

**FAMILY PLANNING AND THE THAI FERTILITY DECLINE:  
APPLYING A CULTURAL FRAMEWORK FOR ANALYSIS**

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**Abstract.** This paper represents the marriage of two research projects that I conducted as an undergraduate at Millsaps College. As a junior, I was assigned a research paper in which I had to examine a contemporary social phenomenon using the major theories of three classical sociologists. I chose to examine the recent and remarkable demographic history of Thailand, a nation regarded by many as providing a highly successful example of voluntary family planning. The results of this academic exercise suggested that there are meaningful patterns in fertility behaviors that correspond to religious and linguistic affiliations. I later decided to pursue a deeper understanding of the Thai demographic transition by studying in Thailand and touring the sites of family planning activity myself. After completing intensive language training, I enrolled as a student at Chiang Mai University in Northern Thailand for the fall semester of my senior year. As I met with public health officials and nongovernmental volunteers who operate Thailand's multifaceted family planning program, and as I became more fluent in Thai culture and Theravada Buddhism, my perspective on family planning has gradually shifted focus. My goal in this paper is to increase awareness of the diverse and interrelated factors involved in individual couples' reproductive decision-making. In the context of Thailand, a unique combination of cultural traits, personal motivations, and institutional supports have precipitated a dramatic demographic transformation over a relatively short period of time.

## AN OUTLINE OF THAI DEMOGRAPHIC HISTORY

*All formations are impermanent (Sakyamuni Buddha, Anguttara Nikaya III.134).*

*A challenging task for future research will be to determine more precisely which particular constellations of cultural traits promote and which hinder a fertility response to the combined forces of socioeconomic change and the organized efforts to promote fertility control that are increasingly characterizing most of the developing world (Knodel, Havanon, and Pramualratana 1984:325).*

The Southeast Asian nation of Thailand has undergone one of the world's most rapid and uniform demographic transitions. In the 1960s, the total fertility rate in Thailand was over 6.6 children per woman, yielding a population growth rate greater than three percent per year (Knodel and Pitaktepsombati 1973:229). The predicted costs of providing social infrastructure to support such a large population—then estimated to surpass 100 million people by the turn of the millennium—led the Thai Cabinet to drop its pronatalist position on population growth and initiate a National Family Planning Program (hereafter, NFPP) in March 1970. Administered by the Ministry of Public Health, the Thai NFPP was specifically charged “to inform eligible women, particularly those living in rural and remote areas, about concepts of family planning, to motivate them to use contraception, and to make family planning services readily available throughout the country” as well as “to integrate family planning activities with overall maternal and child health services and thus mutually to strengthen the activities in these closely related fields” (Gullaprawit 1997:3, 5).

The Thai Cabinet and the Ministry of Public Health designed their NFPP with the intention of reducing the rate of annual population growth from 3 percent to 2.5 percent by 1976, a numerical target outlined in the program charter as well as in a national five-year economic plan (Burintratikul and Samaniego 1978; Knodel and Pitaktepsombati 1973:230). Within just a few years, greater contraceptive prevalence and a decline in fertility were noticeable throughout the kingdom, among urban and rural couples alike. Each numerical target set by the NFPP over the following two-and-a-half decades was met or exceeded, reducing the total fertility to below the replacement level of 2.25

children per woman by the late 1980s or early 1990s (Knodel et al. 1996:308). Demographers now expect the Thai population to peak below 75 million people, a downward revision of almost 35 million from estimates made in the late 1970s (Gullaprawit 1997:21; Population Reference Bureau [PRB] 2005).

The rapid Thai fertility transition has been attributed to the prevalence of free or low-cost contraceptives provided to women throughout the kingdom by the Ministry of Public Health and nongovernmental agencies that cooperate with the NFPP (Kamnuansilpa, Chamrathirong, and Knodel 1982; Rosenfield et al. 1982:43). Contraceptive use skyrocketed from 14 percent in 1970 to 37 percent in 1975, 50 percent in 1979, and surpassed 70 percent in 2003 (Kamnuansilpa et al. 1982:52; United Nations 2003a). Demographer John Knodel and his associates have noted that the fertility transition “permeated virtually all major segments of Thai society, with the partial exception of Malay-speaking Muslims in the lower south” and a few hill tribe communities in the upper north (Knodel et al. 1996:310-311). Socioeconomic differentials that typically delineate the contours of contraceptive use—such as education, income, and urban-rural locality—were virtually insignificant in the Thai context (Rosenfield et al. 1982:43).

Thailand’s success was unexpected primarily because the nation was not as economically developed as many of its peer nations on the stage of replacement-level fertility. Thailand was a relatively less developed country at the time of greatest fertility decline. In their review of 37 countries approaching replacement-level fertility in 1985, Mauldin and Ross found that Thailand was the lowest-ranking country in the “certain [to reach replacement level by 2015]” category in terms of socioeconomic development (57 percent on a composite scale)<sup>1</sup>, primary and secondary school enrollment (63 percent), percent urban residents (18 percent), and life expectancy at birth (65.8 years), and was among the lowest on other indicators such as infant mortality rate (38 per 1,000), gross national product per capita (US \$800), and the percent of male laborers outside the agricultural sector (35 percent ) (Mauldin and Ross 1994: Tables 3 and 5). These 1985

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<sup>1</sup> Mauldin and Ross (1985: Appendix II) include seven items in their composite scale: life expectancy, infant mortality rate, percentage of males employed in nonagricultural jobs, GNP per capita, percentage of the population living in an urban area, percentage of literate adults, and the percentage of school-age children enrolled in primary and secondary school.

figures describe the status of Thailand *after* substantial gains in socioeconomic development during the 1970s. The period of most rapid fertility decline occurred at an even earlier stage of development than depicted by Mauldin and Ross's scores.

The significant of Thailand's achievement—successfully implementing a substantial and nearly universal reduction in fertility while still undergoing the transition from a rural to an industrial economy—raises questions about the traditional model of demographic transition. The demographic transition model stipulates that countries begin to experience fertility decline when forces of modernization reach a sufficient threshold. Roberta Hall summarizes the expectation of the tradition demographic transition model:

From the time of Max Weber, fertility decline has been considered one index of a general social process, initiated by the adoption of industrial technology, that alters the economic and social-psychological fabric of society. In this model, fertility decline is expected to originate in and spread outward from urban areas and to be noted first among the upper classes, i.e., those most exposed to modernizing influences (Hall 1972:212).

Technology, economy, and urbanity are the factors responsible for fertility decline, according to the demographic transition model. Cultural factors, on the other hand, are not traditionally emphasized in this model, Religion, in particular, is seen as “a very poor predictor of fertility behavior” (p. 213).

The data from Thailand suggest that social scientists would benefit from an alternative perspective on demographic transition. While economic factors certainly play an important role in social change, the history of Thailand's “reproductive revolution” highlights the role that cultural factors play in shaping the outcome of family planning initiatives. In particular, religious affiliation may encourage a set of behaviors and living patterns that influence individual couples' reproductive decisions. Religious and communal traditions may exert substantial influence on family structure, household composition, gender roles, and the moral evaluation of birth control. The majority of Thai couples prefer a balanced family with one child of each sex, in order to fulfill the unique responsibilities assigned to each gender in the traditional Thai family structure. In the following pages, I will offer a perspective for examining Thai fertility behaviors that

treats cultural traits as the primary focus, rather than discounting them as in traditional demographic transition models.

#### **THE RELIGION OF THE ELDERS: ANCIENT BELIEFS IN A MODERN NATION**

Approximately 95 percent of the Thai population follows Theravada Buddhist traditions. Along with the king and the Thai state itself, Buddhism is formally recognized as one of the three pillars of Thai society (Mulder 2000). In 1976, the kingdom included over 25,000 Buddhist temples and approximately 328,000 monks and novices (pp. 92-93). Given the ancient history of Theravada Buddhism in the region—the religion long predates the Thai state—it should come as no surprise that Buddhist ideas and their derivatives inform a great deal of daily life and social interaction in Thailand.

Theravada, which means “Teachings of the Elders,” is the oldest and most doctrinally conservative branch of Buddhism remaining today. Theravada Buddhists believe that followers must achieve enlightenment on their own through critical examination of Buddhist philosophy and ritual. Theravada Buddhists trace their individualistic approach from the practice of the Buddha’s original disciples and argue that only enlightened individuals can properly assist others in their pursuit of *nirvana* (Spiro 1970:3-14).

Niels Mulder (2000) posits that Buddhism coexists harmoniously with lingering animistic beliefs in contemporary Thai culture. The popular Buddhism of the Thai majority includes animistic rituals and spirit cults, talismans and magic. Only a small minority of Thais, typically among the elderly, deliberately seek the ultimate Buddhist goal of *nirvana*: escape from the endless cycle of rebirth. Most Buddhists try to live according to five fundamental precepts that inform morality and encourage detachment from worldly desires (Keyes 1983:859). The first precept, perhaps the cornerstone of Buddhist morality, commands Buddhists to refrain from taking life (p. 857). The key issue in the present discussion is the relationship of this first precept to Thai Buddhists’ ideas about family planning.

Theravada Buddhists believe that the creation of new life requires three necessary circumstances. First, a woman and a man must have sexual intercourse. Second, the woman must be in her “season,” or ovulating at the time of intercourse. At this point the

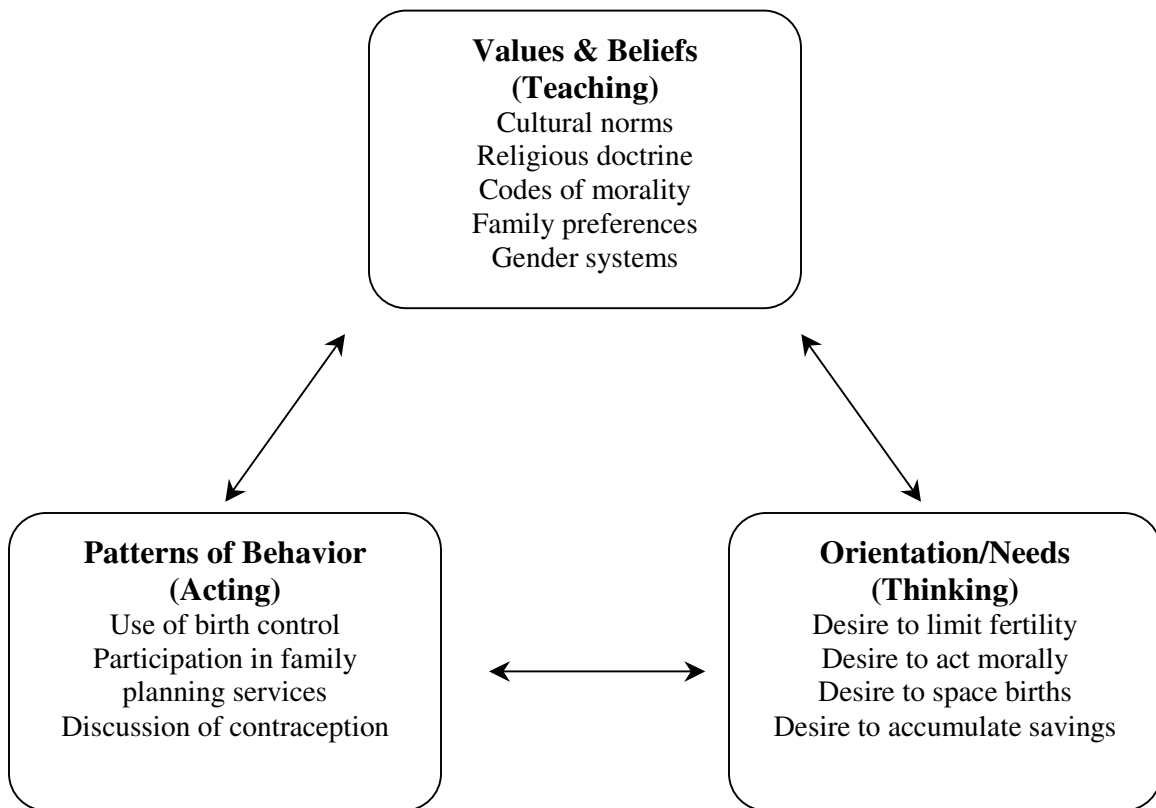
Buddhist interpretation of conception departs from secular interpretation and an additional, religiously-defined element is introduced. Thai Buddhists believe that the creation of new life in a woman's womb requires the presence of a *gandhabba*, a being whose time has come to be reborn as a human child. In Northern Thai language, this concept is labeled *ju-ti*, and is often the soul or *winyaan* of a familial ancestor, such as a deceased grandparent, whose time for rebirth has come. The absence of any one of these factors prevents the conception of new life—only when all three combine does conception take place. Contraceptive devices, however, prevent the *gandhabba* from combining with the requisite physical forces, thus effectively preempting the creation of a new human being. Because the necessary ingredients did not combine, life was not created; neither was life taken (Ling 1969:57). A Thai Buddhist friend simply informed me that “In the Buddhist religion, [the use of contraception] is okay. *May pen ray*—no worries, it's not a problem.”

As in many other areas of life, Buddhism grants its followers a great deal of personal autonomy regarding their fertility decisions. While the life-and-let-live attitude of the precepts establishes some general moral ideals, there is no explicit code of proper behavior or formal institution by which offenders may be punished (Keyes 1983:859). Allan Rosenfield and his Thai associates echo the conclusions of many social scientists in their observation that:

Individualism, nonconformity and freedom of action are considered to be notable characteristics of Thai behavior. These characteristics can be traced directly to Theravada Buddhism: Because a person's store of merit, whether from actions taken in this life or in previous lives, is believed to be primarily of his own doing, Thais tend to be nonjudgmental of (frequently, indifferent to) each other's actions. Thai Buddhism also emphasizes individual privacy and responsibility; such attitudes seem to limit the amount of social pressure either for or against the practice of family planning (Rosenfield et al. 1982:49).

The language of Buddhist doctrine and of religious leaders suggests that reproductive behavior is considered primarily a pragmatic rather than spiritual matter. When T. O. Ling asked a Theravada Buddhist monk in Ceylon if he favored the island's rapid population growth, the monk responded: “No, because not all the children born can

be properly cared for and some will be badly brought up; because they will not be properly provided for, some of the children will fall into crime” (Ling 1969:54). Similar social concerns were voiced by Ling’s Thai monk respondents as well. Pragmatism seems to drive the responses of these modern religious leaders, indicating a generally ambivalent or cautiously antinatalist attitude among the Buddhist clergy and suggesting that the Thai Buddhist laity would likewise see no moral contradictions involved in practicing birth control. Statistical data support this hypothesis. In a 1994 survey of almost 6,000 Buddhist women in the southern region of Thailand, no one considered family planning to be contrary to Buddhist morality (NSO 1995; Knodel et al. 1999, Table 7).



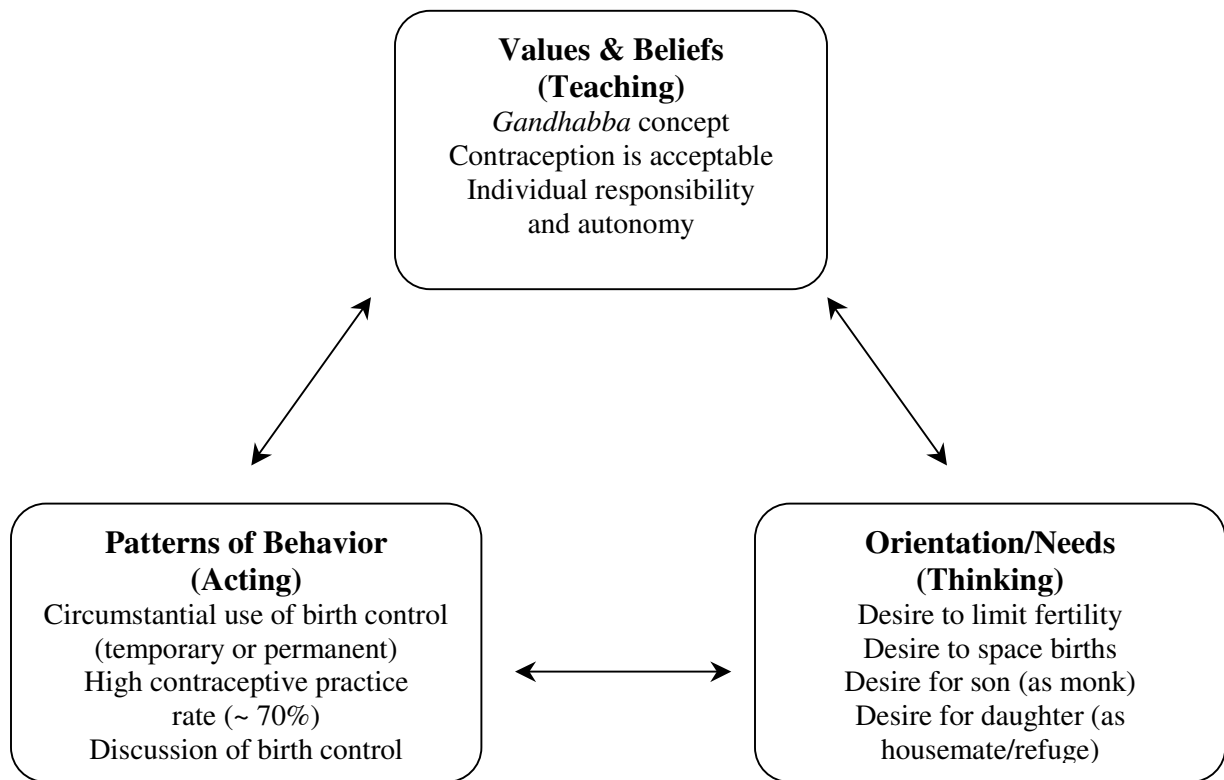
**Figure 1: Basic application of model to the study of Thai fertility**

The sociologist Max Weber offered a simple and practical model for taking religious and cultural factors into account when discussing social systems. Talcott Parsons synthesized the Weberian social system into a three-dimensional model wherein

the components are reciprocally related to each other and combine to make up the social system as a whole (Parsons 1947:3-86; Turner, Beeghly, and Powers 2002:228-229). In the context of Thai society and reproductive decision-making, these three dimensions of social phenomena are the Thai fertility structure, the value systems supported by Thai religious beliefs, and the personal motivations and psychological orientations of the followers of those religions. Figure 1 illustrates the relationship of these three social domains. Social structure is defined by the actual patterns of behavior of individuals. In this application, social structure coincides with the Thai fertility patterns in which people use (or abstain from using) a variety of contraceptive techniques. Cultural values and beliefs are determined in part by the relevant doctrines of Theravada Buddhism. What the moral dialogues of religions say about reproduction, contraception, and behavior in general has a regulatory or definitive effect on individuals' conceptions of morality and proper behavior. Finally, the psychological orientation of actors in this context refers to the personal needs experienced by individuals in the course of their lifetimes, including their orientations toward economic and psychological well-being.

Figure 2 applies Weber's model in order to chart the circumstances that influence Thai Buddhists' low fertility. As noted, Thai Buddhists hold no religious objections to the practice of family planning. In Parsons' synthesis of the model this is reflected in the "values and beliefs" component, which in turn influences Buddhists' orientations and behaviors. Patterns of behavior reflect the high prevalence of contraceptive use among Buddhists and their corresponding low fertility rates. In a 1984 survey of contraceptive practices in Thailand, 70 percent of Thai Buddhist women were found to practice contraception, and their corresponding total fertility rate was 2.6 (Kamnuansilpa and Chamrathirong 1985). This pattern of behavior indicates that people's values and personal motivations lead them to limit their fertility by adopting contraception. Contraception is a culturally and morally viable option that suits their psychological orientations toward lowering family sizes. In turn, the increasing normalization of low fertility and contraceptive use causes Buddhists to regard family planning as a routine activity. Birth control, originally a novel technology, becomes the common means of practicing a normal and desirable lifestyle.





**Figure 2: Application of model to Thai Buddhists' fertility**

**FAMILY PREFERENCES AND GENDER ROLES IN THAI BUDDHIST SOCIETY**

The Weberian model of social systems is also useful for outlining the specific family preferences of Thai Buddhist couples. In Thai Theravada tradition, women are regarded as autonomous individuals who often exert considerable influence of household decision-making, particularly where finances are concerned. The relative equality of women in the Thai worldview is reflected by Thai couples' ideal family preferences. The preference for a son, which is common to many Asian countries, is conspicuously absent in Thailand (Kamnuansilpa et al. 1982:56; Knodel et al. 1996:312; Knodel et al. 1999:157). A 1993 survey of married women's ideal family composition found that 77.4 percent desired an equal number of sons and daughters. While 13.9 percent of respondents indicated that they preferred to have a greater number of sons, this trend was partially offset by the 8.6 percent who said they would rather have a greater number of daughters (NSO 1997).

Traditional gender roles and expectations contribute to Thai parents' tenacious preference for having balanced family compositions. Sons are valued for their contribution to parents' spiritual well-being as temporary monks, while daughters are valued as the preferred caretakers of parents in their old age. The combination of two Buddhist elements—meritmaking and *bunghun* moral obligation—helps explain the important Thai tradition of temporary holy ordainment. Mulder describes this “rite of passage between adolescence and marriage” as a cultural ideal expected of every young man, that typically follows the completion of secondary education or mandatory military service (Mulder 2000:93). For about three months during the rainy season, young men are ordained as monks and reside at temples, where their daily merit-making activities generate good *karma* not only for themselves but for their parents as well—particularly for their mothers.

The traditional role of male children in the family structure originates from Buddhist and animistic beliefs. For most Thais, the ultimate goal of *nirvana* is a distant prospect, while personal security, well-being, and ensuring the good favors of the spirits are more immediate concerns that can be readily addressed by merit-making activities. Niels Mulder, drawing upon the work of B. J. Terwiel (1975), explains that:

The common understanding and practice of Buddhism remains animistic in the sense that merit-making is generally understood as a mechanism to ensure safety and auspiciousness, and thus the institutionalized Buddhism of the masses has become a powerhouse for individual and communal protection. To most Thais...accruing merit is a technique to ensure safety in a world that is replete with unreliable forces, and the consequent understanding and practice of Buddhism can best be described as “Buddhist Animism” (Mulder 2000:34).

Moral responsibility and the performance of merit-making activities can push *karma* in a positive direction and ensure a better future, including better prospects for future reincarnation (*chiwit mày*) (Keyes 1983:856). Thai parents recognize the potential for their sons, as temporary priests, to earn merit on their behalf.

A second element of the Thai Buddhist belief system that has important consequences for family structure and gender roles lies in the concept of *bunghun* relationships. These relationships are characterized by intentions of pure goodness and

endless self-sacrifice by the patron figure for the well-being of the beneficiary, who in turn acquires an eternal moral obligation to his or her patron. The archetypal *bunghun* relationship is between the mother and her children; the relationships of teachers to pupils and of the earth to humans are also conceptualized as *bunghun* patrons and beneficiaries (Mulder 2000:32-33). Mulder counsels that “the feelings that should guide the relationship towards all those people who have *bunghun* to us, its beneficiaries, are trust, warmth, love, protection, dependence, gratitude, reverence and acceptance of one’s identity” (p. 33). If beneficiaries fail to perform their proper roles, they will face the inescapable spiritual and psychological consequences:

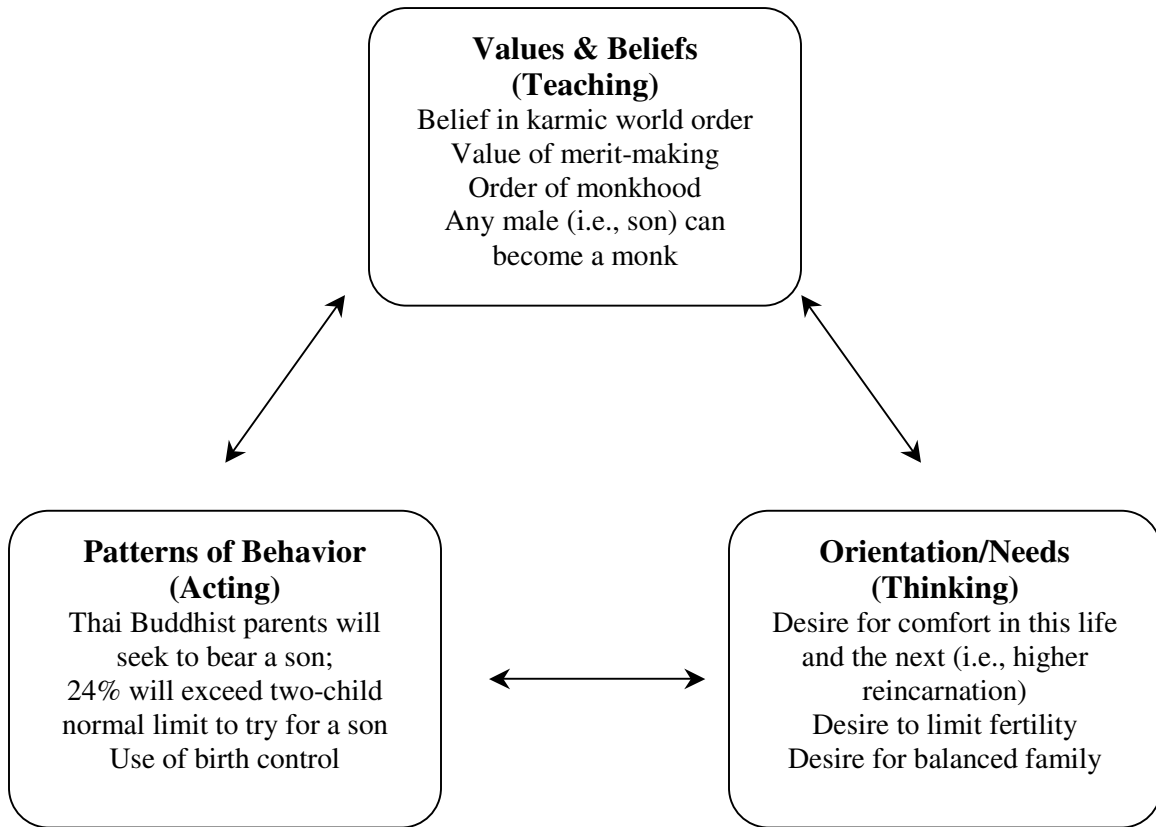
*Nerakhun*, that is ingratitude or the refusal to acknowledge the moral goodness that one has received, is to sin against the dependable order of morality, and will automatically be punished by the principle of moral justice, called Karma. Psychologically, such negative behaviour is a source of guilt feelings (p. 32).

Every Thai is the beneficiary in some relationships—as a child, a student, a junior—and thus owes a moral debt to his/her patrons. Mulder writes that “such profound *bunghun* relationships are...expressed in the periodic rituals of honouring parents, elders, and teachers as the keystones of the unfailing moral order” (p. 33).

The exclusively male order of the Buddhist *sangha* (monkhood) is one of the most institutionalized forms of Thai women’s forced dependence. The unspoken implication of this arrangement is that women are prevented from personally fulfilling their own spiritual needs: they are formally made reliant on their sons for this purpose. A. Thomas Kirsch (1985) has written that “many real-world young men who might otherwise be reluctant are ordained precisely because of their love for their mothers and their desire to provide them with the enormous religious awards they can receive only in this way” (p. 308). One consequence of this arrangement is that young women who might otherwise be reluctant to engage in childbearing may do so because their spiritual well-being depends on having sons.

Figure 3 applies the religious and familial beliefs and obligations that interact to determine Thai Buddhists’ son-oriented fertility behaviors. The cultural value placed on merit-making, and the belief that sons as monks may earn merit on the parents’ behalf as

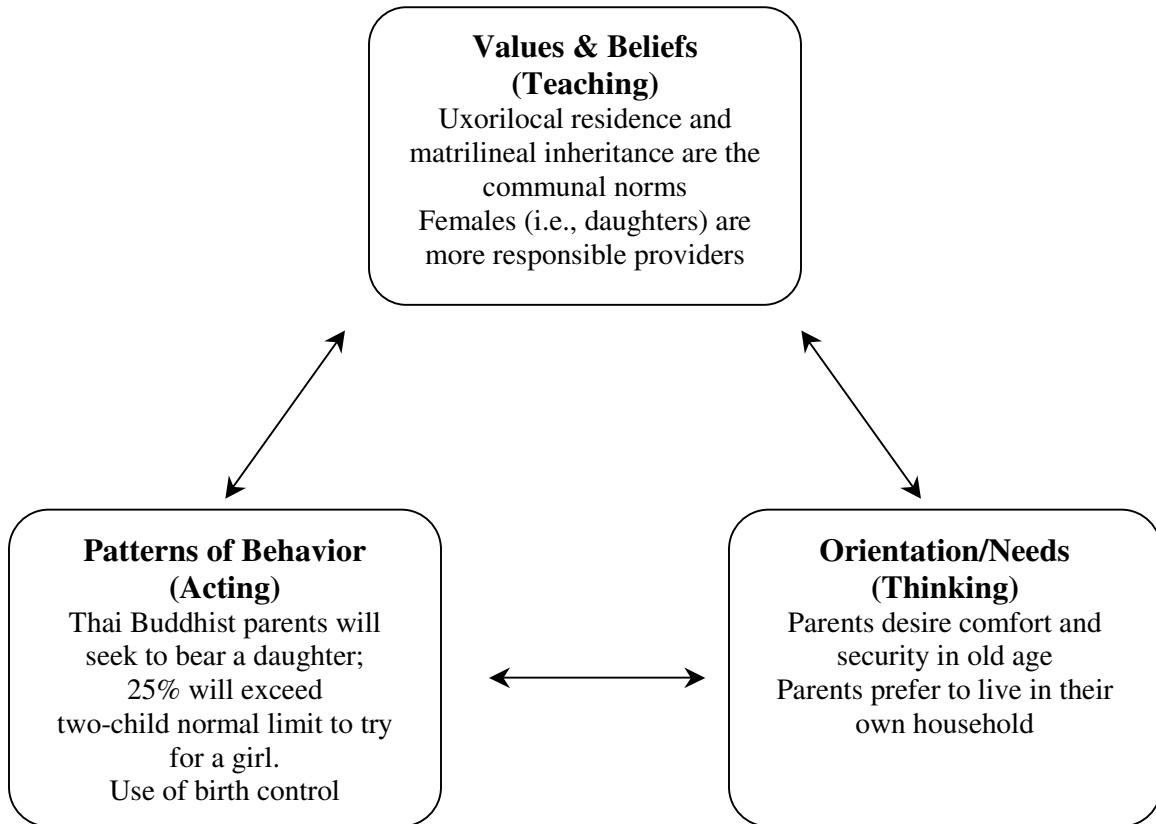
repayment in the *bunghun* relationship, prompt parents to desire sons and to modify their fertility behavior accordingly.



**Figure 3: Application of model to Thai Buddhists' son-oriented fertility**

In his 1969 research, T. O. Ling was informed that the motivation to have a son to serve in the monkhood “could still be a potent factor in determining actual fertility size at a higher level than might otherwise be the case” (Ling 1969:55). Data from Thailand’s Social Attitudes Toward Children Survey in 1993 have confirmed this behavior pattern. Among women who have only one child, 70 percent of those with a daughter want to continue reproducing in order to have a son. A substantial portion of women are even willing to exceed the normative two-child limit in order to bear a son: 24 percent of women with two daughters will pursue an additional pregnancy in hopes of bearing a son (NSO 1997).

Daughters, as well, have a traditional role in the Thai family structure that influences parents' reproductive plans. In most regions of Thailand, uxori-local residence is the traditional pattern of post-nuptial residency (Keyes 1983:852). After marriage, couples typically live on property owned by the wife's parents, often occupying the same household or residence compound. Consequently, it has become common for married couples to reside with their daughters and sons-in-law in their old age, as these children are likely to live nearby or already occupy the same household. Wives typically control the family purse, so the choice of residing with one's daughter presumably ensures that parents will receive adequate care in old age.



**Figure 4: Application of model to Thai Buddhists' daughter-oriented fertility**

While most parents expect some form of support from their sons as well, most Thais regard women as the more responsible gender and thus daughters are expected to be more reliable providers. Visid Prachuabmoh's respondents shared the impression that "daughters living away from home are more likely than sons to send money to parents for

their support” (Prachuabmoh, Knodel, and Alers 1974:613). The traditional preference for residing with daughters helps to enhance the importance of females, relative to their brothers, in Thai family planning decisions (Knodel et al. 1996:312).

The 1993 survey data show that Thai attitudes toward daughters are nearly identical to their attitudes toward sons. Seventy-two percent of survey respondents with only a single male child wanted to have additional children, and 62 percent specifically wanted to have a daughter. Twenty-five percent of women who had two sons and no daughters were willing to continue reproducing in order to satisfy the demand for a girl child (NSO 1997). Thai female children are clearly valued on par with their brothers, a reflection of the relatively sexually egalitarian arrangement of the Thai social system. The social and familial status of Thai Buddhist women is worth further examination, given the obvious and intimate relationship between women and fertility trends.

#### **THAI FEMALE AUTONOMY AND THE EMERGING FERTILITY PARADIGM**

Karen Oppenheim Mason writes that “country-level analysis...has found an inverse relationship between the rate at which women work in the formal sector of the market and the fertility rate” (Mason 2001:167). The demographic circumstances in Thailand aptly fit the pattern identified by Mason. Thai women’s participation in the labor force is relatively high: in 2002, 61.5 percent of working-age women participated in the labor force, compared to 79.8 percent of men (NSO 2002a).<sup>2</sup>

Thai women’s high labor force participation implies a great deal of daily interaction in the public sphere. In 1984, Knodel et al. could firmly state that Thai women were “fully exposed to the socioeconomic change [of the 1970s] and have equal access to the communication and transportation networks that have penetrated the countryside”(p. 314). Such exposure, argued Knodel, is critical for raising awareness and for the adoption of family planning services (Knodel, Debavalya, and Kamnuansilpa 1980:96).

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<sup>2</sup> The Thai government’s One Tambon One Product program, which promotes the local production of a unique trade product by each *tambon* or village, has contributed to substantial household-based handicraft production, particularly in rural areas. In 2002 over 450,000 women were engaged in household-based employment (NSO 2002b).

Another useful indicator of sexual equality is the relatively equitable distribution of educational resources in Thailand. Although the sex ratio of primary-level enrollment is just 93.8 females to 100 males, by secondary level this ratio becomes 111.0 females to 100 males; and by tertiary level the predominance of females increases to 118.3 per 100 males (NSO 2000b). Young adult literacy rates are also nearly equal (NSO 2000a). The UN estimates that 55 percent of professional and technical workers in Thailand are female, and the ratio of estimated female-to-male earned income is nearly identical to the United States level (UN 2003b).<sup>3</sup>

Mainstream Thai society provides many woman a great deal of “freedom of movement” as described by Mason (2001):

The greater the extent to which gender or family systems grant women freedom of movement, encourage their education or familiarity with the world outside the home, and give them control over material resources, the greater the extent to which women will be able to learn about and adopt family-limitation methods (p. 169).

Thai women access the public sphere on a daily basis, are educated as well as or better than Thai men, and perform important roles in the developing consumer economy. Additionally, Thai wives typically control the material resources of their households, although their husbands are recognized as the ultimate authorities over family decisions. Thai women exercise considerable authority in matters of reproductive choice. Rosenfield et al. (1982) found that:

With regard to practicing contraception, women acted independently of their husbands; many husbands in the study group said that practicing contraception was completely up to their wives, since they are the most burdened by child-bearing and child-raising (as well as being the controllers of the family purse) (pp. 49-50).

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<sup>3</sup> The UN Human Development Report for 2003 estimated that U.S. women earned on average 62 percent as much as U.S. men, while Thai women earned on average 61 percent as much as Thai men (see Human Development Indicators for sections 22 and 23). The report warns that “because of the lack of gender disaggregated income data, female and male earned income are crudely estimated on the basis of data on the ratio of the female non-agricultural wage to the male non-agricultural wage, the female and male shares of the economically active population, the total female and male population and GDP per capita” (Footnote c of section 22).

Women may discuss the pros and cons of various contraceptive methods with their more experienced friends, but they are unlikely to turn to parents, siblings, or husbands for advice (Yoddumnern-Attig, Podhisita, and Vong-Ek 1992:69-70). The typical Thai family system is nonlineage-based, which means that parents, grandparents, and other relatives have little or no say in a couple's fertility decisions (Knodel et al. 1984:313; Mason 2001).

Women's relatively equal access to educational and economic resources, combined with their personal identities as autonomous individuals within the Thai Theravada Buddhist worldview, justify the usual academic characterizations of Thai society as sexually equal. However, while Thai women typically enjoy high status, it is precarious to assume that their social roles and the means by which they gain status are identical to those of men. A Thai proverb which perhaps most concisely expresses the traditional ideal woman states that "the woman is the hind-legs of the elephant," meaning that women should provide the greater share of work and effort, while men (as the head of the elephant) steer the family and reap the public rewards. Men are regarded as the more powerful, active, and reckless sex, while women are expected to be nurturing, dependable, and responsible. A Thai woman's public status is thus contingent upon the males with whom she is associated—father, brothers, husband, and sons (Mulder 2000).

The limits of the current research agenda prevent a more comprehensive view of women's status and gender roles in Thailand. However, this brief introduction should suffice to demonstrate that the "high status" noted for Thai women does not preclude significant sexually-biased cultural norms.<sup>4</sup> For the purposes of this investigation, Thai women's reproductive autonomy is obviously of great interest. Other social patterns—some which promote women's freedom, others which constrain it—have influence on family planning outcomes as well. The structures of families, residence compounds, and the broader community determine the pathway of communication and thus shape individual responses to the family planning idea.

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<sup>4</sup> For further information on the status of women in Thai society, please refer to Bencha Yoddumnern-Attig et al., *Changing Roles and Statuses of Women in Thailand: A Documentary Assessment* (Bangkok, Institute for Population and Social Research, Mahidol University, 1992) or *UNESCO, Status of Women: Thailand*, RUSHSAP Series on Monographs and Occasional Papers No. 26 (Bangkok; UNESCO Principal Regional Office for Asia and the Pacific, 1990).



## **ISLAM AND FERTILITY IN SOUTHERN THAILAND**

The fertility practices of most Thai Buddhist women differ substantially from their Muslim counterparts in the southernmost districts of the country. In an in-depth ethnographic study of sites at opposite ends of Thailand, Yoddumnern-Attig and associates concluded that there are important regional differences in community structure and consequently in women's patterns and networks of communication about family planning. Religious affiliation appears to be the key indicator of social organizational type in each respective region. In the southern district of Trang, Islamic influence is reflected in a predominantly communal living arrangement: several nuclear families within a common kin group are likely to share a single residence compound that is relatively isolated from other kin groups' dwellings. Family planning decisions in the South are more likely to be discussed within the extended family and subject to the influence of the wider kin group (Yoddumnern-Attig et al. 1992:iii-iv, 7, 27). In the northeastern district of Surin, nuclear families are the norm, and households are likely to be spatially close together. Reproductive decisions in the Northeast are much more individualistic; women are likely to decide for themselves whether to use birth control, often without even discussing the matter with relatives (pp. iii-iv).

The communicated idea of family planning is qualitatively different in each region as a consequence of the different pathways the idea takes. Each instance of ideational communication is governed by rules specific to the particular relationship. In turn, individuals in different regions may differ in their types of knowledge and attitudes about family planning. An individual's receptivity to the idea is also influenced by the perceived status or wisdom of the idea giver, as well as the manner and context of the discussion. In the Northeast, women were exposed to the idea as presented in mass media campaigns, on billboards, and, perhaps most importantly, by word-of-mouth communication with friends, colleagues, and occasionally medical personnel. Family planning for these women was a public and secular idea that was explicitly validated by governmental and medical authorities. In the South, family planning was discussed within the multigenerational female kin group, wherein the moral-religious evaluations of birth control by senior members determined the acceptability of family planning for all

members. Women has less exposure to the direct media and knowledge campaigns employed by the NFPP (Yoddumnern-Attig et al. 1992).

Another important aspect of communication about family planning lies in normative restrictions about who should have access to information about sexuality and contraceptive technology. Yoddumnern-Attig and associates explain that “In terms of culture, community conventions dictate the timing at which unmarried women can seek and use contraceptives” (Yoddumnern-Attig et al. 1992:46). In the Northeast, Yoddumnern-Attig interviewed a young woman who was denied services by a government nurse because she was “young and unmarried” (p. 44). For many Thais, sexual behavior is permitted solely within the context of marriage. Communal norms dictate that information about sexuality and family planning cannot pass to young women through *intimate* (family) networks.<sup>5</sup> Yoddumnern-Attig and associates explain that “Family planning knowledge is inaccessible, normally, to unmarried women. A curious seeker will be publicly criticized, as well as her family” (p. 50). Consequently, most women find out about these issues through informal and somewhat covert communication with *effective* network members—that is, friends, coworkers, and classmates. Some women are also exposed to media messages about family planning that are broadcast through *extended* networks, including media outlets, medical providers, village leaders, and other socially distant voices (p. 50).<sup>6</sup>

In the predominantly Buddhist Northeast, women may turn to effective network members for contraceptive advice because these same friends were the first people to openly discuss matters of sexuality with them. The pathways of communication about sexuality and family planning necessarily overlap to a great degree. Islamic tradition in Southern Thailand places greater value on group solidarity and discourages discrepant decision-making to an extent. Consequently, matters of sexuality and reproductive health are less likely to be communicated along effective networks in this region and Muslim

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<sup>5</sup> The three types of networks discussed here—intimate, effective, and extended—are drawn from Boissevain, J. , 1974, *Friends of friends: Networks, manipulators and coalitions* (Oxford, England: Basil Blackwell).

<sup>6</sup> Importantly, the legitimacy of messages in extended networks is often enforced by the perceived special authority of these voices (e.g., medical providers’ knowledge of reproductive healthcare). This same authority and specialized knowledge contributes to the social distance of extended network members, although in some cases the networks necessarily overlap (e.g., the family and friends of a doctor or village leader).

women in particular are more likely to confine dialogues about sexuality within their intimate networks (Yoddumnern-Attig et al. 1992; Boissevain 1974). Islamic women in Southern Thailand are also more likely to consult their husbands for a *normative* decision about birth control—that is, whether or not to use contraception at all (Yoddumnern-Attig et al. 1992:61).

The community and family structural differences between Thai Buddhists and Muslims are determined not only by religious tradition, but by the history and status of each group and their respective locations within the larger Thai social structure. Eighty-one percent of Thailand's Muslims live in the South, particularly in provinces near the Malaysian border. In four southern provinces—Pattani, Yala, Narathiwat, and Satun—Muslims outnumber Buddhists and constitute a provincial majority (NSO 1990). Three of these provinces were formerly part of the Sultanate of Pattani, which also included territory now held by Malaysia (Knodel et al. 1999:150-151). This sultanate was incorporated by the kingdom of Siam in 1902 in order to create a buffer against imperial Britain (Chughtai 2004). The recent flare-ups of violence in the South, driven by separatist groups, are linked to a longer history of conflict between Buddhist Thailand—particularly the national government—and a Malay-speaking Muslim subculture that, in many ways, has never been Thai (Chughtai 2004). In part by choice, the Malay-speaking Muslims of Southern Thailand occupy a marginal space in Thai society and maintain strong linguistic, cultural, and familial ties with neighboring Malaysians.

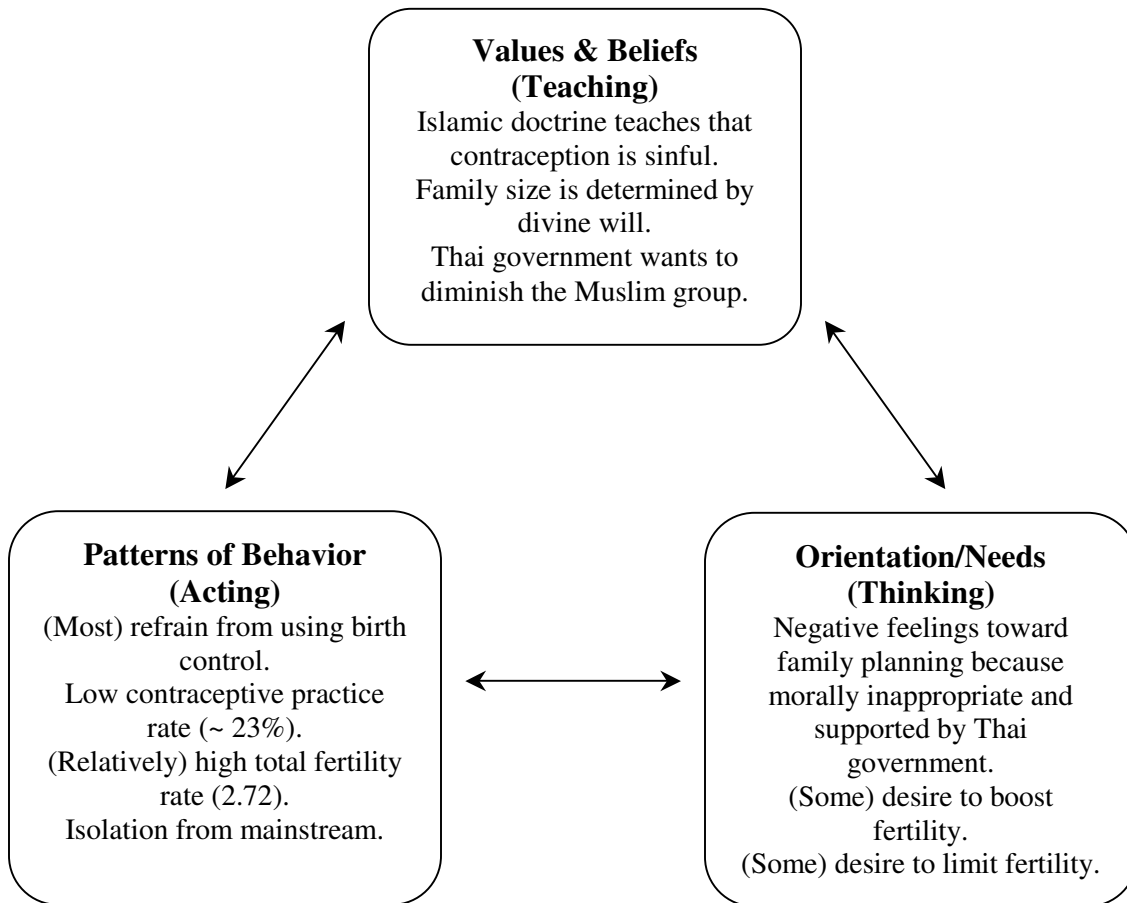
Thai Muslims can be usefully differentiated into two groups according to their primary household language, an indicator of their level of acculturation into mainstream society. The majority of Thailand's Muslims speak primarily Malay rather than Thai, and recent outbreaks of violence and political instability in the South are testimonies to the deep-seated separatist motivations within this religio-linguistic group (*Khaleej Times* 2005; Knodel et al. 1999:150). Thai-speaking Muslims, on the other hand, occupy a less peripheral space in Thai society. Thai-speaking Muslims maintain a distinct Islamic identity, but their constant interaction with Thai Buddhists has influenced their cultural identity and values.

While their differing languages and degrees of social integration help to explain some differences in relative fertility levels, both Malay-speaking and Thai-speaking

Muslims' reproductive decisions are influenced by a common Islamic moral system. Survey data have shown that Thai Muslims view attempts at lowering fertility negatively (Knodel et al. 1999). Contraception is regarded as morally objectionable because the intentional prevention of new life is considered a defiance of divine will and thus a sin (p. 161). In a 1994 survey of attitudes about family planning, 58.4 percent of Thai-speaking Muslims and 87.8 percent of Malay-speaking Muslims reported that family planning violated the tenets of their religion, while every Thai Buddhist respondent found family planning acceptable (NSO 1997; Knodel et al. 1999, Table 7).

Clearly, the negative values associated with contraception in the Islamic moral system have affected followers' orientations toward family planning. As Figure 5 illustrates, the negative evaluation of contraception according to religious beliefs influences Muslims' orientation and family planning behavior. Only about 20.2 percent of the Malay-speaking Muslim women surveyed in the 1994 study admitted to having ever used contraceptives (NSO 1997). When questioned about their options in limiting childbirth, many respondents expressed that the matter was outside their jurisdiction. Although many desired smaller families for economic reasons, the religious and communal rejection of contraception imbued family planning with a negative moral stigma that limited their options for fertility control (Knodel et al. 1999:155).

Fertility *has* declined among Thailand's Muslim population, but at a slower rate than the national average. In 1994 the mean number of children born to Malay-speaking Muslim women in southern Thailand was 3.22—a low level of fertility compared to other developing countries, but significantly higher than the Thai national average of fewer than two children per woman (NSO 1997; Knodel et al. 1999). Contraceptive use is also much lower among the Muslim population. The 1987 Demographic and Health Survey found that about 35 percent of Thailand's Muslims (including both language groups) used contraception, compared to 70 percent of Thai Buddhists (Chayovan, Knodel, and Kamnuansilpa 1988).



**Figure 5: Application of Weber's model to Thai Muslims' context**

Muslims in Thailand who speak Thai as their primary language demonstrate fertility behaviors that are closer to those of the Buddhist majority. Thai-speaking Muslims' ideal family size of 2.69 falls in between Buddhists' 2.31 and Malay-speaking Muslims' 3.36 (NSO 1997; Knodel et al. 1999, Table 3). Thai-speaking Muslims consistently practice reproductive behaviors that limit fertility to a greater degree than their Malay-speaking counterparts. Fifty-one percent of Thai-speaking Muslims were currently using modern contraception in 1994, compared to just 11.2 percent of Malay-speakers (Knodel et al. 1999, Table 6).

If the reproductive behaviors of Thai Buddhists are compared to Thai Muslims as a whole, the results suggest that religious affiliation alone exerts enormous influence on couples' decisions to use family planning. However, the substantial differences between Malay- and Thai-speaking Muslims indicate that factors other than religious doctrine are

at play. In order to understand the differences between and within these two groups, one must consider their positions within the greater Thai social structure.

A 1994 survey of the southern region indicated that more Thai-speaking Muslim women worked in sales occupations than did Buddhists and Malay-speakers combined. It seems that Thai-speaking Muslims have established a niche in the commercial sector as a means of mitigating competition with their neighbors and capitalizing on their mainstream language affiliation (Knodel et al. 1999, Table 1; Turner et al. 2002:335). The concentration of Thai-speaking Muslim women in the commercial sector also implies that this group is likely to interact with a broad customer base on a daily basis. Because they work in the public sphere and play an active role in the national and (increasingly global) economy, these women enjoy some forms of social freedom not enjoyed by their Malay-speaking counterparts. As saleswomen, they likely exercise control over business affairs, which may extend into their personal lives and reproductive decisions.

While Thai-speaking Muslims still recognize the predominant Malay interpretations of Islamic doctrine, the shift in emphasis from group solidarity to individuality implies that Thai-speaking Muslim women have self-focused attitudes about reproductive behavior that are guided by instrumentally-rational choices rather than by observation of the group's traditional norms or values (Weber 1968:24-26). Survey data indicate that Thai-speaking Muslims are more willing to experiment with new family planning practices: in the 1993 survey, over 60 percent of Thai-speaking Muslim women had ever *tried* contraceptives in the past, compared to only 20 percent of Malay-speaking Muslims (NSO 1997; Knodel et al. 1999:158).

Malay-speaking Muslim fertility trends are guided by the group's minority status within the context of Buddhist Thailand. Many Malay-speaking Muslims regard isolationism as a means to cultural preservation. John Knodel and associates describe the communities of Malay-speaking Muslims as relatively isolated, rural settlements that are governed by an imperative to preserve the unique cultural identity of the group:

Rather than merely perceiving themselves as a minority within the Thai nation as many Thai-speaking Muslims do, Malay-speakers identify with the broader Malay-Muslim population that spans the Thai-Malaysian border. ...Consequently, Malay-speaking Muslims in Thailand maintain

their social distance and isolation from the national Buddhist majority to a much greater extent than Thai-speaking Muslims either in the south or central region (Knodel et al. 1999:151-152).

Their greater social distance and isolation contribute to Malay-speakers' relatively low acceptance of innovative practices like family planning. The very fact that Malay-speakers are a minority group in a tense situation has important implications for group behavior and social structure, and implications for reproductive behavior as well.

The higher fertility of southern Muslims is reinforced by Islamic cultural norms that have been reemphasized by community leaders to promote a rational response to the group's environmental situation. Southern Thai Muslims, particularly Malay-speakers who are concerned with maintaining their cultural identity, have incentives to maintain traditional levels of fertility in order to preserve their status as the local majority.

Members of the group must adhere to certain values in order to maintain social order and relieve the stresses caused by the perceptible threats by the Buddhist majority. The reality of such threats has been made explicit by ongoing government-led attempts to assimilate the Malay-speaking population into mainstream society or to establish a Buddhist majority in the region (Knodel et al. 1999:150-151). Thus political motivations seem to influence the interpretation of religious doctrine. The orientation of religious morality toward family planning is determined by wider environmental circumstances.

Rather than concluding that Islamic tradition is necessarily and inevitably opposed to family planning, the evidence from Thailand suggests that moral evaluations are significantly circumstantial. Malay-speaking Muslim women in Southern Thailand abstain from using birth control because their local value system stigmatizes it. The vehicle of moral rejection is Islamic morality; however, the *cause* of this evaluation is likely the tense political situation in which the group finds itself.

#### **CIRCUMSTANTIAL MORALITY: FAMILY PLANNING IN CEYLON AND IRAN**

In T. O. Ling's 1969 comparison of reproductive practices in Ceylon (Sri Lanka) and Thailand, he found that attitudes about family planning differed radically in spite of the populations' shared Theravada Buddhist religion. While Thai respondents evaluated contraception indifferently, Ceylon's leading religious leaders saw lower fertility as a

serious threat to the preservation of the Sinhalese people. According to one Buddhist monk, family planning was “one of the greatest enemies known to man...a killer of men. Sinhala people were already in a minority and the family planning scheme would make their position worse” (Ling 1969:59). The Sinhalese moral evaluation of contraception also differed from the Thai: while Thais referred to the *gandhabba* concept and concluded that birth control did not violate the first precept, the Sinhalese “affirmed that contraception was irreconcilable with Buddhist doctrine because it was a suppression of life” (pp. 58-59).

Sinhalese opposition to family planning sprang from ethnoreligious conflict with competing groups. Following centuries of political oppression at the hands of Western Christian imperial powers, the Buddhist population of independent Ceylon found itself competing politically and economically with a growing Roman Catholic community that, in their minds, threatened to destroy the traditional lifestyle of the Sinhalese people. Ling concluded that the “manifest opposition” to family planning among Sinhalese Buddhists built upon “latent theoretical objection” nested in Buddhist doctrine (Ling 1969:60). Opponents of family planning efforts in Ceylon during the 1960s “[found] it possible to argue not only on practical grounds but also on grounds of Buddhist doctrine” (p. 60). While the Thai case suggests that Theravada Buddhism fosters family planning success, the Sinhalese case cautions us to refrain from generalizing the stance of any given religion toward fertility control.

The Islamic Republic of Iran provides an example of an Islamic society in which family planning has gained approval as the result of changing economic and political realities. Ayatollah Khomeini, the figurehead of Iran’s theocratic government, decreed in 1993 that “When wisdom dictates that you do not need more children, a vasectomy is permissible” (MacFarquhar 1996). This policy reversal followed two decades of staunch pronatal strategies by the Iranian revolutionary movement who, in the words of Grand Ayatollah Nasser Makaram-Shirazi, “wanted to increase the number of people who believed in the revolution in order to preserve it” (MacFarquhar 1996). The Iranian people responded to their spiritual leaders’ requests, and the country’s population growth rate rose to a staggering 4 percent. Economic stagnation and the rising costs of social spending on new infrastructure convinced leaders to change the country’s demographic



direction. Now Iranian couples must attend a one-hour family planning class before receiving their marriage licenses (MacFarquhar 1996). The government provides condoms and pills for free, and the population growth rate has fallen to about 1.2 percent (PRB 2005).

Iran's government and religious leaders were assisted in their manipulation of popular moral evaluation of birth control by emphasizing doctrinal teachings that lent support to whichever stance was preferred. The earlier pronatalist campaigns quoted Mohammad's statement that he hoped the followers of Islam would outnumber Christians and Jews on Judgment Day. Now the Iranian state pursues an aggressive population control agenda facilitated by alternative, pro-small family teachings of Mohammad and other prophets. The readiness of the laity to accommodate these reevaluations of family planning is partially explained by widespread family-level economic problems that have been exacerbated by high fertility (MacFarquhar 1996).

In Iran, the perceived internal social risks associated with high population growth seem to have prevailed over the perceived risk of political conquest by external groups. The different circumstances in which the Iranian religious leaders find themselves have prompted them to use Islam as a vehicle for family planning support. Islam in southern Thailand seems to hinder family planning efforts because the Islamic community feels threatened by external groups, namely, the Thai Buddhists who dominate the country's political structure and who seek to supplant the Muslims' majority at the local level. Buddhists in Ceylon and in Thailand have also differed in their stances toward family planning, largely depending on the environmental circumstances of each society. Each group has been able to bend the official interpretation of its religion to meet the perceived greater interests of the community.

John Knodel and his associates caution that the influence of religion on reproductive behavior is extremely hard to predict:

[T]he national and local context conditions the extent and perhaps nature of Islam's influence. The fact that other cultural, political, socio-economic, and historical factors interact with the relationship makes it difficult, perhaps impossible, to isolate the specific impact of religion per se, especially when religious identity is itself a component of these other factors (Knodel et al. 1999:163).

While some religions may be more commonly supportive of family planning efforts than others, the ultimate impact of religion on fertility depends on the motivations of the group and its religious leaders. Religion is ultimately a tool to serve the interests of the group, though it functions by defining personal ideas about morality and the limits of behavior.

#### **SUMMARY OF FACTORS IN THE THAI FERTILITY DECLINE**

Evaluations of fertility patterns cannot be divorced from the array of social, cultural, economic, and personal factors that influence individual couples' fertility decisions (Klitsch and Walsh 1988:20). Thai couples' fertility demands are shaped by their cultural values and preferences. Theravada Buddhist beliefs are sympathetic to family planning. Gender roles provide exclusive familial roles and responsibilities to individuals of each sex. In order to achieve the spiritual-psychological benefits provided by sons as well as the comfort benefits provided by daughters, an overwhelming majority of Thais prefer to have balanced families. This family preference has set a two-child minimum limit to the Thai fertility decline. While the proportion of Thai couples wanting three or more children has steadily declined, there has been virtually no increase in the proportion wanting fewer than two (Knodel et al. 1996:310).

On the other hand, the negative moral stigma attached to contraception by Thailand's Malay-speaking Muslims reflects a different set of cultural values and psychological orientations among this group, which in turn produces a different pattern of reproductive behavior. Historical tensions are being played out today through demographic contests that serve as a powerful incentive to sustain relatively high fertility. The dynamics of group conflict and interaction appear to exert influence over even the interpretation of religious doctrine.

The clearest lesson to be drawn from this study is that fertility behavior is determined by a much wider set of factors than economics alone. The differences in fertility-related values and desires between Buddhists and Muslims in Ceylon, Iran, and within Thailand suggest that there are no universal explanations for demographic transition. Rather, reproductive behavior seems bound to cultural values and personal motivations at a fundamental level.

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