributions to mothers and children through agencies under the Royal Patronage and various royal projects, at the New Building, Suan Amphon, Dusit Palace, on 2 August 1992.



²³ Image: Queen Sirikit Museum of Textiles (2025)

The UNIFEM Award of Excellence

Presented by Mrs. Sharon Capling Alakya, Director of the United Nations Development Fund for Women (UNIFEM), in recognition of Her Majesty's outstanding work in promoting women's roles, at the New Building, Suan Amphon, Dusit Palace, on 2 August 1993.



²⁴ Image: Queen Sirikit Museum of Textiles (2025)

Louis Pasteur Award

Presented by the International Sericultural Commission (ISC) in recognition of Her Majesty's contributions to the global sericulture industry, at Santi Maitri Building, Government House, on 21 September 2002.⁽⁴³⁾



Donya
"Queen Sirikit"

Flowers Named in Her Majesty's Honor and Royal-Granted Flowers



The Rose
"Queen Sirikit"



The Lotus
"Queen Sirikit"

Her Majesty Queen Sirikit whose beauty and achievements are renowned worldwide, has dedicated herself to the conservation of forests, wildlife, and numerous plant species. In recognition of her contributions, organizations both abroad and within Thailand have received royal permission to name award-winning flowers after her royal cypher. Six such flowers were named to honor her: the orchid Cattleya "Queen Sirikit", Donya "Queen Sirikit", the rose "Queen Sirikit", the lotus "Queen Sirikit", Mok Rachinee, and Mahaprom Rachinee. Additionally, six more flowers were granted royal names by Her Majesty: Dusita, Manithewa, Soi Suwanna, Thip Kesorn, Saras Chantira, and Nimmanoradee.



Mahaprom Rachinee



The orchid Cattleya
"Queen Sirikit"



Mahaprom
Rachinee

24 October

The Day the Angel Returns to Heaven

Her Majesty Queen Sirikit is regarded as an angel who descended as the shining partner of His Majesty King Bhumibol Adulyadej, reigning alongside him from 12 August 1932. 24 October 2025 marks the day she returned to heaven. For the Thai people, this day is remembered as “Blue Day” as expressed in the lyrics and melody of a song composed by His Majesty King Bhumibol Adulyadej on 3 February 1949, during the time they were apart, reflecting a love that blossomed beautifully despite the distance.

Blue day

Gloomy blue day,

When you are far away,

Why must we be apart?

Sweetheart,

Dear, I love you

“With all my heart, I do

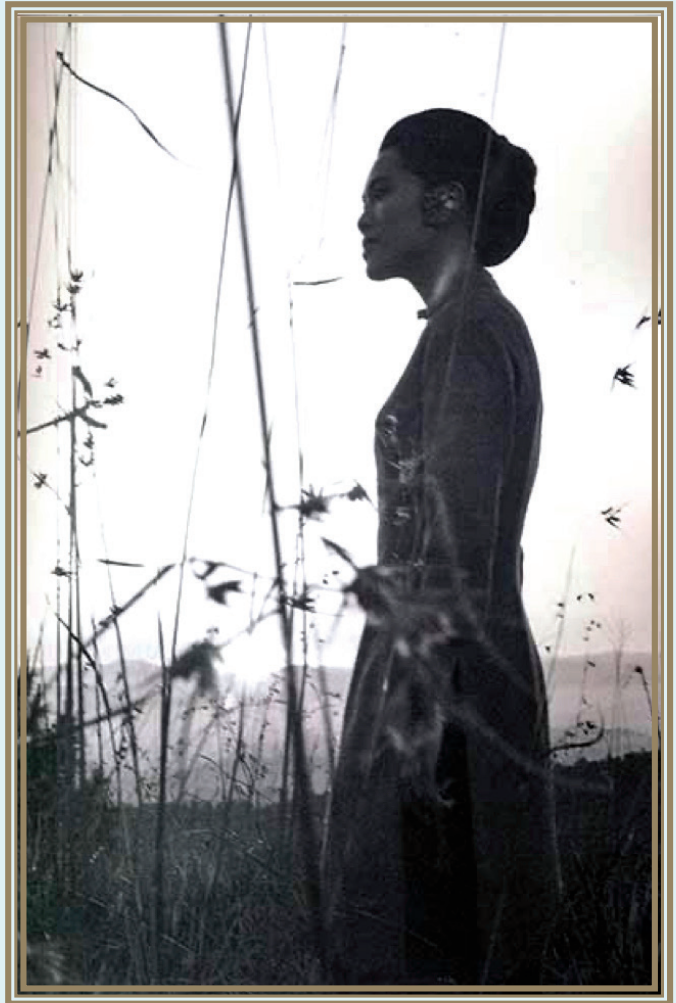
That’s why I feel so blue.



She descended for the Thai people to love and revere, and after 93 years, 2 months, and 12 days, she returned to the heavens, residing “Still On My Mind” of His Majesty King Bhumibol Adulyadej, as expressed in the lyrics and melody composed by His Majesty in 1965:

...The song will
never, never end.
And time we cannot
suspend.
You’ll be ever and ever
‘Still on my mind.’

For the Thai people, Her Majesty Queen Sirikit also dwells in their eternal hearts in the same way.

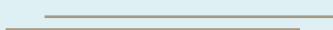


Photographs Through the Lens of
His Majesty King Bhumibol Adulyadej

²⁵ Image: rama9art (2017)



May she enjoy happiness
in heaven alongside
His Majesty King Bhumibol Adulyadej,
and may she continue to protect
and safeguard Thailand and its people,
allowing the land to overcome adversity,
flourish in peace, and prosper
forevermore.



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10 Indicators

Population Change and Thai Health



10 Indicators

“Population Change and Thai Health”

Thai Health 2026 presents the indicator set for “Population Change and Thai Health” to reflect the major demographic phenomena that Thailand is currently facing, from declining birth rates, increasing life expectancy, migration, urban expansion, and changing family structure, to economic and social transitions—all of which affect the physical, mental, and social health of the population.

The indicators in this report are organized into ten categories under four main themes:

- 1 The situation of demographic change in Thailand (Category 1)
- 2 Health outcomes resulting from demographic change (Categories 2–3)
- 3 Demographic change and Social Determinants of Health (Categories 4–9)
- 4 Policies to respond to demographic change (Category 10)

Thailand is undergoing demographic changes that make today’s population very different from the past. For over a decade, the long-term trend of declining birth rates has resulted in the number of deaths exceeding births, and the population number beginning to shrink. At the same time, increasing life expectancy has drastically altered the age structure. With this trend, by 2035 it is projected that the number of children and working-age adults will decrease by over 7 million, while the elderly population will rise by 3.6 million, affecting labor supply and economic potential. Meanwhile, labor quality still faces limitations due to skills mismatched with the labor market, reflecting challenges in both quantity and quality.

These demographic changes are directly linked to health issues. Today, Thais have a life expectancy of 75.6 years, but spend 6.9 years in poor health (rising to 9.6 years for women), reflecting the phenomenon of “long life but prolonged illness.” Risk behaviors starting in adolescence contribute to chronic diseases later in life. Maternal and child health continues to face challenges such as infertility, reduced prenatal and postnatal care,

and inadequate child nutrition. Health challenges therefore span the entire life cycle. In addition, demographic change increases health vulnerability in certain group—poor children and youth increasingly out of the education system, elderly people living alone (increasing to 12.9%) and about half of migrant workers lacking health coverage.

In addition to direct impacts, **demographic changes have altered the structure of Thai families**, which also affects the health of the population. The rise in single-person households and living alone reflects changes in the traditional Thai family structure. Data indicate that single or divorced individuals are sedentary for an average of 14 hours per day, exceeding recommended levels, with over 50% of single women engaging in insufficient physical activity. In contrast, those living with a spouse and children tend to eat complete meals and consume fruits and vegetables more regularly.

As nuclear families decrease and solo living increases, new social trends have emerged, such as treating pets like children, particularly among singles. Furthermore, advances in digital technology have made online social networks increasingly important. Thais use these networks to exchange information, make health-related decisions, and maintain contact with family and friends.





Education and learning represent another social dimension directly affected by declining birth rates. Nearly 2,000 schools have closed, and over 8,000 have downsized in the past decade, impacting both educational opportunities and quality. Meanwhile, family structures and economic constraints increase the likelihood that children from larger families will drop out of school. Additionally, early marriage and teen pregnancy remain obstacles to skill development.

The labor market faces challenges from a shrinking working-age population, while the number of older adults working or wishing to work has increased—from 3.3 million in 2017 to 5.0 million in 2024—reflecting a new role for older adults and a labor market that must adapt. At the same time, family responsibilities and childcare limit work opportunities for some women. Therefore, Thailand needs to plan to increase domestic labor participation, develop skills, and accommodate migrant labor.

The aging population is placing pressure on Thailand’s healthcare system in terms of service access, workforce, and financial sustainability. Even with universal health coverage, older adults remain a group with a high proportion of “ill-but-untreated cases” due to limitations in transportation and long wait times. At the same time, the demand for long-term care is rising rapidly, with projections indicating that by 2037 Thailand may need up to 212,896 home caregivers. All of this presents a challenge for the Thai healthcare system, which must build a sustainable care ecosystem to support an aging society.

Entering an aging society is also creating economic, fiscal, and social pressures. The shrinking workforce and slow human capital development are slowing long-term economic growth. Meanwhile, the social-budget structure is shifting significantly, with retirement-related expenditures rising to as much as 46.2%. At the household level, many older adults have insufficient income to meet consumption needs, while intergenerational conflict is increasing amid social and technological changes.

Addressing Thailand’s demographic changes requires proactive and integrated policies across the life course. The long-term population development plan (2022–2037) serves as the main framework, aiming for “healthy births, healthy living, and healthy aging.” Despite progress, such as expanded maternity leave policies, Thailand still faces significant constraints, including economic limitation, disparity in education quality, shortage of skilled labor, challenges in attracting migrant workers, and pressures on fiscal sustainability in health.

Demographic changes present challenges to the country and the quality of life of Thai people. However, if the country can improve population quality, reduce inequality, and systematically link population policy with economic, labor, and welfare strategies, these pressures can be transformed into opportunities for sustainable long-term development.

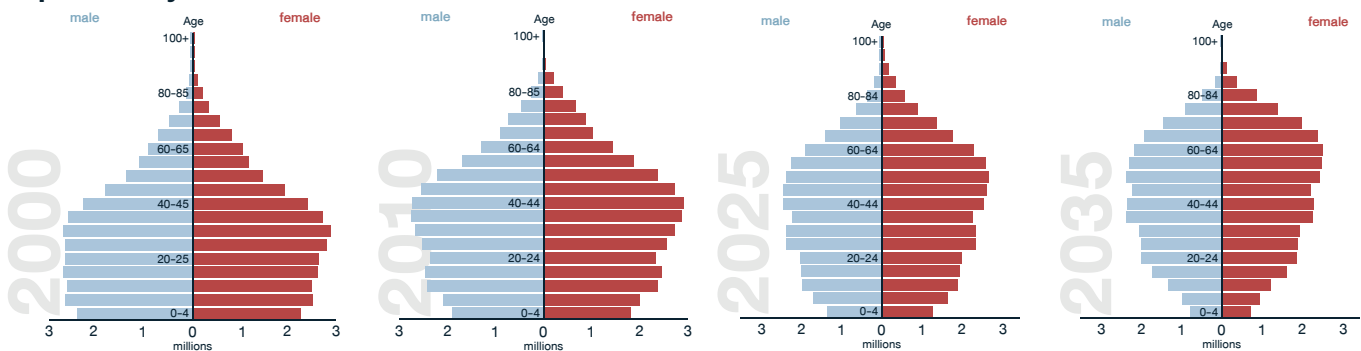
1

Situation and Trends of the Thai Population

The year 2021 marked a pivotal point in Thailand's demographic transition, as the number of births fell below the number of deaths, reflecting the beginning of a population decline.

Thailand is undergoing a demographic transition in both quantity and quality, driven by a rapidly declining birth rate, the full emergence of an aged society, and underdeveloped human capital. All of these factors play a key role in shaping the long-term trajectory of the country's socio-economic development, as well as the quality of life of its population.

Population Pyramids

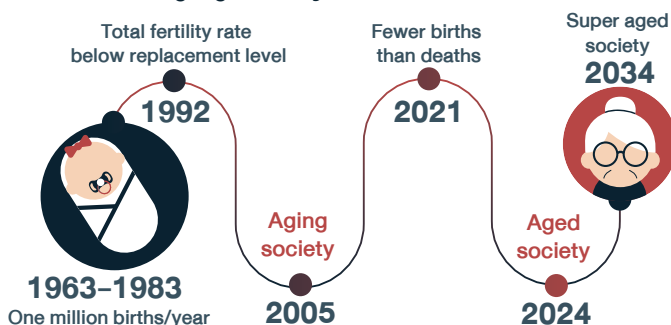


Remark: This projection uses the Cohort-Component Method, with hypothesis that the total fertility rate (TFR) declines from 1.0 to 0.7, while the life expectancy of both men and women continues to increase in line with trends in public health advancement, and that no migration occurs.

Source: Population Censuses 2000 and 2010; 2025 data and 2035 projections calculated by the Institute for Population and Social Research, Mahidol University

Thailand has rapidly transitioned from a working-aged labor-based society to an aging society, particularly over the past two decades. From 2000 to 2025, the population pyramid shows a shrinking base of children and an expanding elderly population. Projections for 2035 further highlight this trend: The pyramid's base narrows while the top widens, reflecting a decrease in the child population alongside a continued increase in the elderly population. By 2035, the number of children and working-age adults is expected to decline by 3.8 million and 3.4 million, respectively, while the elderly population will increase by 3.6 million, marking a significant change in Thailand's population age structure.

Half a century of Thailand's population: From millions of births to an aging society



Remarks: 1. Total fertility rate below replacement level: The average number of children a woman would have over her reproductive lifetime is below 2.1, which is the level needed to maintain a stable population. 2. Aging society: A society in which the population aged 60 or over exceeds 10% of the total population (or the population aged 65 or over exceeds 7%). Aged society: A society in which the population aged 60 or over exceeds 20% of the total population (or the population aged 65 or over exceeds 14%). Super-aged society: A society in which the population aged 60 or over exceeds 28% of the total population (or the population aged 65 or over exceeds 20%).

Source: Report on the 2015-2016 Survey of Population Change, National Statistical Office

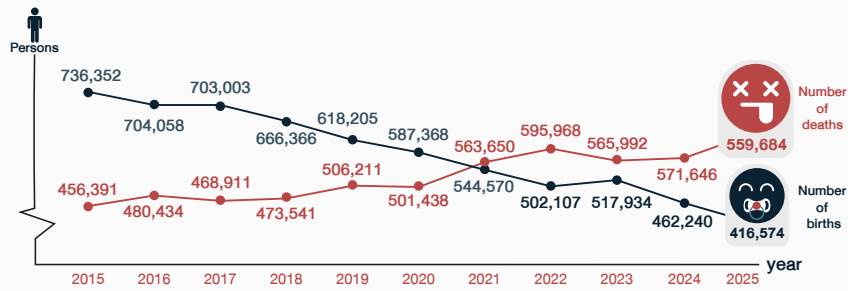
Thai population in the coming decade (millions)

Age Groups	2025	2035	Change
Children (0-14 years)	9.6	5.8	-3.8
Working Age (15-59 years)	41.9	38.5	-3.4
Seniors (60 years or older)	13.9	17.5	+3.6
Total	65.5	61.9	-3.6

: millions

Source: Calculated by the Institute for Population and Social Research, Mahidol University

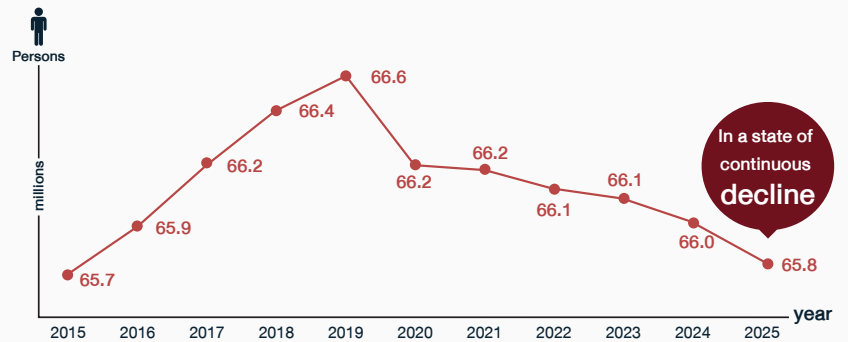
Trends in births and deaths (persons)



Source: Statistics of births and deaths, 2015–2025, Department of Provincial Administration, Ministry of Interior

The year 2021 was a historic turning point, when deaths exceeded births for the first time, signaling the start of Thailand’s natural population decline. Overall, the country’s population began to shrink, from 66.6 million in 2019 to 65.8 million in 2025, and is expected to continue decreasing. This trend poses long-term challenges for the labor force, the healthcare system, and the quality of life of the population.

Trends in the total population (millions)

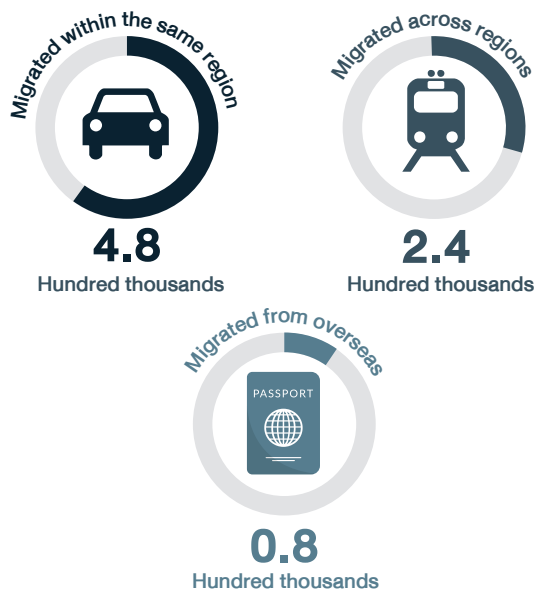


Remarks: Includes both Thai nationals and non-Thai nationals

Source: Annual registered population statistics, 2015–2025, Department of Provincial Administration, Ministry of Interior

Migration is another key factor shaping population structure in different areas. In 2024, nearly 800,000 people moved, with the majority relocating within the same region, followed by interregional migration and international arrivals. Net migration rates reveal spatial differences: Bangkok experienced more people moving out than in, while the North and Central regions saw more people moving in than out. The main reason for migration is employment, accounting for 35.9%, reflecting the geographic distribution of economic opportunities and highlighting the importance of planning to accommodate demographic changes in each region.

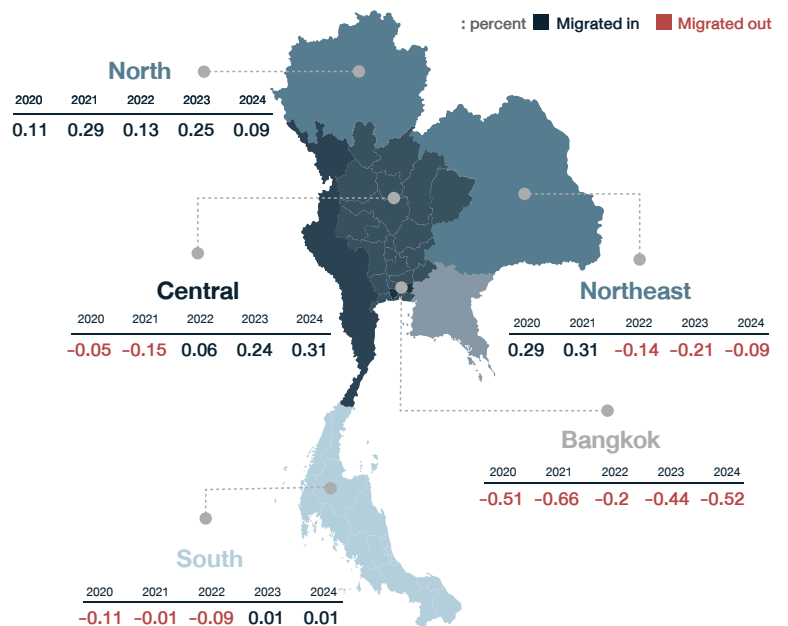
Types of migration in 2024 (hundred thousand)



Remarks: Out of a total of 799,000 migrants

Source: The 2024 Migration Survey, National Statistical Office

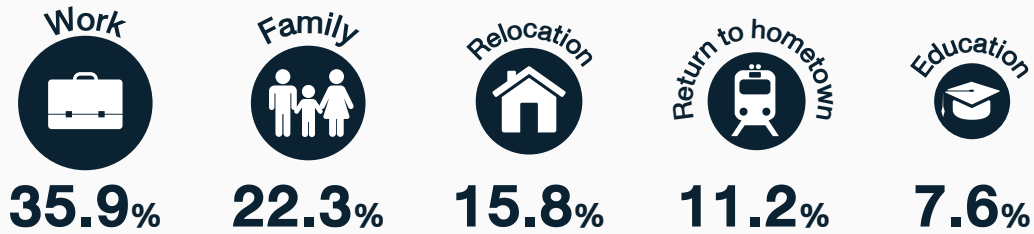
Net migration rate: 2020-2024



Source: The 2024 Migration Survey, National Statistical Office

Changes in age structure are also reflected in birth and death trends between 2015 and 2025. Births have declined rapidly, from 736,352 in 2015 to just 416,574 in 2025, while deaths increased from 456,391 in 2015 to 559,684 in 2025.

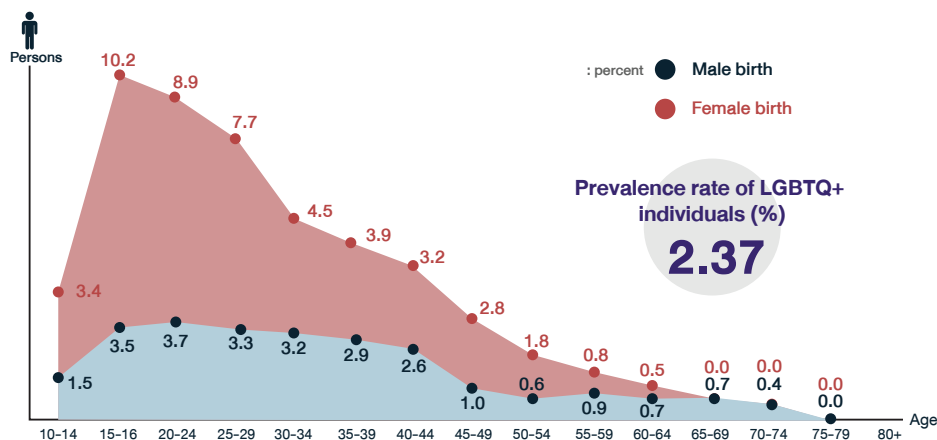
Five main reasons for migrating in 2024



Source: The 2024 Migration Survey, National Statistical Office

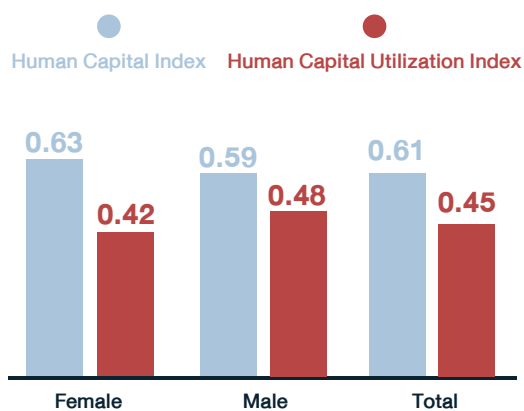
In addition to population size and age structure, the Thai population is also experiencing changes in social characteristics, particularly in terms of gender diversity, which affects family patterns and reproductive decisions. Currently, gender-diverse individuals make up 2.4% of the total population, with females aged 15-19 showing the highest proportion at 10.2%. This diversity highlights the need to design family, health, and welfare policies that more fully account for the population's diversity.

Prevalence of gender-diverse populations by sex assigned at birth and age, 2024



Remark: Adjusted prevalence rates for age groups 20-24, 35-39, and 50-54 among those assigned male at birth, and for age group 35-39 among those assigned female at birth
Source: Report of the Project on Size Estimation of LGBTQ+ Populations and LGBTQ+'s Life and Health, Institute for Population and Social Research, Mahidol University

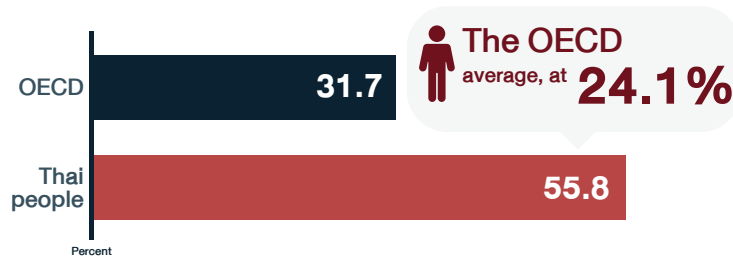
Human Capital Index and Human Capital Utilization Index: 2020



Source: Human Capital Country Brief: Thailand. (2025). World Bank

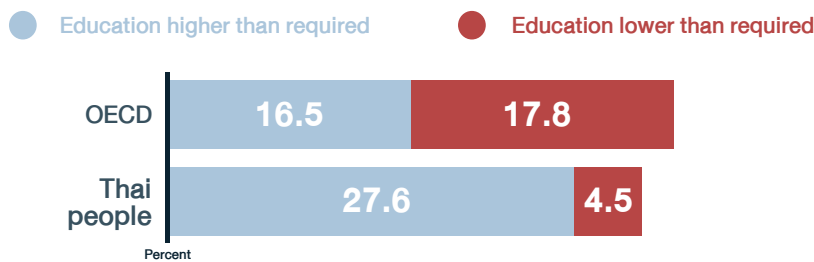
Regarding population quality, Thailand's human potential remains underutilized and misaligned with national needs. Overall, the human capital index stands at 0.61, meaning that children born in Thailand today are expected to develop only 61% of their full potential. Girls have a higher human capital index than boys, reflecting better accumulation of human capital through the education system. However, when adjusted for actual utilization in the labor market, the index drops to 0.45, and girls fall below boys in this measure, indicating that women's potential is not being fully translated into economic outcomes, possibly due to limited employment opportunities or social-role burden.

Horizontal mismatch of labor and labor demand: 2022



Meanwhile, the education system faces challenges in producing a workforce aligned with labor market needs. Horizontal mismatch—working in a field unrelated to one’s study accounting for 55.8%, nearly double the OECD average of 31.7%. Vertical mismatch—working in a job not aligned with one’s education level—shows that 27.6% of Thais are overqualified for their jobs, while 4.5% are underqualified. These mismatches reduce human capital efficiency and negatively affect labor productivity, income, and long-term skill development incentives.

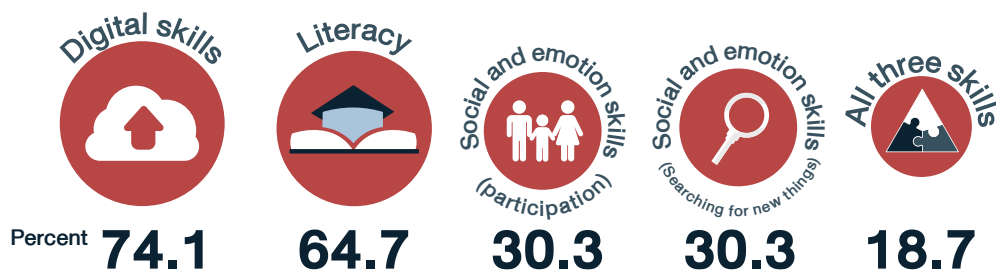
Vertical mismatch of labor and labor demand: 2022



Source: Report on Human Capital Development in Thailand: An Examination of Gaps, Bottlenecks, and Policy Options, 2025, UNICEF-Thailand

Skill data also reveal quality constraints in the Thai population. Many youth and working-age individuals have life skills below the recommended level, particularly digital skills, with 74.1% lacking adequate proficiency. This represents a significant limitation for Thailand’s workforce in adapting to a digital economy, technological change, and future labor-market demands.

Proportion of Thai youth and working-age populations with below-standard levels of basic life skills: 2021



Source: Fostering Foundational Skills for a Sustainable Future of Thailand, 2021, Equitable Education Fund and the World Bank

Thailand’s demographic transition is thus a structural change in both quantity and quality. The country’s future will depend on the perspectives, policies, and measures adopted to manage these structural demographic changes and to enhance population quality in a timely and effective manner.



2

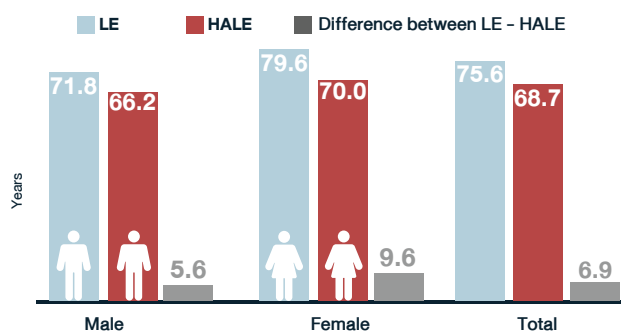
Changes in the Population and Thai Health

Thais are living longer, with life expectancy reaching 75.6 years, but they spend as many as 6.9 years in poor health.

Thailand’s demographic transition—marked by longer life expectancy, fewer births, and an aging society—is clearly reshaping the country’s health landscape across physical, mental, and social dimensions. The challenges are not confined to any single age group but are interconnected across the entire life course.

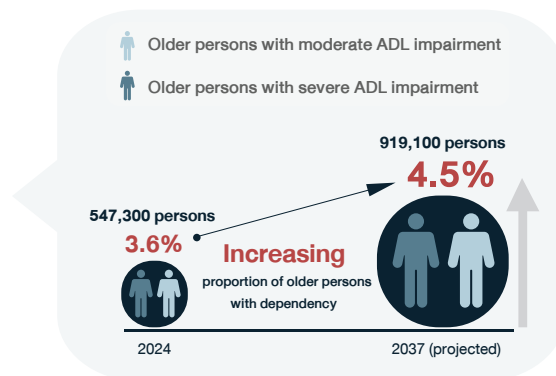
Overall, the physical health of the Thai population reflects a pattern of “long life but prolonged illness.” Between 2009 and 2024, life expectancy at birth (Life Expectancy: LE) increased to 75.6 years, while health-adjusted life expectancy (HALE) stood at 68.7 years. This means that people spend as many as 6.9 years living with illness or dependency—rising to 9.6 years among women. This trend is consistent with the growing number of dependent older persons, projected to increase from 3.6% in 2024 to 4.5% in 2037, with the total number rising from around 547,300 to approximately 919,100.

Life Expectancy (LE) and Health-Adjusted Life Expectancy (HALE) at birth in 2024



Remarks: LE – Life expectancy at birth
HALE – Health-Adjusted Life Expectancy at birth
Source: Report on Life Expectancy (LE) and Health-Adjusted Life Expectancy (HALE) of the Thai Population, International Health Policy Program, Burden of Disease Thailand

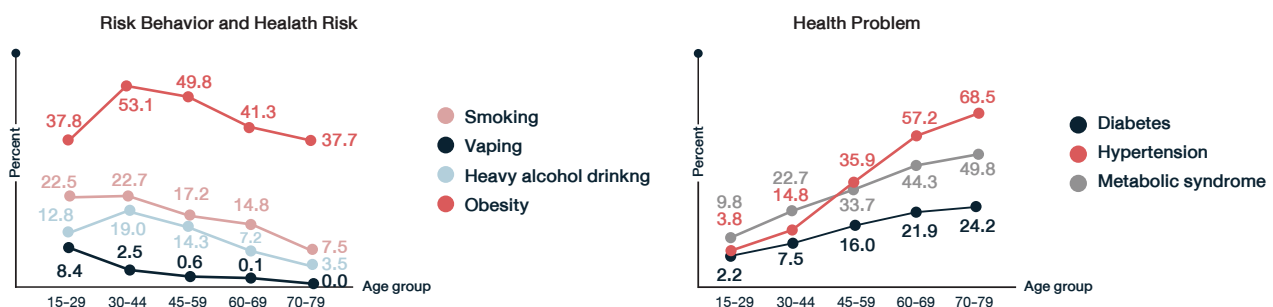
Percentage and number of dependent older Thais



Remarks: Assessed based on moderate and severe limitations in Activities of Daily Living (ADL)
Source: Care at Home: Projecting Thailand’s Need for National and Migrant Labor for Home-Based Care for Older Persons, International Labor Organization (ILO)

Many health problems in old age have their roots in risk behaviors during adolescence and working age. Data from the 7th Thai National Health Examination Survey (2024-2025) indicate that younger age groups continue to smoke and use e-cigarettes, engage in heavy alcohol consumption, and have insufficient physical activity as well as unhealthy dietary behaviors leading to obesity. Meanwhile, chronic conditions such as diabetes, hypertension, and metabolic syndrome tend to become more evident in older age, underscoring the need for proactive prevention policies starting early in life.

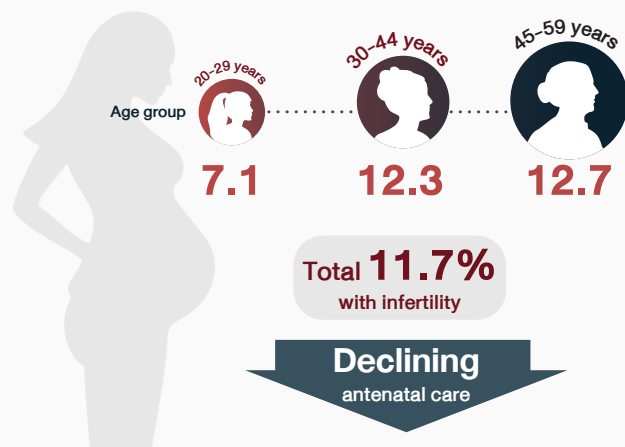
Health behaviors, risk factors, and health problems by age group: 2024-2025



Source: Report of the 7th National Health Examination Survey, 2024-2025, Faculty of Medicine Ramathibodi Hospital, Mahidol University

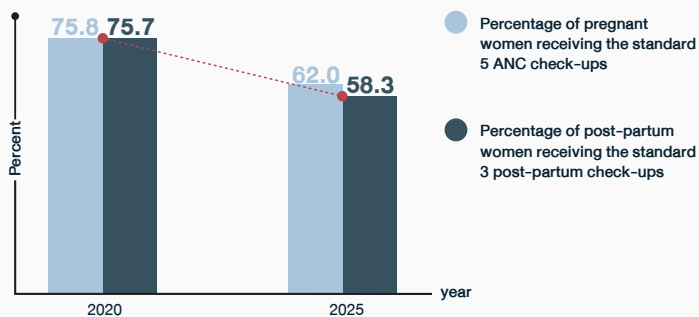
Maternal and early childhood health is a significant challenge at the beginning of the life cycle. Thailand faces both low birth rates and infertility issues, with more than 1 in 10 married women aged 20–59 (11.7%) experiencing infertility. At the same time, indicators for antenatal care and postnatal care are declining, while stunting and overweight among children aged 0–5 are increasing. In 2024, these rates rose to 12.9% and 9.3%, respectively, reflecting vulnerabilities in long-term human health investment.

Prevalence of infertility among married women aged 20-59, 2024-2025



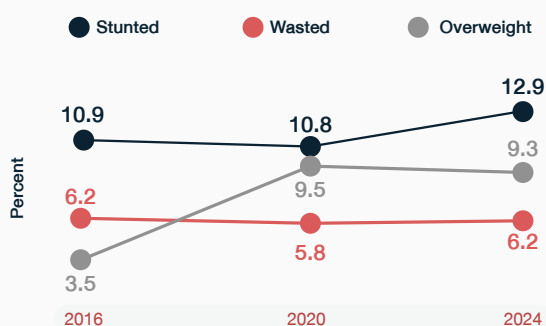
Source: Report of the 7th National Health Examination Survey, 2024–2025, Faculty of Medicine Ramathibodi Hospital, Mahidol University

Antenatal and postnatal Care



Source: National Environmental Health Information System, Department of Health, Ministry of Public Health

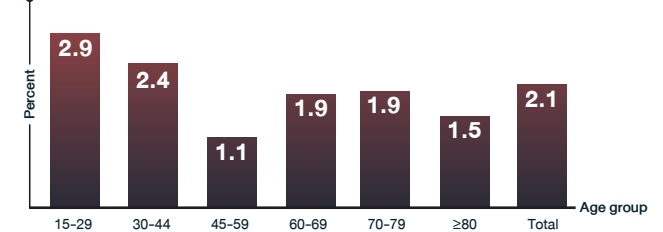
Malnutrition among Thai children aged 0-5 years



Source: Report on Human Capital Development in Thailand: An Examination of Gaps, Bottlenecks, and Policy Options, 2025, UNICEF-Thailand

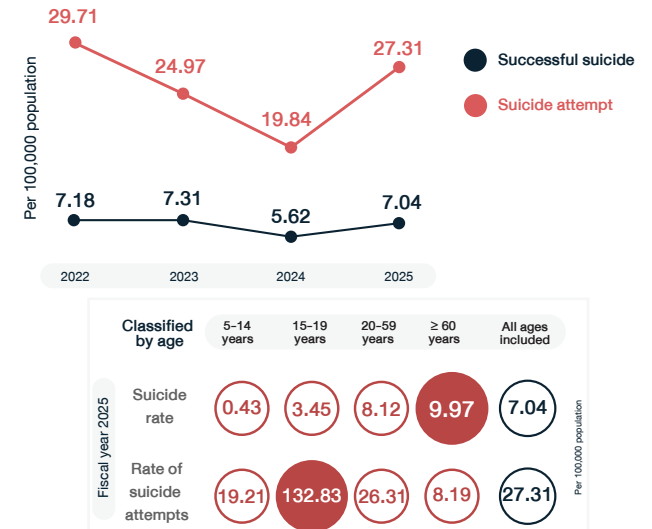
In terms of mental and social health, vulnerabilities are particularly evident among youth and early working-age populations. The 2024-2025 survey found that 2.1% of the population aged 15 or over experiences depression. Although older adults have the highest rate of completed suicide, youth aged 15–19 have the highest rate of suicide attempts. This signals the vulnerability of a transitional age group that represents the country’s future workforce.

Prevalence of clinical depression by age group: 2024-2025



Source: Report of the 7th National Health Examination Survey, 2024–2025, Faculty of Medicine Ramathibodi Hospital, Mahidol University

Suicide completion and attempt rates



Remarks: Includes only cases confirmed as suicide or suicide attempts; therefore, it may not cover all actual cases and has limitations in representing the entire population.

Source: Analysis based on the Self-Harm Surveillance Report, Fiscal Years 2022–2025, and mid-year population data for 2022–2025, by the National Center for Suicide Prevention, Khon Kaen Rajanagarindra Psychiatric Hospital, Department of Mental Health, Ministry of Public Health

Demographic change is not merely about population numbers—it is a life-course health challenge that requires integrated policies, from early-life disease prevention and long-term care to promoting quality births and mental health care, in order to build a Thai society that is both long-lived and sustainably healthy.



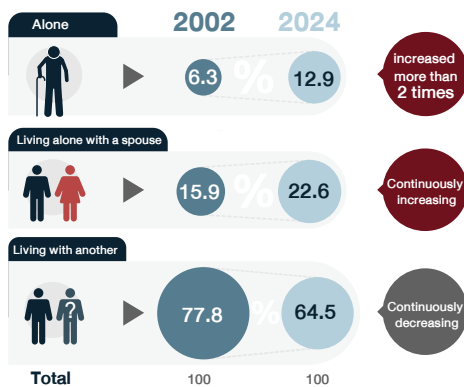
3

Health of Vulnerable Populations

Only 55.6% of young children live with their parents, while as many as 12.9% of older adults live alone, and the number of urban poor is now nearly equal to that of the rural poor.

Demographic, economic, and social changes in Thailand are increasing health vulnerabilities among certain population groups, particularly those facing limitations related to family support, economic status, living environments, and legal or rights status. These factors affect their access to healthcare services and their ability to maintain well-being throughout the life course.

Living arrangements of older adults in Thailand, 2002 and 2024



Source: Survey of the Older Persons in Thailand, 2002 and 2024, National Statistical Office

Vulnerable older adults are a group that requires close attention. Current data indicate that Thai older adults are increasingly likely to live alone or only with an elderly spouse. Many studies have found that older adults living alone face significantly higher risks of unmet healthcare needs and depression compared to the general elderly population. This highlights the need for long-term care systems and community-level social support.



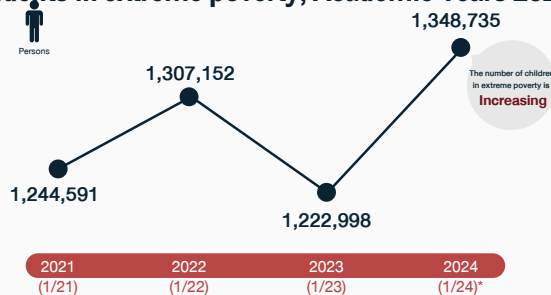
The elderly living **alone** have **1.6 times higher** unmet health needs than those living **with others**⁽¹⁾ and a **1.2 times higher** risk of depression.⁽²⁾

Living alone, particularly in old age, is also associated with **suicide attempts and suicide deaths**. Loneliness and feelings of abandonment are key factors contributing to **suicide in later life**.^(3,4)

Sources: (1) Paek, S. C., & Zhang, N. J., 2025.
 (2) Paek, S. C., & Zhang, N. J., 2019.
 (3) Luo, Z., Wang, J., Chen, X., Cheng, D., & Zhou, Y., 2024.
 (4) De Leo, D., 2022.

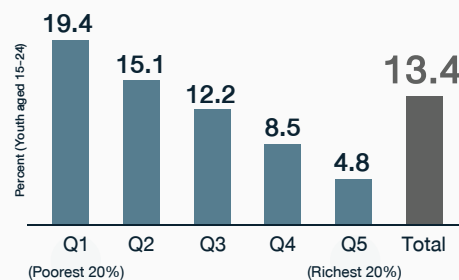
Vulnerable children and youth face risks from an early age. Only 78% of children aged 0-5 years have age-appropriate development, and just 55.6% live with their parents. Co-residence and family interaction are key factors in child development in school age. Poverty further exacerbates vulnerability. The number of children in extreme poverty increased from 1.24 million to 1.35 million between 2021 and 2024. Youth aged 15-24 years in the lowest-income households are four times more likely than their better-off peers to be outside education, employment, and training, which affects their long-term health and opportunities.

Number of students in extreme poverty, Academic Years 2021-2024



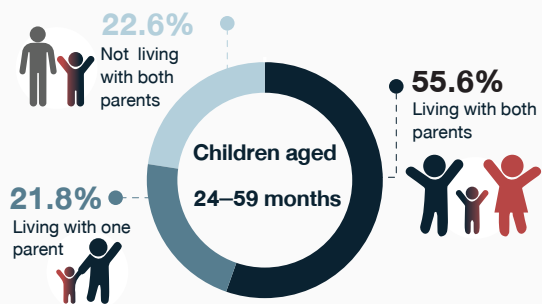
* Data as of October 25, 2024
 Source: Education Inequality Situation Report 2024 and Key Directions for 2025, Equitable Education Fund (EEF)

Percentage of youth not in education, employment, or skills training, by socioeconomic status, 2021



Remarks: (1) Youth Not in Education, Employment or Training (NEET)
 (2) Data from the 2021 Household Socio-Economic Survey
 (3) Socioeconomic status or quintiles 1-5 (Q1- Q5)
 Source: Report on Human Capital Development in Thailand: An Examination of Gaps, Bottlenecks, and Policy Options, 2025, UNICEF-Thailand

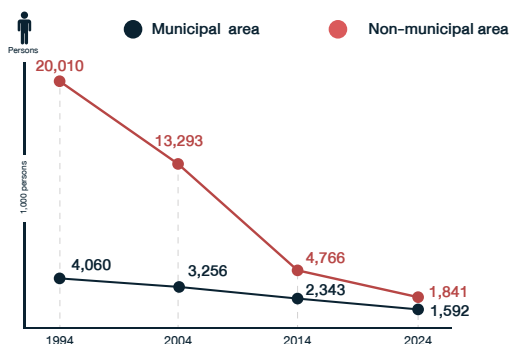
Living arrangements of children aged 24-59 months, 2022



Source: (1) Multiple Indicator Cluster Survey (MICS) 2022, National Statistical Office
(2) Topothai, T., Phisanbut, N., Topothai, C., Suphanchaimat, R., & Tangcharoensathien, V. (2025)

Living with both parents, or at least with either parent, is significantly associated with higher levels of parent-child interaction (adjusted odds ratios = 2.59 and 2.14, respectively), which is a key factor in age-appropriate development. However, about 12% of Thai parents have low levels of interaction with children aged 2-4 years. Meanwhile, Thailand's Early Childhood Development Index (ECDI), or the proportion of children aged 24-59 months who meet developmental milestones, stood at 78% in 2022.

Number of people living in poverty by municipal area (1,000 persons)



Economically vulnerable groups, especially the urban poor, also require attention. In 2024, Thailand had approximately 3.4 million people living in poverty, with the number of urban poor nearly equal to that of the rural poor. Income insecurity, overcrowded housing, and high living costs expose the urban poor to multiple physical and mental health risks.

Number of migrant workers living legally in Thailand



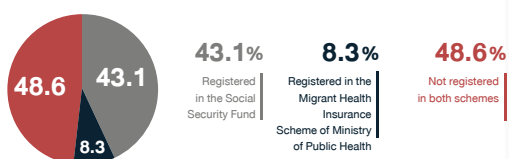
Remarks: Data as of December, except 2025, which are as of November.
Source: Statistics of the number of migrant workers permitted to work nationwide, Foreign Workers Administration Office, Department of Employment

Migrant populations is a group with significant health vulnerabilities due to gaps in health insurance coverage. Overall, only about half of migrant workers in Thailand have health insurance. Although protection mechanisms exist through the social security system and migrant health insurance schemes, practical barriers such as registration, continuity of coverage, and understanding of the system persist. As a result, access to healthcare services for this population remains an important policy challenge.

As of November 2025, a total of 746,346 individuals were registered in the Health Insurance for Non-Thai People System (Tor.99).

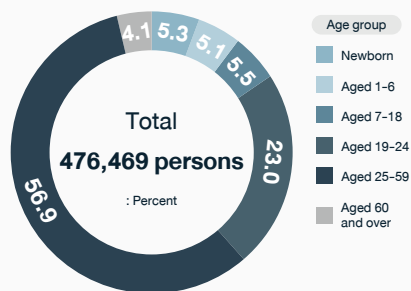
Source: Statistics of registered members of the Health Insurance for Non-Thai People System (Tor.99), Division of Health Economics and Health Security, Ministry of Public Health

Coverage of health insurance for migrant workers, 2024



Remarks: Data as of February 2024, out of a total of 3.02 million documented migrant workers
Source: Thailand Migration Report 2024, United Nations

Registrations for Migrant Health Insurance Scheme, Ministry of Public Health by age, 2024



Remarks: Data as of March 12, 2025
Source: Report on the Implementation of Health Insurance for Migrant Population, Fiscal Year 2024, Division of Health Economics and Health Security

The health of vulnerable populations reflects structural challenges that require integrated policy approaches encompassing family, economic, social, and health insurance dimensions, to ensure that all population groups can equitably access appropriate well-being.



4

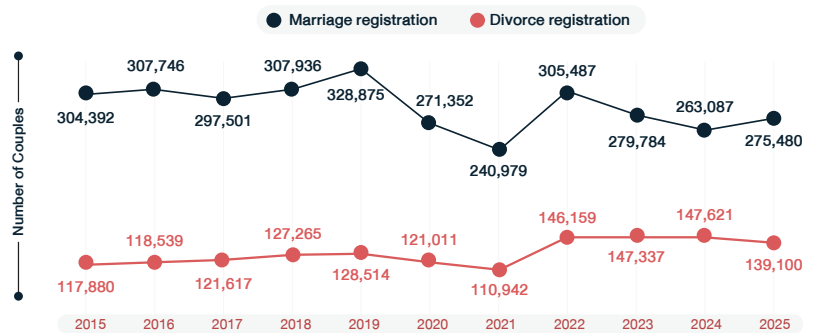
Marital Status and the Family

More than 50% of single women have insufficient physical activity, putting them at risk of developing office syndrome.

The increase in singlehood and living alone reflects changes in Thailand's family structure, driven by declining marriage registrations and rising divorce rates. This is linked to low birth rates and serves as a determinant of health that affects quality of life and risk behaviors among the working-age population in the long term.

Marital status is associated with health behaviors among the working-age population. Survey data show that single individuals and those who are divorced or separated spend an average of up to 14 hours per day in sedentary behavior, exceeding the level recommended by the World Health Organization (WHO). In particular, more than 50% of single women have insufficient physical activity, increasing their risk of office syndrome and non-communicable diseases (NCDs) such as heart disease, hypertension, and diabetes.

Trends in marriage and divorce registrations in the past 10 years



Source: Statistical Reports on Marriage Registration and Divorce Registration, 2015-2025, Bureau of Registration Administration, Department of Provincial Administration, Ministry of Interior

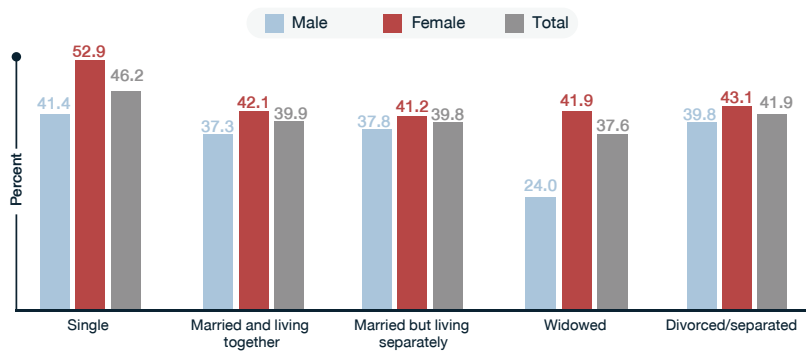
Average number of hours per day spent in sedentary behavior, 2024



Remarks: The average number of hours per day spent in sedentary behavior among working-age individuals, according to WHO recommendations, should not exceed 13 hours per day.

Source: Thailand Physical Activity Surveillance System Project, Thailand Physical Activity Knowledge Development Centre (TPAK), Institute for Population and Social Research, Mahidol University

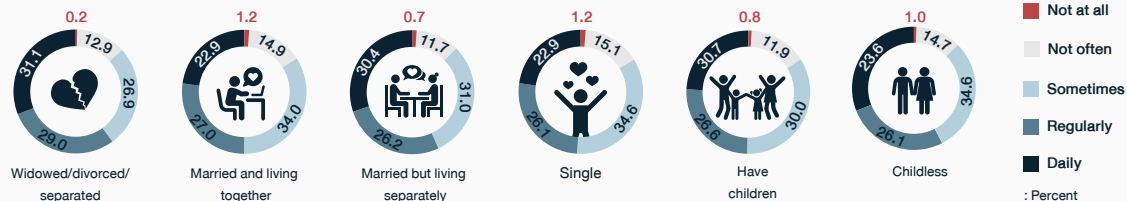
Insufficient physical activity by marital status, 2024-2025



Remarks: Sufficient physical activity, as recommended by the WHO, is defined as at least 150-300 minutes per week of moderate-intensity activity or at least 75-150 minutes per week of vigorous-intensity activity.

Source: Report of the 7th National Health Examination Survey, 2024-2025, Faculty of Medicine Ramathibodi Hospital, Mahidol University

Daily consumption of fruits and vegetables by marital status and having children, 2025

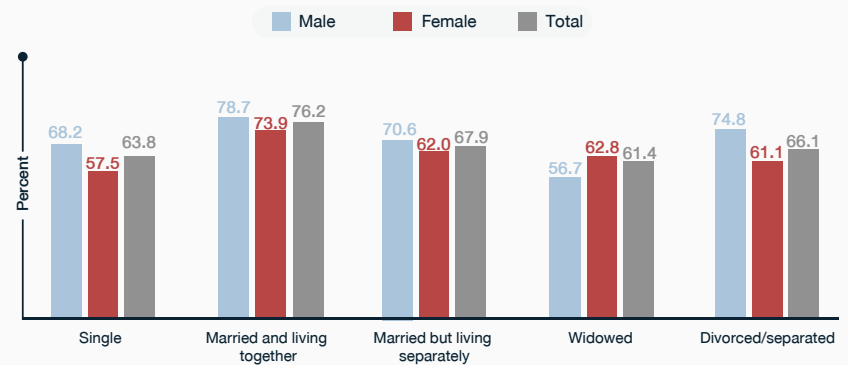


Source: Hapinometer: National Survey 2025, Institute for Population and Social Research, Mahidol University

In addition to physical activity, dietary behavior also varies clearly by marital status. Working-age individuals living with a spouse and children are more likely to consume fruits and vegetables regularly and to eat three meals a day compared to those who are single. This reflects the influence of family living on health care and daily life management. These differences have significant implications for long-term health, especially in light of the rising trend of singlehood in Thailand.

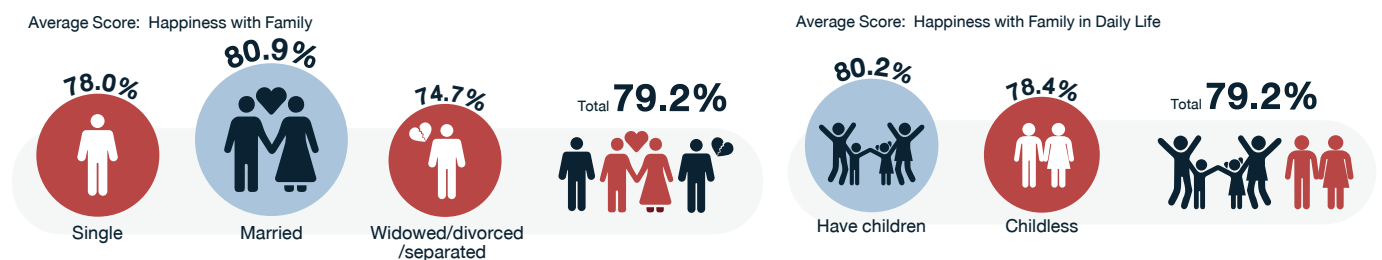
In terms of mental health, findings from the 2025 National Survey on Well-being, Quality of Life, and Productivity indicate that married individuals and those with children report higher levels of daily happiness than those who are single or childless. This underscores the importance of having a partner and children in providing emotional support, reducing stress, and enhancing everyday happiness.

Proportion of Thais consuming three meals per day by marital status, 2024-2025



Source: Report of the 7th National Health Examination Survey 2024-2025, Faculty of Medicine Ramathibodi Hospital, Mahidol University

Average score of happiness with family in daily life, by marital status and having children, 2025



Source: Hapinometer: National Survey 2025, Institute for Population and Social Research, Mahidol University

However, having or not having a spouse is “not the only condition” for happiness. Being single can also support a good quality of life if individuals maintain proper nutrition, engage in sufficient physical activity, pursue self-development, and build meaningful social relationships. Happiness does not have to be tied to having a partner; rather, it arises from living a life that is valuable and meaningful.

7 advantages of single people

Being single isn't a bad thing; it's a great opportunity to live a better life!

- I got to know myself better than ever before.
- I learned how to be happy alone.
- Freedom to try new things freely, without waiting for anyone.
- Indulge yourself completely.
- It opens up to meet new people who are a better match.
- Spent time building good relationships with the people around me.
- Have time to work and stay healthy.

Source: "7 Advantages of Being Single" (2022), Thai Health Promotion Foundation (ThaiHealth)

Changes in Thailand’s family structure are therefore more than a demographic statistic—they are factors that broadly affect population health and welfare. Public policy design must take into account the diversity of family patterns and marital statuses to ensure that all population groups can access opportunities for good health and sustainable quality of life, regardless of how they choose to live.



5

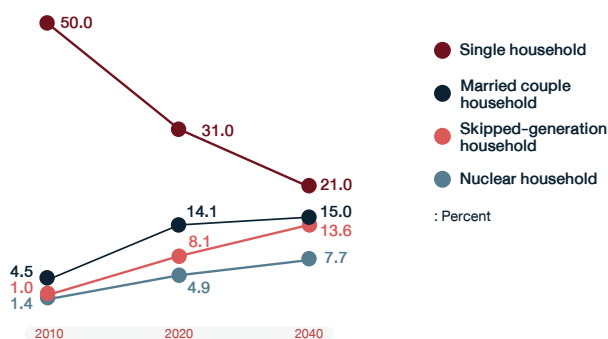
Social and Community Networks

As family structures change, social media has become a primary means of connection, with 58% of Thai people using it to communicate with family and friends.

The decline of the nuclear family and the increase in single-person living arrangements have made social and community networks—both offline and online—more important in connecting people and supporting well-being in daily life. As traditional family structures change, the risk of social isolation and the lack of close caregivers in emergencies also increases.

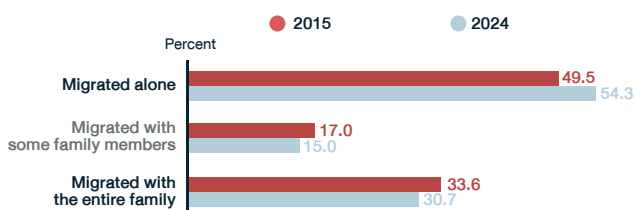
Within the context of changing family structures, migration in 2024—of which 54.3% involved individuals moving alone—has led to a growing phenomenon of “skipped-generation families.” As a result, caregiving responsibilities are increasingly shifted to community networks, neighbors, and local support mechanisms. At the same time, declining fertility and the rise in single-person households have elevated “pets” to the status of “family members” or even “children.” Nearly half of Thai people (49%) keep pets as substitutes for children and, among single individuals, the proportion is as high as 80.7%. Pets thus serve as an important source of emotional support, helping reduce loneliness, alleviate stress, and promote mental well-being.

Trends in the proportion of working-age households by household type



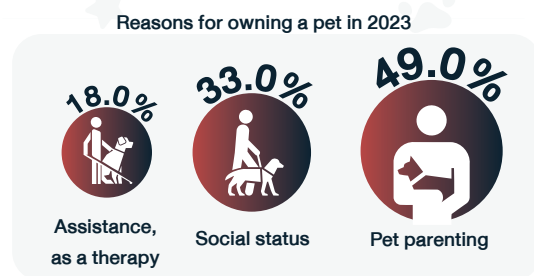
Source: Thai Families in the Future: 2040, Institute for Population and Social Research, Mahidol University

Proportion of migration by type of migration

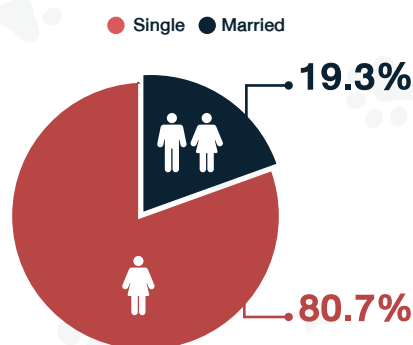


Source: The Migration Survey, 2015–2024, National Statistical Office

Marital status of pet owners



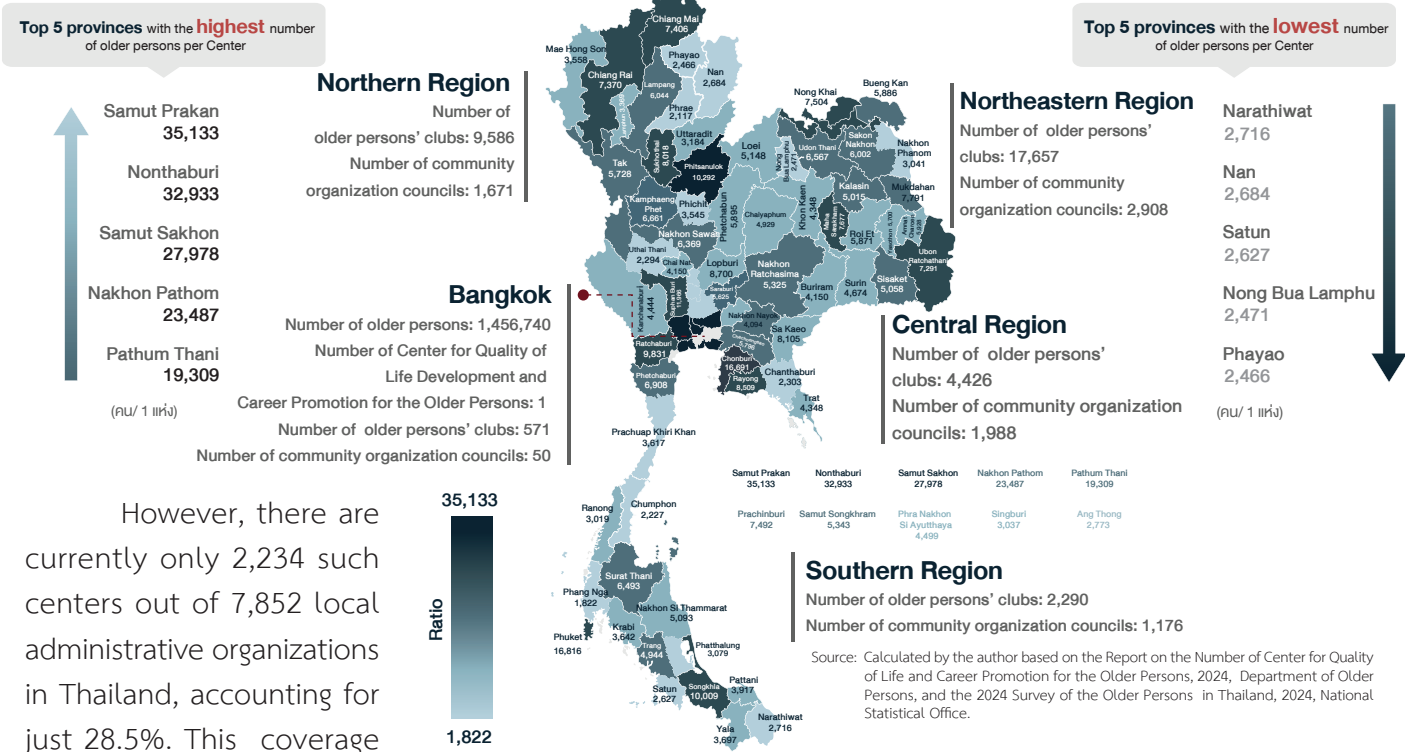
Pet ownership by marital status



Source: “Petsumer Marketing: Insights into Big-Spending Pet Lovers” (2023), College of Management, Mahidol University

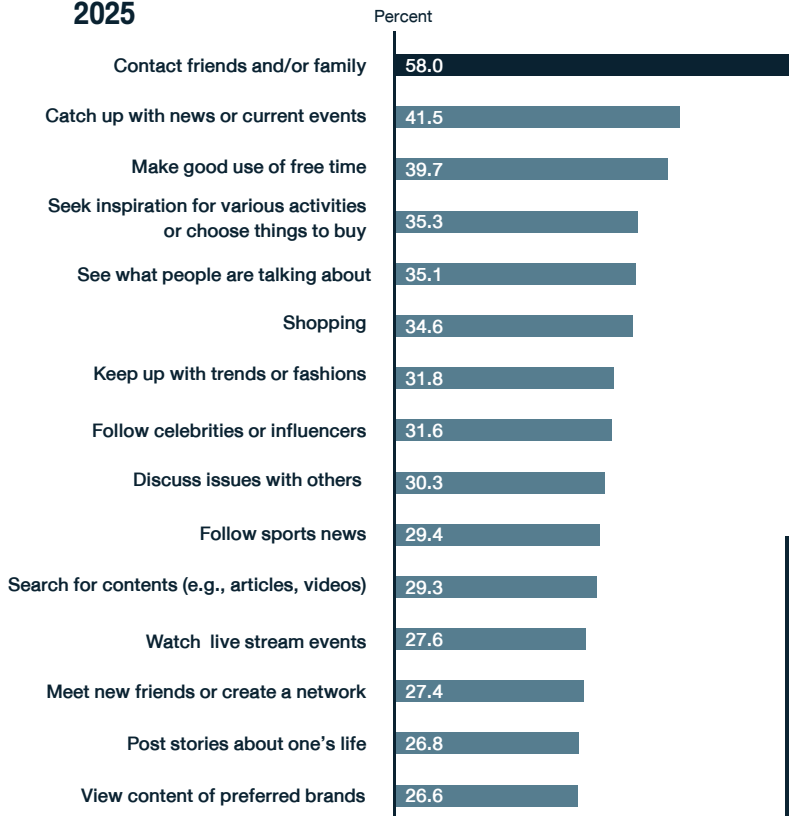
Amid these changes, communities must play an increasingly important role as a support network. One example is the movement to establish “Center for Quality of Life Development and Career Promotion for the Older Persons,” driven by local administrative organizations. These centers serve to support older adults as a vulnerable group affected by changing family structures. They function as community spaces for activities and services covering physical health, mental well-being, social engagement, and economic support—particularly income generation and suitable employment. This represents an effort to enhance social services and welfare to protect, promote, and improve the quality of life of older persons at the community level.

Number of Older Persons per Center for Quality of Life Development and Career Promotion for the Older Persons in 2024



However, there are currently only 2,234 such centers out of 7,852 local administrative organizations in Thailand, accounting for just 28.5%. This coverage is insufficient in light of the rapidly growing older Thai population, leaving many older adults without adequate access to preventive care, awareness of their rights and benefits, and opportunities to participate in essential social activities and networks.

Major reasons of Thai people for using social media, 2025



Source: Digital 2026: Thailand, DataReportal, 2026, We Are Social.

Changes in population structure have also shifted real “communities” into the digital world, thereby forming “online communities.” Social media, in particular, has become the primary space where Thai people communicate and exchange information. These online communities are not merely general communication platforms; they can be highly influential networks that shape decision-making—especially health-related decisions. Examples include disease-specific patient groups and health-focused communities, which serve as sources of information, emotional support, and shared experiences.

Strong social and community networks function like a crucial “social vaccine.” Investing in strengthening health literacy and the resilience of social networks—both offline and online—is therefore an urgent necessity to ensure sustainable health security for all Thais in an era of changing family structures and living arrangements.

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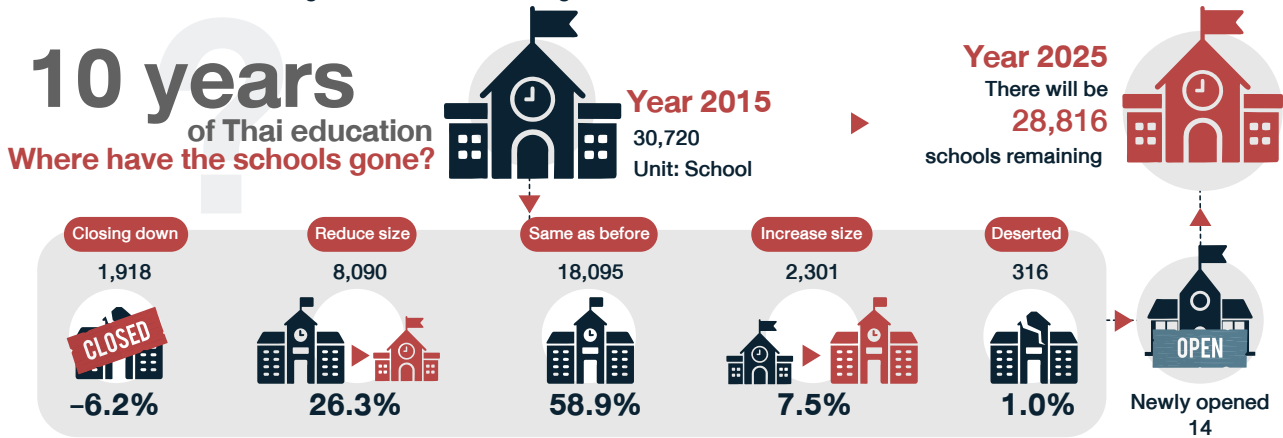
Education and Learning

The declining Thai birth rate is a key factor that has led to the closure of nearly 2,000 schools and the downsizing of more than 8,000 others over the past decade, which may affect access to and the quality of education.

Thailand’s changing population structure is impacting the education and learning systems for people of all ages, with long-term implications for health and quality of life. This is particularly evident in the context of rapidly declining birth rates and shifts in family structures. As a result, the education system has reached a point where it must prioritize quality over quantity—an approach that will have significant implications for human capital development and the long-term well-being of the Thai population.

At the education system level, the rapid decline in birth rates has placed significant pressure on educational institutions, particularly in remote areas. Data from 2015–2025 show that many schools under the Office of the Basic Education Commission have been forced to close—almost all of them small schools. This situation may affect access to quality education and increase educational inequality across different areas, especially in rural communities where children must travel longer distances or lose educational opportunities.

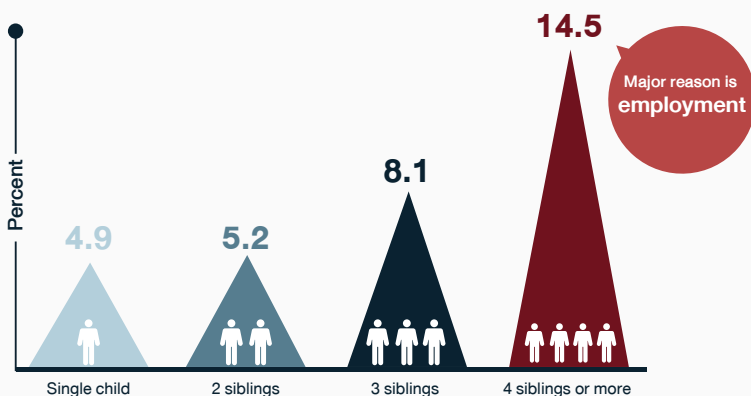
Number of schools closing down and reducing in size in 2015-2025



Source: Fewer Births, Disappearing Schools, and Closing Education, the Active

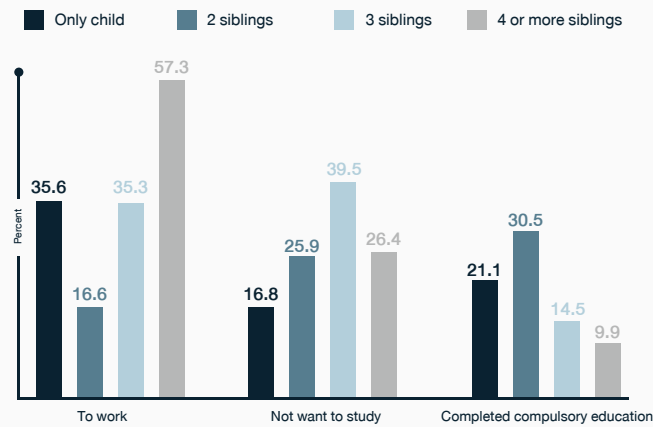
At the household level, family structure is directly linked to children’s educational opportunities. Data indicate that children aged 10-19 who have four or more siblings are nearly three times more likely to be out of the education system compared to only children. A key reason is the need to work, reflecting economic pressures that push children in large families to forgo educational opportunities in order to contribute to household income.

Proportion of population aged 10-19 years who are not being in school by number of siblings, 2024-2025



Source: The 7th National Health Examination Survey, 2024–2025, Faculty of Medicine, Ramathibodi Hospital, Mahidol University

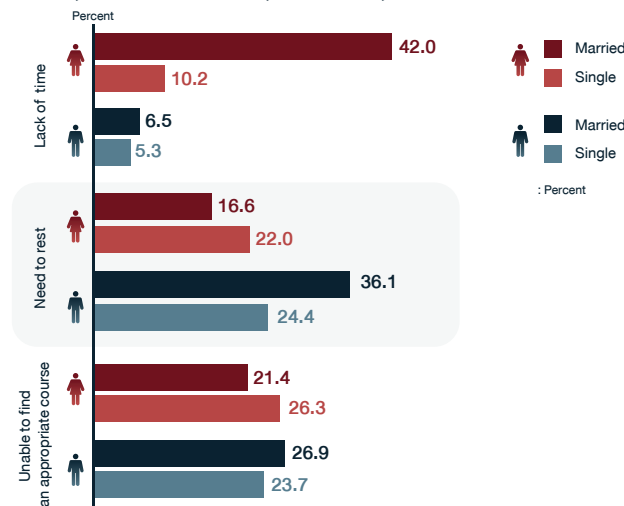
Reasons for not being in school by number of siblings, 2024-2025



Source: The 7th National Health Examination Survey, 2024-2025, Faculty of Medicine, Ramathibodi Hospital, Mahidol University

At the same time, marriage is another limiting factor for learning, particularly among young women who are not in education, employment, or training. It was found that 42% of those who are married do not develop skills due to lack of time, compared to 10.2% among those who are unmarried. This reflects how family responsibilities and roles resulting from early marriage become major obstacles to self-development.

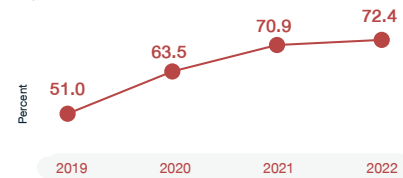
Proportion of youth not being in school, employment or training (NEET) by reason for not developing skills, marital status, and sex, 2021



Source: Report on Human Capital Development in Thailand: Examining Gaps, Barriers, and Policy Options, 2025, UNICEF-Thailand

At the individual level, teen pregnancy remains a significant risk factor affecting educational pathways. Between 2019 and 2022, the proportion of pregnant students who were able to continue their education increased markedly from 51% to 72.4%. This change reflects progress in the adaptation of Thailand's education system to accommodate diverse life paths and a reduction in social stigma.

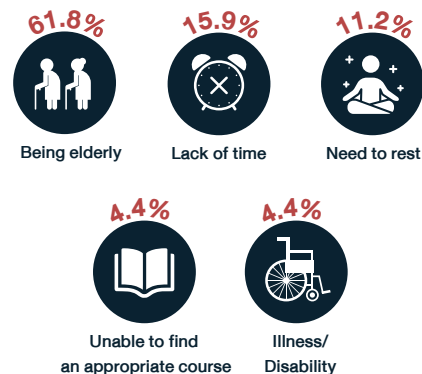
Proportion of female students under 20 years who became pregnant and continued their education in the formal system, 2019-2022



Source: Health Data Center, Ministry of Public Health

In older age, lifelong learning has not yet become a social norm. Around 61.8% of older Thais cite being elderly as the reason for not developing further skills. Such an attitude reflects social norms that limit learning to traditional school age and working age, despite the fact that, in the context of an aging society and rapid technological change, lifelong learning is essential for maintaining quality of life and social participation.

Five main reasons why older Thais did not participate in training, 2021



Source: Potranandana, W., 2024

Thus, changes in population structure affect education and learning across all dimensions—from school closure and inequality stemming from family structure to barriers to lifelong learning. If these challenges are not addressed systematically, they will accumulate into inequalities in human capital, ultimately undermining the health and quality of life of the Thai population in the long term.

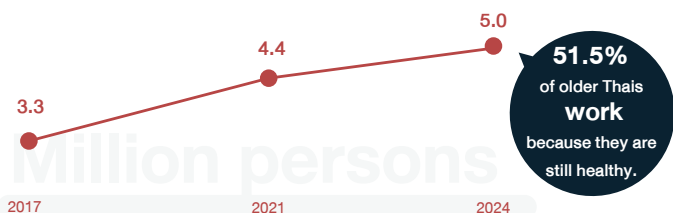


Employment

The number of older adults who are working or wish to work has steadily increased from 3.3 million in 2017 to nearly 5 million in 2024.

Thailand's changing population age structure, particularly the decline in the working-age population, is having a significant impact on the country's economic growth potential. Thailand needs comprehensive labor planning, including increasing domestic labor-force participation, developing the quality of the new generation of workers, and planning for the import of migrant labor to offset indigenous Thai labor shortages.

Number of older persons seeking employment or being employed (millions)

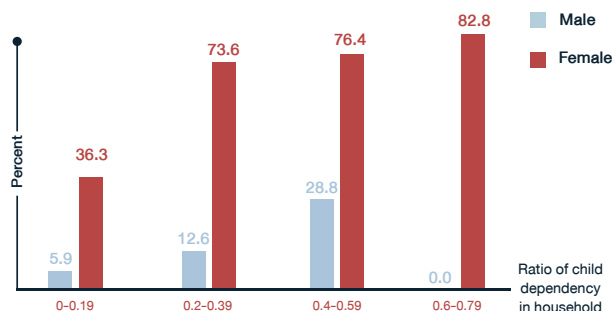


Source: Report of the Survey of Older Persons in Thailand, 2017, 2021, 2024, National Statistical Office

The changing population structure is increasingly making older adults a significant part of the workforce. The main reason they continue to work or wish to work is that they remain healthy and capable of working. This situation indicates that older adults could become a key labor force in Thailand if employment arrangements and working environments are appropriately designed to support them.

Percentage of youth not in employment, education, or training due to homemaking responsibilities and percentage of child dependency by sex, 2021

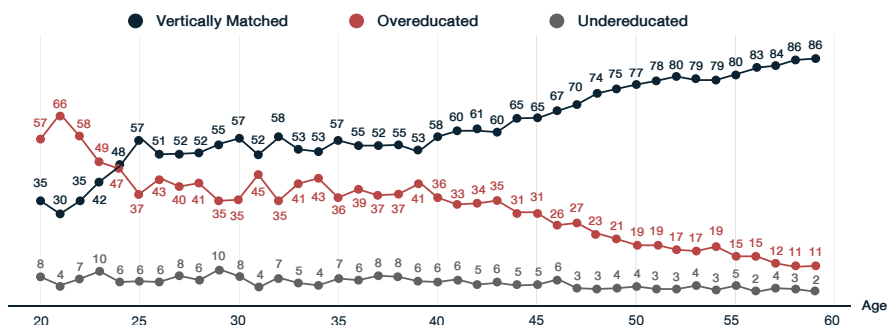
Having fewer children may increase women's opportunities to work. Data on young women who are not in employment, education, or training (NEET) and live in households with relatively high child dependency ratios (0.6-0.79) show that 82.8% cited being homemakers or doing housework as the reason for not working—more than double the proportion of young women living in households with low child dependency ratios (0-0.19).



Source: Report on Human Capital Development in Thailand: An Examination of Gaps, Bottlenecks, and Policy Options., 2025, UNICEF-Thailand

Percentage of workers in jobs misaligned with their education level by age, 2022

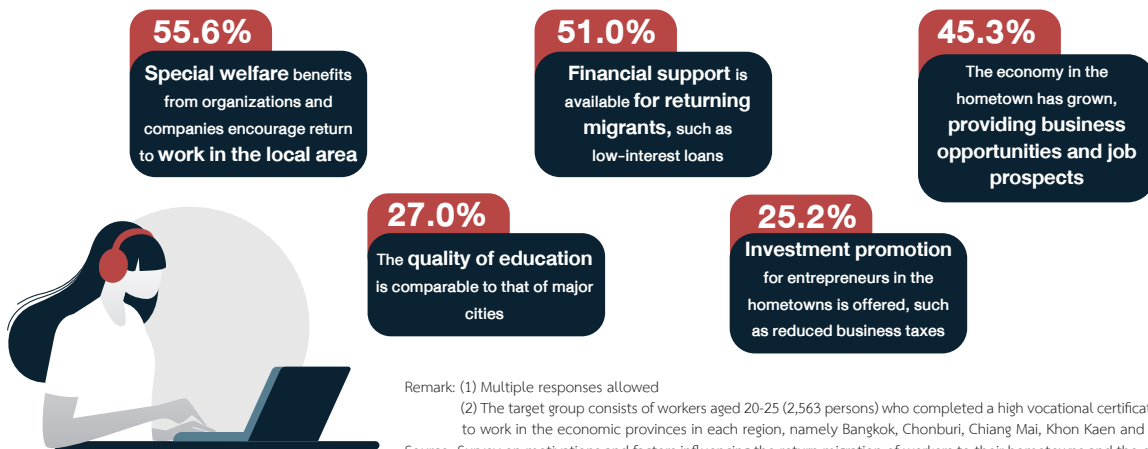
Source: Report on Human Capital Development in Thailand: An Examination of Gaps, Bottlenecks, and Policy Options, 2025, UNICEF-Thailand



At the same time, preparing youth to become quality members of the workforce remains a major challenge. Data indicate that among 21-year-olds, up to 70% are working in jobs that do not match their education level, with 66% of them employed below their education level. This reflects issues in the transition from education to the labor market, and highlights the underutilization of the potential of the new generation of workers.

From a regional perspective, work remains a major driver of internal migration. Data show that incentives for workers to return to work or start businesses in their hometowns are linked to financial motivation, economic opportunity, and the quality of education comparable to that in large cities.

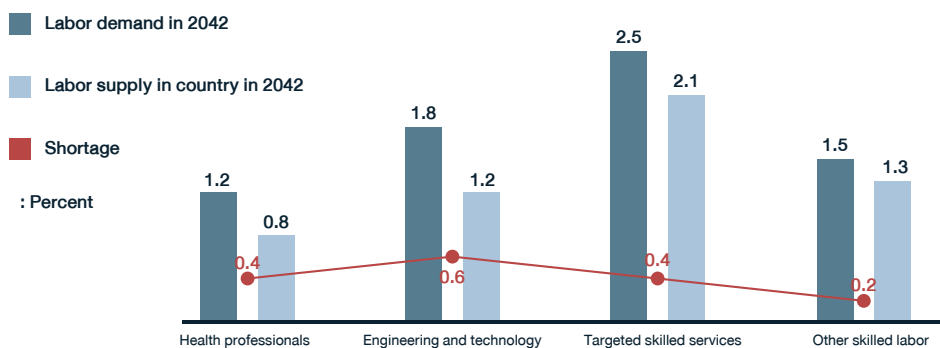
Five key factors that motivate returning to work in one's hometown, 2025



Remark: (1) Multiple responses allowed
 (2) The target group consists of workers aged 20-25 (2,563 persons) who completed a high vocational certificate or higher and migrated to work in the economic provinces in each region, namely Bangkok, Chonburi, Chiang Mai, Khon Kaen and Songkhla
 Source: Survey on motivations and factors influencing the return migration of workers to their hometowns and the enabling environment for returning labor to boost the local economy: Case studies in Bangkok, Chonburi, Chiang Mai, Khon Kaen, and Songkhla, Research Centre for Social and Business Development

In the context of a shrinking workforce, Thailand is facing a shortage of high-skilled labor, particularly in engineering and technology, where demand is estimated at about 1.8 million, while the domestic workforce amounts to only 1.2 million. Effective management and policy designed to attract and develop both domestic and migrant labor are therefore key mechanisms to bridge this gap.

Projected labor shortages by sector, 2042 (millions)



Source: Sakkarin Niyomsilpa, 2025

AI and the Future of Thai Labor

AI technology has been applied to support various tasks and significantly improve labor productivity, suggesting that future labor shortages may not be as severe as previously anticipated.

A study from OECD member countries in late 2024 found that among SMEs, 39.1% reported that AI helped compensate for workers' lack of skills or experience, and 25.2% found that AI could help alleviate overall labor shortage issues.

Source: Generative AI and the SME Workforce: New Survey Evidence 2025, OECD

Changes in population structure are shaping the working life of Thai people across all age groups. Thailand's labor challenges are not limited to quantity but also include designing work systems, labor policies, and welfare to support longer and more diverse working lives, enabling everyone to participate in the economy to their full potential.

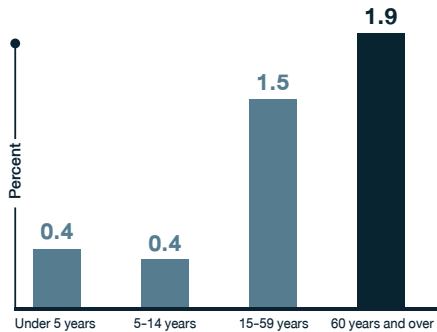


Public Health System

It is estimated that by 2037, Thailand may need approximately 212,896 caregivers for older adults and dependent individuals at home.

Population aging is placing pressure on Thailand’s healthcare system in multiple dimensions, from rising service demand and access limitations to workforce shortages and financial sustainability. Altogether, this highlights the urgent need to transform the country’s healthcare model.

Proportion of Thais who were ill and needed medical care but did not seek treatment, 2023

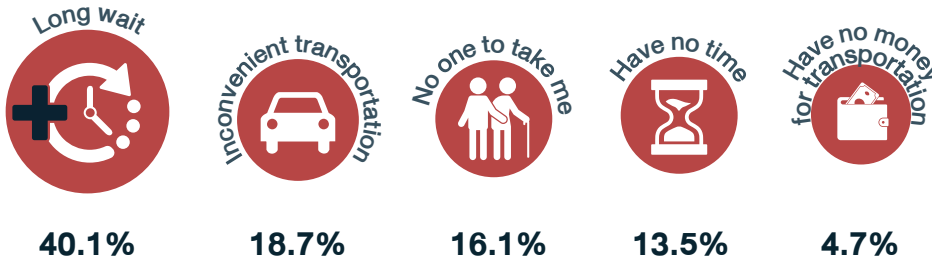


Remarks: Unchanged employment conditions means workers still experience labor rights violations, such as working hours exceeding legal limits and lack of overtime pay. Closing the care gap means ensuring coverage for elderly individuals receiving no care or being unable to afford home-based care services.

Source: The 2023 Health and Welfare Survey, National Statistical Office

The first challenge lies in access to healthcare services for older adults. Although Thailand has a universal health coverage system, older adults have the highest proportion of those who “were ill but did not seek medical care” among all age groups, at 1.9%. Key barriers include long waiting times, inconvenient travel, and the lack of someone to accompany them. This reflects the mismatch between a healthcare system that still relies on facility-based services and the mobility limitations and family structures of today’s older population—particularly as many live alone or with an equally-elderly spouse.

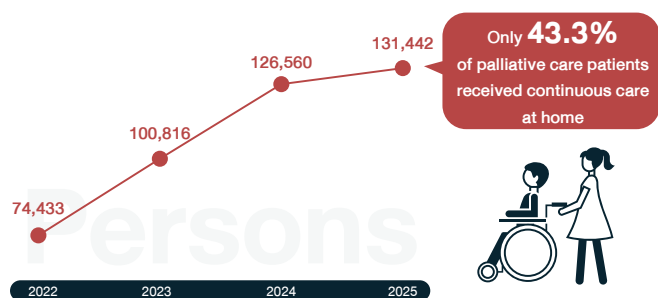
5 main reasons why older Thais do not seek care when ill, 2023



Source: The 2023 Health and Welfare Survey, National Statistical Office

The demand for long-term care in Thailand is rising rapidly. The number of patients in palliative care continues to increase. In Fiscal Year 2025, there were 131,442 older adults in palliative care, yet fewer than half received continuous care at home. This gap is expected to widen as the number of dependent older adults increases in the future. Ensuring an adequate workforce—especially home-based caregivers—along with designing appropriate employment systems, welfare, and labor protections, is therefore a major challenge.

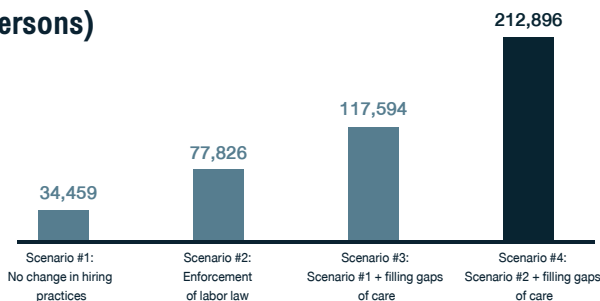
Number of inpatients and outpatients aged 60+ years diagnosed as palliative care cases



Remarks: Data as of December 31, 2025
Source: Health Data Center, Ministry of Public Health

In financial terms, health expenditures are steadily increasing, with most spending still concentrated on medical services, health products, and curative care. Meanwhile, spending on long-term care, health promotion, and disease prevention remains relatively low. This expenditure structure not only places pressure on the sustainability of the public health financing system but also does not align with the needs of an aging society, which requires more preventive and long-term care rather than treatment-focused services.

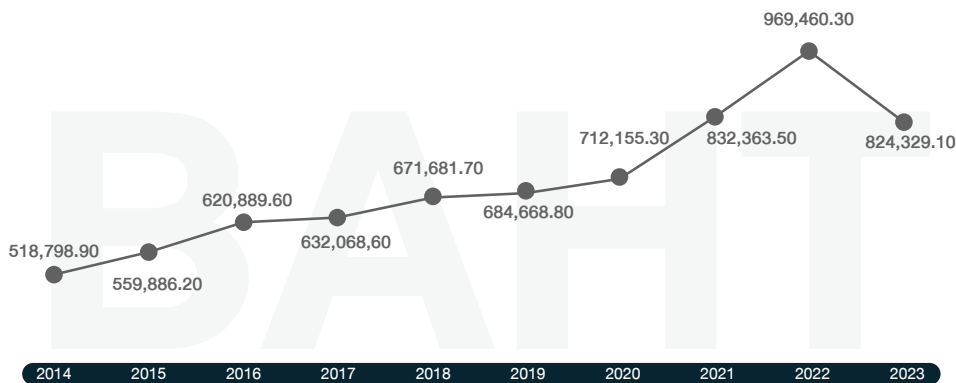
Projected demand for caregivers for older Thais and dependent persons in 2037 (persons)



Remark: Unchanged employment condition means workers still experience labor rights violations, such as workin hours exceeding legal limits and lack of overtime pay. Closing the care gap means ensuring coverage for elderly individuals receiving no care or being unable to afford home-based care services.

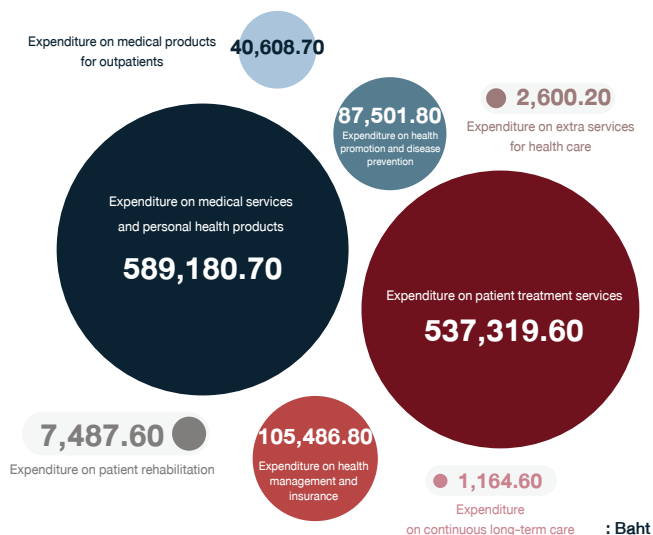
Source: Care at home: Projecting Thailand’s need for national and migrant labor for home-based care for older persons 2024, International Labour Organization

Combined costs of health care (baht)



Source: National Health Accounts in 2024, International Health Policy Program (IHPP)

Categorization of health expenditure by activity, 2023



Source: National Health Accounts in 2024, International Health Policy Program (IHPP)

Medical expenses during two years prior to death averaged 119,318 baht per person, accounting for about half of GDP per capita

Source: Analysis and Estimation of End-of-Life Medical Care of Thai People, Faculty of Medicine Ramathibodi Hospital, Mahidol University

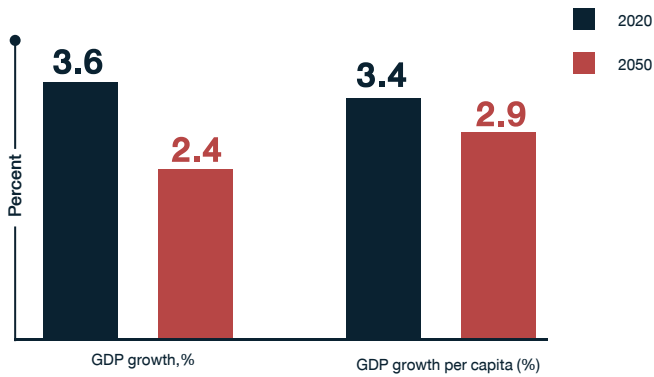
Demographic changes thus serve as a warning signal for Thailand to systematically adjust its health investment direction—from a hospital-centered, treatment-focused model toward community- and home-based care; from reactive treatment to proactive health promotion and disease prevention; and from reliance solely on formal workforce capacity to building a care ecosystem that involves families, communities, and digital technologies. This transformation is essential for ensuring that Thailand’s healthcare system can effectively and sustainably support an aging society.

Economy, Society, Culture, and the Environment

The share of Thailand’s social budget has steadily increased in the area of retirement, while allocations for health and education have declined.

Thailand’s transition into an aging society and its changing demographic structure are placing pressure on the economy, public finances, and social stability. Effectively addressing these challenges requires systematic restructuring of the country’s economic and social systems.

Impact of population aging on the Thai economy, 2020 and 2050

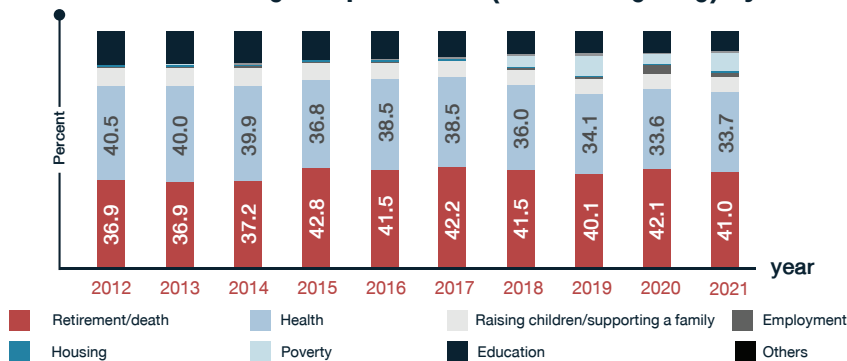


Remarks: (1) GDP – Gross Domestic Product
 (2) Projections based on a business-as-usual scenario
 Source: Bandaogo, M. and R. Van Doorn. 2021

The World Bank estimates that trends of slower population growth, a shrinking workforce, delayed human capital development, and declining investment efficiency will reduce Thailand’s economic growth from 3.6% in 2020 to only 2.4% by 2050. This slowdown will not only affect national income but also the country’s capacity to allocate public resources to meet rising demands for healthcare and welfare.

Fiscal pressure is clearly reflected in changes to the structure of social spending. In 2024, expenditures on retirement and death rose to the largest share at 46.2%, while spending on education declined to just 7.6%. This reflects a shift of resources from investment in younger generations toward care for older adults. Without careful rebalancing, this could lead to a cycle of underinvestment in human capital and lower labor productivity in the long term.

Structure of social budget expenditures (social budgeting) by function



Sources: (1) Social Budgeting: A Tool for Analyzing Social Welfare Provision, 2023, Office of the National Economic and Social Development Council
 (2) Suphannada Lowhachai, 2025

The latest data show that social budget expenditures have continued to increase, with “retirement /death” welfare remaining the largest spending category, rising to 46.2% of total expenditures in 2024. Meanwhile, spending on “education” has declined from around 14% in 2012 to only 7.6%.

At the household level, data from the National Transfer Accounts indicate that consumption among older Thais is not yet sustainable, as it exceeds income from work, and is lower than in pre-old-age periods. Maintaining previous consumption levels would require increased labor participation or accelerated savings from a younger age, reflecting financial insecurity in old age amid limited pension coverage and low levels of personal savings.

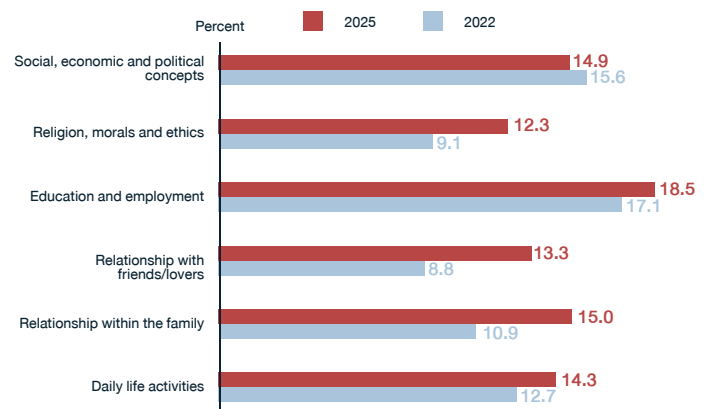
Analysis based on the National Transfer Accounts (NTA) shows that the consumption adjustment factor for the Thai population aged 49 years or over is 0.812. This means that, in order to ensure sustainable consumption in old age, consumption would need to be reduced to 81.2% of its previous level. This reflects that current savings are insufficient to support future consumption. Therefore, individuals would need to work more and consume less (i.e., save more). If they choose not to reduce consumption, they would need to increase their labor force participation at this age by approximately 23% overall.

Remarks: This is based on the assumptions of a life expectancy of 76.1 years and an interest rate of 7% per year. If life expectancy increases or interest rates rise, the "consumption adjustment factor" would decrease further.
Source: Watcharapol Wongniyomkaset, 2023



In the social and cultural dimensions, changes in the world of work, technology, and the sociopolitical context are widening generational gaps. The 2025 Child and Family Situation Report found that a key issue within families is "conflicting opinions," particularly on education, employment, family relationships, and social values, with such conflicts increasing compared to 2022. These tensions not only affect the mental health of family members but may also weaken the family institution, which is a crucial foundation for elderly care and the transmission of social values.

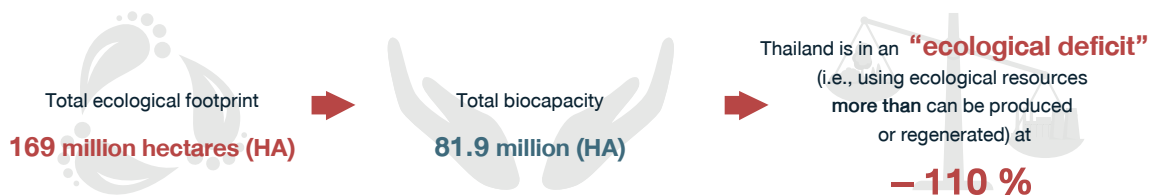
Percentage of youth aged 15–25 who have conflicts with adults in their families on various issues at a 'high' to 'very high' level, 2025



Source: Child and Family Situation Report 2025, Kid for Kids

In terms of resources and the environment, Thailand is facing an ecological deficit, with per capita resource consumption exceeding the country's capacity by more than double. Although population decline may ease pressure on natural resources in the long term, actual outcomes will depend on shifts in production and consumption patterns. Population aging could present an opportunity to transition toward a circular economy and more sustainable consumption, if supported by appropriate policies.

Thailand's ecological deficit, 2025



Remarks: 'Ecological Footprint' refers to the environmental impacts resulting from human activities, such as carbon dioxide emissions, deforestation, mining, and waste management. 'Biocapacity,' on the other hand, is the capacity of an area to support and sustain the ecological footprint of a population, such as through carbon absorption by forests and the regeneration of natural resources.

Source: Ecological Footprint by Country 2026, World Population Review

Thailand's demographic changes are challenging the economy, fiscal system, social relations, and the country's resource base. A sustainable future will require integrated policy adjustments across generations, economic sectors, and the relationship between humans and the environment, ensuring that all generations can coexist with quality of life and fairness.

Population Policy

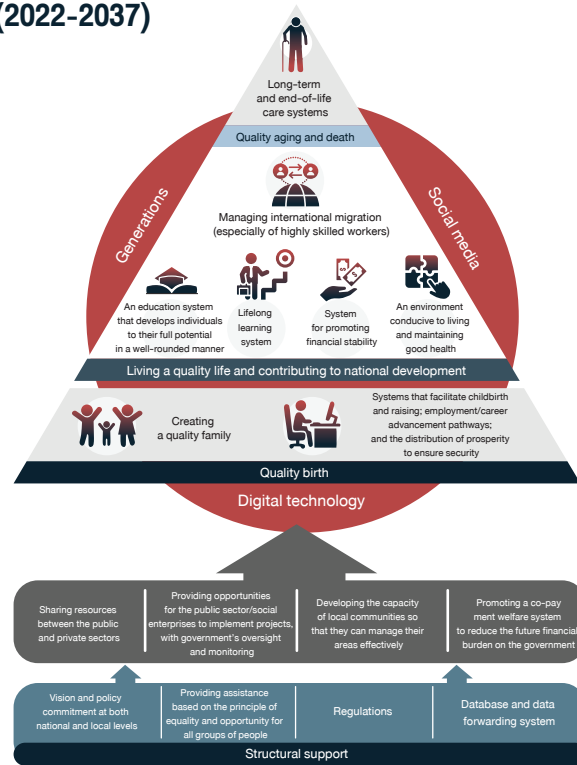
A decline in births may not be a constraint if population policies focus on improving quality, reducing inequality, and preparing the workforce for the future.

Thailand’s demographic transition requires integrated and proactive policies that align with realities across all stages of life. Accordingly, this section reviews the country’s key existing policies to assess their coherence and identify policy gaps in addressing demographic change.

Thailand has the Long-Term Population Development Plan (2022–2037) as its main policy framework, aiming for Thai people to “have quality birth, live well, and age well” by strengthening population security across all stages of life. This includes promoting quality births, improving quality of life throughout the life course, preparing for an aging society, and managing population at the area-based level.

In terms of quality birth, Thailand has the 2nd National Reproductive Health Development Policy and Strategy (2017–2026), which aims to promote voluntary increases in births at levels sufficient for population replacement. All births are intended to be planned, wanted, and supported in all aspects, leading to safe deliveries and healthy newborns who can grow with quality. There have also been policy advances in labor welfare, such as extending maternity leave to 120 days, establishing fertility clinics, and promoting family-friendly policies across four dimensions: time, financial support, childcare support systems, and legal measures.

Key components for population development under the Long-Term Population Development Plan (2022–2037)



Source: Long-Term Population Development Plan (2022–2037), Office of the National Economic and Social Development Council

Examples of population-related policies in Thailand

Born well

Long-Term Population Development Plan (2022-2037)

Coping with an aging society, low birth rates, and population quality

2nd National Reproductive Health Development Policy and Strategy (2017-2026)

Promoting quality births and growth

Labor Protection Act, B.E. 2568 regarding Maternity Leave Rights

Female employees are entitled to maternity leave of up to 120 days (including pre- and post-maternity leave, with employers paying wages for up to 60 days), and an additional 15 days of sick childcare leave with 50% pay.

Born well

	<p>Fathers are entitled to 15 days of maternity leave to assist their wives within 90 days after childbirth, with 100% pay.</p> <p>The Social Security Office provides a maternity allowance (25,000 baht per birth) and 50% compensation for lost income (for 90 days).</p>
Measures to assist couples with infertility	Establishment of fertility clinics in hospitals under the MOPH, and the National Health Security Office’s 2025 announcement on reimbursement for public health services in cases of infertility treatment
Family-friendly policies	National Health Assembly Resolution 16.3: Accelerating the promotion of family-friendly policies across four dimensions—time, financial support, childcare support system, and legal measures
Marriage equality	Replace the terms “husband–wife” with “spouses” to ensure that all couples have equal legal rights and benefits

Live well

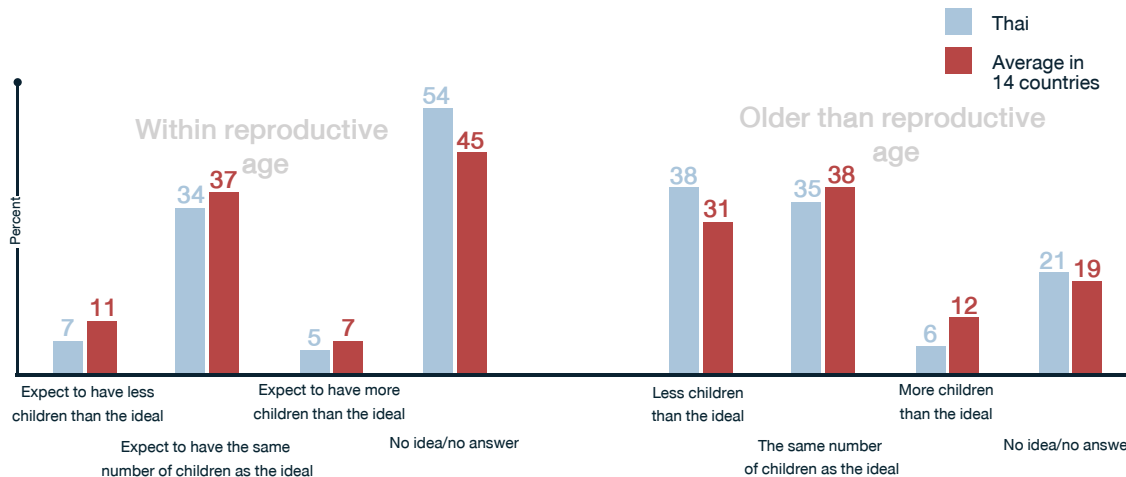
The Learning Encouragement Act, B.E. 2566	Focus on building a learning society in three forms: lifelong learning, learning for self-development, and learning for qualifications at different levels
Measures to drive towards eliminating out-of-school children and youth (Thailand Zero Dropout)	To address the issue of children dropping out of the education system by identifying and tracking out-of-school children, creating flexible learning systems that allow children to study anytime and anywhere, and coordinating among various agencies and organizations
Twenty-Year National Strategic Plan for Public Health (2017-2036)	A master plan for developing Thailand’s health system, focusing on four excellence strategies: health promotion and disease prevention, service delivery, workforce, and management

Age well

3 rd Action Plan for Older Persons (2023-2037)	A proactive framework to support an aging society, with the vision that “older persons have a good quality of life, enjoy security, and are a driving force for development.” It emphasizes preparing people before aging, improving quality of life, reforming management systems, and promoting research and innovation
18 th National Health Assembly, Agenda “Creating Opportunities in the Silver Economy”	<p>Proposes four domains</p> <ol style="list-style-type: none"> 1) enhancing the capacity of older persons to remain in the labor market and have adequate income. 2) ensuring equitable access to essential goods and services for older persons. 3) creating an appropriate and elder-friendly ecosystem. 4) communication to drive momentum in the silver economy.

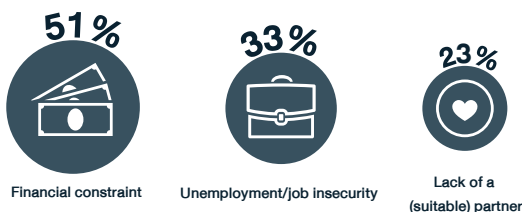
However, survey results indicate that 7% of the reproductive-age population expect to have fewer children than their ideal number, while 38% of those who have passed reproductive age report having fewer children than desired. The main reasons include financial constraints, job insecurity, and the lack of a suitable partner.

Comparison between the ideal number of children and the expected/actual number of children, 2024



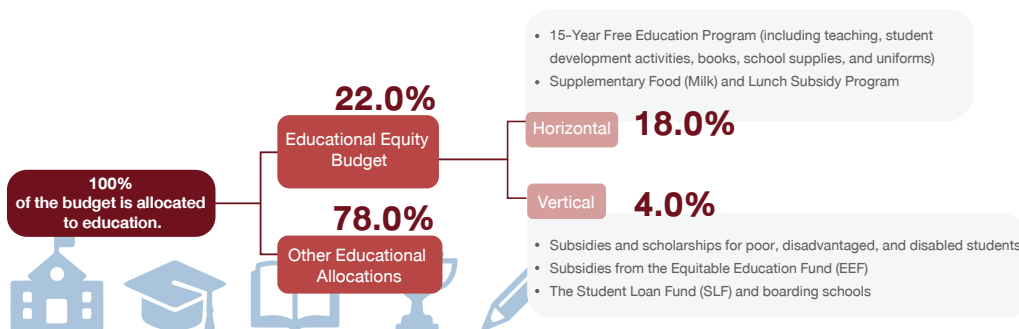
Remarks: In this survey, the reproductive-age population refers to individuals under 50 years old, while those above 50 are considered beyond reproductive age. The countries surveyed include the Republic of Korea, Italy, Hungary, Germany, Sweden, Brazil, Mexico, the United States, India, Indonesia, Morocco, South Africa, Nigeria, and Thailand.
Source: The real fertility crisis: Why people aren't having the families they desire, 2023, UNFPA

Obstacles preventing people from having their ideal number of children, 2024



Remarks: Multiple response allowed
Source: The real fertility crisis: Why people aren't having the families they desire, 2023, UNFPA

Budget allocation for educational equity, Academic Year 2021

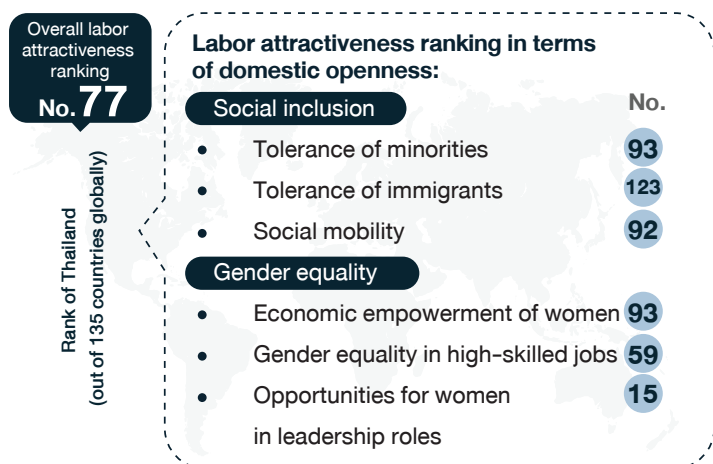


Source: Five Findings to Unlock the Human Capital Crisis for an Equitable Future, 2024, Equitable Education Fund (EEF)

In terms of living well, Thailand has made policy progress through the Learning Encouragement Act, B.E. 2566, which supports lifelong learning, along with initiatives such as Thailand Zero Dropout and mechanisms under the Equitable Education Fund Act B.E. 2561, aimed at reducing school dropout rates among Thai children to zero so that no one is left behind. Despite these education and learning policies, Thailand continues to face constraints in human capital quality, particularly in educational inequality. Data from Fiscal Year 2021 show that Thailand allocated only 4% of its budget to reducing disparities among disadvantaged children and schools (vertical equity).

Attracting high-skilled migrant workers is an important strategy to compensate for the shrinking workforce, but it remains a challenge for Thailand, particularly in terms of public attitudes and social acceptance. Thailand ranks 123rd out of 135 countries in tolerance toward international migrants. At the same time, Thailand has strengths in gender equality, ranking 15th in the world in terms of women’s leadership opportunities.

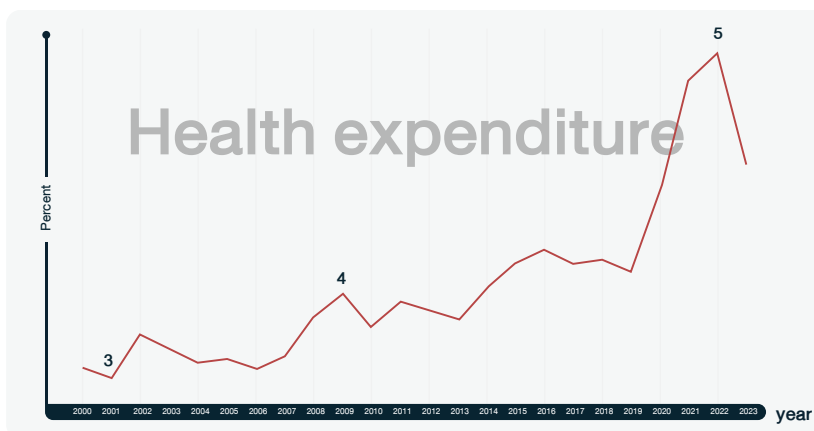
Thailand’s Talent Attractiveness Index, 2025



Source: Global Talent Competitiveness Index 2025: Resilience in the age of disruption, 2025, INSEAD & Portulans Institute

In terms of aging and dying well, Thailand has the 3rd Action Plan for Older Persons (2023–2037), which focuses on preparing people to age with quality. There is also a growing emphasis on the “silver economy,” which seeks to turn demographic challenges into economic and social opportunities. However, policy challenges remain, particularly regarding the sustainability of the healthcare system, as health expenditures relative to GDP continue to rise steadily from 3% in 2000 to 5% in 2022.

Health expenditure as Gross Domestic Product



Source: Global health expenditure database: Health expenditure tracking, 2024, WHO

Policy recommendations

Although Thailand has policy frameworks and strategic plans that comprehensively address demographic changes across the life course, significant gaps remain in cross-sectoral policy integration, the alignment of population policies with economic, labor, and welfare policies, and the adaptation of social attitudes and structures to rapidly changing demographic realities. Elevating policy implementation from merely “having plans” to achieving “system-level execution” is therefore a critical condition for enabling Thailand to effectively, equitably, and sustainably manage its demographic transition in the long term.



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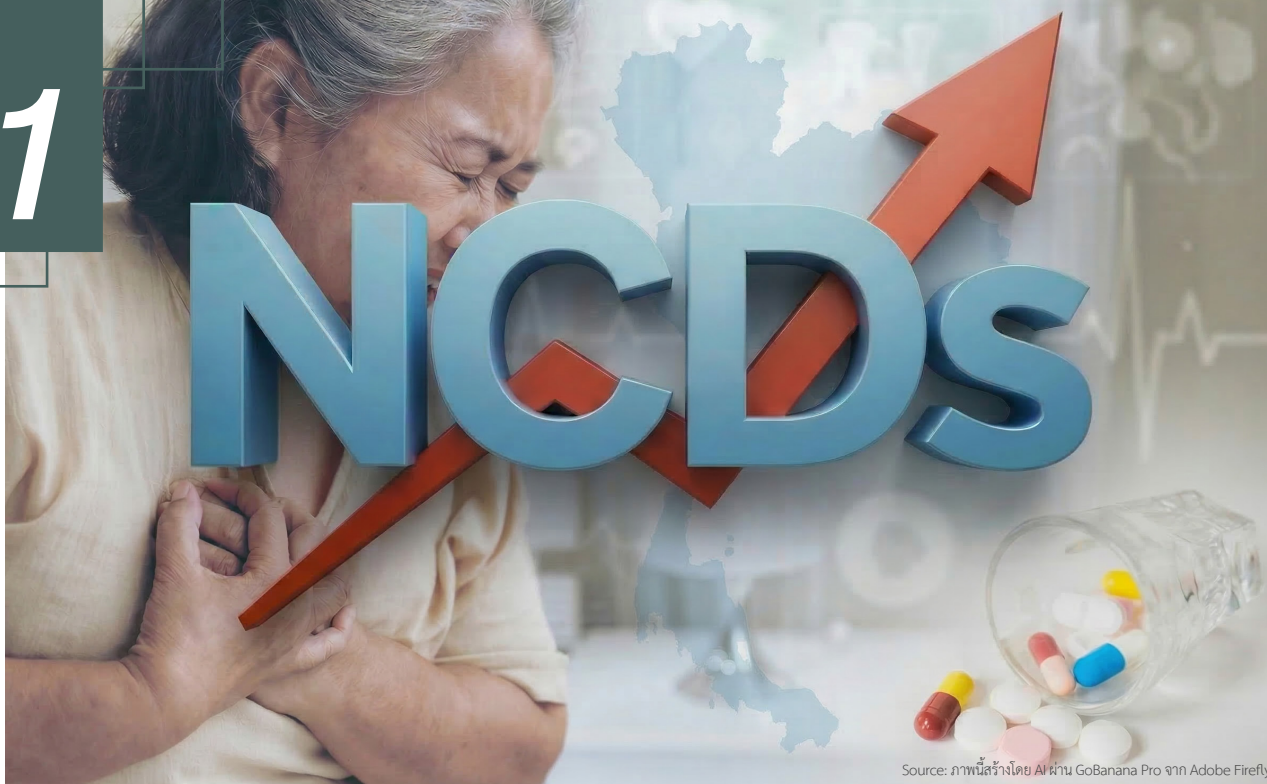
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10 Outstanding Health Situations



1



Non-communicable Diseases (NCDs): A Thai Health Challenge

Non-communicable diseases (NCDs) are among the most significant health challenges facing Thailand in the 21st century. At present, NCDs are the leading cause of death in the country, accounting for 74% of all deaths, with approximately 400,000 deaths per year from this group of diseases.

Introduction

Non-communicable diseases (NCDs) are the leading cause of death in Thailand, surpassing communicable diseases and accounting for 74% of all deaths. The major conditions of concern include cancer, cardiovascular diseases, diabetes, and chronic obstructive pulmonary disease (COPD). Approximately 400,000 people die from NCDs each year. More than 7.5 million elderly people in Thailand are living with NCDs. It is projected that the number of diabetes patients will increase from 4.8 million in 2023 to 5.3 million by 2040.

Currently, Thailand is implementing several policies to address this issue. These include tax measures such as increasing taxes on beverages, expanding smoke-free zones, developing the “Health Wallet” application to promote exercise and health monitoring, using artificial intelligence (AI) to screen at-risk groups in Tambon Health Promoting Hospitals (THPH), and launching campaigns such as “Less Salt, Less Disease” in collaboration with the food industry and “Walk 10,000 Steps to Reduce NCDs” in communities. These measures are expected to save up to 310,000 lives and generate economic benefits of up to 430 billion baht over the next 15 years.

However, Thailand still faces several challenges, including risky behaviors among the population such as overeating, unhealthy diets, physical inactivity, smoking, and excessive alcohol consumption; unequal access to healthcare and NCD prevention services; and disparities in service accessibility, particularly in remote communities that still lack effective screening systems. This article summarizes the situation of NCDs in Thailand and its trend and impact, and proposes policy recommendations to address these challenges.

The Challenge of NCDs in Thailand

NCDs are among the most significant health challenges facing Thailand in the 21st century, particularly in the context of an aged society, as well as rapid changes in the country's economic structure and people's lifestyles. At present, NCDs are the leading cause of death in Thailand, surpassing communicable diseases and accounting for 74% of all deaths¹ of all deaths, covering major disease groups including cancer, cardiovascular diseases, injuries, diabetes, and chronic obstructive pulmonary disease (COPD). Importantly, a large proportion of deaths from NCDs occur during working age, or constitute premature mortality, which directly affects the country's labor capacity and leads to significant economic losses due to reduced productivity.²

Each year, approximately 400,000 people in Thailand die from NCDs, resulting in economic losses of up to 1.6 trillion baht annually, or 9.7% of the country's gross domestic product (GDP). These figures reflect that NCDs are not merely a public health issue, but a structural problem that poses a barrier to long-term national development across economic, social, and quality-of-life dimensions. This is especially evident as chronic illness leads to loss of household income, increased healthcare expenditures, and economic insecurity for workers and their families.

The urgency of addressing NCDs becomes even more pronounced when considered alongside Thailand's aging society. At present, there are more than 7.5 million people aged 60 years or older, many of whom are living with multiple chronic conditions.³ This situation not only increases the burden on the healthcare system but is also directly linked to dependency in an aging society. If public budgets must increasingly be allocated to medical treatment and long-term care, it may reduce the resources available for investment in other areas of national development. As a result, Thailand risks falling into a persistent **“chronic disease trap”** unless serious preventive and systemic measures are implemented starting today.

NCDs in Thailand and their Impacts

The situation of NCDs in Thailand continues to worsen, particularly diabetes, with the number of patients projected to increase from 4.8 million in 2023 to 5.3 million by 2040.⁴ This trend reflects limitations in controlling structural risk factors, particularly dietary behaviors characterized by high sugar, fat, and sodium intake, which are deeply embedded in people's daily lives. These patterns are driven by easy access to processed foods, their affordability, and persuasive food marketing, as well as the growing convenience and popularity of delivered ready-to-eat meals. At the same time, physical inactivity and other risk behaviors—such as smoking and excess alcohol consumption—remain key factors that make it difficult to control diabetes and NCDs overall, despite ongoing health promotion campaigns.⁵

In addition to physical illnesses, mental health issues are another important dimension of NCD that has been increasing at an alarming rate. The number of psychiatric patients in Thailand has risen from 1.3 million in 2015 to 2.9 million in 2023.⁶ This increase can be understood both as a cause and a consequence of NCDs. Chronic illness, the need for continuous treatment, and the financial burden on households can lead to stress, depression, and other mental health problems. At the same time, mental health issues can, in turn, increase risk behaviors associated with NCDs, such as smoking, alcohol consumption, and unhealthy eating, creating a reinforcing cycle of both physical and mental health problems.

The impacts of NCDs are, therefore, not limited to individual health, but extend across multiple dimensions. Economically, they involve rising healthcare costs, loss of labor productivity, and increased public health expenditures. Socially, they impose a caregiving burden on households, exacerbate health inequality, and reduce quality of life. At the system level, they contribute to overcrowding in healthcare facilities, increased workloads for medical personnel, and continuously rising costs of treating chronic disease.⁷ Particularly in rural and remote communities, where access to screening and proactive preventive services remains limited, many patients enter the healthcare system only after their condition has become severe, thereby increasing the long-term burden on the health system.⁸



Thailand's Measures to Address the NCD Challenge

Over the past decade, Thailand has sought to address NCD issues through policy measures by enacting laws, implementing structural interventions, and launching a variety of health promotion programs at both the national and local levels. Key measures include taxation of sugar-sweetened beverages, the expansion of smoke-free zones in public areas, regulations on the advertising of tobacco and alcoholic products, and the promotion of desirable health behaviors through various programs and campaign initiatives. These efforts reflect the government's awareness of the severity of NCD problems at the policy level.

In terms of innovation and technology, the government has developed digital tools to support prevention and healthcare, such as the “Health Wallet” application, which promotes physical activity and monitors health behaviors, as well as the use of artificial intelligence technology to screen high-risk groups in THPH,⁹ including the implementation of community-level campaign programs, such as “Less Salt, Less Disease”¹⁰ (in collaboration with the food industry), and “Walk 10,000 Steps to Reduce NCDs”¹¹ to create an environment conducive to physical activity. Policy-level assessments estimate that these measures could prevent approximately 310,000 NCD-related deaths and generate economic benefits of around 430 billion baht over the next 15 years.¹²

Although Thailand has made progress in policy and innovation, in practice it still faces structural challenges and complex environmental factors as follows:

1. Lack of integration in implementation – The working approach remains largely “**everyone works separately**” across government agencies, the private sector, and civil society, with no central mechanism to link data and systematically monitor and evaluate outcomes. As a result, various measures cannot fully reinforce each other to drive structural-level change.

2. An environment that encourages excessive consumption – The problem is not caused by policy alone, but also by changes in the food system and current behaviors, including:

- **Food quantity and marketing:** The amount of food available in the market has increased rapidly (about 20 times faster than the growth in household purchasing), coupled with intensive marketing by the food and beverage industry.
- **Sedentary lifestyle:** Physical activity has decreased, which contrasts sharply with the caloric intake.
- **Natural taste preferences and sweet consumption:** Humans' innate preference for **sweet, fatty, and salty** flavors leads to the overconsumption of various beverages and sweets beyond what the body needs.

3. Influence of industry groups and legal limitation – The influence of the food, beverage, and tobacco industries remains a major factor hindering the enforcement of health policies, particularly taxation measures and regulations on the advertising of unhealthy products, which currently are still insufficient to effectively reduce access or consumption.

4. Demographic structural change – The rapid transition into an aging society has increased the proportion of the population at risk for chronic NCDs, placing a greater long-term burden on the public health system.

Approaches to Reforming the Ecosystem for NCD Management

Inequities in access to healthcare remain a significant problem, particularly among vulnerable groups such as low-income individuals, the elderly, and people in remote areas, who often lack opportunities for quality screening and proactive preventive services. As a result, patients tend to enter the healthcare system only when diseases have become severe, creating a long-term burden on the health system. Although Thailand has numerous agencies and mechanisms addressing NCDs, a key challenge lies in coordination within this complex ecosystem. Looking at past roles and responsibilities, the **Ministry of Public Health** — including the **National Health Security Office (NHSO)**, the **Department of Health**, and the **Department of Disease Control** — has focused on providing health services, screening, and medical treatment. The **Thai Health Promotion Foundation (ThaiHealth)** and the **National Health Commission Office (NHCO)** have emphasized health promotion and driving public policy through participatory processes. **Other sectors**, including local organizations, manage community-level well-being, and academic institutions produce research. Finally, the private sector contributes both in terms of impact and corporate social responsibility.

From the analysis above, the real gap is not the lack of a new “authority mechanism,” but rather elevating the **Ministry of Public Health** as the **Health Authority** to serve as the central hub for “**policy synergy**.” This role does not rely solely on commanding power, but operates through knowledge-based collaboration with all sectors, guided by the following key principles:

- **Shift from treatment to prevention:** Reorient from a focus on medical treatment to concrete preventive measures and health promotion.
- **Health Promotion & HIAP (Health in All Policies):** Ensure that all government policies consider their health impacts, particularly in addressing commercial determinants that act as barriers.
- **Participatory Health:** Create space for civil society, communities, and local government to participate in designing local-level policies to close systemic gaps.

Sustainable solutions for NCDs require fine-tuning the existing ecosystem to work in a coordinated manner, with the Ministry of Public Health serving as the hub to link various measures, safeguard the public interest, and promote equitable health and well-being for all population groups.

Lessons from Other Countries and Policy Recommendations

Experiences from multiple countries indicate that effectively reducing the NCD burden requires structural policies aimed at changing toward a more “**health-determining environment**” rather than relying solely on modifying individual behaviors. Successful countries typically implement a mix of legal, economic, and social policies combined with systematic public participation, particularly interventions targeting the upstream risk factors for NCDs.

A key lesson from abroad that has been promoted in Thailand is the enforcement of clear and easily understandable front-of-pack nutrition labeling, which effectively influences consumer decision-making.¹³ This also includes designing cities and transportation systems that support walking, cycling, and daily physical activity, alongside regulating the marketing and advertising of unhealthy foods—particularly those high in sugar, fat, and sodium—as well as sustained investment in primary prevention and proactive community-based screening. These measures not only help reduce disease incidence and healthcare costs but also promote long-term health equity. Lessons from other countries highlight the importance of a “whole-of-system” approach, which integrates health policies with economic, education, urban development, and social policies to achieve sustainable structural change.¹⁴

Urban design and transportation system that promote physical activity



Lessons from other countries also indicate that sustainable solutions to NCDs require strong structural policies, cross-sectoral integration, and meaningful participation from civil society. For Thailand, translating these lessons into practical action will be key to reducing the NCD burden and building a health system that is equitable and sustainable in the long term, guided by three main approaches:

- 1 Empowerment:** Empower local government organizations with sufficient authority, roles, and budgets to create health-promoting environments at the community level, such as developing infrastructure for walking and physical activity, and managing food in schools and communities. This will help ensure that health measures align with local contexts and reduce health inequities.¹⁵ However, such efforts require the establishment of intersectoral collaboration mechanisms that link the role of local government with macro-level policies and strong law enforcement from central authorities. This ensures that local-level measures align with the community context and can effectively and sustainably reduce health inequities.
- 2 Health data system development and digital health integration:** To enable seamless care from the community level and THPH to regional and tertiary hospitals, an interconnected information system will support screening, chronic disease patient follow-up, and more accurate and timely policy decision-making.¹⁶
- 3 Social mobilization:** By strengthening the role of civil society as both a driver of public awareness and a watchdog for public policy, it can monitor and balance policy interventions from the business sector that may conflict with the public’s health interests, while working alongside communities to empower people to genuinely participate in shaping policies and managing their own health.

Facts that demand reflection

NCDs are one of Thailand’s most important and urgent health challenges. This health problem is becoming increasingly severe in the context of an aging society, where many older adults face multiple chronic conditions simultaneously, resulting in a growing burden on the health system and a decline in the population’s quality of life. This issue is not solely the result of individual behavioral choices but is shaped by environments and social structures that are not conducive to health, including patterns of food consumption, urban design, transportation systems, working conditions, and inequities in access to healthcare. Thailand needs to seriously advance structural policies through the “Health in All Policies” approach, which integrates health considerations into policymaking across all sectors, while simultaneously strengthening the role of local government organizations and civil society in creating health-promoting environments. If this approach can be implemented concretely, Thailand will have a real opportunity to reduce the NCD burden and build a sustainable and equitable health system in the long-term.

Source: สร้างโดย AI ผ่าน GoBanana Pro จาก Adobe Firefly

Social Security

It Is Time for Reform – Before a Crisis Hits

“The sustainability of the Social Security Fund is a concerning issue, as the fund’s expenditures for the old-age fund are expected to exceed its revenues starting around 2027, and the fund’s accumulated reserves are projected to be depleted by 2042.”

Introduction

Over the past year (2025), there has been growing criticism of the operations of the Social Security Office. These include issues such as the benefits for insured persons being inferior to those of other health funds, and a lack of transparency in fund management—for example, investments in office buildings at prices several billion baht above market value, large budget allocations for overseas study trips by executives, and political interference in the election of the Social Security Board. These issues raise important questions about public confidence in the management of a fund worth trillions of baht, and whether it is sufficiently professional to manage the fund and protect the benefits of insured persons.

Thailand’s social security system is facing problems on multiple fronts, including service quality, governance, and long-term sustainability. As a result, there have been increasing calls for serious reform of the fund. Key issues include: **Long-term financial sustainability**, with projections that the fund may become insufficient in the near future due to contribution rates not keeping pace with rising expenditures, especially pension payments amid an aged society; **Inequality and inadequate benefits**, as insured persons view healthcare benefits as inferior to other systems, and there are perceived unfair differences among those insured under Articles 33, 39, and 40; **Lack of transparency in fund management**, including inefficient spending such as budgets for overseas trips and public relations, as well as limited participation by insured persons in fund governance; and **Declining confidence among insured persons**, particularly among younger people, many of whom increasingly see contributions as a burden not worth the benefits received. This article will analyze the social security system, its problems and challenges, and propose approaches for reform.

Thailand's Social Security System: A Shaky Pillar of Welfare

Thailand's current social security system provides seven types of benefits: Medical care, maternity, disability, death, child allowance, unemployment, and old-age pensions. These benefits are designed to cover all stages of an insured person's life. The system is structured as a "contributory scheme" involving employees, employers, and the government, based on the concept of risk and cost sharing through the principle of "solidarity." Members of society collectively contribute to the fund in order to support those who face risks at different stages of life, rather than leaving individuals to bear the burden alone.

Thailand's Social Security Fund categorizes insured persons into the following three main groups:

Article 33 insured persons: These are formal-sector workers under compulsory coverage, such as general private-sector employees aged 15–60. They are entitled to all seven benefits mentioned above.

Article 39 insured persons: These are individuals who were previously insured under Article 33 but have left their jobs and voluntarily continue contributing to maintain their social security coverage. Their benefits are reduced to six categories, excluding unemployment.

Article 40 insured persons: These are informal-sector workers or self-employed individuals. They can choose insurance plans with varying levels of contributions and coverage, ranging from basic protection to options that offer benefits closer to those of formal-sector workers.

Four Major Challenges of Thailand's Social Security System

When the social security system is viewed as a whole alongside other welfare systems in Thai society, several significant structural challenges become apparent—both in terms of disparities in benefits among different groups of insured persons and in its relationship with other state welfare systems. The key challenges of the social security system can be summarized as follows:

1. Financial sustainability: When increasing contributions alone is not the answer

One of the most widely discussed challenges today is the ability of the old-age pension fund to support long-term pension payments. Assessments of the financial stability of the Social Security Fund from various studies¹ agreed that if current policies continue without structural reform, the old-age pension fund will face deficits in the near future. This is because Thailand's social security pension operates under a Defined Benefit (DB) system, in which pension payments are determined by contribution amounts and years of employment, rather than investment returns. As a result, the financial risk falls directly on the fund, which must ensure it has sufficient resources to meet future pension obligations.

In response to these concerns, the Social Security Board approved a resolution in 2015 to revise the pension formula to a CARE (Career-Average Revalued Earnings) model. Under this approach, pensions are calculated based on *the average earnings over a worker's entire career*, with each year's income adjusted to reflect present value before averaging. The maximum wage ceiling used to calculate contributions has been increased from 15,000 baht to 17,500 baht for the period 2026–2028, then to 20,000 baht for 2029–2031, and to 23,000 baht from 2032 onward. This method helps reduce inequality between those who earn higher incomes toward the end of their careers and those with fluctuating earnings, ensuring that pensions more accurately reflect actual lifetime contributions and improving

fairness within the DB system. The increase in the wage ceiling is also accompanied by enhanced benefits beyond pensions, including higher compensation for illness, disability, unemployment, and other benefits, all of which are adjusted in line with the new wage ceiling.²

However, projections of the financial sustainability of the old-age pension fund under the current scenario, together with improvements to the CARE pension formula by the Thailand Development Research Institute, indicate that the fund’s sustainability remains a concern. This is because expenditures of the old-age fund are expected to exceed revenues starting around 2027, and the fund’s accumulated reserves are likely to be depleted by around 2042. This is partly due to the fact that, currently, only 36% of workers in the social security system earn income at or above the maximum wage ceiling (15,000 baht).³ Therefore, raising the maximum wage ceiling does not significantly increase the fund’s revenues. This deficit reflects a “structural turning point” in the system—from a fund that once had higher revenues than expenditures to one that must rely primarily on reserves and investment returns to finance benefits.

In addition, a key factor undermining the fund’s sustainability is demographic change, particularly the continuous increase in the elderly population. Over the next decade, older persons in Thailand are expected to account for approximately one-third of the total population. This will lead to a rapid rise in the number of eligible pension beneficiaries, while the base of contributors does not expand at the same pace. Therefore, increasing contribution rates alongside gradual adjustments to investment mechanisms or benefit management may help extend the fund’s sustainability for some time. The challenge of sustaining the social security fund is, thus, not merely a technical financial issue, but a structural one linked to demographics, the labor market, and intergenerational equity. Failing to implement policy changes today effectively shifts the burden onto future generations.

2. Inequality in benefits and service quality

Beyond financial sustainability, another issue that inevitably affects insured persons’ perceptions is inequality in benefits and service quality—especially since workers in the formal sector do not have full freedom to choose which system they are covered by. Social security benefits do not exist in isolation but are often compared with multiple other systems, both public and private, that provide similar protections in terms of healthcare and old-age pensions.

Regarding healthcare benefits, when compared with beneficiaries under the Universal Health Coverage scheme (the “Gold Card”), although both systems share the goal of protecting the right to public health, they differ significantly in budget allocation, payment mechanisms, and service delivery. From the perspective of insured persons, social security healthcare benefits are often seen as more limited—particularly in terms of ease of access, waiting times, and scope of treatment—compared to the Gold Card system, which has a broader service network. This perception persists even though insured persons contribute monthly, while Gold Card users do not pay direct contributions. Importantly, insured



Figure 1: Guidelines for adjusting the wage ceiling and benefits of insured persons under Section 33 of the Social Security System

Source: Social Security Office

persons are generally of working age and tend to have fewer health issues than those in the Gold Card system, which includes many children and elderly individuals; yet, the cost of providing services under social security is higher. At the same time, it does not adequately cover health promotion and disease prevention, and additional payments are still required for certain services such as dental care and childbirth.

In terms of pensions and income in old age, inequality becomes even more evident. Benefits for insured persons vary depending on employment status and contribution arrangements. Insured persons under Article 33, who are formal sector workers, have the opportunity to receive higher and more stable monthly pensions. In contrast, those insured under Articles 39 and 40 face limitations in contribution ceilings, contribution periods, and the absence of employer contributions, resulting in lower pension amounts or lump-sum benefits. Moreover, when compared with other public pension systems, such as the Government Pension Fund for civil servants, the latter provides clearly higher and more stable levels of protection than the social security system.

These issues reflect that Thailand's management of health and pension welfare systems remains fragmented, with uneven distribution of protection. Groups with higher income security—such as civil servants or formal sector workers—receive greater coverage, while informal workers, who are more vulnerable, receive the least protection. This imbalance is not only a matter of social equity but also highlights broader policy challenges within Thailand's welfare system, which require a more holistic approach.

3. The Gig Economy and the future of the Social Security System

Over the past decade, the labor market in Thailand and globally has undergone significant transformation. Full-time employment, which once formed the foundation of social security systems, is declining in importance. Meanwhile, new forms of work—such as the “gig economy,” characterized by “temporary job” or “independent contractor” not tied to permanent employment, as well as platform-based digital work, short-term employment, contract work, freelance jobs, and holding multiple occupations simultaneously—have been steadily increasing. A study by the International Labour Organization (ILO)⁴ and the World Bank⁵ consistently indicate that a growing number of workers are engaged in platform-based or temporary forms of employment, alongside an increasing tendency among younger workers to change jobs more frequently. Employment is no longer tied to a single employer, and greater importance is placed on flexibility in time and income rather than traditional job security. However, Thailand's social security system still relies on a clear classification of workers into formal and informal sectors, which may not align with the increasingly fluid nature of the future labor market.

A 2021 study by the Thailand Development Research Institute highlights the diversity within the informal workforce. It distinguishes between traditional informal workers—such as those in agriculture or daily wage labor—and a new group of informal workers who typically have medium to high incomes, are familiar with technology, and work through different platforms. This latter group has employment patterns and benefit needs that differ significantly from those of workers in the traditional formal system.⁶

Many countries have begun to recognize the limitations of social security systems that are tied to traditional employment status, which may not adequately accommodate new forms of work. As a result, efforts have emerged to develop supplementary mechanisms in both pension schemes and social benefits.⁷ In 2025, the Ministry of Labor introduced a policy to expand social protection to platform workers, covering areas such as accident insurance, healthcare, and savings for old age. This reflects an implicit recognition that the distinction between formal and informal workers may no longer be adequate.

4. Governance and fund management: A prerequisite for reform

Addressing the problems of the social security system cannot rely solely on technical adjustments, whether in contribution rates or benefit levels. It requires a complex policy decision-making process involving academic knowledge, public communication to build understanding, and—most importantly—“trust” in the fund’s management mechanisms. Governance issues have therefore become the most urgent priority that must be resolved before reforms in other areas can be effectively pursued.

In recent years, Thailand’s social security system has faced ongoing concerns regarding governance and transparency in fund management. These include questions about the structure of the Social Security Board, particularly its independence and representation of insured persons; limitations in data disclosure that hinder effective scrutiny; as well as media reports concerning the use of funds for activities not aligned with the fund’s core mandate.⁸ These issues have had a serious impact on insured persons’ sense of ownership and trust. Strengthening governance, transparency, and the participation of insured persons should, therefore, be the most urgent priority in reforming Thailand’s social security system.

The most critical reforms that must be undertaken urgently are as follows:

- 1 | Removing the Social Security Office from the traditional bureaucratic system and restructuring it as a public organization, while establishing a governance system grounded in genuine good governance principles; and
- 2 | Fundamentally reforming the investment management of the Social Security Fund by ensuring appropriate investment policy frameworks, transparent and merit-based selection of fund managers, and regular performance evaluations.

Next Steps

Reforming Thailand’s social security system is an urgent task that requires cooperation from all sectors. This includes reforming structures, contribution structures, and benefit schemes to ensure fairness and sustainability, as well as enhancing transparency and participation of insured persons as fund owners. Three key measures must be implemented promptly: (1) Expanding the retirement age and adjusting the contribution formula to align with an aging society, in order to prevent the fund from running into deficits within the next 30 years; (2) Reforming the structure of the Social Security Board into a professional board by reducing the proportion of government representatives and increasing independent investment experts to address conflicts of interest and misuse of funds; and (3) Enhancing transparency through a digital dashboard system that discloses investment portfolios and administrative budgets in real time, allowing insured persons to monitor all processes. If the government lacks the policy courage to implement these measures, it will inevitably lead to the failure of the welfare system, with serious consequences for the economic security of the entire Thai population.



Source: สร้างโดย AI ผ่าน Gobanana Pro จาก Adobe Firefly

US Policy and Its Impact on the Health of the Thai People

The ‘America First’ policy represents a shift in the logic of the global order, sending shockwaves through the health systems of various countries. Responding to this policy cannot be limited to trade negotiations; it requires cooperation from all sectors to integrate economic, trade, social, and health policies.

Introduction

In 2025, the world faced a major shock from the United States’ Reciprocal Tariffs policy under the leadership of President Donald Trump. The policy was announced on April 2, 2025, accompanied by a symbolic statement declaring it as the United States’ “*Economic Independence Day*.” This policy had a clear objective: to impose import tariffs on trading partners that the U.S. viewed as having a trade advantage, in order to address the long-standing issue of trade deficits. The tariff rates varied depending on each country’s level of trade surplus. Countries subjected to the highest tariff rates were those with which the U.S. had significant trade deficits. For example, Vietnam faced a 46% tariff, Cambodia 49%, and Thailand 36%.¹

The reciprocal tariff policy did not stop at being merely a punitive trade measure; it was also used as a “bargaining tool” to pressure trading partners into negotiating new bilateral trade agreements with the United States under conditions more favorable to the U.S. Although many countries, including Thailand, later received reductions in these reciprocal tariffs following negotiations (including the cessation of conflict with Cambodia in accordance with the pressure from U.S. leadership), such concessions came at the cost of accepting conditions related to market liberalization, standards adjustments, and regulatory reforms. These measures have not only economic impacts but have also inevitably extended into social and health dimensions.²

This article aims to explain the origins and underlying logic of U.S. policy in the ‘America First’ era, while also analyzing its potential impacts on Thailand, with a primary focus on the health dimension. It further reviews Thailand’s current policy approaches and offers relevant policy recommendations to cope with the shocks arising from such geopolitical changes.

The 'America First' Policy and Thailand

In the context of modern history, the concept of “*America First*” emerged in a concrete form in the early 20th century. It was used as a political slogan before and during World War I, reflecting the idea of isolationism and the desire for the US to prioritize its domestic interests. President Woodrow Wilson used the phrase during his 1916 campaign to communicate to the public his stance on avoiding involvement in the war in Europe. However, “*America First*” in this period functioned more as a political slogan than as a clearly defined foreign policy, and it did not imply a rejection of the role of the US on the global stage.³

At present, the America First policy has clearly re-emerged in 2025 through Donald Trump’s campaign, with four key elements: (1) The reaffirmation of national sovereignty; (2) The protection of the domestic economy; (3) Distrust of multilateral agreements and institutions; and (4) The prioritization of U.S. interests in trade, security, and diplomacy. This approach has led to a reassessment and near-complete restructuring of existing frameworks of cooperation, and it serves as the foundation for the US reciprocal tariff policy introduced in 2025. The Thai government has entered into negotiations with the U.S. and has reached a preliminary resolution in the form of a joint statement.⁴ The statement indicates that Thailand will receive a reduction in reciprocal tariffs from 36% to 19%, but, in exchange, it must eliminate tariffs on approximately 99% of imports from the U.S., as well as reduce non-tariff barriers and enhance standards in labor, the environment, intellectual property, competition, and the liberalization of certain service sectors.

Agreement establishing digital and services principles, including cooperation on state-owned enterprises, economic security, and supply chains, along with U.S. commercial trade deals



Summary of the key elements of the reciprocal trade agreement between the United States and Thailand (October 2025).

The agreement stipulates that Thailand will eliminate approximately 99% of tariffs, covering industrial goods, food, and agricultural products from the U.S., alongside reducing non-tariff barriers. Thailand will adopt US vehicle and emissions standards, recognize certifications and prior approvals from the U.S. Food and Drug Administration (FDA) for pharmaceuticals and medical devices, permit ethanol imports, amend customs laws to abolish the reward system for informants, and implement Good Regulatory Practices.

In the food and agriculture sector, Thailand will accelerate market access for meat and poultry certified by the Food Safety and Inspection Service (FSIS), remove trade barriers based on scientific principles and risk assessment, and recognize mutually-agreed certifications from US agencies. At the same time, Thailand will enhance labor rights, strengthen labor law enforcement, protect the environment, combat illegal trade in timber and wildlife, comply with fisheries obligations under the World Trade Organization (WTO), and strengthen intellectual property protection (including addressing patent backlogs, suppressing counterfeit goods, and protecting Geographical Indication (GI)).

The agreement also sets out principles in the areas of digital trade and services, such as refraining from imposing discriminatory digital taxes, recognizing cross-border data flows, supporting a moratorium on electronic transmissions duties, relaxing foreign ownership restrictions in telecommunications, and eliminating requirements for domestic processing of payment data. It further includes cooperation on state-owned enterprises, economic security, and supply chains, along with commercial deals with US firms, including agricultural products worth \$2.6 billion per year, energy worth \$5.4 billion per year, and the purchase of 80 aircraft valued at \$18.8 billion.

However, the policies actually implemented may still be subject to change until negotiations reach a final agreement. Subsequent information has revealed significant adjustments, such as the expansion of items for which the U.S. grants exemptions from Reciprocal Tariffs on certain agricultural products on a general basis (applied to all countries), including coffee, tea, bananas, oranges, tomatoes, cocoa, and spices,⁵ and the consideration of country-specific exemption lists under Annex III, which are currently under joint review.⁶

Subsequently, the U.S. announced the “*America First Global Health Strategy*,” reflecting a shift in the country’s role in the global health system—from being a “provider of global public goods” to using health assistance as a strategic instrument. This approach is built on three main pillars: (1) Protecting U.S. security through disease surveillance systems; (2) Enhancing the competitiveness of the U.S. medical industry; and (3) Directly linking foreign assistance to U.S. economic interests.⁷

Impact on Health of the Thai People

Although current empirical evidence remains limited—since many aspects of the agreements are not yet finalized and the America First policy continues to carry a high degree of uncertainty—a review of recent documents suggests that the health impacts on Thailand can be assessed across at least four main dimensions, as follows:

1 Food and health product standards: Certain trade provisions aim to accelerate market access for meat and poultry from the U.S. certified by the FSIS. From a trade perspective, this may help reduce costs and increase consumer choice. However, a major concern is the push to allow imports of pork produced using growth-promoting substances, which Thailand has long strictly banned for both use and import. Scientific evidence indicates potential negative impacts on the cardiovascular system, as well as long-term risks of chronic disease, particularly among the elderly and individuals with a non-communicable disease (NCD). Relaxing such standards is, therefore, not merely a technical trade issue; it raises fundamental questions about the precautionary principle and Thailand’s consumer protection system. Allowing health standards to become negotiable in exchange for short-term economic gains would likely generate long-term public health costs, which would ultimately become a burden on the state and the country’s health security system.⁸

2 Pharmaceutical patents and market monopolies: Strengthening intellectual property protection in line with U.S. approaches—particularly frameworks that go beyond WTO standards—risks exacerbating the problem of evergreening, or extending market exclusivity through secondary patents. These may involve minor modifications such as changes in drug formulation, usage, or delivery methods, without generating significant additional therapeutic value. The result is that high-priced medicines remain on the market longer, delaying the entry of generic drugs and weakening the government’s price negotiation power. This leads to unnecessary increases in the cost of the universal health coverage system. From a policy perspective, this is not only a budgetary issue but also undermines access to essential medicines, particularly for low-income populations and patients with chronic conditions who require long-term treatment.



3 | **Reduction of foreign aid:** The suspension or delay of U.S. funding for NGOs working on refugee and human rights issues directly affects health services along Thailand’s border areas, especially those serving refugees from Myanmar, which rely heavily on international funding to provide basic care such as medical treatment. When these community clinics are forced to suspend or scale back services, the burden of care is inevitably shifted to Thailand’s public hospitals—despite the lack of sufficient budget allocation to support this increased demand. Such a situation not only places a strain on healthcare personnel and public health budgets, but also heightens health security risks, particularly in already-vulnerable border regions.⁹

4 | **Macro-level impacts:** The America First policy tends to suppress global economic growth through slower trade and investment which, in turn, adversely affects government revenue bases and the capacity of countries—including Thailand—to invest in health and social welfare. However, it must be acknowledged that certain aspects of the agreement may generate positive momentum through increased competition. As a large number of imports from the U.S. are granted tariff exemptions, Thai producers who were previously protected will face pressure to adapt, improve efficiency, and upgrade product quality. Such positive effects will only materialize if the state takes on a proactive role as a “development partner” rather than merely opening markets. This requires support in areas where the private sector cannot adjust on its own, such as investment in workforce skills development, research and development, and upgrading production standards, alongside careful management of social and health costs. Otherwise, short-term economic gains may come at the expense of a more fragile health system and greater inequality in the long term.

Table 1: Summary of health risks from the America First Policy and policy recommendations

Issue	Challenge/Risk	Short-term recommendation	Long-term recommendation
Food and health product standards	Market liberalization for meat imports, including pork produced with growth-promoting agents	Meat imports should not be used as a bargaining item in trade negotiations. If unavoidable, imports should be limited as much as possible, for example through quotas in time of shortage	There needs to be a systematic restructuring of Thailand’s economic and social systems—through market diversification, upgrading value chains, and developing skills and innovation—alongside the design of health protection policies, to strengthen the country’s bargaining power and long-term sustainability in the global trading system
Pharmaceutical patents and market monopolies	The stringency of intellectual property standards that may lead to the problem of evergreening patents	Strengthen mechanisms for screening, examining, and opposing patents, as well as promoting essential generic medicines	
Reduction of foreign aid	Suspension of foreign aid to NGOs providing care for refugees along the border	Fund raising from alternative sources alongside strengthening care and oversight mechanisms	
Macroeconomic impacts	Suppresses global trade and investment, but helps stimulate competition for development	Using selective negotiations aligned with development goals, and providing remedies for those affected	



Thailand's Response Strategies and Policy Recommendations

At present, there is no evidence that Thailand has a public policy specifically designed to directly respond to the America First policy. However, Thailand has established long-term health system development plans that can partially serve as a foundation for mitigating its impacts. For example, the aftermath of the COVID-19 pandemic has led Thailand to plan for strengthening domestic production of vaccines, medicines, and medical supplies, as well as reducing reliance on international supply chains.¹⁰

However, for policies that have immediate and severe impacts on Thailand, it is evident that the government has developed issue-specific response approaches. For example, the government has introduced a “transition plan” to sustain border-area health services during periods of uncertainty in foreign funding. This involves expanding the role of public hospitals in caring for critical-care patients, managing referrals, and coordinating with NGOs to prioritize essential services. Nevertheless, such measures remain temporary and do not adequately address long-term sustainability. Thailand should therefore consider the following policy approaches:

Short term

The Thai government needs to engage in careful and selective trade negotiations (selective engagement) to strike an appropriate balance between accepting proposals that may stimulate competition, adaptation, and economic development, and limiting the health-related risks and costs that may affect the population and the public health system.



In the case of imports of pork produced using growth-promoting substances, the most appropriate approach is to exclude such products from trade agreements altogether, given their significant risks to consumer health. However, if it is necessary to include this issue in negotiations, Thailand should impose strict conditions by limiting imports only to pork that does not use growth-promoting substances and restricting import volumes to levels that correspond strictly to domestic shortages.



In the case of patents and trade, in the short term Thailand should strengthen the rigor and effectiveness of its patent examination system to filter out low-quality patents or those that constitute unnecessary extensions of patent protection (evergreening patents). This should be accompanied by reinforcing mechanisms for patent opposition by both the public sector and civil society, as well as promoting the use of essential generic medicines to help reduce the financial burden on the public health system and limit monopoly during the transition to new trade rules.



In the case of reductions in foreign aid, Thailand must urgently restructure its approach to refugee health care by mobilizing replacement funding from other donors, while integrating services into the provincial public health system, strengthening workforce stability, and developing appropriate financing mechanisms. At the same time, disease surveillance along border areas should be enhanced under the framework of “national health security,” rather than being treated solely as a humanitarian mission.



In addressing macro-level impacts, overall Thailand should adopt a strategy of selective negotiation by separating highly sensitive goods—particularly those with significant economic and health implications—from the bargaining table. This should be complemented by targeted support measures for affected entrepreneurs and exporters to mitigate volatility and shocks to the economic and social system.

Long term

Responding to new trade agreements must shift from reactive negotiations to concrete structural planning, with the following key measures:



Upgrading value chains and the creative economy: Accelerate investment in targeted industries (S-Curve) and the Creative Economy by leveraging soft power and cultural capital to add value to goods and services, rather than competing on price, in order to create distinctive advantages that are difficult to replicate in the global market.



Technology and innovation: Provide tax incentives and funding support for research and development to transform Thailand from a component producer into a “technology owner” or a producer of advanced innovations aligned with environmental and international standards.



Risk diversification and export markets: Reduce dependence on the US market by expanding into new economic cooperation groups (such as BRICS+ or the Middle East) and maximizing the benefits of existing FTA frameworks.



Human capital development: Reform workforce skills (reskill/upskill) to align with the digital economy and automation, thereby enhancing productivity and bargaining power in global trade.



Flexible health protection policies: Design robust health financing mechanisms and social protection systems to serve as a “safety net” against the pressures of trade liberalization—particularly to ensure that access to essential medicines and basic health services is not constrained by overly stringent intellectual property requirements.

Coordinated action across all these dimensions will help build resilience, enabling Thailand’s economy to grow in a balanced and sustainable manner under the new global order.

Conclusion remark

The America First policy is not merely a trade or diplomatic policy; it represents a shift in the logic of the global order, sending shockwaves through the health systems of countries around the world, including Thailand. Responding to such a policy therefore cannot be confined to trade negotiations or technical public health measures alone. It requires collaboration across all relevant sectors to integrate economic, trade, social, and health policies in order to protect the health of the Thai population in a world increasingly shaped by geopolitical turbulence. Preventive investment, maintaining standards for food and pharmaceuticals, designing flexible social protection systems, and strengthening the capacity of the public health system to withstand external shocks are essential conditions for national development under a new world order in which politics, economics, and health are inseparably interconnected.

Only states that can manage these risks in an integrated manner will be able to safeguard both the well-being of their populations and their capacity for sustainable economic growth.



Source: สร้างโดย AI ผ่าน GoBanana Pro จาก Adobe Firefly

From Call Center Gangs to Cross-Border Human Trafficking

The revenue of scammer networks in Myanmar, Laos, and Cambodia reached USD 43.8 billion, or over THB 1.5 trillion, in 2023, accounting for nearly 40% of the combined GDP of the three countries.

The United Nations High Commissioner for Refugees (UNHCR) reported that more than 120,000 people were deceived into working in Myanmar and 100,000 in Cambodia.

Introduction

Thailand ushered in the year 2025 with news that made headlines worldwide, when Wang Xing¹ or ‘Xingxing,’ a Chinese actor, disappeared from Mae Sot in Tak Province on January 3. He was later found to have been held in KK Park in Myawaddy, Myanmar, an area notorious for being a hub of scammer operations. Xingxing was lured under the pretense of auditioning as an actor in Thailand before being abducted, having his head shaved, and being forced to engage in cybercrime. The incident caused significant outrage in the Chinese government, prompting Assistant Minister of China’s Ministry of Public Security, to visit the area. This led to pressure on the Thai government to implement measures cutting off public utilities in the Thai-Myanmar border areas linked to the scammer networks.² These measures prompted some scammer groups in Myanmar to relocate their operations to Cambodia.³

Another major incident occurred on August 8, 2025, when the body of Park Min-ho was found.⁴ He was a 22-year-old South Korean student, who was deceived and forced into drug delivery work before being sold to a scammer network in Cambodia and beaten to death. The incident caused Cho Hyun,⁵ the Minister of Foreign Affairs of South Korea, to visit Cambodia to pressure Prime Minister Hun Manet to accelerate the crackdown on scammer networks that deceive and exploit South Korean workers. Meanwhile, the Amnesty International⁶ reported that there were more than 53 large scam centers in Cambodia, with the Cambodian government being complicit in these illegal operations. Meanwhile, the United Nations High Commissioner for Human Rights⁷ reported that 120,000 people were deceived into working in Myanmar, and approximately 100,000 in Cambodia.



South Korean Minister of Foreign Affairs Cho Hyun visited Cambodia

Source: Agence Kampuchea Presse (AKP), <https://akp.gov.kh/post/detail/352795>

This case illustrates that scammer networks in the Indochina region are closely linked to cross-border human trafficking routes. Call-center gangs often use the Indochina region as a base of operations due to weak regulatory and law enforcement systems. The operations of human trafficking networks in Indochina involve the following:

- 1 | Luring victims in various countries – such as Thailand, Vietnam, and Indonesia – with high-paying overseas job offers, commonly advertised as IT or service industry positions
- 2 | Cross-border transportation – trafficking routes often exploit poorly controlled border areas, such as Thailand-Cambodia, Thailand-Myanmar, and the Golden Triangle
- 3 | Forced labor in call centers – upon arrival, victims are coerced into working as telephone scammers. Those who refuse may face violent punishment, including detention, torture, or physical abuse. The forced work may include scam calls, account hacking, or social media fraud.

This article discusses the problem of human trafficking linked to scammer networks in Indochina, the resulting impacts, and potential solutions.

The Expansion of Scammer Groups in Thailand and the Greater Mekong Subregion

Scammer networks in the Greater Mekong Subregion originated in China, beginning with casino operations and gambling websites, which started spreading into Southeast Asia in the early 2000s.⁸ A key turning point was the COVID-19 pandemic, which caused casino tourism profits to drop sharply. Casinos began being converted into “fraud centers” for online scams. According to a 2023 report by the United States Institute of Peace (USIP), the revenue of fraud and human trafficking networks in Myanmar, Laos, and Cambodia reached over USD 43.8 billion, or more than THB 1.5 trillion, accounting for nearly 40% of the combined GDP of the three countries.⁹ The enormous revenue has driven the expansion of this industry and attracted new, smaller players to establish cyber-fraud operations, some of which have set up small-scale bases in Thailand as well.¹⁰

These criminal organizations have evolved into complex networks and are connected with powerful actors in various countries within the Greater Mekong Subregion, ranging from armed forces, government agencies, and national and local politicians to influential businesspeople. Weak political institutions and conflicts in some countries, such as Myanmar, have allowed scammer networks to operate freely under the protection of local power brokers, creating a space for these illegal businesses to grow rapidly.

In Thailand, certain individuals have also been identified as having links to scammer networks. On November 12, 2025, the Office of Foreign Assets Control¹¹ (OFAC), the U.S. Department of the Treasury issued a statement sanctioning individuals and companies in Myanmar and Thailand for their involvement with cybercrime organizations, including Trans-Asia International Holding Group Thailand Co., Ltd. (Trans-Asia), directed by Mr. Chamu Sawang, a Thai national also known as ‘Yu Jianjun.’

Rangsiman Rome, a party-list member of the People’s Party, stated during a joint parliamentary session on September 29, 2025, that Benjamin Mauerberger, also known as Ben Smith, a South African man with a history linked to scammer networks in Cambodia, has connections with high-ranking politicians in the government.¹² The politician acknowledged knowing Ben Smith but denied any wrongdoing and called for proof of his innocence.¹³ Furthermore, the Police Complaint Review Committee has filed disciplinary charges against the former Commissioner General and approximately 200 other police officers for allegedly being involved in receiving benefits from extortion operations linked to online gambling websites connected to scammer groups.¹⁴

Voices of Survivors: Documenting the Cruelty of Scam Centers

Stories from survivors provide crucial evidence of the brutality of modern human trafficking networks in 2023.



'Ice' (pseudonym), a 33-year-old from Lampang Province, and his girlfriend, who were unemployed and being threatened by an illegal debt-collection gang, decided to travel to Mandalay, Myanmar, for work after being offered a monthly salary of 25,000 baht through a job posting on Facebook. Upon arriving in Laukkai, a town in northern Myanmar near the Chinese border, they had their documents seized by soldiers, and were forced to engage in online scams, with threats of physical harm or being sold if they failed to meet targets. Ice was compelled to create fake online profiles and scour various applications to lure victims into online investments. Failure to meet the targets would result in physical abuse or being sold to other groups. Ice survived due to the "Operation 1027" on October 27, 2023, when the Chinese government supported armed forces in cracking down on online crime centered in Laukkai.¹⁵

In 2024–2025, 'Khae' (pseudonym), a teenage student, was deceived into working as a waitress in Cambodia during her school break. However, she was not immediately forced to become a scammer. Instead, she was forced to act as a "mule account," i.e., compelled to use her personal bank account to receive money obtained from scamming others, and forced to scan her face to verify transfers. When the account was frozen, she was sold to a call-center gang. She attempted to escape but was punished, enduring both physical and psychological abuse, before being abandoned in a field and rescued by Cambodian locals.

"They hit my right foot with a metal rod," Khae said, showing her scars. "They locked me up and handcuffed me to the bed."

She has now returned to Thailand and faces charges of money laundering because her 'mule' account was used illegally. Khae's case reflects the fate of human trafficking victims who, upon returning, become suspects due to being forced to commit crimes by the gangs.¹⁶



Data from the International Organization for Migration (IOM) indicates that human trafficking cases involving forced criminal activity in online fraud centers in Southeast Asia rose from 296 cases in 2022 to 978 cases in 2023, an increase of 230%.¹⁷



Human Trafficking

Thailand's Measures to Address Cross-Border Human Trafficking

Because cross-border human trafficking poses significant security and economic impacts on Thailand, the country has prioritized it as a national agenda to be addressed. The main measures are divided into five areas as follows:

Policy



Policy and legal measures: Thailand has strengthened the enforcement of the Anti-Trafficking in Persons Act, B.E. 2551 and its amendments to cover new types of offenses, particularly the “forced labor or services” that often occur in cross-border labor movements.¹⁸ In addition, the National Referral Mechanism (NRM) action plan has been implemented to ensure that all agencies follow a standardized procedure for identifying and assisting victims.¹⁹

Prosecution



Measures for investigation and suppression: The government has enhanced the efficiency of cross-border investigations through specialized agencies by establishing joint operation centers. Data integration between the Cyber Crime Investigation Bureau (CCIB) and the Anti-Trafficking Persons Division (ATPD) has been implemented to dismantle networks that use social media to lure people into working in border special economic zones.²⁰ Additionally, the Anti-Money Laundering Office (AMLO) has played a key role in seizing the assets of human trafficking networks to disrupt the funding cycles used for cross-border operations.²¹

Protection



Protection and rehabilitation measures: This involves screening victims to prevent them from being prosecuted for illegal entry through the National Referral Mechanism (NRM). The Thai government has established a “recovery and reflection” period to provide care for individuals suspected of being victims before they enter the formal screening process.²² The government also has set up border assistance centers, and screening points have been established at key border checkpoints, such as Mae Sot and Sa Kaeo, to identify at-risk groups returning from neighboring countries.²³

Prevention



Prevention measures: The focus is on intercepting trafficking at the source and building resilience among at-risk groups through the management of foreign labor. This includes establishing memoranda of understanding (MOU) with neighboring countries to legally import labor, reducing reliance on illegal brokers who are a main channel for human trafficking, and monitoring natural border crossings to prevent networks from taking victims across borders to work in casinos or call center operations.²⁴

Partnership



Cross-border partnerships: Because human trafficking is a transnational crime, Thailand has collaborated with international organizations and neighboring countries, particularly through ASEAN, in implementing the ASEAN Convention Against Trafficking in Persons, Especially Women and Children (ACTIP), to facilitate the transfer of evidence and the safe repatriation of victims.²⁵ Thailand cooperates with the United States, by improving operational standards to achieve a higher ranking in the Trafficking in Persons (TIP) Report.²⁶

At the ASEAN Summit in Kuala Lumpur, Malaysia, from October 26-28, 2025, discussions were held on cooperation to combat scammers and transnational online crime. Thailand promoted the idea of establishing a “Special Joint Taskforce” to target scammers within ASEAN countries, with collaboration from China, Japan, and South Korea.²⁷

In addition to the government, civil society plays a key role in addressing cross-border human trafficking and assisting victims. The Immanuel Foundation, a private organization, plays a central role in helping victims who have been deceived into working in neighboring countries, particularly Cambodia. The foundation coordinates the repatriation of victims, provides psychological rehabilitation and therapy, raises awareness to prevent repeat exploitation, and encourages victims to participate in breaking the cycle of human trafficking, as follows:²⁸

Rescue and assistance for cross-border victims: The foundation serves as a key channel for receiving complaints and coordinating the return of Thai nationals who have been deceived into illegal work, such as working in call centers or as mule accounts in Cambodia, back to Thailand.

Rehabilitation and recovery for victims: It provides therapy and care for returnees who often suffer from stress and psychological trauma, helping them reintegrate into society and lead normal lives.

Awareness and advocacy: The foundation shares the real experiences of former victims to warn and prevent youth and other members of the public from being lured into working as scammers.

Breaking the human trafficking cycle: It works to get insight and facts of the problems and develop strategies to prevent and reduce the number of people falling into the hands of cybercrime gangs.

Legal and social support: The foundation helps victims access the justice system and collaborates with government agencies to address the complex issues of human trafficking.

Future Direction

Cybercrime combined with human trafficking in Southeast Asia has become a “Human Security

Threat” on the same level as terrorism and drug trafficking. Scammer networks and transnational human trafficking in the region continue to pose severe threats, causing economic, human rights, and public security harms worldwide, particularly from operational bases in Myanmar and Cambodia. Currently, efforts to suppress these networks are underway in several countries, including Thailand’s measures to disrupt cross-border utilities, financial channels, and communications. Strengthening international cooperation, reforming laws to protect victims, using technology to prevent and detect scammers, and building digital resilience among the public are expected to gradually undermine the foundations of these criminal networks. Thailand should further enhance international cooperation to dismantle the digital infrastructure and financial routes of scammer networks. This should focus on establishing joint operation centers capable of real-time information exchange to track cross-border crypto transactions and mule accounts, alongside the rigorous, consistent, and straightforward enforcement of laws on telecommunications providers and social media platforms.





Source: สร้างโดย AI ผ่าน GoBanana Pro จาก Adobe Firefly

Borderless Education: Transnational Students and Thai Society

In 2022–2023, Thailand had more than 134,821 students assigned G-codes (migrant, stateless, or undocumented children). This group faces significant challenges, including overcrowded schools with limited resources, constrained education budgets, language and cultural barriers, and prejudice from surrounding communities.

Introduction

The Thai–Cambodian conflict in 2025 not only had physical impacts on people on both sides of the border, but also fueled rising nationalism in both countries, escalating into racial and cultural discrimination, and even affecting the education of migrant students. On August 28, 2025, an incident occurred in which a 13-year-old Cambodian student studying in Thailand was arrested by police and prepared for deportation to Cambodia after being reported as a foreign national without legal residence documents, despite the fact that the child was born and raised in Thailand.¹ Online opinions regarding the incident are divided into two sides. Some people sympathized with the student, while others viewed the child as having violated legal requirements and therefore felt that the law must be enforced without exception, even though Thailand has a policy of Education for All or EFA).² A Thai Cabinet resolution granted all children the right to access education, in force since 2005 (Cabinet Resolution of July 5, 2005). This resolution stipulated that every child—including migrant and undocumented children—are eligible to receive 15 years of free education regardless of legal status. However, up to the present, the education of this group continues to face challenges, and there are ongoing societal debates about whether it is appropriate for Thailand to support education for migrant children.

Currently, the number of migrant students in Thailand—including children of migrant workers, refugees, and stateless children—has increased rapidly, particularly in areas along the Thai–Myanmar border (such as Mae Sot District in Tak Province and Sangkhlaburi District in Kanchanaburi Province). This growth is due to several factors.

- 1 Migration of families of migrant workers, especially those working in agriculture, fisheries, and construction, tend to be located near border areas.
- 2 Instability in neighboring countries, particularly political conflict in Myanmar—especially following the 2021 coup—has driven many Burmese to seek refuge in Thailand.
- 3 Many of children lack official documents from their country of origin, such as birth certificates or national ID cards, and this obstacle creates barriers to accessing education there. As a result, some parents choose to enroll their children in Thai schools in the hope that they will receive a better education than in their home country.

These factors have led to several problems^{3, 4, 5}



Overcrowding in border schools—Schools in many areas, such as Mae Sot (in Tak) and Sangkhlaburi (in Kanchanaburi), have seen student numbers exceed their capacity. In some schools, more than 50% of students are migrant children, resulting in insufficient educational resources and personnel.



Budget constraints—Schools with large numbers of migrant children often do not receive adequate funding, as these children frequently lack legal status, making it difficult to allocate budgets based on student numbers.



Language and cultural barriers—Most migrant children are unable to speak Thai, creating obstacles in teaching and learning, with teachers facing challenges in communication as well as in adapting curricula to suit cultural diversity.



Community tensions—In some areas, Thai communities may be dissatisfied with migrant children receiving educational opportunities, perceiving it as competition for resources such as school lunches or learning materials.

This article discusses the situation of migrant students in Thailand, measures to address these issues, and proposals from various network partners.

Why Are Migrant Children Coming to Attend School in Thailand

Looking back to August 27, 2024,⁶ a video clip of Myanmar students at a learning center in Surat Thani Province singing the Myanmar national anthem was shared by a TikTok user. The clip drew widespread public attention, prompting Thai authorities to investigate and order the closure of the learning center. Siraporn Kaewsombat, a representative of the Help Without Frontiers Foundation Thailand, which oversees ten migrant learning centers serving more than 2,400 students nationwide, explained that the issue in Surat Thani Province stemmed from the fact that many areas in Thailand had never previously had migrant learning centers. However, due to ongoing unrest in Myanmar, more Myanmar workers have migrated to Thailand, and many school-age children have accompanied their parents.

Data from the 2021 academic year showed that Thailand had a total of 43,318 students assigned G-codes (migrant, stateless, or undocumented children)⁷ before surging to more than 134,821 in 2022–2023. Following the coup and ensuing violence in Myanmar, the country entered a severe “education crisis,” with an estimated over 5 million school-age children out of the education system. After the 2021 coup, the state education system collapsed, and many schools were bombed or repurposed as military bases.⁸ The education crisis is not limited to Myanmar alone. A UNESCO report reveals that there are currently 272 million children and youth worldwide who are out of the education system, of whom 18 million are in Southeast Asia.⁹

For this reason, Thailand has become one of the destinations for students from neighboring countries such as Myanmar, Cambodia, and Laos. The main reasons are the quality of the Thai education system, the Education for All policy that accepts children of all nationalities, the focus on learning Thai to enhance future employment opportunities, and the fact that children’s parents migrate to Thailand for work.

However, some schools still face limitations in accepting cross-border students, whether due to a lack of resources and personnel, biases against foreign groups, or concerns about how well these students will adapt to Thai children. This has led to the establishment of learning centers for cross-border children outside the formal Thai education system, aiming to fill the educational gap for these children and assist their adaptation before entering Thai schools.

Migrant Learning Centres: A Helping Hand for Thai Schools

Migrant Learning Centres (MLCs) are alternative educational institutions established by migrant worker communities, non-governmental organizations (NGOs), or religious groups. They ensure that the majority of migrant children can access education, even if they lack formal academic records or face barriers from academic transfer into the formal Thai school system. The existence of these learning centres benefits Thai society in several ways. They keep children within the educational system and away from illegal activities. The Thai Ministry of Education does not need to allocate a budget to support them. Finally, these centres serve as a pipeline for the Thai economy’s long-term workforce, as many centres provide vocational training and Thai language instruction.¹⁰

Furthermore, in Thailand’s border areas, there are groups and organizations striving to help children in remote regions access education. An example is Bamboo School in Bong Ti Subdistrict, Sai Yok District, Kanchanaburi Province. This shelter provides assistance to migrant children and those who lack opportunities due to family hardships. Catherine Ruth Riley-Bryan, the founder of Bamboo School, stated that children who arrive here spend their initial period adapting and learning to communicate in Thai. Afterward, they are enrolled in local schools to serve as a stepping stone toward pursuing higher education.¹¹

“I believe that while they are still young, we can make them feel like they are part of society. We provide opportunities for the children at Bamboo School to participate in community service activities, so they can see for themselves that they have a future here,” said Catherine.

It is not only in the border regions; even in the capital city of Bangkok,¹² there are policies to manage education equitably for all children. In the 2025 academic year, there were a total of 256,703 students across 437 schools under the Bangkok Metropolitan Administration. Among them, 24,221 students—or 9.4%—lack civil registration documents or Thai nationality. Admitting these students does not infringe upon the rights of Thai students in any way. On the contrary, if Thailand’s birth rate remains consistently low as it is today, the Thai economy faces a potential labor shortage in the future.¹³ A case in point is the closure of Patai Udom Suksa School, a long-standing private institution, which was partly caused by the declining number of Thai births.¹⁴ Therefore, providing education to migrant children is, in a sense, a long-term investment in Thailand’s economic and social systems. Education is considered a form of the country’s Soft Power.¹⁵ If migrant students have a positive experience, they will become long-term supporters of the host country where they are educated.

From Surplus to Becoming Part of Thai Society

Thailand is among the countries with the very large number of stateless children. In 2024, this number reached 169,241,¹⁶ with the majority originating from ethnic communities that have resided in the country for decades. These students—referred to as "G-Code" students—receive an average annual educational subsidy from the government of 2,556 THB per person.¹⁷ It has been observed that even when these children successfully graduate with high-level degrees and integrate into Thai society, they face significant challenges in finding employment due to their lack of Thai nationality.¹⁸ To address this, UNICEF has recommended a path toward integration¹⁹ by officially recognizing the role of Migrant Learning Centres as a complementary part of the Thai educational system. This involves creating legal registration channels through relevant educational authorities, such as the Department of Learning Encouragement (DOLE). A successful case study can be found in Tak Province, where the Migrant Educational Coordination Center coordinates between civil society organizations and government agencies to oversee 18,591 students enrolled in local learning centres.²⁰ Furthermore, increasing support for Thai language instruction alongside the students' native languages will serve as a vital bridge, helping migrant children adapt to the standard curriculum of Thai public schools.²¹

To address the challenges surrounding the education of migrant children in Thailand, international organizations and Thai educational networks have proposed the following systemic solutions:

- 1 Elevate and certify the status of Migrant Learning Centres (MLCs):** MLCs, in border regions and areas with high concentrations of migrant children (not limited only to borders), should be formally and legally registered. This involves registering teachers and students to qualify for "per-head" budget allocations from the Office of the Basic Education Commission (OBEC). Furthermore, curricula should be aligned to allow for easier transfers into the public school system, and bilingual instruction (Thai-Burmese/Khmer) should be supported to reduce language barriers. Additionally, the National Human Rights Commission (NHRC) has proposed the establishment of a Coordination Center for Migrant Education. This center would coordinate with schools to ensure the admission of all children and expand the MLC model into industrial zones, such as Samut Sakhon and Chonburi.²²

- 2 **Improve the allocation of budgets and resources to cover all migrant children:** This includes adjusting the Office of the Basic Education Commission (OBEC) budget allocation criteria to include every migrant child (regardless of legal status) based on actual headcount. This can be done through providing supplementary funding for border schools where migrant students exceed 50% of the population, covering expenses such as school lunches, learning materials, and additional teacher compensation. Furthermore, a special fund should be established from the central budget to manage the increased influx of children resulting from border crises. UNICEF points out that budget shortages prevent schools from fully supporting migrant children, while the International Organization for Migration (IOM) recommends integrating migrant children into the educational budget and welfare systems to ensure sustainable development.²³

- 3 **Address barriers regarding language, culture, and teacher training:** Bilingual education curricula should be developed for border schools and areas with high concentrations of migrant children. This includes training teachers to have skills in multicultural instruction and teaching Thai as a Second Language, as well as adding subjects that align with the students' cultural contexts. Furthermore, intensive Thai language preparation classes should be provided before students enter regular classrooms. UNHCR reported in 2024 that intensive Thai language training helped increase enrollment in the public school system by 62%.²⁴ UNICEF also recommended strengthening teachers' capacities in managing diversity to reduce dropout rates.

- 4 **Reduce community conflict and build social acceptance:** There should be advocacy on fostering understanding within communities and schools that providing education to migrant children is beneficial to society (e.g., reducing crime, decreasing child labor, and increasing the potential of the future workforce). This should be done in collaboration with local organizations and the media to mitigate bias and the perception of “resource competition” and to implement non-discrimination policies in schools. Since, proposals to cut budgets for migrant children tend to fuel hatred, the state should uphold human rights principles to cultivate supportive and contributing citizens.²⁵

“What Should We Do Next?

• The educational challenges facing migrant children in Thailand, particularly in border areas, are structural issues stemming from overcrowding, lack of funding, linguistic and cultural barriers, and community conflicts. These factors significantly impact the development opportunities and future prospects of these children. Although Thailand has had a progressive “Education for All” policy since 2003 and has issued resolutions to accelerate legal status solutions for stateless individuals during 2024–2025, gaps in implementation remain—especially regarding budget allocation, teacher resources, and community acceptance. If the government and partner networks implement systemic recommendations—such as certifying and subsidizing Migrant Learning Centres (MLCs), adjusting budgets based on actual headcounts, developing bilingual curricula, and campaigning to reduce bias—it will help reduce inequality and create educational sustainability. Ultimately, this will empower migrant children to grow into high-quality global citizens, aligning with the Sustainable Development Goals (SDGs) and Thailand’s commitment to fundamental human rights.

.....”



Earthquakes: A Disaster That Should Not Be Overlooked

When compared with countries that face high earthquake risk, such as Japan and New Zealand, Thailand's key weakness does not lie in a lack of knowledge or engineering standards, but rather in practical gaps in early warning systems, centralized communication, and data integration among agencies. These shortcomings directly affect public behavior during emergencies.

Introduction

On March 28, 2025, a magnitude 7.7 earthquake occurred, followed by a 6.4 aftershock along the Sagaing Fault near Mandalay, Myanmar, at a depth of 10 kilometers. The quake caused severe impacts in Myanmar and affected neighboring countries, including Thailand, Laos, Bangladesh, and China. In Myanmar, more than 3,471 deaths were confirmed, and over 4,800 temples and pagodas were damaged.¹ In Thailand, damage was reported in 23 provinces, with 97 deaths and 35 injuries.² In Bangkok, one building under construction collapsed, some buildings were found to have structural damage, and many high-rise buildings sustained architectural damage. Inspections of 5,741 buildings across 76 provinces found that 298 buildings had moderate damage but remained usable (yellow category), while 50 buildings had severe structural damage and were ordered to be taken out of use (red category).³

This earthquake was caused by strike-slip movement along the Sagaing Fault, which lies between the Indian and Eurasian tectonic plates. The fault has an estimated recurrence interval of about 100 years for magnitude 8.0 earthquakes, resulting in strong ground shaking near the epicenter. In Bangkok, the amplification of seismic waves is related to the presence of thick soft soil layers, which can increase both the amplitude and duration of shaking—particularly long-period ground motions that affect high-rise buildings. However, Thailand has enforced earthquake-resistant building design laws and standards since 2007. Buildings constructed after that year, if properly designed and built in accordance with these regulations, should not experience structural damage, or may only sustain minor damage rather than collapse. At the same time, buildings constructed before 2007 may also have sufficient strength if they have been properly assessed and retrofitted. As a result, the damage in Thailand from the Myanmar earthquake was not severe. This article discusses Thailand's disaster situation, risks, future disaster management approaches, and recommendations.

Thailand and Earthquake Risk, and Major Earthquakes in the Past

Earthquakes most commonly occur along active fault lines. In Thailand, most active faults are located in the northern and western regions. While large earthquakes are less frequent compared to countries along the ‘Ring of Fire,’ Thailand remains at risk from the Sunda subduction zone in the Indian Ocean, which caused the major earthquake and tsunami on December 26, 2004. Similar events could occur again, stretching from the Andaman and Nicobar Islands to the Arakan coast along western Myanmar, potentially affecting Thailand, including Bangkok—even from distant large earthquakes, as seen in past events. Nevertheless, faults in northern and western Thailand should not be underestimated. Although large earthquakes have not occurred frequently in the past, a significant event did take place on May 5, 2014, when a magnitude 6.3 earthquake struck the Mae Lao, Phan, and Mae Suai districts. This resulted in damage to more than 10,000 buildings, with around 400–500 buildings deemed unsafe and approximately 20–30 buildings collapsing.⁴ Northern and western Thailand are also capable of experiencing earthquakes of up to magnitude 7, particularly along the Mae Chan and Si Sawat fault lines. However, even a magnitude 6 earthquake along the Mae Tha fault could have severe impacts on densely populated areas such as Chiang Mai.

On March 28, 2025, a magnitude 7.7 earthquake occurred along the Sagaing Fault near Mandalay, Myanmar



Source: https://www.banthaluang.go.th/index/load_data/?doc=16166

At the regional level, Thailand’s earthquake risk is considered moderate compared to countries located directly along tectonic plate boundaries, such as Indonesia and the Philippines, while Japan faces very high risk from both subduction zones and inland faults. Nevertheless, Thailand’s risk has distinct characteristics. Although the frequency of large earthquakes is lower, the country is influenced by both active faults within its territory and major earthquakes in neighboring countries such as Myanmar, China, and Laos—especially from Myanmar and the Sunda subduction zone in the Indian Ocean. Although the Sagaing Fault experienced a major earthquake in 2025, complacency is not advisable, as a significant earthquake could occur in the southern region near Yangon, where no major event has occurred for nearly a century. Such an earthquake could generate long-distance ground shaking that affects Bangkok through the amplification of seismic waves in soft soil layers. This type of risk contributes to Thailand’s systemic vulnerability.⁵

Earthquake research in Thailand conducted over more than 20 years has played a crucial role in providing data to support ministerial regulations and safety standards. This has been achieved through collaboration between two key ministries: Ministry of Higher Education, Science, Research and Innovation, as the knowledge generator, and the Ministry of Interior, as the regulator and enforcer of laws, in order to strengthen the country’s disaster prevention efforts. The private sector also plays an important role, particularly building design engineers. If they properly understand earthquake-resistant design principles, they can ensure adequate safety while also maintaining cost-effectiveness from a business perspective. The lessons learned from the 2025 earthquake should be used to sustainably enhance safety standards for everyone.⁶

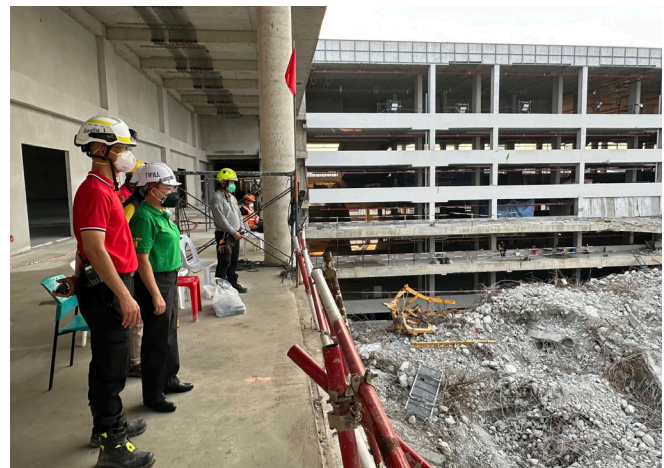
Impact of Earthquakes on the Economic, Social, and Health Systems

The 2025 earthquake caused widespread panic among the public, leading to rushed and uncoordinated evacuations from high-rise buildings. There were reports of people evacuating via elevators and stairways in large numbers without waiting for the shaking to stop. Such evacuation behavior increased the risk of accidents, falls, overcrowding, and unnecessary injuries. This situation reflects gaps in public knowledge and risk communication, particularly regarding appropriate behavior during and after earthquakes in high-rise buildings. The lack of clear evacuation guideline—especially in hospitals, where patients depend on medical equipment or close care—can lead to avoidable losses. At the same time, anxiety over building safety following incidents of structural collapse has had long-term impacts on mental health, quality of life, work efficiency, and public confidence in the government’s disaster management system.

Following the earthquake, the Bangkok Metropolitan Administration (BMA) instructed private building owners to inspect approximately 11,000 buildings. Of these, 251 buildings were found to have moderate damage but remained usable (yellow category). Public assistance and consultations were provided through the Traffy Fondue platform; as of May 10, 2025, a total of 20,432 reports had been received, with 19,029 cases resolved.⁷ Inspections of government buildings conducted by the Department of Public Works and Town & Country Planning, covering the period from March 28 to May 10, 2025, included 309 agencies and 908 buildings. Of these, 75 buildings were found to have moderate damage but remained usable (yellow category), while one building had severe structural damage and was deemed unsafe for use (red category). In addition, the Thailand Structural Engineers Association reported that volunteer engineers inspected 129 buildings—mostly residential—in Bangkok and

surrounding areas between March 28 and April 24, 2025. The findings showed that 108 buildings (83.7%) had no structural damage, 18 buildings (13.9%) had minor damage, and 3 buildings (2.3%) had moderate damage. These data indicate that most buildings remain structurally sound and safe for use.

In terms of economic impact of the earthquake, the Kasikorn Research Center estimated total damages at no less than 20 billion baht, with Thailand’s GDP in 2025 potentially decreasing by approximately 0.06%. The real estate sector has also been affected, with condominium sales and transfers in Bangkok slowing down. Conversely, demand for rental housing may increase, as people may be reluctant to take on ownership burdens amid ongoing uncertainty. As for the tourism sector, foreign tourists have canceled or postponed trips—particularly to Bangkok and Chiang Mai—resulting in a downward revision of international tourist arrival projections for 2025.⁸



Rescue mission at the collapsed Office the Auditor Generation building

Source: Facebook เพจสำนักงานเขตดุสิต

State Measures to Address the Challenge

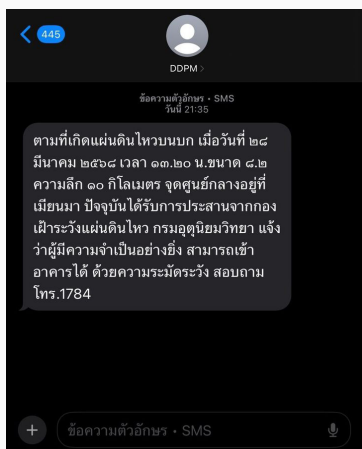
Although Thailand has had earthquake-resistant building design laws since 2007, and buildings constructed before 2007 may still be strong enough to withstand earthquakes if properly assessed and retrofitted, several structural weaknesses remain unresolved in a systematic way.

First, a large proportion of older buildings constructed before 2007—especially in major urban areas—are not yet subject to proactive requirements for structural assessment and retrofitting. Second, most of the damage observed has been to non-structural components, such as walls, ceilings, piping systems, and interior equipment. While this type of damage does not cause structural collapse, it can create significant panic and pose risks of injury to occupants. This reflects gaps in standards and practices that do not sufficiently prioritize architectural and whole-building system safety. Third, Bangkok’s geological context as a soft-soil basin leads to the amplification of long-period seismic waves, which particularly affect medium-to high-rise buildings.

When compared with countries that face high earthquake risks, such as Japan and New Zealand, clear systemic differences emerge. In Japan, early warning systems can alert the public and critical infrastructure from a few seconds to several tens of seconds before seismic waves arrive. These systems are integrated with mobile phones, mass transit systems, hospitals, and industrial facilities, enabling automatic shutdowns that effectively reduce accidents and public panic. In New Zealand, earthquake monitoring data are integrated into a unified system that serves as both a surveillance tool, a risk communication platform, and a public database. Citizens can access earthquake information, safety guidance, and impact assessments from a single source, reducing confusion and increasing trust in government disaster management systems. In comparison, Thailand’s key weakness does not lie in a lack of knowledge or engineering standards, but rather in practical gaps in early warning systems, centralized communication, and data integration among agencies—factors that directly influence public behavior during emergencies.

Emergency communication through a Single Command Center approach would enable more effective control of situations. Investment in early warning systems would allow the public to respond to hazards in a timely manner, along with regular drills and clearly defined procedures to ensure preparedness at all times. However, because multiple agencies in Thailand are involved in disaster management, integration among them is crucial. Each agency should have clearly defined roles, share information with one another, and conduct joint drills to ensure an effective response during emergencies.

Earthquake warning via SMS from DDPM



Source: <https://www.sanook.com/news/9771194/>

Recommendations for Disaster Management

Thailand’s disaster management needs to be upgraded from a reactive, post-disaster response approach to a proactive and systematic risk management framework, in line with the principles of the Sendai Framework for Disaster Risk Reduction 2015–2030⁹ which emphasizes reducing disaster risk rather than merely managing events, as follows:

- 1 Strengthening governance and clarity of institutional mechanisms (Sendai Priority 2: Strengthening Disaster Risk Governance)** by reviewing and improving laws and regulations related to disaster management to clearly define the roles and responsibilities of relevant agencies across the entire disaster management cycle—from observation, monitoring, and early warning to response, recovery, and rehabilitation.

- 2 | **Enhancing data systems and knowledge on disaster risk (Sendai Priority 1: Understanding Disaster Risk)** by integrating academic data and disaster monitoring data to ensure they are up-to-date, comprehensive, and practically usable. Research funding should prioritize area-based studies, which will improve the effectiveness of risk assessments, risk reduction planning, and the development of appropriate location-specific measures.

- 3 | **Adopting a community-based approach (Sendai Priority 4 and the “Build Back Better” principle)** by strengthening the capacity of communities, local administrative organizations, and civil society to play active roles in risk assessment, planning, preparedness, and post-disaster recovery. This approach helps build local synergy, enhances self-reliance, and strengthens long-term societal resilience to disasters.

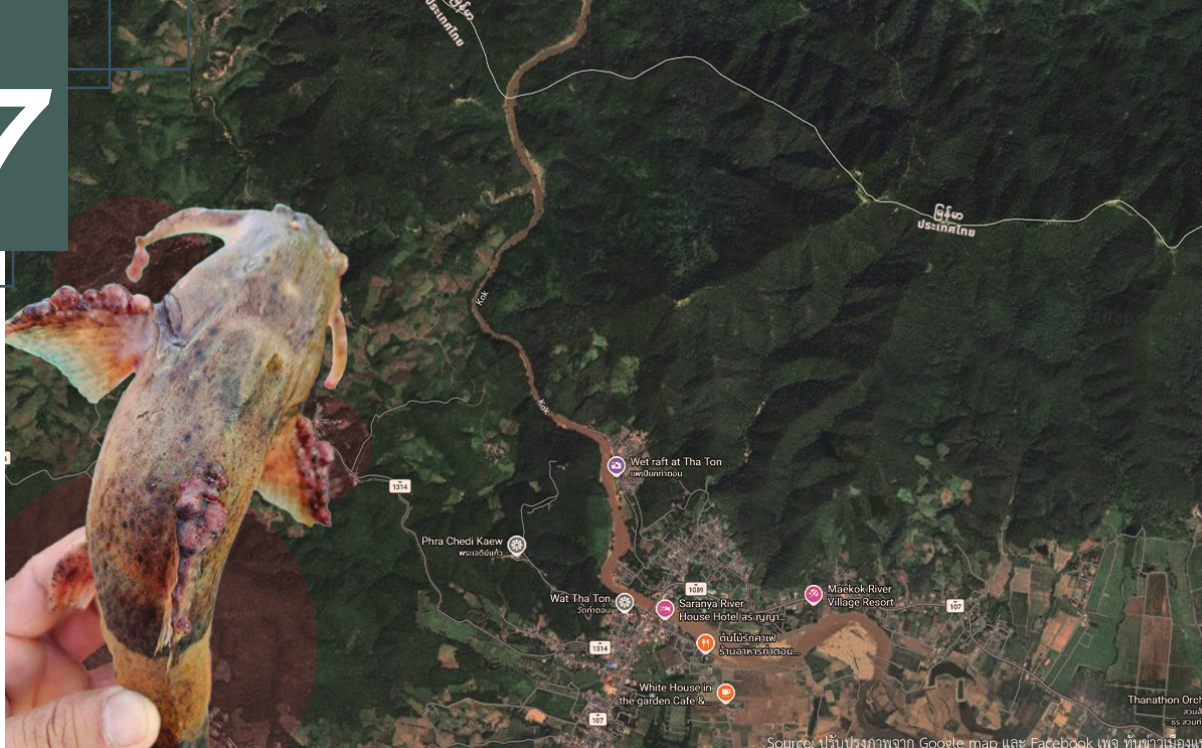
- 4 | **Investing in preventive, cost-effective, and sustainable infrastructure (Sendai Priority 3: Investing in Disaster Risk Reduction for Resilience).** Infrastructure design should follow a multi-purpose approach so that it can also be used during normal times—for example, as public or recreational spaces—thereby improving cost-effectiveness and public acceptance.

“Lessons Learned for the Future

Although Thailand has internationally aligned laws and practices for disaster prevention and mitigation, disaster risks remain unavoidable if the public lacks confidence in system safety or does not clearly understand appropriate procedures. Therefore, Thailand needs structural reform in line with the Sendai Framework, encompassing governance, data, community participation, and preventive investment. The core of such reform is the creation of systems that are safe in both engineering and technological terms, incorporating fail-safe mechanisms and reliable backup systems to minimize losses caused by system or human error. In addition, establishing a Single Command Center is crucial for ensuring unified data and communication during emergencies. At the same time, all sectors must clearly understand their roles, share information, and regularly conduct joint drills in order to transition toward an effective, safe, and sustainable disaster risk management system that builds public confidence for the future.

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A Toxic Transboundary River: Contamination in the Kok, Sai, Ruak, and Mekong River Basins

Since the beginning of 2025, the Kok River and its tributary basin have faced a transboundary pollution crisis caused by arsenic originating from more than 40 rare earth mines in Shan State, Myanmar. Arsenic levels have exceeded standards by more than twofold, spreading into the food chain and affecting the health of hundreds of thousands of people in Thailand.

Introduction

Toxic contamination—such as arsenic—in transboundary river ecosystems constitutes one of the most serious environmental and public health threats in Thailand, particularly in the Kok, Sai, Ruak, and upper Mekong river basins, which cover areas of Chiang Mai and Chiang Rai Provinces.¹ Such contamination affects not only surface water quality and sediment, but also spreads into the food chain, with long-term impacts on human health, fisheries, and agriculture.

The problem became clearly evident in March 2025, when residents in Tha Ton Subdistrict, Chiang Mai Province, noticed that the water in the Kok River had turned unusually murky. This prompted civic action and investigations by government agencies, ultimately confirming arsenic contamination exceeding the standard for surface water quality (not exceeding 0.01 mg/L, according to the Ministry of Natural Resources and Environment).² As of early 2026, the problem persists. Although there has been temporary dilution during periods of heavy rainfall (such as after Typhoon Wipha in September 2025), recent monitoring results still detect arsenic levels exceeding standards at multiple locations, particularly in the Sai and Ruak rivers, which are closer to the source.³ This contamination affects not only water quality and sediment, but also spreads into the food chain, with long-term impacts on public health, fisheries, agriculture, and the economies of riverside communities.

This article aims to analyze the development of the problem, its sources, monitoring data, impacts on ecosystems and health, as well as possible solutions, drawing on information from government agencies, mass media, and civil society organizations.



Source: Sayan Chuen-udomsawat, <https://bkktribune.com/รายงานพิเศษชุด-สายน้ำพี/>

Origins and Development of the Problem

The problem became clearly evident in March 2025, when residents of Tha Ton observed unusual discoloration in the Kok River. The river originates in the mountain ranges of Shan State, Myanmar, before flowing into Thailand at Mae Ai District, Chiang Mai Province, and continuing through Chiang Rai Province before joining the Mekong River at Ban Sop Kok in Chiang Saen District.⁴ Member of Parliament Somdul Utcharoen (Constituency 7, Chiang Mai Province, People’s Party) initiated the investigation and publicized the initial information, leading to formal monitoring by the Pollution Control Department (PCD) and the Environment and Pollution Control Office 1, Chiang Mai. The first official test, conducted on March 19, 2025, found arsenic levels at Ban Kaeng Tum in Mae Ai District at 0.026 mg/L (more than double the standard), along with turbidity levels 8–9 times higher than normal.⁵

Later, on June 5, 2025, the People’s Network for Protecting the Kok, Sai, Ruak, and Mekong Rivers organized an event titled “Poi Luang to Close Mines and Restore the Kok, Sai, Ruak, and Mekong River Basins,” and submitted an open letter in five languages (Thai, English, Chinese, Burmese, and Shan) to the governments of Thailand, Myanmar, and China, as well as the United Wa State Army (UWSA), calling for the closure of mines and the restoration of the ecosystem.⁶ The activity drew attention from the Chinese Embassy in Thailand, which expressed concern and affirmed that it would investigate Chinese investors.

Following this, the Pollution Control Department established a continuous monitoring plan from March to September 2025, collecting water samples twice a month and sediment samples once a month. The results from 11 monitoring rounds (March–September 2025) found arsenic levels exceeding standards on multiple occasions, particularly during the rainy season when water flow was strong and discharges from the Chiang Rai weir occurred.⁷ In addition, lead (Pb) exceeding standard levels was detected at certain locations and times, while other heavy metals—such as cadmium, copper, nickel, chromium, zinc, and mercury—remained within acceptable limits.

Evidence from satellite imagery (Google Earth and GISTDA) clearly indicated land clearing and mining activities at more than 40 sites in the headwaters of the Kok River and the Sai–Ruak river system in Shan State, Myanmar—particularly in Mong Hsat, Mong Yawn, and areas controlled by the NDA and the UWSA.⁸

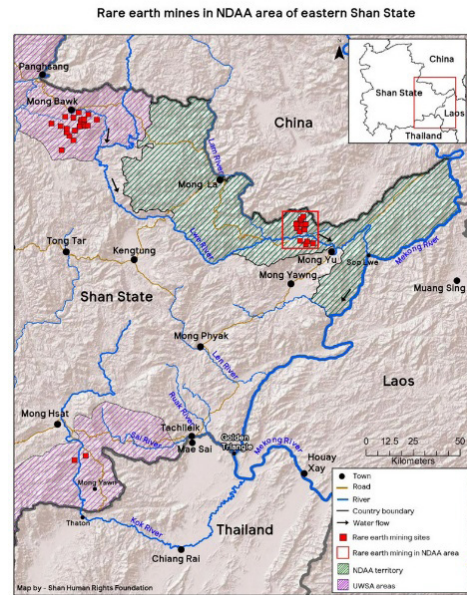


Figure 1: Rare earth mining sites in eastern Shan State, including in the Northern Wa, Southern Wa, and Mong La areas
Source: <https://prachatai.com/journal/2025/08/114381>

The Shan Human Rights Foundation (SHRF) reported on August 25, 2025, that 19 new rare earth element (REE) mines had been identified over the past four years (up from only three sites in 2021). These mining operations require the use of chemical-leaching processes, causing arsenic and other heavy metals to flow into the Lwe River, a tributary of the Mekong, located just 125 kilometers from the Golden Triangle (Figure 2).⁹

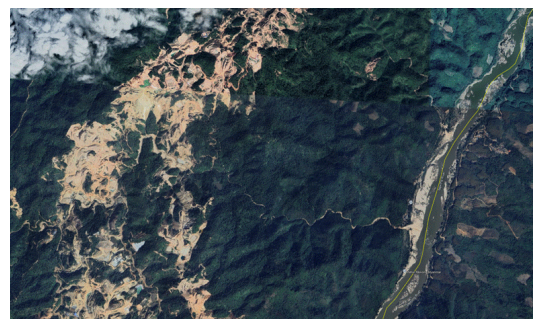


Figure 2: Rare earth mining sites along the Mekong River basin and its tributaries (including the Kok, Sai, and Ruak rivers) near the Golden Triangle
Source: <https://www.stimson.org/2025/toxic-rare-earth-mining-is-ruining-mekong-tributaries-in-the-golden-triangle>

In addition, an 8-kilometer stretch of manganese mining was found along the Lwe River, employing more than 1,000 Chinese workers. Some rare earth mines are located as close as 25 kilometers from the Thai border, with certain sites only 2.6-3.6 kilometers from the Kok River (Figure 3).¹⁰ It was found that drilling activities increased significantly from mid-2023 to 2024, corresponding with the period when abnormalities in the Kok River first began to be observed.



Figure 3: Rare earth mining sites on the western side of the Kok River in southern Shan State, Myanmar

Source: <https://www.aljazeera.com/news/2025/8/7/satellite-images-show-surge-in-rare-earth-mining-in-rebel-held-myanmar>

Impacts on the Food Chain and Public Health

Arsenic contamination clearly affects the food chain. Initial fish test results from the Department of Fisheries indicate arsenic levels of < 0.13 mg/kg, which do not exceed the standard.¹¹ However, villagers have reported abnormalities in fish such as Goonch and Bagridae, including lumps on their heads and barbels. This reflects an ecological imbalance caused by prolonged water turbidity, which prevents plankton from photosynthesizing and leads to a decline in fish populations. Test results from the Regional Medical Sciences Center 1 Chiang Rai detected lead and arsenic in village tap water, vegetables, and some fish species.¹² Additionally, arsenic was detected in the urine of two children (aged 6 and 2) in Kaeng Sai Mun Village, who regularly consume fish from the Kok River.¹³ Meanwhile, the Chiang Mai Provincial Agricultural Office tested 119 samples of vegetables and crops, finding arsenic in 21 samples; however, the levels were still within standard limits.¹⁴ However, long-term accumulation remains a risk, especially for children, pregnant women, and the elderly, as arsenic is carcinogenic and toxic to the nervous system, kidneys, heart, and liver.¹⁵ In addition, the use of raw water sources for producing tap water has been severely affected. The Provincial Waterworks Authority Chiang Rai has had to find new water sources. Many villagers have stopped using tap water due to skin rashes after bathing and have had to purchase bottled water instead.¹⁶

Actions Taken by the Government and the Public to Address the Problem

The public sector, particularly the People’s Network to Protect the Kok, Sai, Ruak, and Mekong Rivers, has been a key driving force behind this issue since early 2025, as follows:

- 1 Organizing ongoing campaigns and demonstrations. On June 5, 2025 (World Environment Day), an event titled “Poi Luang to Close Mines and Restore the Kok, Sai, Ruak, and Mekong River Basins” was held in Mae Fah Luang District, Chiang Rai Province, along with the submission of an open letter in five languages (Thai, English, Chinese, Myanmar, and Tai Yai) to the governments of Thailand, Myanmar, and China, as well as the United Wa State Army. (UWSA).¹⁷ From mid- to late 2025, online advocacy forums and continuous field activities were organized to raise awareness and pressure government agencies.
- 2 Formal demands and petitions were submitted. For example, on October 3-5, 2025, a letter outlining ten demands was submitted to the Prime Minister (at the time, Anutin Charnvirakul), calling for action within four months. These included: securing new raw water sources to replace those used for regional and village water supply; testing soil quality in 12,000 rai of sediment-affected areas in Tha Ton Subdistrich, Mae Ai District; inspecting over 100,000 rai of in-season rice fields in Chiang Rai Province before harvest; establishing a provincial heavy metals testing center; identifying new water sources for agriculture and consumption; providing compensation to affected villagers; setting

up a joint task force among the government, academics, and the public to develop solutions for mine closure, monitoring, and remediation, as well as long-term preventive measures; and advocating for placing the issue onto the national agenda.¹⁸ Subsequently, on November 26, 2025, a letter was submitted to the Mekong River Commission (MRC), requesting that transboundary pollution be placed on the urgent agenda, that water quality be monitored along the entire Mekong River, and that a unified water quality standard be adopted across the region.¹⁹

3 They have collaborated with academics to organize seminars with parliamentary committees, the Mekong Studies Center at Chulalongkorn University, and international organizations such as the Heinrich Böll Foundation to push this issue onto the national and regional agenda, as well as to call on the new government to establish a national-level committee to address the problem.²⁰

Since arsenic contamination in the Kok River became clearly evident in March 2025, the Thai government has taken action at multiple levels, including monitoring, health surveillance, and international negotiations, as follows:



Source: www.freepik.com

1 **Water quality measuring and monitoring.** The Pollution Control Department and the Environment and Pollution Control Office 1 Chiang Mai have increased the frequency of water quality testing in the Kok, Sai, Ruak, and Mekong Rivers (including sediment) since March 2025. The results of the 11th round of testing (September 1–5, 2025) continued to find arsenic levels exceeding standards at several locations in the Kok and Sai Rivers.²¹ The Department of Water Resources has therefore increased the frequency of measuring and regulated the opening and closing of the Chiang Rai weir gates to reduce the flow of contaminated sediment.²²



Source: <https://pr.moph.go.th/online/index/news/316997online/index/event>

2 **Health and food chain surveillance.** The Ministry of Public Health has conducted ongoing health screening of the population and testing of food samples (village tap water, vegetables, and fish) from April to August 2025, particularly among high-risk groups (children, pregnant women, and the elderly).²³ In addition, the public has been advised to wash fruits and vegetables before consumption and to avoid consuming freshwater fish from high-risk waterways.



Source: www.khaosod.co.th/around-thailand/news_4922516

3 **Operational mechanisms.** The government has established a subcommittee to address water quality issues in the Kok River basin, with a three-phase plan:

- **Short term:** Increase measuring equipment (Acoustic Doppler Current Profiler: ADCP) by three sets and develop a cloud service for real-time tracking
- **Medium term:** Dredge river sections at critical points
- **Long term:** Construct sediment-trapping weirs (currently under study and public hearing).²⁴



Source: www.naewna.com/local/927116

4 International negotiations and cooperation. Thailand has used the Mekong River Commission as the main mechanism for coordinating with Myanmar, Laos, and other member countries. Since mid-2025, the MRC has produced reports and conducted water quality assessments, finding arsenic levels exceeding standards at several locations along the Thailand–Myanmar–Laos border (at 0.025 mg/L, or more than 2.5 times the World Health Organization standard).²⁵ The Mekong River Commission has proposed a Joint Water Quality Monitoring plan, which has been supported by member countries and Myanmar (although Myanmar is not an official MRC member, it holds “dialogue partner” status). However, Myanmar has indicated that it may not be able to access certain areas controlled by ethnic armed groups.

Recommendations

Given the situation, most measures so far have focused on domestic responses, which are limited and cannot fully address the problem at the regional level. Thailand should therefore take urgent action by accelerating negotiations and establishing a high-level mechanism (Thailand–Myanmar–China–Laos) under the MRC framework or through bilateral channels to gain access to mining areas and set standards for waste management from rare earth mining. In addition, monitoring and public health systems should be strengthened by expanding real-time monitoring points across the river basin, establishing permanent heavy metal health screening centers in Chiang Rai and Chiang Mai, and extending screening among high-risk groups every 3-6 months. Efforts should also be made to secure alternative water sources and restore ecosystems by accelerating the development of new untreated water sources for water supply and agriculture, improving village water systems, and studying the rehabilitation of contaminated soil and sediment. Finally, a joint task force and compensation fund should be established by forming a tripartite working group (government–academia–public), as proposed by civil society networks, along with a compensation fund for villagers affected economically and in terms of health.

Conclusions

Toxic contamination in the Kok-Mekong river basin is a transboundary pollution crisis that reflects the fragility of international water resource management. Without urgent action to address the problem at its source, it could lead to long-term environmental and public health disasters affecting millions of people in the lower Mekong basin. This issue should be elevated to the national and regional policy agenda by incorporating transboundary pollution from mining into national environmental policy and by strengthening the role of the Mekong River Commission in managing cross-border mining-related pollution in the Mekong subregion.

กรมอนามัยและประชาชนหลีกเลี่ยงการดื่ม-ใช้น้ำกก

Source: Facebook เพจ สวท.เชียงราย กรมประชาสัมพันธ์



Breath of the Border – On the Day the Gunfire Has Not Yet Ceased

The Thai-Cambodian border clash in 2025 resulted in nearly a hundred officials and civilians killed or injured. In addition, about 258,000 people had to be evacuated to more than 900 temporary shelters across the provinces of Si Sa Ket, Surin, Buriram, Ubon Ratchathani, Sa Kaeo, Trat, and Chanthaburi, including over 46,000 vulnerable individuals requiring special care.

Introduction

The Thai-Cambodian border tension in 2025 is considered the most severe crisis since the Preah Vihear Temple dispute between 2008 and 2011. The events began early in the year in the Chong Bok area, Nam Yuen District, Ubon Ratchathani Province, and escalated into a major clash in late July 2025. On July 24, 2025, artillery was fired across the border into Thai civilian areas in Si Sa Ket and Surin Provinces, resulting in deaths and injuries, damage to homes, and multiple skirmishes along the border, including areas such as Phu Makheua, Chong An Ma, Chong Bok, Ta Kwai Temple, and Ta Muean Thom Temple. Clashes occurred again on December 7, 2025, starting at the Si Sa Ket border and spreading to nearby areas. The fighting was prolonged and intensified, with Thailand conducting both ground and air operations, while Cambodia fired artillery and multiple rocket launchers (e.g., BM-21) into several Thai civilian areas, affecting multiple provinces, including Buriram, Surin, Si Sa Ket, Ubon Ratchathani,

Sa Kaeo, and Trat. Hundreds of thousands of people were forced to evacuate, and there was extensive damage to homes, schools, temples, and infrastructure. The clashes ended on December 27, 2025 when both sides signed a joint statement through the General Border Committee (GBC), agreeing to an immediate ceasefire under international pressure. The fighting impacted civilian lives, trade, tourism, and bilateral relations. Although the ceasefire has held up to the time of this writing, tensions remain and could flare up again without permanent negotiations to address the root causes. This article summarizes and discusses the issues that arose, the effects on border communities, measures to mitigate impacts on civilians, and preparations for potential future outbreaks of violence.



Medical workers visited Sa Kaeo and provided care for displaced persons and vulnerable people.

Summary of the Cambodian-Thai Conflict in 2025

The Thai-Cambodian border clashes in 2025 stemmed from overlapping disputed areas (such as Chong Bok, Hill 481, Ta Muean Thom Temple, and Preah Vihear). There were two main rounds of fighting: The first in July (the most intense), and the second in December (following the dissolution of Thailand's parliament). The clashes resulted in dozens of deaths among soldiers and civilians, as well as hundreds of thousands of displaced and evacuated people. Key events in the timeline include:



Source: <https://thestandard.co/border-clash-thai-cambodia-650m-trench/>

May 28, 2025: The first clash occurred at Chong Bok, Ubon Ratchathani Province, when Cambodian troops dug trenches in a disputed area. The incident ended quickly with no injuries. The Joint Boundary Commission (JBC) convened on June 14–15 in Cambodia, but no joint statement was issued.



Source: กรมประชาสัมพันธ์

July 16–23, 2025: Thai soldiers were injured by landmines at Hill 481 and Chong An Ma. One soldier lost a leg, and several others were injured. Thailand closed four border checkpoints and some ancient temple sites.



Source: Youtube เกิดเหตุปะทะชายแดนไทย-กัมพูชา วันที่ 24 กรกฎาคม 2568 #NBTZHD

July 24–28, 2025: Full-scale clashes broke out across multiple locations (Ubon Ratchathani, Si Sa Ket, Surin), involving artillery and BM-21 rockets. Thailand issued evacuation warnings for civilians within a 20–40 km radius. On July 28, negotiations in Putrajaya, Malaysia, resulted in an unconditional ceasefire agreement (effective at midnight), comprising 13 provisions, including troop withdrawals and a GBC meeting.



Source: <https://themomentum.co/report-thailand-cambodia-joint-declaration-of-relationships-an-summit-2025/>

October 26, 2025: A peace declaration was signed in Kuala Lumpur by Anutin Charnvirakul and Hun Manet, with U.S. President Donald Trump and Malaysian Prime Minister Anwar Ibrahim as witnesses. The declaration included four main points: (1) Withdrawal of heavy weapons, (2) Demining, (3) Suppression of scam operations, and (4) Joint management of overlapping areas.



Source: กองทัพอากาศที่ 2

December 7–27, 2025: A new round of clashes began at Phu Pha Lek–Phlan Hin Paet Kon in Si Sa Ket Province and spread to Ubon Ratchathani, Buriram, and Surin. Cambodia deployed suicide drones and BM-21 rockets, while Thailand conducted retaliatory airstrikes using F-16 aircraft and seized certain areas (e.g., Chong Khana and Chong Rayi). Large numbers of civilians were evacuated. On December 22, ASEAN held discussions but failed to achieve a ceasefire. Finally, on December 27, negotiations through the GBC in Chanthaburi led to an immediate ceasefire (effective at 12:00 hrs.). Thailand released 18 Cambodian prisoners after 72 hours of monitoring, and allowed civilians to resume normal cross-border livelihoods.



Source: www.thansettakij.com/politics/647659

Negotiations to resolve the conflict took place four times. The first agreement was reached on July 28, 2025 under the Pheu Thai-led government following talks in Malaysia with participation from ASEAN, the United States, and China. The second, on August 6, 2025, produced a 13-point agreement from a GBC meeting. The third was a peace agreement reached during the ASEAN Summit in Malaysia. The most recent was the ceasefire agreement on December 27, 2025.¹

Border Conflict and Its Impact on Civilians



Safety of life and property The clashes resulted in significant casualties among both soldiers and civilians. In the first round of fighting, eight Thai soldiers were killed and 103 were injured. In the second round, 15–26 soldiers and security personnel were killed, and 120–270 were injured. Additionally, 42–44 Thai civilians died, both directly and indirectly (according to summaries by the Royal Thai Army and the Ministry of Defense as of December 23, 2025), with many others injured. According to the Khmer Times, the prolonged clashes in December led to 30 Cambodian civilian deaths and displaced more than 600,000 people.² In Thailand, as many as 258,000 people from seven provinces were displaced by mid-December.³ The damage extended to homes, schools, temples, and infrastructure. In addition, there were instances of clandestine landmine placement and unexploded ordnance, creating long-term risks.



Impact on living of people As of July 29, 2025, during the first round of clashes, a total of 188,734 people were displaced by the border unrest. In the second round, this number increased to 258,000. They were accommodated in more than 900 temporary shelters across seven provinces (Si Sa Ket, Surin, Buriram, Ubon Ratchathani, Sa Kaeo, Trat, and Chanthaburi). Among them were over 46,000 vulnerable individuals requiring special care, including the elderly, children, persons with disabilities, patients with chronic illnesses (such as those requiring dialysis or with heart conditions), and pregnant women.⁴

Conditions in the temporary shelters were overcrowded. Patients with chronic illnesses lacked continuity of care, increasing the risk of death (such as those requiring dialysis or with heart conditions). The local healthcare system was under heavy strain, with many hospitals closed or operating with limited services. There were also increased risks of infectious diseases, mental health issues, and sanitation problems.⁵ Even after the ceasefire, although the number of displaced people decreased, tens of thousands still remained in temporary shelters.



Impact on education UNICEF Thailand reported that tens of thousands of children had to stop attending school in order to evacuate to shelters. Children and youth faced fear, stress, and anxiety. The prolonged clashes disrupted learning, increasing the risk of students dropping out of the education system. Numerous studies have found that school closures and compensatory online learning are less than half as effective compared to classroom learning. Thailand has experienced learning loss among early childhood groups in language, mathematics, and cognitive development since the COVID-19 pandemic, affecting children's skills such as counting and reading.⁶



Impact on the mental health of people in the vicinity The Thai Department of Mental Health, which conducted field visits, found that most people were stressed due to the uncertainty of the situation. The Ministry of Public Health reported that it had screened the mental health of more than 150,000 people in shelters, identifying over 1,300 individuals with accumulated high stress levels, and 169 at risk of self-harm.⁷ The most concerning group is frontline soldiers, as research confirms that those who have experienced combat develop accumulated stress.⁸



Economic system and livelihoods of people The closure of border checkpoints or restrictions on cross-border movement affected border trade and the incomes of people who depend on cross-border commerce. Border tourism declined, impacting local businesses. The Krungthai COMPASS Research Center estimated damages of no less than 17 billion baht per month. Border trade alone may have lost more than 14.011 billion baht per month (with exports decreasing by about 11.41 billion baht and imports decreasing by about 2.601 billion baht).⁹



Exodus of Cambodian laborers from Thailand The closure of border checkpoints, along with campaigns by Cambodian leaders urging their nationals to return home, led to more than 600,000 working age Cambodians in Thailand returning to their country (approximately 300,000 registered workers and another 300,000 undocumented workers).¹⁰ Cambodian authorities reported that as many as 940,000 workers returned to the country.¹¹ This migration severely impacted Thailand's labor market, which was already facing shortages, particularly in the construction, agriculture, and food production sectors.¹²



Social conflict The Thai-Cambodian conflict fueled a surge of **nationalism**, leading to physical assaults on Cambodian workers in Thailand and attacks on Thai people in Cambodia. Thai society itself became clearly divided into two groups: Those who supported the war and those who opposed it. Disputes between these groups escalated intensely on social media, even leading to threats of violence, as seen in cases involving Angkhana Neelapajit, a senator and human rights activist, and Kan Jom Palang.¹³ As a result, Ms. Angkhana and other human rights defenders were attacked, harassed, and subjected to death threats online.

Mary Lawlor, the United Nations Special Rapporteur on the situation of human rights defenders, issued a statement via X (Twitter), Facebook, and Bluesky, saying: “*I am extremely concerned about reports of death threats and online attacks against Angkhana Neelapajit. Defending truth, justice, and human dignity is not a crime. She should be protected, not condemned.*” She also called on the Thai government to ensure Ms. Angkhana’s protection.¹⁴

Thailand and Management of its International Borders

The Thai government implemented various measures to mitigate the impacts of the border conflict, as follows:

- 1 Management of displaced persons and evacuation** The Thai government, through the Royal Thai Army and the Ministry of Interior, established temporary shelters and civilian assembly areas in border provinces. Civilians were rapidly evacuated from high-risk areas, and schools in safe zones were used as temporary shelters. Multiple agencies were integrated into the response, including the Volunteer Defense Corps, village security units, and local administrative organizations.¹⁵
- 2 Safety and security** The focus of security measures was on protecting civilian lives and reducing risk from weapons and landmines. The 2nd Army Area and relevant agencies established strict checkpoints and closely monitored the border. Early warning systems and preemptive evacuations were also implemented. In addition, coordination with public health agencies was carried out to provide healthcare in shelters, especially in areas hosting large numbers of displaced people.¹⁶

3 *Education and schooling* The Thai government used schools in safe areas as temporary shelters, with some continuing to provide basic learning activities to prevent education from being disrupted. The Ministry of Education and local agencies coordinated to provide volunteer teachers and learning materials. In some cases, temporary classrooms were set up in evacuation centers to maintain educational continuity. However, the main challenges were shortages of teachers and learning resources in emergency situations.¹⁷

4 *Livelihoods and income* Most people in border areas rely on agriculture, cross-border trade, and migrant labor. The fighting led to abandoned farmland and disrupted trade, resulting in significant income losses. The Thai government implemented initial relief measures, such as distributing essential goods and providing emergency financial assistance. However, in the most recent situation, the focus has been more on immediate relief rather than long-term recovery.¹⁸

5 *Relief and compensation* In 2025, the Cabinet approved a central budget of over 2,444 million baht for the Royal Thai Army and relevant agencies to support evacuations, the management of shelters, and assistance for affected individuals. The Ministry of Interior and local agencies were responsible for distributing aid such as food, drinking water, and medicine, with a focus on vulnerable groups including the elderly, children, and persons with disabilities.¹⁹

Compensation rates are as follows: Government personnel (including soldiers, paramilitary rangers, police, and border patrol police) who were killed or permanently disabled received ten million baht per person, while those seriously injured received one million baht per person. For civilians who were killed or permanently disabled, they received eight million baht per person. Those seriously injured received 800,000 baht per person, while those moderately injured received 400,000 baht per person.²⁰

These measures reflect the Thai government’s approach of prioritizing civilian protection through coordinated military and civilian mechanisms. However, challenges remain, such as long-term economic recovery and preventing the recurrence of conflict, which will require continued diplomatic negotiations and international cooperation.

“Key issues”

• The Thai-Cambodian border conflict highlights the fragility of peace at both bilateral and regional levels. Although multiple ceasefire agreements have been signed and some troop withdrawals has taken place, the overall situation remains fragile and carries the risk of renewed escalation at any time. War never has true winners—the people who suffer the most loss and pain are civilians on both sides.

• In the long-term, resolving this issue requires a genuine commitment to peaceful approaches and diplomacy, with ASEAN serving as the primary platform for negotiations and the development of mechanisms to prevent renewed conflict. This must go hand in hand with continuous improvements in the quality of life for border populations, including in economic development, education, public health, and social security. If both countries are willing to set aside short-term interests and work together constructively through bilateral and regional frameworks, this conflict can become a valuable lesson, and ultimately be resolved.





Source: สร้างโดย AI ผ่าน GoBanana Pro จาก Adobe Firefly

Equal Marriage: Social Acceptance of Sexual Diversity

The struggle for the right to build families for the LGBTQAN+ community in Thailand did not happen overnight, but is the result of over 20 years of civil society advocacy, aimed at communicating to society that love should not be limited by gender identity.

Introduction

January 23, 2025, marks the official enforcement of the Marriage Equality Act, or the Civil and Commercial Code Amendment Act (No. 24) B.E. 2567, granting the right for individuals of any gender identity to register their marriage equally under the law. The law recognizes and grants the right to marry for couples of all genders, not limited to male-female couples only. It affirms gender diversity and various forms of love, which are fundamental human rights. The Marriage Equality Act has led to revisions in related regulations, such as the Ministry of Interior’s family registration rules, changing terms from “male-female” to “individual” and from “husband-wife” to “spouses.”

The law establishes that any individuals, regardless of gender, may register their marriage according to their wishes.¹ Thailand is the first country in ASEAN to enact an equal marriage law and the third in Asia to do so, following Taiwan and Nepal. The Marriage Equality Act is closely linked to the development and formation of the rights of sexual and gender minority groups (LGBTQAN+). Historically, LGBTQAN+ individuals have long been marginalized, but with advocacy and efforts to secure marriage rights, the enactment of the Marriage Equality Act has advanced the rights of LGBTQAN+ people, particularly in health and social welfare, ensuring equality on par with men and women. Therefore, this law is considered a significant milestone that marks the beginning of broader societal recognition of LGBTQAN+ rights.

This article discusses rights and gender equality in Thai society, highlighting the key points, strengths, weaknesses, and various impacts of the Marriage Equality Act, and provides recommendations for future actions.

Law and the Struggle for LGBTQAN+ Rights

Understanding “equal marriage” requires examining the historical context, status, and relationships of individuals through religious literature, historical texts, and old laws, which form the foundation for social organization and guide planning and anticipation of future developments. Thai history does not explicitly mention equal marriage, but there is evidence of same-sex relationships. Under the “Three Seals Code,” effeminate men (katoey) and bandoh were legally barred from serving as witnesses.² The Royal Family Law prohibited high-ranking women from engaging in same-sex behavior.³ In the game of politics and power struggles, same-sex relationships were sometimes used as grounds for accusation, punishment, or defamation. For example, Krom Luang Rak Ronnaret (Mom Kraisor), a royal son of King Rama I who held immense power during the reign of King Rama III, was executed by being crushed with a sandalwood log after being accused of multiple offenses. These included “**embezzlement of public funds**,” accepting bribes in overseeing the courts and religious affairs, “**engaging in same-sex behavior**” by lavishly spending tax money on male performers, as well as “**displaying ambition**” and “**conspiring to amass power**.”⁴

The modern state is what caused LGBTQAN+ to disappear from societal recognition. When the bureaucratic system was reformed to transform Siam into a modern state, Western ideas—especially Victorian sexual norms—were introduced. These emphasized monogamy and a binary view of gender, which greatly influenced the development of Thai policies, society, and law. As a result, the modern state recognized only male and female genders, forcing LGBTQAN+ populations to disappear from state awareness and live hidden within society.

In more recent history, the struggle for same-sex marriage rights began when records show that on Wednesday, May 2, 1928, a marriage took place between Mrs. Choi and Miss Thom. Newspapers of the time covered the event in several editions, mostly using headlines like “Gender-Swapping Wedding” or referring to it as a “Bridegroom in Disguise.”⁵

The struggle for the right to build families for the LGBTQAN+ community in Thailand did not happen overnight. It is the result of over 20 years of civil society advocacy, beginning with grassroots movements and the establishment of sexual diversity rights organizations in the 1997, which sought to communicate to society that love should not be limited by gender identity.⁶

Later, in September 2011, the National Human Rights Commission and non-governmental organizations proposed a draft law on same-sex marriage and sought government support for it. Then, in September 2013, Mr. Natee Teerarojanapong, chairman of the Gay Political Group of Thailand, attempted to register his marriage with his male partner but was denied by officials. Later, between June 2020 and 2022, the Move Forward Party proposed a same-sex marriage bill, but it did not pass parliamentary consideration.

A critical turning point occurred in 2021, when a same-sex couple submitted a petition to the Constitutional Court requesting a ruling on whether Article 1448 of the Civil and Commercial Code violated the constitutional principle of equality (Article 1448 sets the legal conditions regarding the “age” and “gender” of persons eligible to marry under Thai law). Although the court ruled that the existing law did not violate the constitution, the case sparked political and social awareness that the law was “outdated” and inconsistent with modern global dynamics, creating pressure to draft the Marriage Equality Act to replace the earlier concept of the “Civil Partnership Bill,”⁷ which was criticized for creating unequal rights compared to male-female couples.⁸

After the general election in 2023, the issue of equal marriage became an urgent agenda item, receiving unanimous support from both the ruling and opposition parties. The Cabinet under Prime Minister Srettha Thavisin approved the principles of a same-sex marriage bill, and on March 27, 2024, the House of Representatives overwhelmingly passed the Civil and Commercial Code Amendment Act. This was followed by approval from the Senate on June 18, 2024.

The key feature of this law is the legal redefinition from “male and female” to “two individuals” and the change of pronouns from “husband and wife” to “spouses” [the Civil and Commercial Code Amendment Act (No. 24), 2024]. This change granted same-sex couples full rights in all aspects, including marital property management, joint adoption, inheritance as legal heirs, consent for medical treatment, and state-provided spousal benefits.

On May 19, 2025, His Majesty the King and Her Majesty the Queen officiated the first royal-sanctioned marriage for an equal marriage couple in Thailand, marking a historic milestone that reflects openness and diversity in love.

Thailand is the third country in Asia to enact an equal marriage law, following Taiwan and Nepal. In Taiwan, the equal marriage law was implemented following a ruling by the Constitutional Court, clearly stipulating the legal rights and duties of spouses.⁹ In Nepal, however, the situation is different. The country’s equal marriage framework stems from an interpretation of a Supreme Court ruling, which has resulted in certain limitations and ambiguities regarding some spousal rights.^{10,11} Thailand and Taiwan are similar in that their equal marriage laws are enacted at the level of statutory law, clearly defining the rights and duties of spouses.

Analysis of the Marriage Equality Law

The Marriage Equality Act, or the Civil and Commercial Code Amendment Act (No. 24) B.E. 2567 (2024),¹² is intended to amend the family provisions (Book 5) of the Civil and Commercial Code. This new law recognizes marriage between two individuals without specifying any gender, using the wording: “*A marriage may take place only when both persons have reached 18 years of age.*” It also revises the principles of engagement, marriage, the rights and duties of spouses, property management, and the status of children and adopted children, which previously applied to “a man and a woman,” to instead refer to “both individuals.” This is to ensure that persons of any gender can marry and receive equal legal rights.

In addition, the new law helps address issues concerning spousal rights in other legislation. In Thailand, many laws related to marital rights use terms such as male, female, husband, and wife. The new law stipulates that any legal provisions—laws, regulations, rules, notifications, orders, or cabinet resolutions—that refer to husband, wife, or husband and wife shall be interpreted as referring to spouses registered under this law, except in cases specifically tied to biological sex (such as maternity leave). Furthermore, the law requires all state agencies to review and revise the laws under their responsibility to ensure consistency with the rights and duties established under the new legislation.

The strengths of the Marriage Equality Act lie in the legal rights and duties under family law, including rights to jointly manage property acquired during the marriage, to manage a spouse’s property, parental rights, and inheritance. In terms of health, the law grants spouses the right to care for one another, including the ability to give consent for medical treatment on each other’s behalf. This is particularly important for LGBTQAN+ couples who have lived together for a long time without maintaining contact with their “direct or blood relatives.” When illness occurs and a patient is unable to communicate, healthcare personnel often seek decisions from blood relatives and may refuse to recognize the patient’s partner as a decision-maker. Such situations significantly affect the quality of care, as relatives may not know the patient’s wishes, while the partner—who understands them best—is excluded from decision-making, ultimately impacting the patient’s quality of life.

However, if LGBTQAN+ partners do not wish to register their marriage, there are still ways to ensure care in advance. For example, both partners can prepare a “living will”¹³ by designating one partner as the decision-maker for medical care at the end of life in place of blood relatives.

A weakness of the Marriage Equality Act is that rights are granted only upon official marriage registration; without registration, individuals do not receive the legal rights provided under the law. Therefore, there is a need for public awareness campaigns to inform LGBTQAN+ couples about their legal rights, as well as to develop mechanisms for providing legal assistance to those who are unable to marry.

Another weakness in advancing the Marriage Equality Act and the development of LGBTQAN+ rights is bureaucratic delay. Although the law requires all state agencies to revise legislation under their responsibility to align with equal marriage, the slow pace of the bureaucracy has hindered timely legal reform. **A clear example is that equal marriage couples are still unable to have children through assisted reproductive technologies under existing law,** which currently allows only legally married male-female couples to access such services. The Department of Health Service Support, which oversees this law, is in the process of proposing amendments to make it consistent with the Marriage Equality Act.^{14, 15}

The Challenge Going Forward

Although the Marriage Equality Act has come into force, there has still been ongoing opposition from certain political parties and religious groups who believe that a marriage by a same-sex couple should not be legally recognized in Thailand. However, over time, the voices of opposition have gradually diminished. More importantly, the law has sparked greater awareness regarding the provision of state welfare for LGBTQAN+ individuals. This has led to forums, discussions, and public debates on the rights of sexual and gender minorities, including access to healthcare and various forms of state welfare. The scope of these discussions has expanded to emphasize that LGBTQAN+ individuals should be granted legal rights appropriate to their gender identity, no different from those of men or women. At present, the development of rights for LGBTQAN+ partners has progressed to the point of supporting even single individuals who wish to have children¹⁶ or to change name titles for LGBTQAN+ individuals to better reflect their gender identity.¹⁷



Source: www.freepik.com

At present, access to healthcare services for LGBTQAN+ individuals across the three major health insurance schemes remains unequal. The National Health Security Scheme is more progressive than the Social Security Fund and the Civil Servants Medical Benefits Scheme. Under the **National Health Security Scheme**, six types of gender-affirming hormone therapies—both oral and injectable—are covered.¹⁸ Individuals seeking hormone therapy must undergo assessment by a psychologist and a physician. Gender-affirming surgery is also available if the patient is diagnosed with a medical indication of “Gender Dysphoria, meaning a mismatch between gender identity and assigned sex that adversely affects their health.”¹⁹ In addition, preventive and health promotion services include free screening for HIV and sexually transmitted infection (STI), as well as access to pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).

The Social Security Fund, however, does not cover gender-affirming hormone therapy, except when hormones are prescribed for medical treatment based on necessity. Gender-affirming surgery is also not covered, as it is classified as cosmetic surgery.²⁰ However, equal marriage couples are entitled to Social Security benefits, including child support allowances, childbirth expenses, and joint pension rights.

For the **Civil Servants Medical Benefits Scheme**, hormone therapy can be reimbursed if it meets medical indications and the criteria set by the Comptroller General’s Department. There is no specific benefits package for LGBTQAN+ individuals, nor are there provisions allowing civil servant patients who are LGBTQAN+ to undergo gender-affirming surgery, except in cases of congenital genital abnormalities or clear medical indications. However, civil servants who are LGBTQAN+ can immediately include their same-sex spouse under the “direct billing” system.

“Filling the Gap

The Marriage Equality Act is the result of the development and long-standing struggle for LGBTQAN+ rights in Thai society. It represents the first key step in opening opportunities to further advance the rights of these populations. Moving forward, efforts should focus on raising awareness and encouraging LGBTQAN+ couples to register their marriages so they can access these rights. Additionally, state agencies must be urged to revise laws and regulations to align with the Marriage Equality Act, alongside continued efforts to promote values and perspectives on equality for sexual and gender diversity, ensuring they are treated on par with men and women—particularly in areas such as access to healthcare services.



Source: www.freepik.com



Source: <https://prachatai.com/journal/2025/07/113815>

From “Welfare” to the Protection and Promotion of the Livelihoods and Rights of Ethnic Groups

The rights of ethnic groups are not merely cultural issues; they are structural issues linked to law, state policy, and the management of national resources. The Act on the Protection and Promotion of the Way of Life of Ethnic Groups reflects the Thai state’s effort to shift its framework for managing diversity from an assimilationist approach toward one that places greater emphasis on the rights and dignity of ethnic groups.

Introduction

On February 5, 2025, the House of Representatives approved the Draft Act on the Protection and Promotion of the Way of Life of Ethnic Groups (B.E. ...) in its third reading, with 312 votes in favor, 84 against, and 2 abstentions. This law aims to protect rights and promote the ways of life of various ethnic groups in Thailand, with an emphasis on preserving the identity, cultures, traditions, and languages of each group.

The main objectives of this law are to recognize and protect the rights of ethnic groups in accordance with the Constitution and international human rights principles, to address the challenges they face—such as land issues, access to public services, and discrimination—as well as to promote the country’s cultural diversity and foster a peaceful, inclusive society.

However, the law faces challenges regarding the designation of protected areas for ethnic ways of life, as this involves natural resource management and land rights, which may conflict with the interests of certain groups or organizations. Some civil society groups have expressed concerns that these protected areas must still comply with other laws, such as the Forest Act, the Wildlife Preservation and Protection Act, and the National Parks Act. Meanwhile, some political groups have opposed the law on the grounds that it could affect national security.

This article discusses the rights of ethnic groups within legal and cultural frameworks, analyzes the key provisions of the law, examines the development of Thailand’s ethnic policies, and explores the challenges and opportunities that this legislation presents for ethnic groups in Thailand.

Rights of Ethnic Groups in Thai Society

Over the past several decades, “ethnic group rights” have been a key issue in academic debates and public policy discussions in Thailand as a multicultural society. Although cultural diversity has not been fully recognized or comprehensively protected across all sectors, it has instead been situated within a nation-state framework that primarily emphasizes territorial integrity.

The term “rights,” in legal and human rights contexts, refers to the fundamental powers or freedoms that individuals or groups are entitled to, and which should be protected by the state under the law. In the context of ethnic groups, rights are not limited to civil or political rights, but also include cultural rights, community rights, and the right to self-determination and identity. These rights reflect the deep relationships between people and their land, resources, systems of production, and knowledge passed down through generations.

Conceptually, ethnic group rights can be understood across the following three main dimensions:¹

- 1 | **Recognition**, which refers to being acknowledged as part of society without being marginalized
- 2 | **Protection**, which involves preventing rights violations, exclusion, or discrimination
- 3 | **Promotion**, which enables ethnic groups to sustainably develop and preserve their ways of life, culture, and knowledge systems. Within this framework, ethnic group rights are not merely cultural issues, but structural ones connected to law, state policy, and national resource management.

The drafting of the Act on the Protection and Promotion of the Way of Life of Ethnic Groups, B.E. 2568² reflects the Thai state’s effort to shift its framework for managing diversity from an assimilationist approach³ toward an approach that places greater importance on the rights and dignity of ethnic groups. This law did not emerge in isolation or easily, but is the result of policy development, civil society movements, and the continuing influence of international human rights trends on Thai society.

His Majesty King Bhumibol Adulyadej visited hill tribes.



Source: <https://lek-prapai.org/home/view.php?id=5254>

Information from the website of the Social Development Center Unit 83 in Mae Hong Son Province describes *the development of policies for the support and welfare of hill tribes, which may be considered the starting point of the process of developing ethnic groups*. This began in 1957, when the state defined the problems of hill tribes or various ethnic groups living in mountainous and/or remote border areas as including poverty, poor health, lack of full Thai citizenship status, and, in some cases, livelihoods that posed risks to natural resource conservation.⁴ To address these issues, the government established the Hill Tribe Welfare Division and set up Hill Tribe Development and Welfare Centers in 1963. The term “welfare” implied that hill tribes or various ethnic groups were in a disadvantaged position compared to the majority population in the country.

In parallel with government efforts, **His Majesty King Bhumibol Adulyadej the Great** visited hill tribe communities in various areas, and initiated a Royal Project. As stated in his royal speech on January 10, 1974, during his visit to the Faculty of Agriculture at Chiang Mai University: “Help the hill tribes, help our people, help the world.” To obtain more accurate data on hill tribe populations, His Majesty also devised the creation of commemorative hill tribe medals.⁵ These medals were bestowed upon hill tribe people living in Thailand. They later became an important foundation for civil registration and reflected an effort to integrate hill tribes into Thai society.

A key policy on hill tribe development and welfare introduced in 1976 was the “Integration Policy,” which aimed to enable hill tribes, as Thai citizens, to live peacefully alongside the broader Thai population. In academic circles, numerous works have been written about hill tribes and ethnic groups, such as *Thirty Ethnic Groups in Chiang Rai* by Boonchuay Srisawat.⁶ That book proposed a form of “cultural nationalism,” viewing various ethnic groups as kin of the Thai people who remained in remote areas. Therefore, it called for the urgent study and documentation of these groups as part of the nation’s cultural heritage, and recommended that the state introduce modernization-oriented development to replace beliefs in spirits and superstition, in order to “elevate” ethnic groups to a more civilized status and fully integrate them into the Thai state.

During this period, there was also works on community rights and new approaches to ethnic studies that expanded beyond traditional ethnography and anthropology. These works examined unequal power relations and sought ways to transform such structures, as seen in the research of Chaweewan Prachuabmoh on ethnic studies,⁷ or Pinkaew Laungaramsri, editor of the book series *Identity, Ethnicity, and Marginality* published by the Princess Maha Chakri Sirindhorn Anthropology Centre.

The people-centered development trend during the 8th National Economic and Social Development Plan, which emphasized local wisdom, led to a significant body of research on ethnic groups, such as the works of Yos Santasombat et al⁸ on ethnic ecology, and the research of Rattanaporn Settakul on the community rights of hill tribes in northern Thailand, which helped generate momentum around hill tribe community rights. This was further supported by academic works that challenged mainstream state-led development approaches, such as those by Niti Pawakapan⁹ which argues that state-led development is often used as a tool to control and regulate ethnic groups by transforming diverse identities into the “other.” In addition, the work of Chairat Charoen-sinolan¹⁰ emphasized participatory development, followed by the local research led by the Thailand Research Fund. Together, these formed a social ecosystem that later helped promote the development of ethnic group rights.

Another milestone in the development of ethnic groups occurred on September 18, 2025, with the enactment of the Act on the Protection and Promotion of the Way of Life of Ethnic Groups, B.E. 2568, which states:

“Ethnic groups possess their own identities and accumulated cultural heritage, with historical and cultural continuity connected to Thai society. It is therefore necessary to establish legal provisions to protect the rights of ethnic groups so that they may live with human dignity, have the right to live in society equally, and maintain their traditional ways of life voluntarily and peacefully, insofar as these do not conflict with public order, good morals, national security, or public health.”



Source: Facebook เพจ ชาติพันธุ์ประชาชน

Key Provisions of the Act on the Protection and Promotion of the Way of Life of Ethnic Groups

The law aims to formally recognize the rights of ethnic groups to live according to their own ways of life, cultures, and wisdoms. It assigns the state a role in protecting, promoting, and refraining from any actions that would undermine these cultural foundations.

The key provisions of the law are divided into five sections:

Section 1: General Provisions Defines “ethnic groups” as groups with their own distinct languages, ways of life, and cultures, based on principles of self-identification and mutual recognition. It affirms the principles of human rights, participation, and cultural diversity.

Section 2: Rights of Ethnic Groups Recognizes the rights to maintain ways of life, beliefs, languages, resources, traditional knowledge, and community self-governance. This includes rights related to agricultural systems, food, traditional medicine, and mother-tongue education.

Section 3: National Ethnic Committee Establishes a committee composed of representatives from ethnic groups, government agencies, and qualified experts to jointly formulate policies, promote rights, and monitor state implementation.

Section 4: State Promotion and Support Requires the state to allocate budgets, land, and various measures to support the preservation of ethnic ways of life and to foster broader cultural understanding in society.

Section 5: Transitional Provisions Sets timelines for establishing relevant mechanisms, allows communities to register as ethnic organizations, and requires state agencies to review laws that conflict with the intent of this Act.

When considering the Act on the Protection and Promotion of the Way of Life of Ethnic Groups as a policy and legal instrument, it becomes evident that the law holds both the potential for structural transformation and limitations that may affect its practical implementation. Analyzing its strengths, weaknesses, and challenges is therefore essential to understanding the extent to which it can generate meaningful outcomes in terms of rights and culture within the Thai social context.

Strengths of the Act

- **Elevating ethnic group rights from policy to statutory law:** This law formally recognizes cultural rights, community rights, and the right to maintain the ways of life. In the past, ethnic group rights were often framed in ideological or policy terms without clear enforcement mechanisms.
- **Creating space for participation in decision-making structures:** The Act enables ethnic groups to participate through the establishment of committees and councils for the protection and promotion of ethnic ways of life. These bodies include representatives of ethnic groups who are involved in policymaking, monitoring, and proposing solutions.
- **Recognizing traditional ways of life and wisdom as valuable systems:** Particularly in areas such as natural resource management, production systems, and balanced livelihoods, this approach challenges conventional development paradigms that have viewed ethnic ways of life as backward. It opens opportunities for local cultures to serve as foundations for more sustainable development.

Weaknesses and Limitations of the Act

- **Ambiguity in definitions and scope of application:** Key terms such as “ethnic groups” and “traditional ways of life” may be interpreted differently in practice. This ambiguity could lead to inconsistent recognition and enforcement across regions and may create new forms of inequality.
- **Overlapping legal frameworks:** The Act must operate alongside existing laws on forests, land, and natural resources, which are often based on centralized control. Although this law creates space for community-based resource management, without harmonizing related legislation, the rights recognized in principle may not be effectively realized in practice.
- **Capacity of enforcement mechanisms:** Effective implementation depends on resources such as budget, personnel, knowledge of ethnic issues, and the attitudes of state officials. Without strong institutional capacity, the law risks becoming symbolic rather than producing genuine structural change.

Challenges of the Act

The most significant challenge lies in balancing cultural rights with modern economic and development structures. While traditional practices—such as rotational farming or subsistence economies—are recognized as rights, they often generate limited income within a market economy, potentially leaving ethnic groups economically vulnerable. Another key challenge concerns the power to define identity. Although the law seeks to protect diversity, state-led processes of recognition may “fix” ethnic identities within state-approved frameworks, rather than allowing communities the flexibility to negotiate and adapt their identities dynamically.

Challenges ahead

The Act on the Protection and Promotion of the Way of Life of Ethnic Groups has significant potential to transform the framework through which the Thai state manages diversity. It represents an important milestone in long-standing efforts to protect and promote the ways of life and rights of ethnic groups. However, the success of the law does not depend solely on its provisions; it also hinges on interpretation, implementation, and the ability to balance rights, culture, and economic structures. This raises a crucial question: how can ethnic groups effectively use this law to benefit their own cultures?

If we view ethnic group rights as part of “cultural well-being”—which encompasses dignity, security, and the freedom to choose one’s way of life—achieving this goal requires more than legal measures alone. It calls for supportive policies that are aligned with real-world contexts and that create space for ethnic groups to actively participate in shaping their own futures, grounded in fairness and respect for diversity. One possible approach is the development of community cultural plans, which can serve as a foundation for collaborative creation with various partners across society.



Source: www.freepik.com



4 Outstanding Accomplishments for Health



Thailand Produces Imcranib 100: A Major Step Forward in Targeted Cancer Therapy



Source: <https://www.hfocus.org/content/2025/07/34612>

Cancer is one of the leading causes of death among the Thai population. Data from hospital-based cancer registries indicate that the detection rate of new cases has been steadily increasing.¹ In the past, the main treatment for cancer was chemotherapy, which affects both cancerous and healthy cells, causing patients to endure severe side effects. However, advances in molecular biology have led to the development of “targeted therapies” that act specifically on proteins or genes controlling cancer cell growth. These drugs significantly improve both survival rates and patients’ quality of life. Yet, due to the high cost of imported drugs, many patients could not access these treatments. Thailand’s ability to produce “Imcranib” domestically represents a pivotal shift in reducing medical inequality. Imcranib 100 is a Tyrosine Kinase Inhibitor (TKI) used to treat critical conditions such as chronic myeloid leukemia (CML) and gastrointestinal stromal tumors (GIST), showing efficacy in patients who cannot undergo surgery.

The success of Imcranib 100 mg (Imatinib Mesylate) stems from integrating research with industry. Professor Dr. Her Royal Highness Princess Chulabhorn Krom Phra Srisavangavadhana, played a vital role as a “royal scientist,” laying the foundation through the Chulabhorn Research

Institute to support oncology research. Her mission was to ensure cancer patients at all levels could access high-quality medications at affordable prices.² This has led to the translation of research into commercial production for the benefit of the Thai population. In 2025, Thailand entered the second phase of its cancer drug production project, expanding manufacturing capacity to meet the rapidly increasing demand as follows:

- 1 Inclusion in the essential medicines list:** By early 2025, Imcranib was fully incorporated into the government’s centralized procurement system, allowing healthcare facilities nationwide to purchase the drug at a cost reduced by over 20% compared to the previous year.³
- 2 Enhanced medical security:** In 2025, Thailand was able to self-produce up to 80% of the domestic demand for Imcranib, reducing the risk of shortages due to global supply constraints.
- 3 Health Tender Offer Project:** Beyond the drug itself, collaboration with the private sector established a modern distribution system to ensure rapid delivery of the medication to patients in remote areas.

The production of Imcranib 100 brings multiple benefits to the public health system, including reducing budgetary burdens—allowing funds to support treatment of other rare diseases—and improving patients’ quality of life, as they can access continuous treatment at nearby healthcare facilities without worrying about costs.

Looking ahead, Thailand plans to further advance targeted drug production by developing biopharmaceuticals for more complex immunotherapy treatments.⁴ Thailand also aims to become an exporter of high-quality cancer drugs to the CLMV countries by 2027. In addition, it plans to develop personalized medicine by integrating genetic data with drug administration to maximize the effectiveness of individualized treatment.

Siriraj Produces Titanium Hip Sockets Using 3D Printing Innovation

Hip osteoarthritis or avascular necrosis is a significant public health issue that greatly affects patients' quality of life. While standard total hip replacement surgery is highly effective, patients with severe bone loss or congenital abnormal bone structures often cannot achieve stable fixation with conventional hip implants.¹ For this reason, the Faculty of Medicine Siriraj Hospital has collaborated with various research agencies, including private companies such as Meticuly and OSS3O, to develop the production of “patient-specific hip implants” or PSI using titanium and 3D printing technology. This approach aims to address the complexities of surgery and enhance treatment effectiveness.² Most recently, in 2025, Siriraj achieved a world first by producing patient-specific titanium hip implants using 3D printing within the hospital (Point-of-Care Manufacturing). The process utilized the Vulcan Box system, and the implants were successfully used in actual surgeries starting early in the year.³

The core innovation lies in the **metal shaping process** called Selective Laser Melting (SLM), which differs from traditional manufacturing methods. It consists of:

Layered metal powder forming – Medical-grade titanium powder is spread onto a printing platform, then a high-powered laser melts the powder, fusing it layer by layer into a solid structure according to the digital model

Creating a “porous” hip socket – Mimicking the natural bone structure, something impossible with conventional casting or machining, which encourages bone cells to grow and integrate seamlessly with the metal

Micrometer-level precision – A computer system controls the thickness of each printed layer, producing a hip socket that perfectly matches the patient's bone contours and irregularities.⁴



Source: Facebookเพจ sirirajpr

From the practical application of this innovation at the Faculty of Medicine Siriraj Hospital, it was found to be highly effective for both revision surgery patients (those who had previously undergone hip replacement) and patients with congenital abnormalities (those with abnormally shallow hip sockets). In cases where the original hip socket had deteriorated to the point that a standard prosthesis could not be used, the medical team employed 3D printing technology to design a hip socket with customized “anchoring” projections precisely where the patient still had bone remaining. The results showed that patients were able to bear weight and walk again within a short period.⁵ For patients with congenital abnormalities, the use of 3D-printed hip sockets reduces the need for extensive bone grafting, which often carries the risk of the transplanted bone resorbing over time.⁶

This innovation offers multiple benefits to patients, including: high precision that reduces issues with poorly fitting implants; faster recovery; a reduction in surgery time by approximately 30-50%; decreased blood loss and lower risk of infection; durability due to titanium's high biocompatibility, which prevents allergic reactions or toxicity; self-reliance by reducing the need to import expensive equipment; and the advancement of precision medicine. Moreover, it can be extended to produce other implants, such as jawbones or cranial bones.⁷

Model Healthy Communities: Scaling Up Toward Sustainable Well-being



Source: Facebookเพจ สุขภาพชุมชน

In the past decade, Thailand has faced a critical health transition, marked by its entry into an aged society and the rising burden of non-communicable diseases (NCDs). The Thai Health Promotion Foundation (ThaiHealth) recognizes that “hospitals” are not the only answer to achieving good health and well-being; rather, “communities” serve as the first line of defense. Scaling up model communities, therefore, is not merely about replicating activities, but about transferring approaches to self-management in order to achieve sustainability at the structural level of society.¹ Through the “Healthy Community” project, which aims to create livable local communities by emphasizing public participation in sustainable health care, the initiative has expanded significantly. In Fiscal Year 2025, the project scaled up extensively, covering more than 3,000 subdistricts nationwide. It uses community spaces as a foundation for developing health-oriented policies, integrating efforts across the public sector, private sector, and civil society.

The “Healthy Community” project promotes a total well-being, balancing physical, mental, economic, Thai Health Report 2026 -134

social, and environmental dimensions. It seeks to build communities capable of managing their own health, empowering them to become “designers of their own future.” The scaling up of model communities is guided by three key concepts:

Tri-Power Strategy² This refers to the integration of three forces—knowledge power (research/knowledge), social power (community mobilization), and policy power (local government/municipal action)—to systematically drive health issues forward³

Social Determinants of Health (SDH), focusing on the conditions that influence health, such as income, education, housing security, and access to safe food⁴

Knowledge Management transforms the experiences of “practitioners” into tangible lessons, enabling other communities to replicate and adapt them without having to start from scratch.

The scaling-up process is driven through a variety of activities designed to fit local contexts, including:

- 1 The development of “community weavers” (Social operators)**, a key activity focused on strengthening the capacity of local leaders to effectively coordinate between government agencies and community members⁵
- 2 Health charters and community rules** involve creating “shared agreements.” For example, in the Northeast, the expansion of the “alcohol-free funerals” initiative has significantly reduced accidents and eased household debt burdens
- 3 Innovative use of community spaces** transforms abandoned areas into “sports grounds” or “community vegetable gardens.” These activities not only promote physical activity but also serve as spaces for intergenerational connection, allowing children and older persons to engage in activities together.⁶

In 2025, ThaiHealth organized the forum “Synergizing Power, Creating Innovation toward Sustainable Community Well-being 2025” from July 3-5, 2025, at IMPACT Muang Thong Thani. The event brought together more than 3,000 participants from livable community networks across 3,658 subdistricts nationwide to exchange knowledge and jointly declare commitments on 12 priority issues and 34 targets aimed at driving a grassroots-based well-being system.⁷ For example, initiatives include NCD prevention, disease surveillance, promotion of physical activity, and healthy diets; the development of “community master plans” using local technologies such as community health tracking apps; the creation of intergenerational learning centers; and the promotion of a circular economy linked to health. They also support community-led health management plans, such as reducing salt and sugar consumption, encouraging annual health check-ups, and organizing community exercise activities. In addition, in 2025 there has been the scaling up of model initiatives such as the “Nakhon Phanom Model,” which uses village health volunteers as the primary mechanism to manage and potentially reverse diabetes, through the integration of community efforts and primary health care services.⁸

4

Thailand Bans Plastic Waste Imports in 2025: Toward Environmental Sustainability and the Well-being of the Thai People



Source: www.freepik.com

Over the past decade, plastic waste has become a global crisis, severely impacting ecosystems both on land and in the oceans. Thailand, as one of the countries with the highest volumes of plastic waste flowing into the sea, has faced the dual challenge of managing domestic waste while also dealing with the influx of plastic scrap from abroad.¹ To address environmental problems in a sustainable manner, the Thai government has announced a policy to “ban the import of plastic waste from abroad.” The Ministry of Commerce issued a regulation designating plastic scrap (customs tariff code 39.15) as a prohibited import item. The announcement was published in the Royal Gazette on December 16, 2024, and came fully into effect on January 1, 2025.² This policy is not only an environmental measure but also a key strategy to drive Thailand toward a circular economy and to protect the long-term health of its citizens.³

Looking back to 2018, after China announced its policy to halt the import of plastic and electronic waste, the global waste chain shifted toward Southeast Asia. At that time, existing legal measures were insufficiently strict, and the massive inflow of plastic scrap caused domestic prices to plummet rapidly, directly affecting the livelihoods of informal waste pickers (“saleng”) and small-scale waste sorters.⁴ In addition to the economic impact, inspections of imported plastic scrap often found contamination with hazardous waste and plastics that were not truly recyclable, creating disposal burdens and causing cumulative pollution in soil and water sources.

The significance of Thailand’s 2025 ban lies in rebalancing the waste management structure by pressuring the industry to invest in sorting technologies, using domestic plastic scrap as the primary raw material instead.⁵ The Cabinet approved a phased import quota for plastic scrap, with a plan to implement a full 100% ban starting on January 1, 2025.⁶ The end of plastic scrap imports in 2025 not only helps reduce accumulated waste, but also has significant positive impacts on the social dimension and public health of Thai citizens, as follows:

- 1 Reduction of pollution from improper waste management:** In the past, imported plastic waste was often accompanied by “illegal factories” that secretly sorted and melted plastics without proper air filtration systems, releasing carcinogenic substances such as dioxins and furans into nearby communities. With the import ban and stricter enforcement requiring factories to use domestically sourced waste with better-controlled origins, the incidence of respiratory illnesses and chronic diseases among residents around industrial estates is expected to decrease.⁷
- 2 Strengthening the grassroots economy:** When industries can no longer rely on imports, the demand for plastic waste within Thailand rises, stabilizing and increasing the selling price of plastic waste for waste collectors and waste pickers.⁸ It directly distributes income to vulnerable groups in society and helps elevate the profession of waste collectors into the formal waste management system.
- 3 Instilling discipline and a culture of waste separation:** This policy also impacts households. As factories demand plastic, citizens are supported and incentivized to separate waste at the source, creating sustainable “social discipline” because sorted waste can be sold at a fair price and actually recycled.⁹

Format for Citation

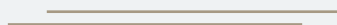
Thai Health Project. 2026. Title of article. Thai Health 2026 (page number of article). Nakhon Pathom:
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Feature Article
Health Literacy
and
the Role of Digital Communication





Health Literacy and the Role of Digital Communication

Introduction

Just imagine! If everyone were to seriously take care of their own health and that of those around them by seeking health information on topics such as diet, lifestyle, and exercise, adapting that knowledge to fit their own lives, consistently practicing those behaviours, sharing useful information with others, and even supporting and encouraging others to take health care seriously.

It is certain that Thailand's public health system would be greatly relieved of its burden. This would help address shortages of healthcare personnel, medical supplies, and service capacity, as people would become healthier, the number of patients would decrease, and individuals would be more capable of taking care of themselves effectively, at least at a basic level.

It is this very idea that has driven the promotion of “health literacy” as a key lever which the World Health Organization (WHO) believes can lead to truly sustainable health outcomes. It emphasizes involving the public in the process of health care (health co-creation), generating tremendous collective power to drive public health forward.

In 1998, the World Health Organization (WHO) defined “health literacy” as “*the cognitive and social skills that determine the motivation and ability of individuals to access, understand, and use information in ways that promote and maintain good health.*”¹ Later, in 2019, WHO promoted the advancement of health literacy to respond to the rising burden of non-communicable diseases (NCDs). It organized training in various countries and emphasized bringing together medical experts and community members to collaboratively design strategies suited to the context of each area.²

Thailand began to place importance on health literacy in 2014, when the National Reform Council (Public Health sector) designated the reform of health literacy and health communication as one of the eight key goals for national public health reform. This initiative was subsequently entrusted to the Department of Health as the lead implementing agency. This effort later led to its inclusion in the Constitution of the Kingdom of Thailand B.E. 2566, as well as in the 20-Year National Strategy (Public Health), which clearly sets the goal of achieving “health-literate societies.”

Major advancements include:

The Thai Health Literacy Association (THLA) was established in 2018.

Nationwide surveys of health literacy among the Thai population

Development of 66 key communication issues to enhance public health literacy

Formulation of a 10-year strategic plan for health literacy development

The core principle of health literacy lies in four key competencies of individuals: The ability to access health information; To understand that information; To appraise the reliability of health information; and To apply it effectively.³

Later, when the Department of Health implemented this concept in Thailand, it was adapted into six competencies: Access to health information; Understanding health information; Interaction; Decision-making; (5) Self-management; and (6) Dissemination.

The principles of health literacy are closely tied to communication, making communication strategies and technologies critically important to health outcomes. This is especially evident in an era where digital media and artificial intelligence (AI) are highly effective in reaching all segments of the population, across genders and age groups. They enable two-way communication, greatly influencing changes in attitudes and behaviors, as well as the dissemination of information.

The changing landscape of health information

The development of digital technology in the 21st century has transformed the landscape of health information in many dimensions, requiring careful consideration to ensure the effective advancement of health literacy.

- **The first** key issue is that digital spaces allow people to widely produce health-related content, unlike in the past when health knowledge primarily came from experts and rigorously reviewed academic sources. The open nature of digital media enables the general public to act as both producers and users of health information, while the accuracy of such content cannot yet be fully controlled. This may lead to harmful consequences for the public. It can also serve as a channel for spreading fake news, exaggerated advertising, and misleading information.
- **The second** issue is that there are challenges related to maintaining privacy and data security of health information, adapting to rapid technological changes, designing content that meets the diverse needs of target audiences, and building credibility and trust in digital health systems.

A survey on health literacy among the Thai population aged 15 years or older was conducted in 2017 (Phase 1).⁴ This survey covered a sample of 722 individuals from six provinces representing each region of Thailand. It found that 61.2% of the sample still had an “inadequate” level of health literacy (scoring below 261 out of 348). This was particularly evident in behavioral dimensions such as decision-making and practical application. Although some groups—such as those with higher education or those living in urban areas of certain provinces—demonstrated relatively high score (for example, in areas of Chonburi Province outside the capital city, scores for information review and decision-making were as high as 73.1% and 71.7%, respectively), the survey also revealed that even groups with high overall scores could still fall victim to health-related misinformation or deception.

The second round of the survey in 2019⁵ was conducted at the household level, using a sample of 7,380 households nationwide. It found that health regions with higher average scores—such as Health Region 1, with an average score of 69—contrasted sharply with the lowest-scoring regions, which had an average of only 33. This highlights significant disparities in health literacy levels across different areas.

Although a large proportion of the sample demonstrated “adequate” or “good” levels of health knowledge according to the criteria, the data also indicate that knowledge alone is not sufficient to protect against scams. These include deceptive marketing of exaggerated health products or online persuasion based on false health information. Many respondents showed an ability to “understand health information” but lacked the skills to “critically evaluate and make informed decisions,” making them more vulnerable to deception.

This suggests that, while campaigns to improve health literacy have been successful in terms of access to and understanding of information, there is still a need to strengthen “critical literacy” and analytical thinking so that individuals can use information safely and effectively in their daily lives.

This special feature in Thai Health Report 2026, titled “**Health Literacy and the Role of Digital Communication,**” presents an overview of the concepts and progress of health literacy in Thailand, analyses opportunities and challenges, and offers policy recommendations for advancing health literacy through digital media.

Three generations, three individuals, on the journey toward “digital” health literacy

On a weekend morning, three people of different generations living under the same roof wake up and each find themselves dealing with their own health-related issues, in very different ways.



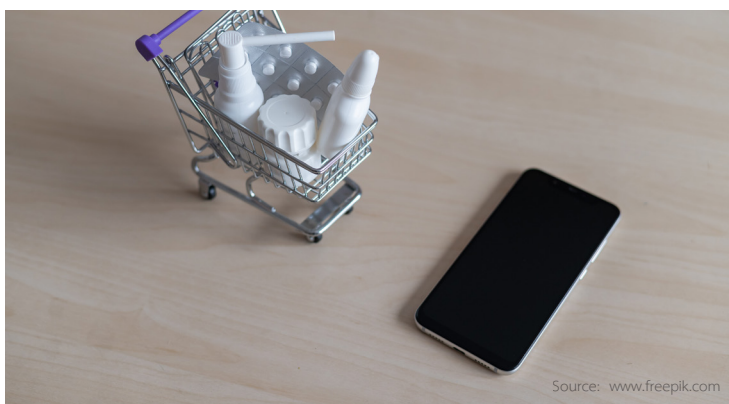
Jamie, 19 yrs: Gen Z and the trap of online advertising

Jamie, a 19-year-old girl, woke up late after staying up the night before playing online games with friends—typical of her generation. At home, there is no strict expectation for her to wake up early to help with chores like in the past. Though awake, she was still groggy, half-asleep, as her hand reaching around until it found her smartphone beside the pillow.

The first app she opened was “TikTok.” She began “scrolling” endlessly through content perfectly tailored to her interests, thanks to the sophisticated algorithm that seemed to know her better than anyone—perhaps even better than she knew herself. Then one clip made her stop. Its content felt uncannily personal, as if it had been created just for her.

“Lose weight in 7 days! No exercise needed!” A slim, model-like influencer was holding a bottle of dietary supplements, backed by 2.3 million views. Jamie scrolled down to read the comments: *“It really works!”* *“I already ordered two bottles.”* She knew she should be cautious and verify the information. Some comments seemed sceptical, making her hesitate for a moment

But just a few minutes later, she placed an order, transferring 2,500 baht without consulting a doctor at all. The voices of the reviewers she chose to believe are enough to convince her that she will become slim without breaking a sweat!





Daddy Bank, 42 yrs: Gen Y and concerns about emerging technologies

Meanwhile, **Bank**, a 42-year-old Gen Y man, sat at the dining table in the kitchen. He felt a slight sore throat since yesterday but has not had time to see a doctor. He mentioned it to a colleague, who suggested trying telemedicine—online medical consultation—which they had used before and found convenient, saving time from traveling to the hospital.

He picked up his phone and searches using several keywords: “*telemedicine,*” “*online consultation without going to the hospital,*” and similar terms. Various websites suggested multiple options, including apps that seem relevant. He found it interesting and thought it might help him.

But... he did not know where to start. He was afraid of doing something wrong, intimidated by the complexity, and unsure whether online doctors were trustworthy. In the end, he decided to close his phone and drive to the hospital, spending half a day there as usual.



Grandma Phis, 68 yrs: Older adults and the scammers

At the same time, **Grandma Phis**, aged 68 years, was about to send a bright yellow flower sticker with the message “Happy Monday” to her friends, children, and grandchildren. Suddenly, a Short Message Service (SMS) notification popped up: “*Congratulations! You have received a new round of COVID-19 relief benefits worth 3,000 baht. Please click the link below to register...*” Grandma Phis was excited. During the COVID-19 epidemic, she did not receive compensation from the insurance policy her daughter had arranged for her, so she assumed this must be a delayed payment.

Overjoyed, she immediately clicked the link and prepared to enter her Thai national ID number and phone number, and nearly provided her bank account details to receive the transfer. Fortunately, her daughter walked in just in time and warned her that this was a scam currently being reported in the news.

The stories of these three individuals may seem unrelated—different ages, different challenges, and different platforms. But if we look more deeply, we find that at their core, **these issues are interconnected within the complex relationship between health and the digital world.**

Jamie, is a member of Gen Z teenager and a true digital native. Thus, she has strong media literacy skills. She is highly proficient in using digital tools, easily accesses content, quickly adopts new applications, understands information well, and knows how to evaluate it. **TikTok allows her to access information effortlessly** and discover new products quickly without having to search for them. However, at the same time, **TikTok and influencers** can also lead her to make poor decisions due to her lack of experience.

Daddy Bank clearly sees the benefits of telemedicine. He has a reasonable level of knowledge and digital readiness, even if he is not as fluent as Jamie. He is capable of finding information that could help him save time—avoiding travel, long queues, and reducing both energy use and environmental impact. Yet, telemedicine also **makes him uneasy**. It does not inspire confidence, appears complicated, and leaves him uncertain about the credibility of online doctors. He also remains attached to the familiarity of visiting a hospital and consulting a doctor face-to-face.

As for Grandma Phis, she belongs to an age group with ample free time and can spend much of the day on social media. Although government communications regularly warn that older adults are often targeted by scams—especially those using health-related claims as a lure, since older people commonly face various health issues—social media continues to deceive people of her generation using the same old tricks and formats, repeatedly making headlines.

Greater health literacy, but health behaviors have not improved

This is a concerning **paradox** of health literacy in the digital age.

Thai people have **greater access to health information**, driven by the power of digital communication. Thailand’s health literacy policies have been advancing since 2014, supported by laws, strategic plans, responsible agencies, and dedicated budgets.

Meanwhile, digital platforms have expanded rapidly. Smartphone penetration has increased, internet access has become widespread, social media can be accessed anytime and anywhere, and digital health services are increasingly available. Technology has therefore made health care **easier, better, and more accessible**.

However, in reality, risky health behaviors **have not declined**.

Research shows that adolescent girls have an increasing rate of consuming dietary supplements without consulting a doctor.⁶ Many medical service innovations that could help reduce hospital overcrowding are not trusted because of a lack of effective communication.⁷ Older Thais fall victim to scammers even though they are aware that there is a large amount of fake news today, and that many scams use health-related issues as a means of deception.⁸

Health literacy: “knowing”... and then... “changing”

An ounce of action is worth a ton of theory



Ralph Waldo Emerson

A philosopher and writer who laid the intellectual foundations for the ideas of self-reliance and intellectual freedom in American culture

The subject “**Health Education**” has been included in the standard Thai curriculum since the kindergarten level, with the aim of equipping children with knowledge needed to live healthy lives—such as eating nutritious food, taking care of their bodies, exercising regularly, and avoiding health risks.

Over time, however, Health Education has come to resemble many other subjects: it **has shifted from practical knowledge for everyday living into content studied primarily for examinations, with the goal of achieving good grades and advancing to the next level**. The focus has moved away from understanding and effective practice toward rote memorization aimed at selecting the correct answers on tests.

As for whether people who learn health education actually follow what they have learned... there is no guarantee, and no real way to measure it.

No one can definitively answer whether people in society truly live according to what they have learned in health education, or how many patients in hospitals are suffering from illnesses caused by unhealthy lifestyles in everyday life.

The article “*Health Literacy as a Public Health Goal: A Challenge for Contemporary Health Education and Communication*”⁹ by Dr. Donald Nutbeam, an Australian public health scholar, was published in the journal *Health Promotion International* in 2000. The article is widely recognized as an influential publication that has served as a foundation for the subsequent development of the concept of health literacy.

The article portrayed “health literacy” as an umbrella term, reflecting the outcomes of various health education and health communication activities. These outcomes are key components leading to health literacy, encompassing **knowledge, attitudes, motivations, behaviors, intentions, personal skills, and self-efficacy** related to health.

Accordingly, health literacy emerged as a means to encourage people in society to translate the health knowledge they learn from the Health Education and other sources into actual practice, in order to reduce health risks and improve quality of life.

In essence, health literacy—particularly in terms of enabling people to access health information and knowledge widely—is an important tool for **empowerment** and **equity**. It enables individuals to take care of their own health by providing accurate knowledge and information, helping prevent them from engaging in behaviors that are potentially harmful to their health.

Five decades of “health literacy”

1970s: The beginning

This concept of health literacy first emerged in the 1970s. It is based on the idea of communicating health-related information through various channels, including the education system so that children and young people can learn important health knowledge, the healthcare service system, and mass media.¹⁰ Part of this arose from the fact that **people receiving healthcare services were unable to communicate effectively with medical personnel**. It was related to literacy (e.g., being able to read prescriptions and medication labels, understanding the pharmacist’s instructions, reporting numbers and other health-related information about themselves, etc.).

Therefore, in its early stages, health literacy was mainly about reading comprehension and understanding spoken information. People with low literacy rates were therefore at higher risk of poor health outcomes.¹¹ Even more complex is the fact that *people with low literacy skills are often also poor. As a result, the WHO has placed importance on the **social determinants of health** in promoting health equity.*¹²

1990s: Personal health management

In the 1990s, this concept focused on individuals’ skills and capacities to manage their own health and cope with illnesses—what is understood as individual health literacy. It encompasses the ability to access and understand information related to health care, diseases, and conditions, as well as an understanding of different levels of the health service system.¹³ These competencies, in turn, support sustainable changes in health behavior.

1998: WHO's definition

In 1998, the WHO expanded the definition of health literacy to include personal behavior and the use of various types of health information. It defined health literacy as **cognitive and social skills that determine an individual's motivation and ability to access, understand, and use information to promote and maintain good health.**¹⁴

Subsequently, health literacy has been further distinguished into two levels: Personal health literacy, which relates to an individual's ability to access and use information to promote and maintain their own health; and Organizational health literacy, which refers to the responsibility of health organizations and other related institutions to support people in accessing and using information to promote and maintain health, as well as to encourage healthy behaviors.¹⁵

The World Health Organization and the Advancement of Health Literacy

For nearly two decades, WHO has prioritized and promoted the concept of health literacy as a shared approach among its member states. The goal is to build a sustainable global healthy society, reduce the burden of disease, and ease pressure on healthcare systems.

A major turning point in advancing health literacy occurred at the 9th Global Conference on Health Promotion, held in Shanghai, People's Republic of China, in 2016.

At that meeting, a policy declaration on health promotion was announced, identifying health literacy as **one of the three key pillars for achieving health promotion and sustainable development goals.** The other two pillars are good governance and healthy cities.¹⁶ In this regard, the WHO plays a role in providing resources and experts to support countries in advancing health literacy strategies. It offers training to build the capacity of personnel and facilitates the sharing of information to support policy development and decision-making related to health literacy.

Three levels of health literacy

Health literacy can be divided into three levels: **functional, interactive, and critical.** Each level reflects progressively higher skills and competencies for managing health effectively.¹⁷

1. Functional Health Literacy

It refers to basic reading and writing skills that enable individuals to access health-related information, understand it, and apply it in their daily life.

Examples include reading medication labels, understanding numbers and consent forms, taking medicine correctly, reading medical appointment slips or health education materials, and recording one's own health information.

Functional health literacy is considered an outcome of health education and health communication efforts that disseminate information about risk factors, useful knowledge, and guidance on using health services. It is beneficial at both the individual level—helping people improve their health and reduce risky behaviors—and the societal level, as it strengthens overall resilience and reduces the burden on the healthcare system.

2. Interactive Health Literacy

This involves more advanced cognitive skills beyond the functional level. It includes more complex thinking and literacy abilities, the application of new information, and social skills that enable individuals to interact with others and adapt to changing environments. It also involves the ability to differentiate between complex information.

For example, people can ask questions when in doubt, seeking clarification to build confidence, and compare treatment options before making decisions or taking health-related actions.¹⁸

This interactive level focuses on developing individuals' skills and capacities to build motivation in seeking advice, consultation, and information related to health care.

3. Critical Health Literacy

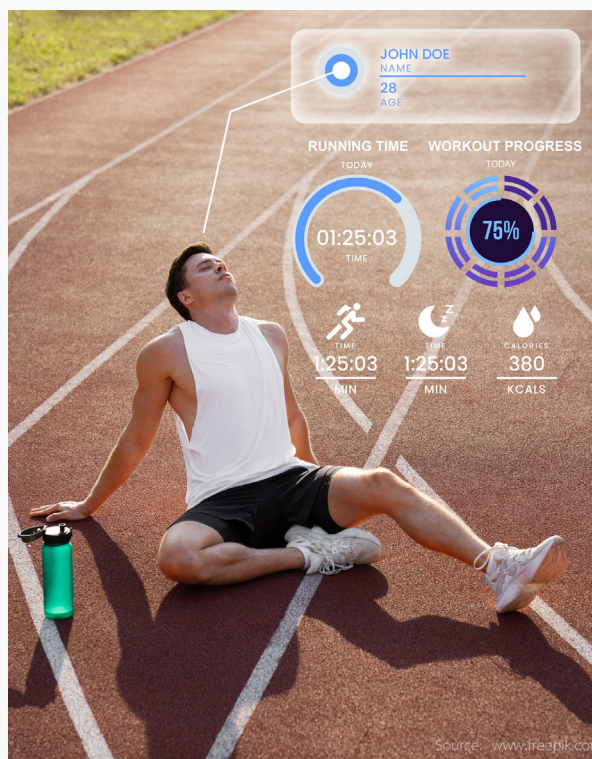
Critical Health Literacy is the highest level of health literacy. It encompasses the ability to critically analyze health information, understand the broader determinants of health, and plan and take action to manage those factors for control, prevention, or problem-solving.

For example, individuals can use local air pollution data to reduce the risk of respiratory diseases.¹⁹ This level also involves the ability to adapt health advice to one's own context—rather than following information rigidly without considering personal circumstances.

Critical health literacy reflects the ability to carefully evaluate health information before making decisions or taking actions that affect one's own health, others, and society as a whole. It encompasses all social determinants of health.

Designing measures to enhance health literacy should take these levels into account, so that people not only understand health information but are also able to use it to improve health outcomes at both individual and societal levels.²⁰

The three levels of health literacy are interconnected in a progressive sequence. When functional health literacy is sufficiently strong, individuals are able to effectively access and understand health information and knowledge received through various channels. Interactive health literacy enables individuals to seek new health information when their environment changes, verify whether their understanding is correct, and filter health information. This process leads to adjustments in attitudes, intentions, and behaviors based on the filtered information. Critical health literacy, in turn, leads to changes in health-related behaviors—not only for oneself, enabling a healthier way of living, but also for those around them and society as a whole—through taking action to manage the social determinants of health within one's environment.



The components of health literacy to “shift” Thailand’s public health system

In 2014, the National Reform Council (Public Health) set a goal for the country’s public health reform plan.

People in all sectors should have health literacy, participate in designing health care systems, and have equal access to necessary public health services.....²¹

The plan also set five-year health literacy targets (2018–2022), consisting of the following:



1. All Thai people have the skills to access and process health information in order to make decisions about their own health care.

2. Thai society becomes a health-literate society, in which all people can access, understand, and apply health information and health services, enabling them to make appropriate decisions for their own and their family’s health.

3. Thailand has public health, education, social welfare, and environmental systems that enable people to access, understand, evaluate, and apply information and services in society to make appropriate decisions about their own and their family’s health.



The national policy framework on health literacy has become clearer and more concrete through the establishment of three main pillars.

The first pillar is the Constitution of the Kingdom of Thailand B.E. 2560, which mandates that the state must ensure that people receive appropriate health information and basic health knowledge. This elevates health literacy to a structural responsibility of the state.

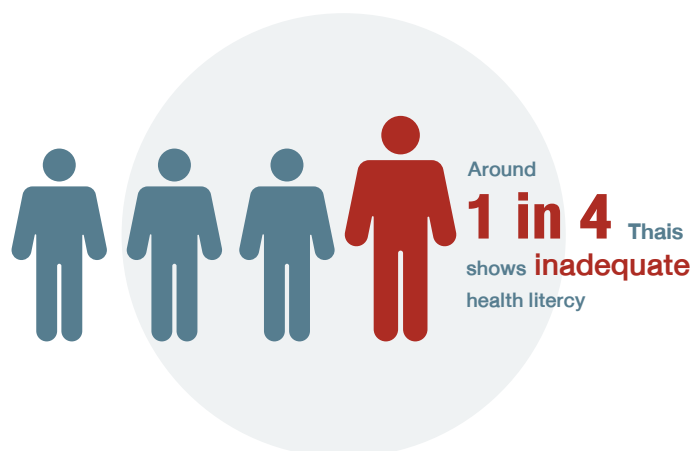
The second pillar is the 20-Year National Strategy (2017–2036) in public health, which sets “a health-literate population” as one of the strategic goals of Thailand’s health system.

The third pillar is the Public Health Reform Plan (2018–2022), which identifies “health literacy and health communication reform” as a key reform agenda. This has strengthened governance and monitoring mechanisms, with the **Department of Health serving as the main implementing agency through dedicated units**, such as the Office of DoH 4.0 and Health Literacy. It also established the goal of a “health-literate Thai society” and developed 66 key messages to enhance public health literacy.²²

In addition, the **National Health Literacy and Health Communication Committee** was established to oversee and monitor the advancement of health literacy. It collaborates with multiple agencies—for example, the Ministry of Public Health to promote **health literate hospitals**, the Ministry of Education to promote **health literate schools**, and the Ministry of Interior to promote **health literate communities**—so that health literacy is developed at all levels.

The goal is to make Thai society a health-literate society, where people have the skills to access and process health information in order to make informed decisions about their own health. **The Thai Health Literacy Association (THLA)** was also established to provide academic support, integrate knowledge, and coordinate efforts to advance health literacy.

These developments in policy and institutional structures have led to a major national survey to measure health literacy among the Thai population. A 2017 survey by the Department of Health found that **over 80% of Thai people aged 15 years or older had a moderate level of health literacy, while only 18.6% were at a high level.**²³ Meanwhile, a 2019 survey by the Health Systems Research Institute found that about **one in four Thais still had an inadequate level of health literacy.**²⁴ This reflects structural challenges in developing people’s capacities in line with the goals set at the policy level.



In addition to the government mechanisms, particularly the agencies under the Ministry of Public Health, there are other organizations that have been continuously working together to drive health literacy. These include the National Health Security Office (NHSO), which has established reform plans regarding health literacy at both the individual and organizational levels, and the Thai Health Promotion Foundation (ThaiHealth), which consistently produces various media to build correct understanding about health literacy. Other entities are also involved, such as private hospitals like Bangkok Dusit Medical Services (BDMS), which continuously produces video content via YouTube to foster correct knowledge, understanding, and practices in line with health literacy guidelines.

However, **implementation still faces several limitations, including fragmented operations across agencies, discontinuity of resources and budgets, and constraints in monitoring and evaluation systems that are not yet able to systematically capture behavioral health outcomes.** In addition, **digital inequality remains a major concern, as the ability to access health information through technology varies across regions and population groups.** As a result, reliance on online or digital media may limit some groups’ access to accurate and essential information, alongside ongoing issues related to the quality and reliability of information available through digital platforms.

V-shape: Six Components of Digital Health Literacy—from Access to Sharing

In 2012, Kristine Sørensen, a Danish researcher and founder of the Global Health Literacy Academy, and a key driving force behind the health literacy movement replacing traditional health education, proposed that health literacy is a process consisting of four key components: **access, understand, appraise health-related knowledge, and importantly, apply**— which involves behavioral change to achieve good health. These four components were later promoted and adopted by the WHO as a framework for advancing the concept of health literacy.

In Thailand, the Department of Health, which has been assigned as the main agency to advance health literacy, expanded the framework from four to six components. This adjustment was not merely an addition of processes, but a refinement to better align with Thailand’s public health context. The six components are: access, understanding, interaction and exchange, decision-making, self-management, and dissemination.²⁵ These are discussed further below.²⁵



Access in this context does not refer only to accessing health information—such as illness, what is good or bad for health—but also includes access to information about health services. It involves the skills and ability to seek out information, assess its accuracy and reliability, and verify it until one is confident that the information is of good quality and trustworthy.

These abilities are critically important, as they serve as the gateway to health literacy. Without access, the subsequent steps cannot take place.



Understanding focuses on the ability to comprehend information and content that has already been screened for reliability. Once information is received, individuals should know how to use it, understand its limitations and precautions, and grasp its basic rationale—even if they do not fully understand the underlying scientific complexity. For example, being able to read medication labels correctly, provide information, and fill out health records for medical professionals.



Interaction/exchange includes communications skills—the ability to communicate one’s illness, needs, and health concerns, as well as to engage in discussions to exchange accurate information. It also involves the ability to negotiate with knowledgeable and authoritative figures such as doctors, nurses, pharmacists, hospital staff, and others, in order to obtain appropriate health information and services suited to one’s personal, family, and community context.



Decision-making refers to whether to believe or not believe the information received after analyzing, comparing, and carefully considering it. This is a crucial skill that leads to forming judgments about information. It can be seen as critical thinking or judgment, which varies from person to person—even when exposed to the same information—depending on individual cognitive skills.



Self-management involves adjusting one’s behavior based on decisions about whether to accept or reject health information. It includes managing oneself and one’s environment to support or avoid certain practices, as well as adapting them to fit one’s own context in order to achieve personal health goals.



The final component is **dissemination**—providing guidance, sharing, or spreading health information that one has already evaluated as reliable and beneficial. This may involve advising family members, friends, colleagues, neighbors, and the broader public, thereby contributing to the development of a health-literate society and promoting healthy behaviors.

Source: www.freepik.com

A Success Story from Phasi Charoen: Building Health Literacy in the Community***

One morning in a small community in Phasi Charoen District of Bangkok, a blood pressure monitor was picked up and used with familiarity. The conversations were no longer filled with worry as they once were, but instead revolve around exchanges like:

“How many days did you walk this week?”

“I tried cutting down on sweets at dinner—my sugar level really dropped.”

Scenes like this did not happen by chance. They were the result of a shared journey through a community leader development project that gradually transformed “patients” into “informed individuals,” and turned “health information” into a “tool for life decisions.”

The starting point: Access that leaves no one behind

The project began with a simple yet important question: How well do people in the community understand their own health? Measuring blood pressure, checking fingertip blood sugar, and measuring waist circumference were not used to “judge” who was sick or not, but as a starting point for everyone to truly access their own health information for the first time. Many people had never before understood what those numbers meant or how they related to their daily lives.

Information was not delivered in complex documents, but through visuals, stories, and the lived experiences of fellow community members—making access to information less about formal education and more about everyday relevance.

When understanding grows, health becomes personal

As community leaders and participants began to understand the meaning behind the numbers, high blood pressure was no longer just “what the doctor says is dangerous,” but became linked to dizziness, fatigue, or the risk of stroke they had seen in people they knew. Blood sugar levels were no longer just test results, but connected to dinner habits, sugary drinks consumed daily, and prolonged sitting behaviors.

Learning was no longer about memorization, but about “seeing one’s own life” through health data.

From understanding to appraisal and personal choice

At the heart of the project was not telling people what they “must do” but encouraging them to ask themselves, “Which option fits my life best?”

Some chose to start by walking 10 minutes a day.

Some reduced sugar but were not ready to quit entirely.

Some focused first on managing stress, recognizing that stress raised their blood sugar.

This is where health literacy moves from knowledge to appraisal and decision-making. Participants did not follow a single set of instructions, but instead chose approaches that aligned with their own life conditions.

***The Phasi Charoen Health-Literate Community Development” is a pilot project aimed at empowering local communities to effectively manage and care for patients with hypertension and diabetes. Supported by the National Health Security Office (NHSO), the project is led by Associate Professor Dr. Chanuanthong Thanasukarn.

Behavior change driven by confidence, not fear

When decisions are truly one's own, change gradually follows. For example:
Small groups formed within the community to exercise together.
Snacks shifted from sweets to fruits and vegetables.
Blood pressure checks were no longer feared, but became a shared routine.

Importantly, community leaders began sharing their own experiences—not as experts, but as “peers who had once been in the same place.”

Outcomes beyond the numbers

While health outcomes clearly improved—over 92% of community leaders were able to change their own health behaviors, and nearly 90% were able to extend these changes to patients in the community—the more significant success was the emergence of a community capable of thinking, deciding, and taking action together. People who once waited for instructions from the healthcare system became individuals who could use information to take care of themselves. And this self-care expanded into mutual care within the community.

A story that reflects the meaning of health literacy

The Phasi Charoen Project demonstrates that health literacy is not merely about knowledge. It is a process that enables people to “**understand themselves, build confidence, and choose health pathways that fit their own lives.**” As health literacy grows within a community, its overall well-being begins to improve in tangible ways.

Challenges of the “V-shape” in the digital era

Whether the traditional four-component model of health literacy or Thailand's six-component framework, both were developed in an era when digital communication was not as widespread as it is today. In the digital age, communication approaches and tools—now increasingly powered by artificial intelligence—have become a double-edged sword in advancing health literacy.

Accessing health information... in the age of information freedom

Searching for information in the “analog” era might have meant opening books, researching in libraries, or consulting printed materials, calling medical personnel, or even dialing various hotline numbers. But in today's digital age, simply picking up a smartphone and typing “one-sided headache for several days” is enough.

In fact, even typing can feel inconvenient for people with disabilities, the elderly, or even Gen Z children—many no longer bother to type at all. Instead, most searches are done by speaking queries into Google, with answers appearing in a fraction of a second.

If one prefers not to read and wants explanations delivered directly, YouTube offers countless pieces of content created from multiple perspectives. For even faster, more concise responses suited to the short attention spans of the digital age, platforms like TikTok provide brief, engaging presentations designed to convey key points quickly.

Moreover, if a person’s health issue is complex and highly specific, they can post questions on various platforms—whether blogs on different websites or social media posts on Instagram, X, and others. Responses will come from a wide range of people, both known and unknown, offering diverse perspectives. These responses may range from “serious and well-intentioned,” to “serious but misguided,” to “not serious and not well-intentioned,” with some simply replying for personal amusement.

Accessing information in the digital age has never been easier.

And importantly, there are no office hours—you can search anytime, anywhere!

This ease of access to health information represents a major transformation, significantly **empowering both health service users and providers.**

That means not only the general public but also medical professionals.²⁶ An enormous volume of information is accessible—virtually limitless for those who are equipped to access it. This can lead to “**information overload,**” as content is generated and fed into the system by anyone: from those with genuine expertise, to those with partial knowledge, to those with no real knowledge at all but who create information for various purposes.

This double-edged sword becomes even sharper—offering both a vast amount of useful information and, at the same time, an equally large volume of potentially harmful information.



Digital information... “easy” to understand, even “easier to be fooled”

Amid this vast volume of information, regardless of whether content creators have good intentions or hidden agendas, they share one common goal: to ensure that people can access and understand the information—so that they will be persuaded and act accordingly.

This goal drives content creators to make information as easy to understand as possible, and within the shortest time. This is not merely about reducing airtime costs or saving space, because in the digital age, content creators are given an abundance of space and time— “so much” so that traditional mainstream media, once constrained by high broadcasting costs, have struggled to adapt and, in some cases, disappeared.

What truly drives digital content to become shorter and more concise is the declining “attention” span of audiences. The thumbs of younger users—and even the index fingers of older users—are ready to “scroll” away immediately when encountering content that feels “difficult or overly lengthy.”

Health information creators in the digital era have significantly adapted by making content more concise and engaging. This includes distinctive presentation styles associated with “influencers,” as well as short-form videos that continue to shrink in length—from videos lasting tens of minutes on YouTube to content that must deliver its message within 30 seconds on TikTok.

Moreover, the human brain can process and recognize images in as little as 13 milliseconds, compared to 150-300 milliseconds needed to comprehend individual words. This significant difference has led to the widespread use of infographics, combined with breaking information into smaller parts and gradually presenting it piece by piece—known as microlearning—to facilitate easier understanding and retention.²⁷

However, health information is grounded in scientific evidence and reasoning, which cannot be oversimplified or excessively condensed. Even more concerning is the use of exaggerated or overdramatic beyond what is factually accurate—something that should be avoided.

Furthermore, research has found that audiences receiving health information from social media tend to trust content based on the quality of production—such as visuals, sound, and overall presentation—as well as the presenter. This means that if the camera angles, imagery, audio, and delivery appear polished, audiences are more likely to believe the information without questioning its source.

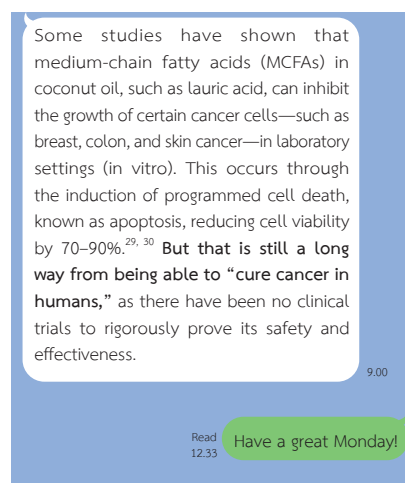
Influencers who are physically attractive, articulate, and dressed in a lab coat can easily gain credibility in the eyes of viewers, regardless of **whether they are actual medical professionals or whether the information they provide is accurate.**²⁸ However, providing lengthy explanations with detailed reasoning and extensive evidence—especially when it involves complex scientific experiments—may not necessarily improve public understanding. In fact, it can sometimes lead people to reject important information altogether.

Example “Coconut oil cures cancer!”



A primary school friend of Grandma Phis received a message from their high school friends’ group and learned that Grandma Phis had just been diagnosed with oral cancer after chewing betel nut for most of her life. The friend immediately forwarded the message to her. Grandma Phis, in turn, quickly went out to buy several bottles of coconut oil—and might even forward this miraculous information to other friends across all her LINE groups.

The message she received was extremely concise, easy to understand, and sparked hope. But the reality—and the underlying evidence—is far more complex.



If all this detailed information were sent to Grandma Phis via LINE, she would likely scroll past it because it is too long for her attention span and eyesight—or perhaps forward it to another group without even reading it.

Unless, of course, Granny Phis were a scientist!

Instant questioning and interaction... but “who” is actually answering?



Source: <https://spd.moph.go.th/mohprompt/>

Many health-related issues are complex, difficult to explain, and hard to understand—for both healthcare providers and recipients. Illnesses, feelings, and certain needs can be challenging to articulate.

Moreover, some topics are sensitive and difficult to communicate, as they relate to personal behaviors and private matters—such as internal organs or intimate conditions. Speaking about them directly can cause embarrassment, discouraging people from seeking consultation or discussing their concerns with healthcare providers at hospitals, clinics, or pharmacies.

Automated response systems, or chatbots, have significantly reduced this discomfort. People can ask questions and seek information—no matter how sensitive or troubling—more freely.

Today, chatbots have been developed as channels for the public to communicate and inquire about health information and healthcare services across various platforms. One widely recognized health chatbot in Thailand is MohPrompt (originally called MOPH Connect), developed by the Ministry of Public Health in 2018. It has played a significant role in enabling direct communication with the public, particularly in areas such as vaccination, symptom monitoring, and access to health services.³¹

In addition, there are other chatbots that function as two-way communication channels between service users and healthcare providers, such as “Psyjai” (ใส่ใจ) developed by Siriraj Hospital; “Chat Sure” (แชทซัวร์) developed by the Ministry of Public Health and the Thai Health Promotion Foundation (ThaiHealth); “AN AN BOT” (อัน อัน บอท) developed by Vimut Hospital; and “Panthai AI Doctor” (แผนไทย เอไอ ด็อกเตอร์) and “Panthai Chatbot” (แผนไทย แชทบอท), developed by the Ministry of Public Health in collaboration with King Mongkut’s University of Technology North Bangkok. These latter tools focus specifically on Thai traditional medicine services and were officially launched in August 2025.



Source: Facebook เพจ Psyjai

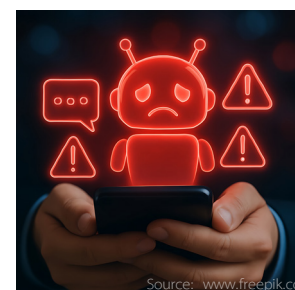


Source: Facebook เพจ Social Marketing Thaihealth by สสส.

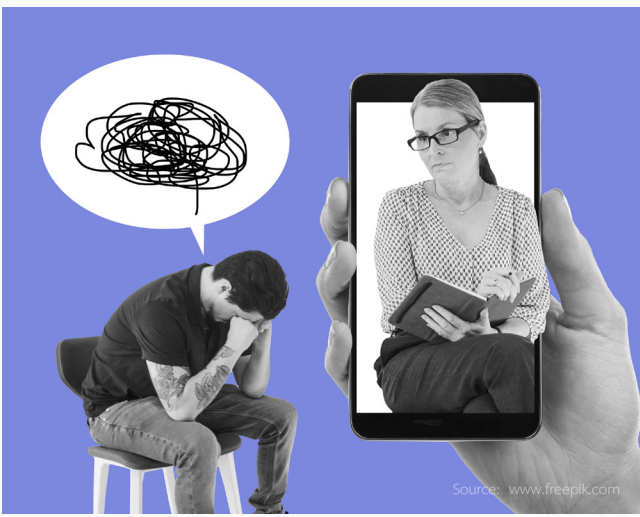
Chatbots represent the application of advances in digital technology and artificial intelligence to provide rapid preliminary health advice and service information. They significantly reduce waiting times—both from phone inquiries with staff or healthcare providers and from traveling in person—and can greatly shorten the time needed for early identification of symptoms and screening. However, there are important cautions that users should be aware of, and service providers themselves must continue to improve and refine these systems.

Nevertheless, research from Stanford University has reported that most chatbots are designed to be compliant and agreeable to users, avoiding confrontation. In certain situations, this may be inappropriate—for example, when chatbots based on large language model systems (LLM-based systems) are used to provide mental health counseling.³² A simulation study from Yale University also found that chatbots recommended unnecessary laboratory tests in 91.9% of cases and prescribed inappropriate medications in 57.8% of cases.³³

The harmful consequences of these shortcomings may only become apparent when it is already too late, much like accidents involving autonomous cars—where responsibility remains unclear. This creates a critical gap in the digital health literacy ecosystem.



Source: www.freepik.com



In 2023, the Department of Mental Health reported that around 4.4 million people in Thailand were affected by psychiatric disorders and mental health problems. Among Thai children, approximately 2,200 per 100,000 were diagnosed with depression, and more than 17% were at risk of self-harm.³⁴ However, only 10.6% are able to access mental health services.³⁵ In such circumstances, chatbots offer great promise in helping to ease the strain on mental health service systems. However, they must be thoroughly tested to ensure their safety; otherwise, they could become even more dangerous, as large numbers of people can access these tools very quickly.

“Reviews” and “comments” help with decision-making

Greater access to information always comes with more “choices.”

In the past, healthcare options were largely determined by doctors—whether to use medication or undergo surgery. If surgery was chosen, there might be further options, such as which equipment or technique to use.

The final decision, however, rested with the patient, which often created considerable anxiety—even when doctors provided detailed explanations along with dense scientific pamphlets.

Today, “Google” has become the first point of consultation when seeking additional information to make decisions. From there, people are gradually guided toward various sources and communities of individuals facing similar decisions or who have gone through similar experiences, offering their opinions and advice.



More advanced than Google are various forms of artificial intelligence, which further simplify decision-making. Beyond assisting decisions, they may also introduce alternative options that were not previously suggested by doctors or others.

When choosing health products or services today, reading “reviews” and “comments”—opinions from people who have used those products or services—helps individuals make decisions that better fit their own context, including their symptoms, convenience, and financial situation. Sometimes, these are topics people may feel uncomfortable asking about directly.

However, most—if not all—reviews and comments are written by unknown individuals, whose actual knowledge and experience cannot be verified.

In addition, digital media innovations have evolved to enhance understanding beyond simple graphics. They can now present realistic or simulated visuals through emerging technologies such as **Augmented Reality (AR)**, which overlays digital elements onto the real world; **Virtual Reality (VR)**, which creates fully immersive environments viewed through devices like VR headsets; **Mixed Reality (MR)**, which combines AR and VR to integrate digital and physical objects; and **Extended Reality (XR)**, which encompasses all these technologies.

For instance, VR has been tested as a tool for communicating and assessing information related to chronic pain conditions—an issue that significantly affects quality of life for many people. Results have been quite promising, and efforts are underway to expand its application to other health conditions,^{36, 37} including the use of VR and AR to support rehabilitation for patients after surgery or for those with movement impairments due to stroke (stroke rehabilitation).³⁸



Managing health behaviors through digital platforms and devices

Do not be alarmed if, during a meeting, someone suddenly stands up at the back of the room and walks around a bit after their smartwatch on their wrist gently vibrates.

That vibration is a message from the smartwatch reminding them that they have been “sedentary” for too long—it is time to move or stand up to ensure they get sufficient daily physical activity. Just a few years ago, this was something hardly anyone paid attention to.

Modern conveniences have made life far more comfortable, but they have also reduced physical movement to levels that can be harmful to health. Furthermore, as people become increasingly addicted to using their mobile phones, physical activity has declined even more alarmingly.³⁹ This has led to campaigns encouraging people to achieve an appropriate number of steps per day, along with the development of wearable devices capable of tracking daily step counts. Over time, these devices have become increasingly advanced, able to collect data reflecting other aspects of daily health and well-being, as well as various vital signs such as body temperature, heart rate, respiratory rate, and blood pressure.

These data are more convenient and accurate than self-measurement and manual recording, making them valuable records for assessing both health status and daily lifestyle.

Moreover, these devices support self-management by providing alerts, displaying basic analyses, and sending motivational messages.

Studies have confirmed that these devices can increase daily walking by about 1,500 steps—roughly a 25% improvement—and help strengthen people’s confidence in the overall health benefits of physical activity.⁴⁰ It would not be far-fetched to say that **these devices are acting as personal “coaches.”**

When friends compete by sharing their step counts or exercise hours on social media, it can further motivate and generate collective momentum for improving health at a broader group level. In addition, these devices can function like personal nurses, monitoring for abnormal signs in the body—such as irregular heart rhythms—and issuing alerts, or even notifying doctors.



These wearable devices work in conjunction with continuously evolving applications. Today, there are more than 350,000 health-related apps available on platforms such as App Store and Google Play.⁴¹ They also cover other aspects of daily life, including eating, sleeping, and even air pollution, such as PM2.5.

However, these digital devices also have some downsides, such as excessive preoccupation with tracking data (tracking obsession).

Research has found that some users experience “anxiety” from checking their data too frequently—feeling uneasy when not wearing the device, guilty when they fail to meet targets, and unable to stop monitoring even when they want to take a break. A 2019 study by University of Copenhagen found that many people develop unnecessary fear and anxiety from obsessive self-monitoring.⁴²

A 70-year-old woman in the United States with paroxysmal atrial fibrillation wore a smartwatch to monitor her heart rate. However, she checked it so frequently that it led to severe anxiety, requiring six sessions of psychological therapy to manage her condition.



Additionally, many people may not realize that these devices are not medical-grade equipment and may have accuracy limitations. They are designed to provide approximate data and often tend to overestimate actual values. Moreover, their relatively high-cost limits access for lower-income populations, meaning that “health inequality” remains a significant issue in society.

“Clicking and sharing”... does that mean “good intentions”?

In principle, data on the internet can travel at about 299,000 kilometers per second—close to the speed of light, yet even that is still not considered fast enough!

Scientists believe that internet data could travel even faster if the issue of “network latency” can be resolved.

As a result, “sharing” health information in the digital age can happen extremely quickly—and even more easily, since the tools for sending and receiving are **in everyone’s hands**.

Shared information does more than simply add to the recipient’s knowledge; it can also influence thoughts, shape attitudes, and even change behavior—if it is powerful enough.

During the COVID-19 pandemic, social media played a crucial role worldwide in reaching people and communicating how to respond effectively to the situation. This truly reflected the democratization of information.

Sharing positive stories can spark large-scale movements, from the national to the global level, driving meaningful change. One such positive example is the ALS Ice Bucket Challenge, which involved people pouring ice water over themselves to raise funds for research on Amyotrophic Lateral Sclerosis. The campaign raised around \$115 million, with more than 17 million participants worldwide—without anyone needing to travel at all.⁴³ The campaign also raised widespread and powerful awareness about the disease.

In today’s digital communication era, there are numerous communication channels, each suited to different groups. For example, Facebook is often used for sharing personal stories, and tends to target Generation Y, while Instagram is more suitable for reaching Generation Z. For more information-oriented communication, X may be more appropriate than other platforms. Speed and wide reach are no longer major issues. Instead, the credibility and appropriateness of the information being shared are far more concerning in the digital age, as they significantly influence attitudes and behavior.

An analysis of data shared on Twitter (currently X) between 2006 and 2017 found that “false information” was 70% more likely to be shared than factual information across all types of content. Moreover, falsehoods tended to spread farther, faster, and more widely. At the same time, studies have shown that over 94% of physicians in North Carolina, USA, had encountered patients who received incorrect health information from social media.

In addition, many users share information with good intentions—but without fully reading the content, verifying sources, or carefully assessing credibility. As a result, misinformation—such as miracle vitamins, cure-all medicines, or teas that claim to treat every symptom—continues to spread widely and create misunderstanding on a large scale.

The digital world thus presents both “opportunities” and “challenges” for health-related work across all components of the V-shape framework—from easier access to information that increases exposure to misinformation; rapid understanding that is easily

influenced; instant interactive communication without guaranteed accuracy; decision-making overwhelmed by excessive information and anonymous sources; behavior change driven by advanced technology that may come with high costs; and effortless sharing that, without proper verification, can spread risks and misunderstandings.

Ultimately, good intentions may not lead to good outcomes without “critical judgment” in receiving and sharing information.

Conclusion and Recommendations

Three gaps that undermine the thorough promotion of health literacy in the digital world

In the digital age, health information is overwhelmingly abundant—easily accessible, quickly understood, and conveniently shared. Yet reality does not always meet expectations, as seen in the fictional stories of Jamie, Bank, and Grandma Phis.

An analysis of digital health literacy highlights three critical gaps, as discussed below:

The 1st gap is the “missing mechanism.” In the past, especially for health information, dissemination required multiple layers of verification. In the digital world, these mechanisms have largely disappeared. Anyone can publish health information without expert review. Influencers without medical knowledge can promote health products, scammers can create fake websites, and untested chatbots can provide bogus health advice. Existing laws were written more than 40 years ago—before the Internet and AI—and are therefore unable to keep up with current challenges.

The 2nd gap is the “malfunctioning mechanism.” Social media algorithms are designed to maximize “engagement,” not to promote accurate information. Content that is novel, sensational, or emotionally stimulating is prioritized over factual accuracy. Claims like “Coconut oil cures cancer!” spread faster than academic articles on oncology. Review systems are also flawed, with purchased reviews and bot-generated comments. Even digital health devices designed to help can create new problems. For example, obsessive self-monitoring of health indicators can lead to severe anxiety, while inaccurate data can result in poor decision-making.

The 3rd gap is the “insufficiency mechanism.” Telemedicine services exist but remain inadequate. Health communication is available but cannot compete with well-funded misinformation. Most importantly, the development of critical health literacy is still lacking. Surveys show that even individuals with high health literacy scores can fall victim to misinformation. Knowledge alone is not enough—people need critical judgment, i.e., the ability to think analytically, ask questions, verify sources, compare information, and make rational decisions. However, education systems still emphasize rote memorization over critical thinking, mass media prioritizes speed over accuracy, and social culture often values respect for authority over questioning.

Thus, health literacy in the digital age is not just about knowing more, but about knowing carefully—being careful in accessing reliable sources, in understanding correctly, in communicating with trustworthy individuals, in making rational decisions, in adopting healthier behaviors, and in sharing accurate information.

Health literacy cannot be developed through simply providing or receiving information. It requires an enabling ecosystem that helps people “think critically, make informed choices, and take care of themselves appropriately within their own life context.” As demonstrated by lessons from the Phasi Charoen Project, when communities have shared learning spaces, trusted leaders, and appropriate tools, health literacy gradually grows from within and expands into mutual care at the community level.

Therefore, advancing health literacy in the digital space must move beyond focusing on “individuals.” The movement for health literacy must move toward addressing the broader “systems” and “structures” surrounding people—including policy, technology, communication, and the culture of using health information.

Key considerations for driving policy forward

To address the 1st gap in the health literacy movement, we need to develop regulatory organizations to oversee health information on digital media, establish standards for chatbots and health applications, certify advisors, create verifiable public trust marks, and collaborate with platforms to build alert systems. In addition, we may need to develop AI systems that analyze health content in real time—detecting exaggerated claims, comparing them with scientific evidence, and triggering automated warnings. Having a central platform that aggregates certified digital health services, links treatment entitlements, and securely stores health records would help build public trust.

For the 2nd gap, ethical standards must be established for those who disseminate information, especially health-related content. Providing medical advice without proper qualifications should be prohibited, and all claims should be evidence-based and accountable. However, ethical guidelines are meaningful only if there are effective enforcement mechanisms. At the same time, incentives should be created for social media platforms to adjust their algorithms—promoting high-quality health information, reducing exaggerated content, increasing content from credible sources, adding context, and possibly introducing friction mechanisms to slow the sharing of potentially false information. Establishing standards for digital health devices—covering accuracy, alerts, data protection, and clear disclosures of limitation—would also help prevent problems.

In addressing the 3rd gap, the key question is how to cultivate critical judgment in everyone. Education is the foundation. Health education curricula must teach children to question, verify sources, compare information, and guard against bias and conflicts of interest. People of all ages should be equipped with analytical thinking and critical judgment skills. There should also be accessible centers where the public can ask questions and receive reliable answers through multiple channels—supported by experts, databases of frequently asked questions, and rapid response systems.

Most importantly, **a culture of responsible health communication** must be fostered—across government, media, content creators, and the general public. It must be recognized that “clicking and sharing” does not always come from “good intentions,” as every act of health communication can affect the decisions and lives of others.

Guidelines for verifying online health information

Five key questions before you trust and share:

1. **Who is the author?** Do they have relevant health or medical qualifications?
2. **What is the source?** Are there citations from research studies or credible references?
3. **Is the information consistent with other sources?** Cross-check with multiple reputable sources.
4. **Are there conflicts of interest?** Is there an attempt to sell a product or service?
5. **Does it sound too good to be true?** If it appears miraculous, it likely is not accurate.

Trusted sources of health information:

- Ministry of Public Health website (moph.go.th)
- Department of Health website (anamai.moph.go.th)
- MohPrompt application
- Websites of leading hospitals
- Professional medical associations

In the digital world, health literacy is not a destination, but a collective learning process for society. Transitioning from being “literate” to being “discerning” is a critical challenge for Thailand. This is the agenda that requires a combination of wisdom, technology, and shared responsibility. The goal is to ensure the digital world serves as a catalyst for well-being, rather than a trap of misinformation that grows more intense and dangerous by the day.

The path ahead may be long and challenging, but if we work together, we can build a society that is both health-literate and health-discerning. We can create a future where people truly leverage digital technology for their well-being, and where no one is left behind in the digital age.



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4 Outstanding Achievements for Health

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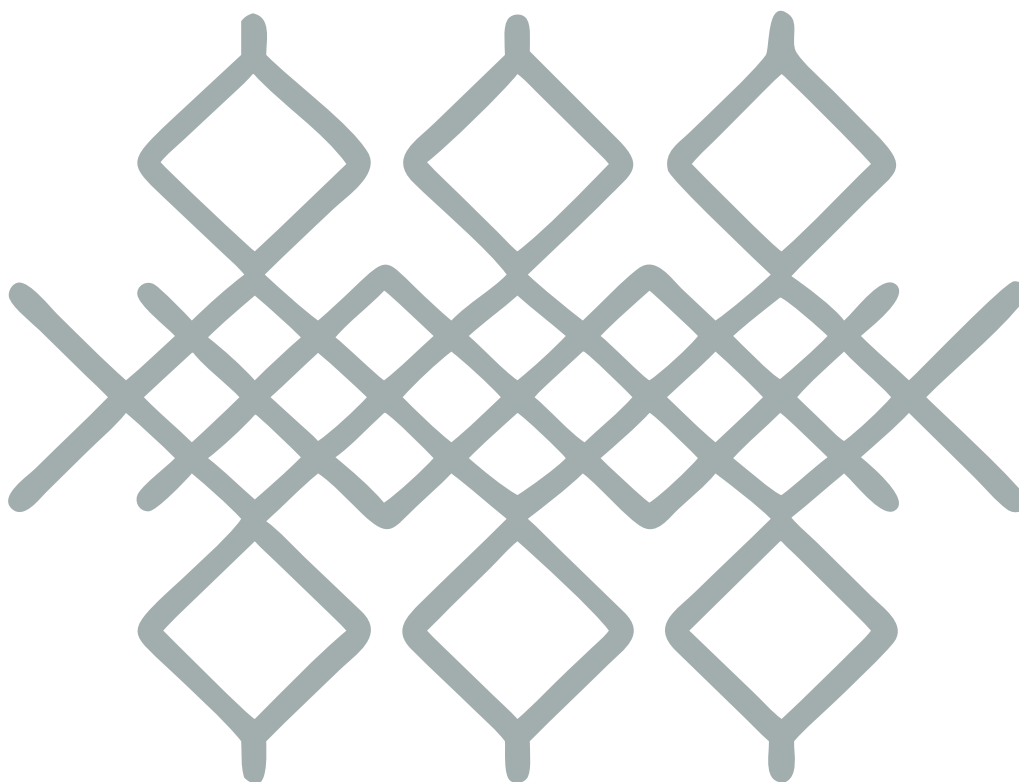
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Appendices

Criteria for the 2026 Thai Health Report

Part 1: Health Indicators

Work Process

1. Select key issues in population and health indicators through joint consideration by the Steering Committee and the Project Working Team.
2. Coordinate with experts who possess extensive knowledge and experience in the specified indicators, and who have access to reliable data sources with continuous annual data collection, to ensure up-to-date information.
3. Establish a timeline for article preparation, which includes jointly defining writing guidelines, presentation objectives for each indicator category, and a preliminary timeframe for data research and content development by the responsible working team.
4. Draft the health indicator content.
5. Hold brainstorming meetings to review the draft health indicators, jointly assessing their appropriateness, content coverage, and potential overlap through meetings of the Academic Working Team and the Thai Health Steering Committee.
6. Recruit experts to review and evaluate the health indicator categories by considering the overall picture of the entire “Thai Health Indicators” set, and provide recommendations for content revision and improvement.

Criteria for Developing Health Indicator Content

1. Define a clear key message for each category to ensure that the content presentation maintains a focused direction and does not become scattered.
2. Compile and analyze statistical data for the selected indicators, emphasizing annual data to demonstrate trends over time, as well as the latest survey results to reflect the current overall situation.
3. Present the content in a concise, easy-to-read, and accessible format for readers of all age groups.

Part 2: 10 Health Milestones in the year and 4 achievements to support Thai health

The situations of the year consist of the top 10 key situations and 4 positive achievements for Thai health. This section is collectively referred to as the “Top 10+4 Key Situations.” The criteria for selecting and ranking these key situations are as follows:

Criteria for Selecting Key Situations

1. Situations that occurred in the preceding year, or situations previously reported but presented again to highlight recent developments or changes as lessons for Thai society.
2. Issues that have a significant and wide-ranging impact on the health of the Thai people, including those related to safety and security.
3. Health-related policies that have been implemented or have demonstrated clear, practical outcomes within the year.
4. Emerging issues that have never occurred before.
5. Issues that occurred with high frequency throughout the year.

For the “achievements” toward advancing the health of the Thai people, these refer to successful innovations, advancements in health science, and the discovery of new approaches that benefit public health and Thai society at large.

Part 3: Feature Topic

The special topic of each edition takes two forms: target-group-oriented topics and issue-oriented topics. Different topics of interest may be selected each year. The topic may be chosen from the top 10 key situations of the past year or from notable health indicator topics.

Criteria for Selecting the Special Topic

1. The topic holds policy-level significance.
2. The topic is highly beneficial to the public.
3. The topic presents diverse issues and perspectives.

Work Process

1. The Thai Health Steering Committee meets to select the special feature topic for each year.
2. The Project Working Team defines the framework and outline of the report.
3. Experts in each relevant area are contacted for interviews to support the report’s preparation.
4. The Project Working Team compiles and edits the academic content to ensure it is suitable for public consumption, and verifies its accuracy again with academics and subject-matter experts.
5. Experts review the draft report and provide final revisions.

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10 Outstanding Health Situations & 4 Outstanding Accomplishments for Health

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