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Nursing Perspectives on Women, Health and Work in the Socio-Cultural Context of Poor Communities in Northeast Thailand

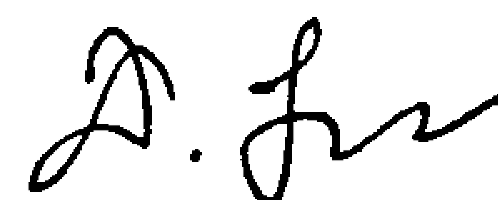
Darunee Jongudomkarn

A thesis submitted in partial fulfilment of the requirements of The Robert Gordon University for the degree of Doctor of Philosophy

Centre for Nurse Practice Research and Development
School of Nursing and Midwifery
The Robert Gordon University
Aberdeen
Scotland

June 2001

I declare that this thesis has been written by me, and that the work is entirely my own



Darunee Jongudomkarn

29 / 06 / 2001

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Nursing Perspectives on Women, Health and Work in the Socio-Cultural Context of Poor Communities in Northeast Thailand

Abstract

Women from poor communities in Northeast Thailand can be considered as a disadvantaged group who have struggled against several problems in their daily living and who have worked hard to sustain their lives through unskilled labour. In such a strong Buddhist culture these women have vital roles within the household and in earning money. The combination of which it is suggested, has had an impact on their physical and psychological health. In Thailand, there is limited data available about such women's health, life experience and work. A better understanding of their situation is required in order to inform and redesign effective health intervention programmes to promote the health and well-being of women from these communities. An holistic nursing perspective was used to inform the design of this research. Only by understanding the context, the living experiences and the understandings of the women themselves is it possible to construct effective health intervention programmes.

Thus the purpose of the study was to understand women's health and work in the socio-cultural context of poverty in Northeast Thailand. A combination of quantitative and qualitative techniques were used in the overall data collection process. The study was conducted in two distinct phases. Phase 1 provided an overall of baseline account of the socio-cultural context of six communities and the health of a sample of women who live therein. It involved focus group interviews (N=102) with residents and a survey (N=209) of households. Phase 2 was a more focused case study (N=49) of women's life experiences, their health and work in one selected community.

Phase 1 of the study found that the majority of women had a substantial role in household economics. Coping strategies that women frequently used were '*Tam Chai*' (accept and not think too much about it). The majority of women in the communities were primary breadwinners and were self-employed as vendors. Regarding women's health, the findings showed a high level of musculoskeletal and psychological complaints. The study showed that nearly all of the women were optimists and felt happy.

In the second phase of the study. Buddhism and the Thai way of living emerged as the major factors which influenced women's views on health and well being. The data illustrated that women struggled to survive in the community and that they had to work hard to make ends meet. Women used networks in the community as resources for coping.

They saw 'health in terms of being strong enough to work and earn a living'. Health per se is the lowest priority in their life. To work and earn money to support their families is the highest. Indeed, the Buddhist teaching of 'self-reliance' has a great impact on them. The conclusions reached suggest that nursing interventions and health campaigns could be used to promote and maintain the optimum health of women and their families. Finally recommendations are made with regard to further research; development of services; development of nurse-education and health promotion for women in low-income communities.

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Glossary

The following transcription system will be used throughout the report (thesis) for Thai and Lao terms.

The system used below is based upon the application by the Royal Institute (1999).

Consonants

Thai	First Consonants	Last Consonants
ก	k-	-k
ข ค ฆ	kh-	-k
ง	ng-	-ng
จ	-ch-/j-	-t
ฉ ช ฌ	Ch-	-t
ญ	y-	-n
ด ฎ ฑ (เสียง ด)	d-	-t
ต ฏ	t-	-t
ถ ฐ ท ฑ (เสียง ท)	th-	-t
ธ ฒ		
น ณ	n-	-n
บ	b-	-p
ป	p-	-p
ผ พ ภ	ph-	-p
ฝ ฟ	f-	-p
ม	m-	-m
ย	y-	-
ร	r-	-n
ล ฬ	l-	-n
ว	w-	-
ซ ทร ศ ษ ส	s-	-t
ห ฮ	h-	-
อ	-	-

Vowels

Thai	Roman
อะ อั-	a
รร-, อา	
รร	an
อำ	am
อิ. อี	I
อึ. อื	ue
อุ. อู	u
เอะ. เ-. เอ	e
แอะ. แอ	ae
โอะ. -(โอะลดรูป)	o
โอ. เอาะ. ออ	
เออะ. เอิ (เออะลดรูป)	oe
เออ	
เอียะ. เอีย	ia
เอือะ. เอือ	uea
อัวะ. อัว	ua
-ว- (อังลดรูป)	
ใอ.ไอ.อัย.ไอย.อาย	ai
เอา.อาว	ao
อุย	ui
โอย. ออย	oi
เอย	oei
เอือย	ueai
อวย	uai
อิว	io
เอ็ว. เอว	eo
แอ็ว. แอว	aeo
เอียว	iao
ฤ (เสียงรึ). ฤา	rue
ฤ (เสียงริ)	ri
ฤ (เสียงเรอ)	roe
ฦ. ฦา	lue

Definitions

Low-Income Community or Slum: means disorderly and temporary residential buildings or shelters with a housing density of more than 15 households per 1 *rai* (1,600 square metres), or a residential density of over 80 persons per 1 *rai*. Additionally, there are normally problems of lack of drainage, stagnant water retention created by uncollected garbage and refuse, bad ventilation, and inconvenient walkways.

Work-Related Health Problems: Health problems (in terms of injury or illness) that result from an acute or chronic episode related to women's work.

Workload: The amount of time taken to perform activities to earn money, and includes the domestic work of women. It also refers to a balance between the number of family members assisting with work and the number of activities (in terms of quantity and quality) they perform. It is usually referred to with regard to the health effects of overload and imbalance.

Work: Work or paid employment, typically performed away from home or at home, which bring money, food or both.

Health Status: The health state (as specified by women's perception) especially with regard to the effect this has on the roles of women.

Definitions (continued)

Baht: Unit of Thai currency; during the period of 1995-1996, one pound was equivalent to *Baht* 41-42, compared to *Baht* 60-64 equivalence in 1997-2000.

Low-Income: State of being poor and resulting in inadequate housing and the creation of health hazards. Most people in the low-income communities earn less than 5,000 *baht* (£ 83) per household per month (< 60,000 *baht* per household per year).

PREFACE

I grew up in the northeastern region of Thailand; and have lived and worked as a family nurse in this region for many years. I have noticed that when poor people, especially women in this area were sick, they took care of themselves by trusting luck. There seemed to be no recourse to, or sufficient access to, health care or assistance from the government health care system. Healers, on whom they seemed to rely, may have been private physicians, traditional healers, injection doctors, drug store owners or drug vendors. Furthermore, even people who had chronic diseases such as hypertension, diabetes, tuberculosis or other severe disabilities, did not routinely benefit from any follow up treatment, reports, aids or attention from the government (Khon Kaen Provincial Office, 1991). Hence, it appeared that the provision of health care services to groups of low-income women who worked hard has been neglected. Moreover, there is still no clear fundamental knowledge or the imparting of nursing care knowledge to these groups of women in the Northeast. This lack of knowledge concerning the care of people in low-income communities is a barrier to teaching and learning in nursing, to the development of nursing practices; and the enhancement of nursing education curricula.

The author is in agreement with the Robert Gordon University's address in its guide for students, which states that "research is the process of generating knowledge in a systematic way" (Robertson & Mc Ardle, 1996: C2). I felt that each problem that emerged during the course of research provided an opportunity for learning, as expressed in the English proverb which states that "experience is the mother of wisdom" (Simpson, 1988). Even though I have experienced both quantitative and qualitative research before, I

considered the experiences obtained from this research as the most valuable. I conducted the research without any assistance from colleagues, which left a great impression, especially when contacting and familiarising myself with the experiences of the women in these communities.

When I finished this study I asked could it be improved? I feel satisfied with the research methods. This inquiry was humanistic. The combining of quantitative and qualitative approaches had advantages by providing a more open- ended and comprehensive type of inquiry. By using a case study approach under the constructivist paradigm, I collected information to cover all dimensions of the people involved. I selected one community that contained useful information relating to women's experiences of work. I then explored their health problems and life experiences. The advantages of such a case study approach includes the fact that "everything in the community is data". All scenes taking place in the community were able to be observed and a series of discussions and in-depth interviews regularly took place. It was clear that the research methods employed were rigorous enough, which then served as a context and a basis of empirical generalisation (Popay, Rogers & Williams, 1998: 347). Furthermore, the case study approach was not limited by the sample size, and I was able to triangulate information by collecting data using multiple techniques. These techniques included observations, participant observations, individual interviews, group interviews, group discussion and field note records. The information garnered came from multiple sources, and included a wide array of people (both men and women), health professionals, government officers, health volunteers in the community, key informants in the community and general informants in the community. Therefore, given the chance to restart this research, I would maintain the current research methodology.

My initial concern was to investigate how work effects the health status of women. As the research progressed I became disatisfied when collecting the qualitative data. I found the terms work and health too narrow for the methodology which required expansive enquiry. Obtaining a nursing perspective required an holistic approach which assessed not only the health of the women but also understood the social and cultural context of life and work.

I believe that this study into "Nursing perspectives on women, health and work in the socio-cultural context of poor communities in Northeast Thailand" will be a part of a knowledge quest, providing information and a better understanding. It will also provide information to fill the existing gaps in nursing education, in order to enhance teaching and learning for nursing in the Northeastern region. In addition, it aims to benefit nursing officers in providing information which will help them carry out high quality nursing practices with this group of women. Most of all, this study may be helpful to the government in making policies about health services for less opportune groups in the city, by providing more precise information and a more concrete direction.

During its long gestation, this thesis benefited from the contributions of many individuals and peer reviews. The preliminary findings were presented at the Third International Nursing Conference, held in Brunei Dalassalam, 1-3 November 1998. It was also published in Thai Nursing Journal in 1999 (*Warasarn Khana Payabalsat Maw Khaw*). An abbreviated version of this thesis was presented at The Triennial International Nursing Research Conference, held April 2001 in Glasgow, Scotland. I wish to thank colleagues who attended my session for their valuable feedback. I am also grateful for the helpful comments provided by the anonymous reviewers. My thanks also to Prof.Dr.Eileen Zungolo, senior *Fullbright* nursing scholar, USA and Dr. Eunchil Kim, Professor of the

Women Study Centre, Ewha University, South Korea for their helpful discussion on earlier ideas of writing the thesis.

To provide an adequate answer to the question, the thesis is structured in the following way.

Chapter one. Concise introduction to the focus of the research is given including the background and the context for the study.

Chapter two. Presents the literature, which has been consulted and analysed. The explored framework for the study is outlined and an overview of the major themes namely: women and work, poverty occupations, health beliefs and holistic nursing are presented.

Chapter three. Presents the combined research methodology which has been used.

Chapter four. Details the findings of the household survey phase of the study. This chapter is organised into five sections: the characteristics of the study site, the characteristics of the respondents, the migration experiences of the respondents, women's work and health status and finally the secondary analysis of influential factors.

Chapter five. Presents a discussion of the findings of the survey and outlines the direction for the next phase.

Chapter six. Presents a profile of the selectively studied Railway Community

Chapter seven. Presents the findings from in-depth interviews with women living and working in the Railway Community. Key emerging main themes are identified, extracted and analysed.

Chapter eight. Depicts a clear picture of women who live in the low-income community, through their way of life, and a profile of the roles of these women. It also highlights women's beliefs, attitudes and practices with regard to self and family health care and health seeking behaviours, the meaning of health and illness, self-medication, and health service utilisation. Moreover, this chapter presents the summarised extracted data from the case study, which permitted a description of the experiential dimension of women with great workloads and how this has impacted on their health.

Chapter nine. Interprets and discusses the key findings from the in-depth study of the Railway community. The relevance of the findings to the literature and the professional nursing and health care implications of the findings are presented.

Chapter ten. Concludes the study with an interpretation of the findings and a discussion of the implication of these to nursing and health care provision in NE Thailand. The chapter also covers the recommendations proposed for the improvement of the disadvantaged women's health and also their family members; for education and health care delivery and health care reform; and finally, directions for future nursing care and further research are suggested.

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

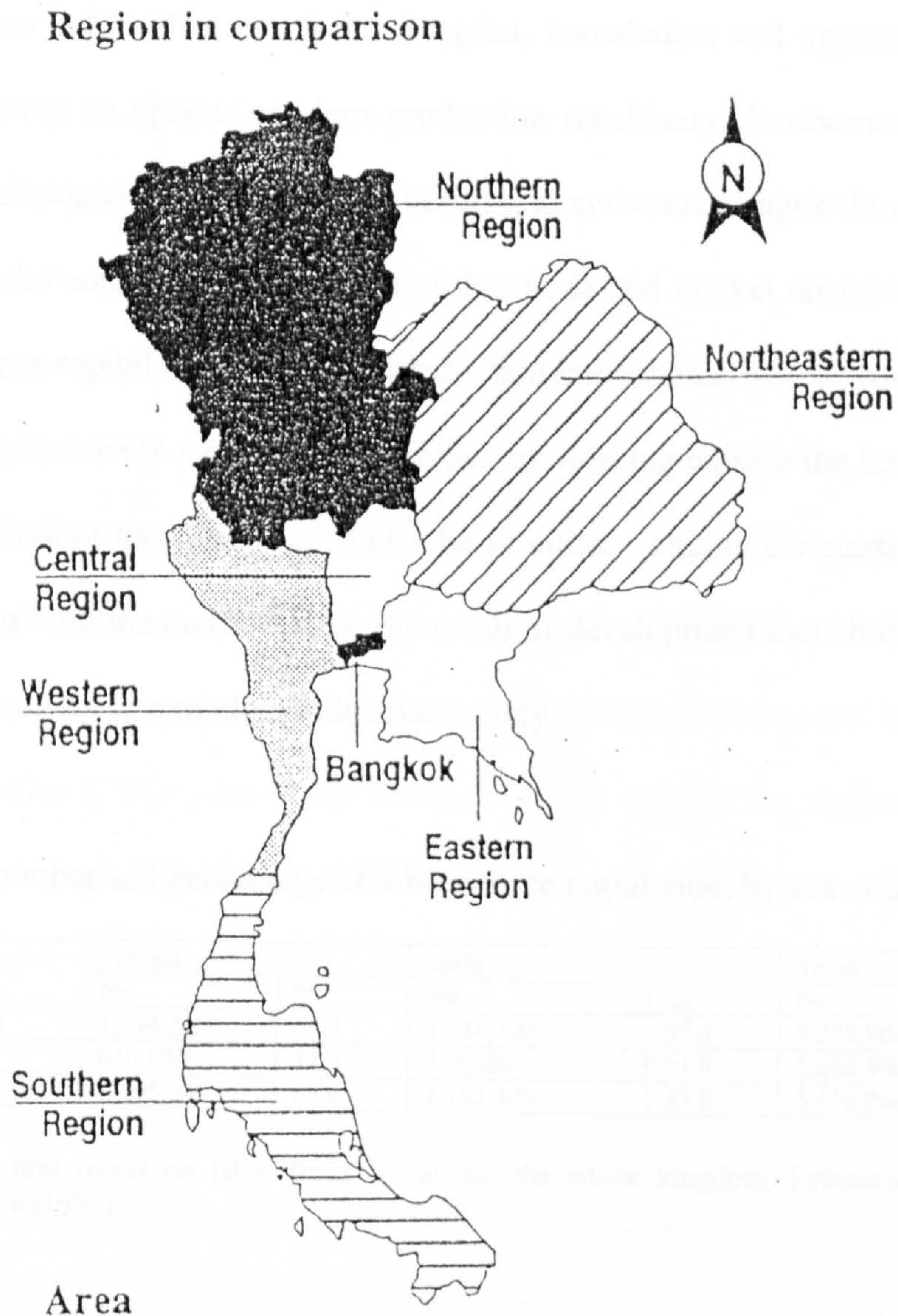
This chapter sets out the background and context of this study. It provides information on Thailand, the Northeast region and the particular context of Khon Kaen. The major themes which will be explored in more depth in subsequent chapters are briefly considered here in order to illuminate some cultural difference.

1.1 Background

During the past two decades (1976-1996), Thailand has directed its economy through many National Economic and Social Development Plans. With the rapid pace of economic growth, there have been dynamic migratory movements within the labour force. People who worked in the agricultural sector migrated to seek jobs in industry, construction, and service sectors in cities. Seasonal migration became permanent migration, with rural people moving to work in cities and then not moving back to their domicile. The economic growth that was industry-oriented thus resulted in the emergence of many big city slums, where migrant women were to be found (RDI, 1996).

From the period of the First National Development Plan to the present, sole emphasis has been placed on the promotion of industry, while the agricultural sector has been neglected. The consequences of this kind of development have caused big changes in northeastern rural families, especially in the role and function of rural women. Women have had to adapt themselves and change their roles in order to survive. Agricultural production has changed from traditional agriculture, which was labour-intensive, to modern agriculture or

Figure 1.1 Map of Thailand



Area

Region	Area (sq.km.)	% of total
Bangkok	1,565.2	0.3
Vicinity of Bangkok	6,193.0	1.2
Central	16,593.4	3.2
Eastern	36,502.5	7.1
Western	43,046.7	8.4
Northeastern	168,854.3	32.9
Northern	169,644.3	33.1
Southern	70,715.2	13.8
Whole kingdom	513,114.6	100.0

a capital-intensive system, which relies more on new technology to increase productivity (Suntornchai, 1996:76). As a result, women could no longer be involved in farm production as before due to a lack of capital, knowledge, and opportunity to obtain the skills necessary to operate modern production machinery. Furthermore, the production system has changed from subsistence farming to commercial agriculture. Thus, they have had to face the unpredictable situation of free trade and market uncertainty, and a system, which requires capital to buy modern production implements. These women have struggled to earn extra income to support their families by working outside the households. This has meant abandoning their farms to find jobs in cities. This is the starting point of labour migration for both men and women; the result of development that shifts the country from an agrarian society to a modern industrial society.

Table 1.1 Number and percentage of labour force population, by sex and area (1993)

Area	Female		Male		Total	
	No	%	No	%	No	%
Whole Kingdom	3,234,200	44.5	4,024,700	55.5	7,258,900	100
Municipal Area	838,600	11.5	842,300	11.6	1,680,900	23.1
Non-municipal Area	2,395,600	33.0	3,182,400	43.8	5,578,000	76.8

Source: The first report on labor force survey for the whole kingdom, February 1992, The National Statistical Office (1993).

Table 1.1, it can be seen that half of the population in this labour force survey is female. It has become customary to see women working both inside and outside the household, especially in urban societies. Thai women play an important economic role, as indicated by the proportion of women participating in the labour force. This figure is nearly half (26 million) of the whole country's formal labour force (The National Statistical Office, 1993). Work in the informal sector is unregulated and is not recorded in the official statistics. Many women are informal sector workers (e.g. hawkers, housemaids, homeworking

subcontractors) and are not entitled to any legal employment protection. Women, especially those who have migrated can be considered as income earners who support entire families. However, this migration to cities to earn a living causes problems of encroachment on public and private areas and the creation of slum areas (Lapanun, 1998).

1.2 Low-Income Women

Generally low-income women have a low level of education, i.e. they have completed primary school only, and indeed some are illiterate. They lack the knowledge and skills appropriate for higher-status occupations (Tulapunt, 1998: 105). The labour market for these women consists of only low-status work, which is comprised of lower-paid jobs where no welfare is provided. These women have neither the time nor opportunity to obtain more education or skills that can enable them to earn higher wages. This is because they have family responsibilities as well as occupational demands. Both housework and occupation are a necessity for women who have a duty to support their families to survive. In Khon Kaen province alone, there are more than 6,000 women who now work as home-working subcontractors, i.e. sewing articles of clothing, making artificial flowers, or cutting gems. 75 percent of these women are married, have children and have been educated to primary school level. The average age of these women is 25.5 years (Labor Force Protection Office, 1996).

Traditional values state that men are the income earners who support families. As a result, they are considered to be superior to women, who are raised to be sweet, gentle, attentive, and to take care of the elders in the family. Sons, who will inherit family names and feed their families in the future, are be encouraged to obtain more education than daughters.

There are beliefs in Thai society that when women get married and have children, they will be housewives thus the saying "*why should women get much education for it will only make it difficult for them to get married*" is widely used. These beliefs and values in varying degrees are influenced by a religion (Buddhism) which gives importance to men, (Sindhu, 1992).

Research on women's occupations, their family roles and the subsequent psychological impact on well-being has been widely reported in western societies, particularly the United States of America. The studies found that a heavy workload has an impact on health conditions (Barnett et al, 1993:794; Messing, 1997:40; and Messing, 1993:1). However, most studies of this nature have been limited to professional women (Noor, 1995:87). Some have paid attention to women in low-income parts of society in western contexts (Harphan, 1994:233-45) whose society, culture and economy are vastly different from a comparable Asian context (Lai, 1995:11-37), and not at all comparable to the Northeast of Thailand, which is the poorest region of the country. This research study is an endeavor to understand the role of women, specifically the impoverished people who live in the highly populated area of Khon Kaen Municipality.

1.3 Aim: To understand women's health and work in the socio-cultural context of poverty in Northeast Thailand.

Objectives:

(1) To understand the meaning of health and wellness for women living in poor communities in Khon Kaen Municipality.

(2) To explore the work and familial roles of these women.

(3) To understand the women's perspectives on health, work and their caring ability within

the family.

1.4 The Economic Context of the Research

The primary location of the research was the suburban areas of Khon Kaen Municipality, in northeastern Thailand. The Northeast is the most economically disadvantaged part of Thailand and has a long history of labour migration (Refer to Table 1.2 and 1.3 - RDI, 1996: 30). Khon Kaen Municipality covers an area of 46 square kilometers with a population of 142,314 people. It is estimated that the total population of Khon Kaen Municipality is much higher, even double the official figure, since there are many people who move into the area without registering in the municipality. Moreover, as the city has expanded very rapidly in the past ten years, there are many low-income communities occupied by migrants. Nowadays there are six recognizable low-income communities, known as, Guardian, Rental, Stranger, Temple, Railway, and Joss respectively[1]. Reports show that more than 40 percent of the people in these low-income communities earn less than 5,000 *baht* (£ 77) per household per month (< £ 1000 per household per year), and a further 40 percent earn between 5,000-10,000 *baht* (£ 77 - £ 155) per household per month (£1000-£1863 per household per year). The last 20 percent earn between 10,000-20,000 *baht* (£ 155 - £ 310) (£ 1863-£ 3726 per household per year) (RDI, 1996). These figures are quite different from the city records of per capita income, which show that the monthly per capita income of people resident in the city in 1996 was 39,139 *baht*(£ 607). This was calculated at 156,556 *baht* (£ 2430) per household (estimated to four persons in one family) per year (Chanawongse, Kamnuansilpa, Wongtanavasu, and Techmanee, 1999: 27).

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[1] To assure confidentiality pseudonyms has been used for these communities.

Table 1.2 Thailand/North-East Region: Per Capita Income 1990-1995 (*baht* per person per annum in current prices)

	1990	1991	1992	1993	1994	1995
Thailand	39,104	44,307	49,476	54,809	61,909	70,754
North East	13,506	15,050	17,055	17,811	20,601	24,331
North	20,356	22,781	25,867	27,169	30,521	34,565
Central	31,500	38,595	44,162	47,859	56,360	64,869
South	26,109	29,358	32,616	35,074	40,976	47,947

Source: National Economic and Social Development Board

Table 1.3 Thailand: Percentage of the Poor by Region, 1988-1996

Region	**1988**	**1990**	**1992**	**1994**	**1996**
North East	48.4	43.1	39.9	28.6	19.4
North	32.0	23.2	22.6	13.2	11.2
Central	25.2	20.5	12.1	8.4	5.9
South	32.5	27.6	19.7	17.3	11.5

Source: National Economic and Social and Development Board

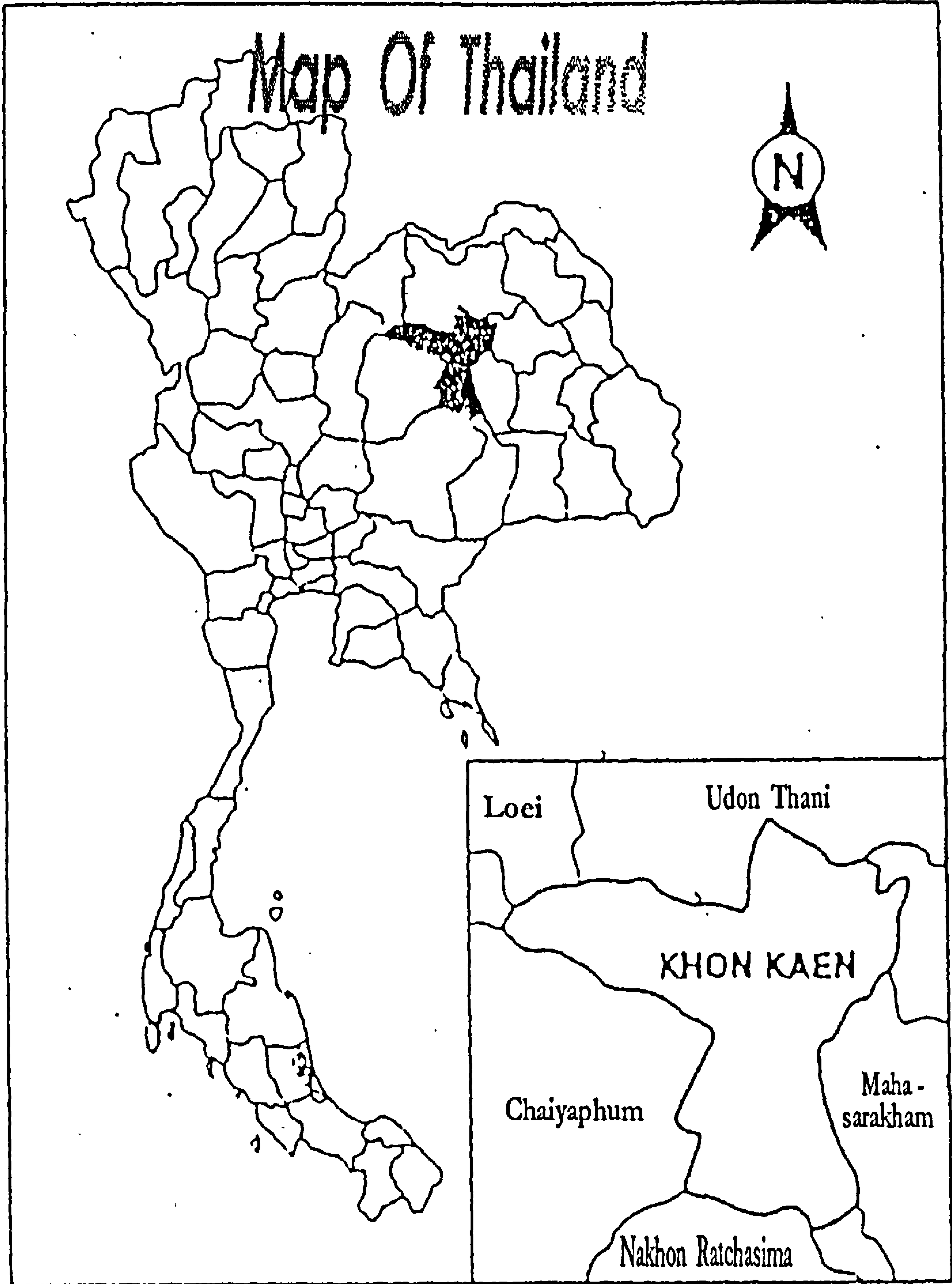
In order to define "low-income community", the proposed research builds upon an earlier, preliminary study, which I conducted amongst low-income earning women who work as housemaids at faculty houses on Khon Kaen University campus. In addition, discussions were held with a Thai scholar who does research on low-income communities, and with an officer from Khon Kaen Municipality who has responsibility for low-income communities and could provide information to assist with the profile of these communities.

1.5 The Cultural Context

The Northeast of Thailand (*Isaan*) covers some 170,000 square kilometres, almost exactly one-third of the total area or the country, with about 3.4 million people in 1995 (Roger, 1989: 33). *Isaan* officially consists of 18 provinces. About 80% of the population of *Isaan* are in the rural and agricultural sector (Cummings, 1997: 598).

Figure 1.2

Location of Khon Kaen



A mixture of Laos and Khmer has evidently influenced *Isaan* culture and language.

Isaan culture is different from that of other areas such as the Central and Southern Thailand. This culture is known as the *'Heet 12 Kong 14' Model.* The words *'Heet 12'*, includes the synonym for *'Jareet'*, meaning customs or traditions of *Isaan which includes* merit making during the twelve lunar months. *Isaan* people have followed these practices for so long wherein they would go to the temple, have a merciful heart, and avoid being sinful. The twelve merit-making traditions are a process for celebrating crop production, reminding people to think about sins, and remembering the ancestors and village spirits.

As for *'Kong 14'* this tradition includes practices for different classes of people in *Isaan* society, namely, the kings or the governors, the monks, and the people. *'Kong 14'*, for the people in general, consists of reminding people to have a public mind, to behave themselves decently, and devote themselves to their religion (Boonjerm, 1993: 555; and Sohm-In, 1994: 76-77). It can be concluded that *'Kong 14'* teaches people to be a good, to behave well, and to strictly follow Buddhism. Therefore, any person who follows *'Heet 12 Kong 14*, will be a good person in the society, one who doesn't create any problems for other people.

1.6 The Municipal Context

Khon Kaen Province is situated in the central part of the Northeast region, on the highway between Bangkok and Nongkhai which is on the border with Laos, and opposite Vientiane. It is approximately 449 kilometres from Bangkok (Pocket Thailand Figures, 1996).

Municipalities in Thailand were established by the Municipal Act of 1953 to provide large urban areas with limited self-government. (DANCED, 1996: 15). Budget is derived from

two sources, partially from the support by the central government and from tax collections.

(1) Urban Slum Settlements

The NSO (1989) reported the results of a survey on the reasons for immigration, particularly to Khon Kaen Province. According to this report, those who immigrated had four main reasons: (1) returning home (47.8%), (2) following their husbands / fathers (35.5%), (3) seeking jobs (5.4%), and migrating for job assignment, job training, or studying (11.3%).

In Thailand, the rapid growth of urban populations throughout the country is accompanied by a rapid growth in the number of slum communities. For Khon Kaen, the socioeconomic change began in 1959 when the government stipulated Khon Kaen as the centre for the development of the Northeast. Following this, the university was established in 1967 and then Ubolratana Dam was constructed for the purpose of electricity generation. Expansion also meant the establishment of the official centre, the radio station, Mitraparp Highway, and other important infrastructures. Khon Kaen has therefore changed from quiet agricultural town to the business, service, and financial centre of the Northeastern region (Lapanun, 1998). These developments also led Khon Kaen to grow rapidly with slum settlements.

Urban slum settlements can be defined as places where a high proportion of the residents, in slum or squatter settlements, are people who were originally migrants from rural areas (cited in Lapanun, 1998: 127). 'Slum' means disorderly and temporary residential buildings or shelters with a housing density of more than 15 households per 1 *rai* (1,600 square metres), or a residential density of over 80 persons per 1 *rai*. Additionally, there are

problems of lack of drainage, stagnant water retention created by uncollected garbage and refuse, bad ventilation, and inconvenient walkways (cited in Lapanun, 1998: 127).

The magnitude of the health problems of the urban poor, in many countries, is rarely reflected in official statistics. This is mainly because the people often occupy land illegally or unofficially and are therefore under-enumerated (Harpham, 1994). The World Health Organisation (1988: 20) states that urban poor are "at the interface between underdevelopment and industrialisation". The disease patterns are a reflection of both the burden of infectious diseases and malnutrition, and the spectrum of chronic and social diseases, such as cardiovascular disease, cancer, mental diseases and accidental injuries (WHO, 1988).

The limited literature covering the health status of people living in slum in Khon Kaen Slums has been reviewed. In 1991, there was a report of the common diseases detected which included common cold (66%) and digestive disorders (12.2%) such as stomach aches and diarrhoea (Kasemmanat, et al, 1991). Thongbor (1996) examined the mental health status and coping devices among the heads of families in slum areas in Khon Kaen Municipality and indicated that in general the mental health status was relatively low. These studies suggest that there are specific health issues of concern and worthing of further study.

1.7 Health Services in Thailand

The health service infrastructures in Thailand can be categorised into three types, or sectors, namely government, private, and informal sectors, which includes profit-making

clinics or institutions.

1.7.1 The Health Service Infrastructures

The Ministry of Public Health is the main provider of health services in Thailand. All provincial health services are the responsibility of the Provincial Health Office which reports professionally to the Office of the Permanent Secretary and administratively to the Provincial Governor (Ministry of the Interior). The next hierarchical level is the District Health Office, which reports to both the Provincial Health Office and District Office. The District Health Office provides technical and logistic support to all health centres. A health centre is usually staffed by a nurse and a sanitary officer, and is the main health facility at a *tambon* level (sub-district). Its services range from curative and preventive activities to promotional work for maternal and child health care (Bureau of Health Plan and Policy, 1997).

Additional health services provided by other government organisations include a network of university hospitals under the jurisdiction of the University Bureau. Many ministries and some state enterprises also have their own hospitals whose services are made available to the general public as well as their own staff. The services provided by these hospitals are mainly curative, but certain preventive and health education measures are available (Archavanitkul and Pramualratana, 1990).

1.7.2 Private Sector Health Services

The private sector is comprised of private hospitals, polyclinics, clinics, and pharmacies or drug stores. Private hospitals and clinics have become a rapid growth industry in recent years in Thailand.

They tend to be clustered mainly in urban areas. Private clinics usually operate in the evenings and weekends because most of the staff work for the government during office hours. Polyclinics operate 24 hours a day and seven days a week, providing inpatient beds, laboratory facilities and more specialised services than clinics (Mongkolsmai, 1996). Most doctors who working for the government have their own clinics or practices in private hospitals after working hours.

1.7.3 Pharmaceutical Service

There are two types of private drug stores: type I and type II. According to the law, the first type of drug store must have one pharmacist available during official hours. These drug stores sell sophisticated as well as prescription drugs. In practice, all kinds of medicine can be purchased without prescription. The second type of drug store sells simple pharmaceuticals and medicinal packages (Mongkolsmai, 1996).

In rural areas, people are familiar with a mobile drug store moving from village to village to sell a smaller range of medicines and give simple medical treatment to villagers. Moreover, there are 'quacks' or 'injectionists', in Thai terms, who unlicensed practice western therapies at a low cost to rural people. The usual therapy administered is an injection coupled with oral medication (Archavanikul & Pramualratana, 1990).

1.7.4 Informal Services and Thai Traditional Medicine

This sector includes individuals who specialise in forms of healing which are either sacred or secular, or a mixture of the two. These healers are not part of the official medical system (Kleinman, 1978). Thai traditional medicine is based on the belief that illness is caused by a disturbance in the correct balance of the four basic elements of the human

body. These elements are termed wind, earth, water, and fire (Le Grand et al, 1993).

Although recourse to traditional medicine in Thailand nowadays is declining, there are still various types of informal or folk healers at work in Thai society. The decrease occurs because most traditional doctors now transfer their knowledge only through their relatives (Mongkolsmai, 1996). Traditional doctors usually use herbs as curing agents, occasionally in combination with food restrictions and certain traditional beliefs and practices. In general, most patients who seek traditional treatment have been unsuccessfully treated by modern therapy methods (Chanposri et al, 1990).

1.7.5 Health Insurance Schemes

In Thailand, there are many types of health insurance schemes. These include: (1) Government free medical care, (2) Social security schemes and workman's compensation schemes, (3) Civil servant's medical benefit schemes, (4) Private health insurance, and (5) The Health card (the government free medical care for the poor).

Although there are many types of health insurance schemes in Thailand. The government free medical care and the health card are the preferred choices of the poor to gain access to services.

1.7.6 Health Services in Khon Kaen Province

Health services in Khon Kaen Province exist in both the public and private sectors.

Public Sector: There are four government working units managing the system of public health services for the urban population in Khon Kaen Municipality: (1) Khon Kaen

Provincial Health Office (KKPHO) which is responsible for provincial health activities; (2) Khon Kaen Regional Hospital or Khon Kaen Hospital (KKRH); (3) Khon Kaen Municipal Office or Municipal Health Centre (KKMO); and (4) Khon Kaen Promotion Centre (KKPC). Khon Kaen Hospital and the Khon Kaen Municipality Health Service are responsible for six urban communities in Khon Kaen Municipality. In terms of practice, choice of servicing is up to clients.

The Ministry of Public Health's additional health facilities in Khon Kaen Municipality include two maternal and child health hospitals (200 and 60 beds respectively), and a selection of specialised health service facilities. Health facilities in Khon Kaen Municipality is provided by other Ministries including Khon Kaen University Hospital (KKUH) which has 800 beds, one military hospital, two health stations belonging to Khon Kaen Hospitals, and two other health stations belonging to the Municipality. (Khon Kaen Provincial Health Office, 1996).

Private Sector: Khon Kaen Province has eight private hospitals and 188 medical clinics. Other private sector health facilities include 23 dental clinics, 69 midwifery facilities and 206 drug stores including 73 Type I, 95 Type II and 38 traditional drug stores (Khon Kaen Provincial Health Office, 1997).

1.8 Work-Related Health in General

Work-related health problems are well recognised by the nursing profession. To determine the relationship of work and health it is important to understand the type and nature of hazards in the working environment. Approximately one fourth to one third of an

individual's working day is spent at the workplace. Adults are likely to spend 50 years or longer in their working environment. This affects their health and their attitudes about health during a large portion of their lives. Maintaining the health of workers is the central theme of occupational health care. Measuring and evaluating occupational exposures must be considered in terms of the effects on workers. Nurses must be constantly aware of the hazards that may endanger the well -being of their worker clients.

Work-related health problems can be classified into three groups according to certain characteristics, namely occupational diseases, occupational injuries, and occupational-related stress diseases.

Occupational diseases are somatic complaints due to work conditions. They include stress and fatigue, muscular tension, apathy, and musculoskeletal problems. Long working hours, high workload, shift work, and redundancy are also major factors affecting body function (Sutherland & Cooper, 1993).

Occupational injuries are the most common cause of work related disability and are mainly due to inadequate work environmental factors, limited safety knowledge, lack of protective equipment, and poor general health.

Occupational-related stress diseases cause abnormal physical conditions. These include coronary disease, hypertension, peptic ulcers, several of nervous conditions, diabetes mellitus, and arthritis (Atwell, 1996; and Salazar, 1991).

However, there is still only a limited amount of accurate data about work-related health problems amongst workers in the informal sector, such as the participants in this study. An understanding of the problems and processes of living amongst Thai low-income women will enable Thai nurses to provide culturally sensitive care and help them cope with the physical and psychosocial impact of hard working. New insights gained from the study will guide the development of nursing interventions and provide direction for nursing practice and education in the areas of occupational health, community and family nursing. Moreover, an understanding of these women from this study will also guide the development of programme planning and proper intervention to enhance Thai low-income women's health.

1.9 Conclusion

In this chapter a concise introduction to the focus of the research has been given including the background and the context for the study. It is suggested from previous research that low-income women are a disadvantaged group who struggle against several problems in their everyday life, and who work hard in order to survive. They have vital work roles both in the household and in earning money. The combination of these roles has an impact on their physical and psychological health. This study is thus designed to explore the effect of work on the health of women in an impoverished setting in Khon Kaen, Northeastern Thailand. In an attempt to explore the experiences of Thai low-income women's health problems related to work, the following research question was posed: What life experiences and health problems, relevant to their work, do Thai low-income women perceive?

CHAPTER TWO

REVIEW OF THE LITERATURE

2.1 Introduction

This chapter begins with a review of selected literature to provide an understanding of women's health and work in the socio-cultural context of poverty in Thailand and how they perceive their health. This literature review covers the following themes: underdevelopment and health, holistic nursing and women's health, background of Thai women, low-income women's work, migration and health, women's work and health, and health seeking behaviour in Thai culture. Sources have been obtained from libraries in Bangkok, Khon Kaen, The Robert Gordon University, specialist seminars as well as Thai scholars' unpublished work. Literature was traced back to the 1960s for historical coverage. Research papers for the last 10 years were generally included.

During the past 20 years researchers have begun to pay more attention to women's health (La Rosa, 1997). In the past there was only limited research in relation to working age and the effects of working on the health of women (Nieman, et al, 1997: 13; and Waldron, et al, 1998a). The World Health Organization (WHO) definition of health is defined as 'a state of complete physical, social, and mental wellbeing, and not merely the absence of disease or infirmity (cited in Archavanitkul & Pramualratana, 1990:2). For Tillich (1961), the meaning of health is related to two basic elements of the life processes-self-identity and self-alteration, which are simultaneously ongoing elements of human existence. Herlich (1993) defined health as follows: 1) As a state of being, which implies the condition of not being sick and living without any abnormality. 2) The individual's own perception of their health status, including what constitutes good and bad health

behaviours can be considered to be part of the overall definition of health. 3) Another definition of health is equilibrium, which comes from felt personal experiences in terms of whether there is equilibrium or not. It could be shown by having a good livelihood, by being healthy and energetic, or by having a balanced positive and negative state of mind. From the aforementioned definition, it could be concluded that people would have good health as long as they feel themselves as being in a state of equilibrium, and as long as they can take part in the activities they wish to.

2.2 Underdevelopment and Health

From another more macro perspective there is sufficient evidence to suggest that health is determined by socio-economic and socio-political factors (Ride, 2000: 73 & Thomson, et al. 1995). The WHO World Health Report (WHO, 1995) saw the elimination of poverty and social deprivation as being central to health potential, as well as social and economic productivity. Several studies have been carried out which explore underdevelopment health and economics globally (Thomson, et al. 1995 & WHO, 1996). The global nature of underdevelopment and health is not the concern of this thesis rather the present research is focused on women health and work in a context of poverty within specific communities in Khon Kaen Municipality Thailand.

Thailand is one of 78 developing countries worldwide. In 1997, Thailand experienced a serious economic crisis, resulting in the proportion of poor people rising from 11.4 percent in 1996 to 13.0 percent in 1998 (Thailand Health Profile, 1998). Poor Thai people in the urban context are faced with crowded housing, unhygienic water supplies and improper sanitation. In addition there are major inequities of service provision within Thailand (in terms of quality and accessibility) (Bureau of Health Policy and Plan, 1996). The rich and

poor in urban areas have different opportunities with regard to getting access to health services (Ministry of Public Health, 1998). However, Thai people have their own way of thinking, "life, health, illness and death are continuous processes, people should not worry too much about them", according to religious and cultural philosophies (Butr-Indr, 1995 & Bukkyo Dendo Kyokai, 1996). The tight-knit nature of kin support and cultural beliefs amongst Thai people help to buffer the adverse effects of economic crises on people's health (Siamwala, 1998). At present there are a number of temporary schemes for improving health. There are run both by government and non-government organisations and have been in existence for many decades (Lapanun, et al. 1998).

The health of poor women in underdeveloped contexts has been a neglected topic in the literature (Bushy, 1994 & O'Brien, 1983). There have been some studies which indicate that poor women in developing countries have been socialised to accept their subordinate position (Arber & Ginn, 1993; Baksh et al, 1994; Bisgrove & Popkin, 1996 & Thomson, et al. 1995). The man's wage is often not sufficient to maintain the family, therefore the wife has to take on wage work, whenever it is available, in addition to her already heavy burden of tasks such as farm labour for women in Mexico (Young, 1978), additional domestic worker for women in Columbia (Meleis & Bernal, 1994), or migrant farm-work for Latina women (Farr & Wilson-Figueroa, 1997). Furthermore research has shown that such combined work has a subsequent negative effect on women's health (Facione, 1994, Farr & Wilson-Figueroa, 1997).

For many underdeveloped countries with limited resources curation has been identified as the key priority rather than health promotion and disease prevention (Caputo, 1995; Robinson, 1999 & Williams, 1994). My own understanding of underdevelopment and health is that one must look at people's own wisdom. What has allowed them to survive;

what are their self-care practices and folk remedies. Without the bias of a developed country's point of view, local health scholars and local health policy makers need to consider promoting their own body of knowledge within their locality using scientific methods. This is a key strategy, which could be the basis to create sustainable health care development for underdeveloped countries- especially Thailand.

2.3 Holism

The phrase 'Holistic Approach' as been generally used for two decades, but the term was first coined by Jan Christian Smuts in 1926 (Blattner, 1981; and Sarkis & Skoner, 1987). His holistic views, together with the evolution of science, concluded that scientific discovery at that time was the study of parts without considering the whole. It was study by isolation. In contemporary nursing, Holism is defined as 'a philosophical and biological concept, which refers to wholeness, relationships, process, interactions, freedom, and creativity in survival of all living'. This philosophy has been developed further into the fundamentals of a holistic nursing model (Blattner, 1981; and Dossey, et al, 1995).

It is also important to acknowledge that holistic nursing is harmoniously in accordance with the roots of an *Isaan* view of the world; a world that does not separate body and soul but sees each life as unified (Chunchumnong, 1997; and Bukkyo Dendo Kyokai, 1996: 74-76).

2.3.1 Holistic Health

Holistic health is the term that describes concepts and practices of health care, which include the practices of humanistic medicine, alternative health care, pre-primary care, and altered provider-patient relationships (Fink, 1976 cited in Blattner, 1981: 13). It is this model which enables us to have a holistic understanding of clients. Furthermore, the concept of holistic health, which is applied to this research, is in line with Tao and Buddhist ideas (Chunchumnong, 1997; and Bukkyo Dendo Kyokai, 1996: 74-76).

The concept of humanistic health, one of the sub-concepts of holistic health, has emphasized that nurses should not provide health care by only considering clients, diseases and its diagnosis as the only model for health practice (Armentrout, 1993 and Benson & Mc Devitt, 1989). They have to consider other physical, mental and spiritual elements to create a dynamic balance amidst changing social circumstances and surroundings. This concept is in accordance with concepts found in *Isaan* Buddhism and Tao, which do not emphasise only one direction, but rather a middle path which is most suitable life (Bockmon & Riemen, 1987, Dossey et al, 1995: 18 and Sodsuchat, 1993). The concept of alternative health care is also related to *Isaan* beliefs regarding the causes of illness, which are influenced by semi-Buddhist beliefs and spirit, where curses are found in magic. *Isaan* people believe that there are 3 causes of illness, therefore, the treatment would be successful in curing disease according to these causes. Firstly, the illness could be due to natural causes such as stomach pain because of bad food. Secondly, preternatural causes relate to unnatural illness caused by the casting of a spell, which in turn can be averted by another spell. Lastly, illness caused by supernatural causes is the act of one's soul being possessed by evil spirits. This has to be cured by witch doctors, who would act as a medium to apologize to the spirit. However, concepts of alternative health care may not require health professionals to believe in spirits, but

rather to value people's beliefs and allow them to perform rituals of faith, which are not harmful to health. Rituals can also provide mental support. Therefore, it could be said that the holistic model is the fundamental basis which is in line with the teaching of Buddhism and Tao, the major eastern beliefs.

2.3.2 The Holistic Nursing Model

The model that I have chosen to present here is the Holistic Nursing Model of Blattner (1981) because of its easy implementation style. The model is composed of nine important processes, and all these processes involve the idea of overlap. Those are the processes of self-responsibility and self-awareness; life caring; human development; the stress in life; the individual life style; individual communication; individual problem solving; the nursing profession teaching role; and the individual and group life changes.

These nine important processes are interrelated and help nurses in achieving their nursing goals through the principles of nursing, which include preventive, nurturative and generative nursing care. These are important for clients in order for them to reach optimal health.

An important point that nurses cannot neglect is an interest in client factors, including culture, development, gender, personality, health beliefs and socio-economic status. Furthermore, they should be interested in provider factors relating to how much they can support clients. This can lead to useful solutions only after they have assessed the clients' problems, which can be done through teamwork using multidisciplinary case conferences without neglecting the factors of caring communication, and creativity, with the clients (Barnum, 1987; Vessey & Richardson, 1993; and Wenger, 1993).

In conclusion, the Holistic Nursing Model emphasizes factors that cause any abnormality within the human body, and works on the belief that illness is caused by the imbalance of body, soul, and surroundings. For these reasons the nursing practice could empower a person. This is especially true in the case of women, because women would be able to provide and prevent self-care disease by avoiding risks and taking care of oneself and one's family members. Performing exercises to decrease tension by holding daily activities and following the middle path is in accordance with the Buddha's teaching.

In this research, I have used the Holistic Model to inform the conceptual framework in order to understand the behaviour of respondents with regard to family and the community in which they live. In addition, respondents way of living, working, their work places, family system, socialisation habits, sub-culture in the community, customs, beliefs, values and spiritual elements have all been studied and analyzed. All of the information studied is used as a guide to discussing women's health.

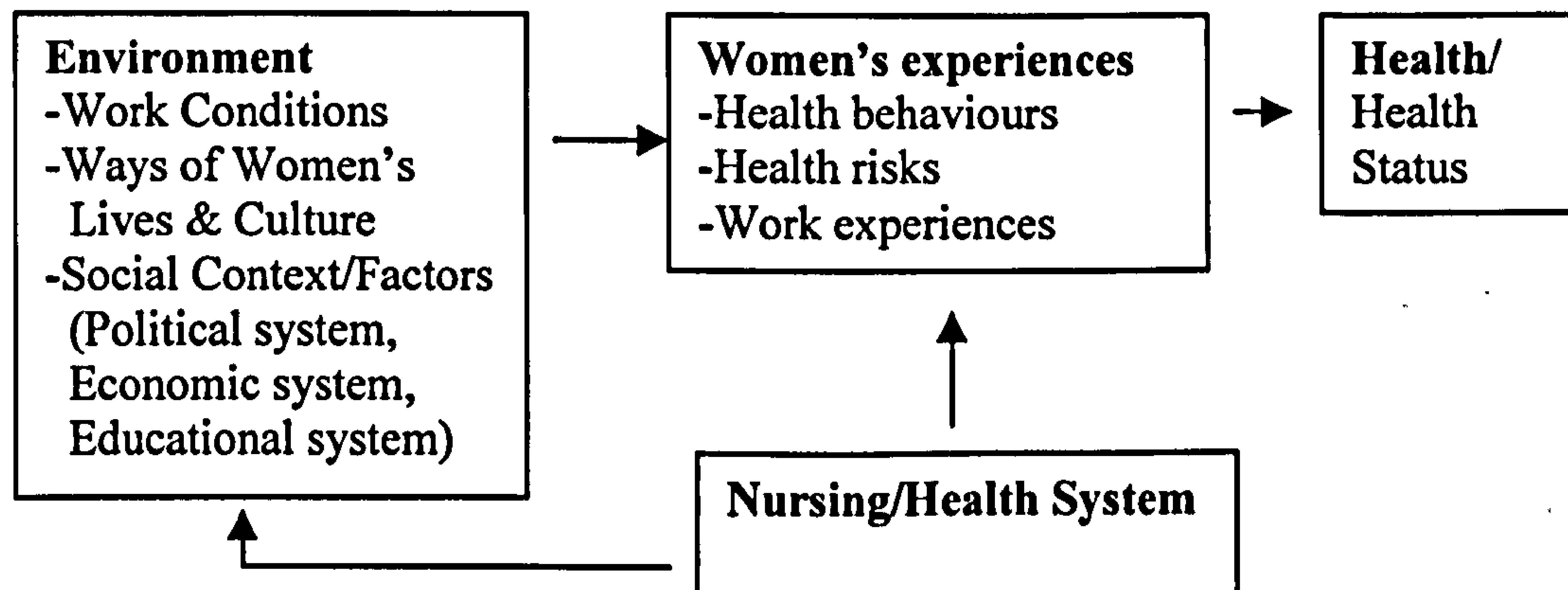
2.4 The Framework and the Outline

Building on these definitions and perspectives a conceptual framework for understanding women's work conditions and their health status was used to guide this study. This framework is viewed and categorized into four components: (1) environment, (2) women, (3) health status, and (4) nursing system. (Figure 2.1)

Environment is the first component of the framework and includes three factors, work conditions, women's way of life, and their social context. These three factors influence one another and affect a person's experience in terms of health behaviour and health risk. Health behaviour and health risk influences the person's health status. Finally, procedures

involved in nursing or health systems can become to alter and modify a person's environment and experience and therefore can influence a person's health status.

Figure 2.1 The Conceptual Framework for Understanding Women's Work Conditions and their Health Status.



In addition, the social context or environment can be seen to be composed of four dimensions: the political, economic, educational, and cultural systems. All of these factors, both independently and interactively, can cause changes in an individual's health status. It is the interpretive of these themes which allows for the understanding of the major issues and the contribution of nursing.

In order to clearly explain each component of the conceptual framework used in this study, the following literature themes were reviewed. Selected literature which provides an understanding of the impact of work on women from low-income communities in Thailand, and how they perceive their health is considered. It then covers the following themes, holistic nursing and women's health, the background of Thai women, low-income women's work, migration and health, women's work and health seeking behaviour in Thai culture.

2.5 Thai Women

A brief review of the literature relating to Thai women is given in order to gain a better understanding of the viewpoints regarding Thai people and especially women, their family and social relationships and social attitudes towards women.

2.5.1 Thai World View and Cultural Values toward Women

The roles of Thai women have changed. Thai society has greatly changed, resulting in women being more educated allowing more opportunities to be employed in different sectors of the labour force. Women who received less education however and who are in a low socioeconomic status group still face constraints. This is particularly true in families with limited financial resources, where the son will be the first to be invested on through education. Daughters will stay home, do housework, or help do jobs which bring money for the family (Archavanitkul, 1988).

Due to the majority of Thai people (95%) being Buddhists, Buddhism has become "a symbol of unity" (Limanonda, 1995: 69). Buddhism plays a very significant role in the daily life of the Thai people. Buddhism relates to almost every occasion including birthdays, marriages, moving to a new house and funerals (Chadchaidee, 1994: 42). "Matriarchy" in the Thai society was overthrown owing to changing social conditions, which in turn resulted partly from the influence of Buddhism both from India and China that limited the status of women to a level lower than men.(Wongphrom, 1998).

Iawsriwong (1995) gave an overall profile of the status of Thai women according to the former Thai cultural frame, particularly in rural areas. It was shown that the roles and status of Thai women were lower than men in many aspects, especially where Buddhism

is concerned. For instance, women could not be ordained to be a monk, who obtains a famous position as a disciple of Buddhism. Men were conditioned to build up the family's prestige, and thus a greater portion of the family's money was spent on their education than on women's. On the contrary, women held roles in the family's finances, from assisting in paddy fields to selling products at the market (Kabilsingh, 1984: 63-74).

However, the structure of Thai society in the early days attached importance on women's family lineage. After marriage, a man usually settled in the family of his wife. This custom can still be seen in these days in *Isaan* families. A man held a status of a new comer amongst his wife's relatives. The women or the wife held the rights of subsistence land and was the heir who carried on the traditions and accounts of her village and family from her mother and grandmother. A woman was conditioned to remain in the family, to look after children and household, and to propagate customs and rituals from the former generation to the next. She was also assigned to follow her ancestors' supernatural beliefs, and was most often assigned the responsibility of rituals such as paying respect to the ancestors' spirits or to the village's spirits and performing spirits' possession rites. Therefore, what underlay the unequal traditions which made Thai women not as inferior as women in other Asian countries (Wongphrom, 1998).

According to Buddhist belief, "to be born female indicates that one has less merit than a male" in part due to the belief that "women are born from lust". For Buddhists, merit is very important as it is the result of previous good deeds performed in past lives. Doing good or making merit by supporting Buddhism in various forms such as entering the monkshood, (which is considered to provide great merit), offering food to the monks, contributing money to build temples and giving alms would provide rewards for the next life. Therefore, because women cannot be ordained as monks like men, they receive part

of the merit through the monks indirectly. Thus, is clear that Buddhism has an impact on women's status.

From the empirical data obtained in previous studies, one notes that Thai women have received less formal education than men.

Table 2.1 Illiteracy Rate (%) of the Population Age more than 15 by Sex

Sex	1980	1985	1990
Female	16.0	13.3	10.1
Male	7.7	5.3	3.9
Total	23.7	18.6	15.0

Source: NCWA, 1996: 23

The overall picture of women and education indicates that chances of women continuing their education has improved but is still not equal to men. It can be seen that there are higher percentages of women in higher education than men. From this data, it can be explained that if women have a chance to further their higher education, the women's educational ability is not less than men, indeed it appears to be better than men in Bachelor's degrees. However, the figure shown here is the number of those who have an opportunity to study at a level higher than primary school, but the population studied in this research are poor, and lack opportunities to study. Therefore, it is shown that 5 to 6 % of the whole population who graduated with primary education do not have an opportunity to further their education. This is the plight of poor women and the population at large, who do not have as equal an opportunity as those who are in middle and high- economic groups (National Commission on Women's Affair-NCWA, 1994: 108-111).

Beyond religion and education we can explore Thai women status through politics. Thai women have a small number of roles in political participation (Tantiwiramanond & Pandey, 1996; 106-107).

The fact that women take fewer roles in politics arises partly from Thai social factors, which call for women to be attached to and work for the family. Moreover, even if laws have been changed, offering more opportunities for women to take part in politics; their roles in this area have only begun recently. According to former laws (1914), the qualification of a village head was stated as "a man who is the head of the family and is a Thai". This law was applied for 68 years, resulting in women having no chance to study and get themselves acquainted with politics. Thus, their roles in politics are only at a beginning, similar to the law which has just been amended. A role women has taken in politics has been to support applicants for political positions at all levels.

2.5.2 Being an *Isaan* Woman

The difference between *Isaan* women and women from other parts of Thailand are limited. *Isaan* women are generally characterised as having a lower status.

Thammawat (1992) conducted a study on the status and roles of women in *Isaan* and found three distinctive female responsibilities: (1) Females work as labour in farming and handicraft production. (2) Females are responsible for sustaining ethics. (3) Females are the reproductive source. Women are the major form of household labour for agricultural and handicraft production. They produce food and clothing from farming, husbandry as well as weaving during their free time.

Sons will be taught to be diligent in earning a living, to know how to grow plants and rice, to know how to sell farm products, to know how to repair the house, and to be responsible for the family.

Isaan women are taught to be close to their family because *Isaan* culture holds that "women's role is to stay home, while men is to leave". Family therefore, has a great impact on women's psyche. *Isaan* women are expected to be the core group responsible for running family activities. Women are required to bring children up to be "good people", educated, aware of traditions and to be aware of work responsibilities. *Isaan* women hold a major role in teaching their children to behave decently, according to accepted social standards.

In sum, the status of Thai women is influenced by Thai traditions and Buddhism. This explains their submission to this patriarchal society. They are characterised by their chief concern for family happiness, security and peace, and tend to place less value on quality of life. So, these factors have an influence over women's values, and provide an insight into the life experiences of these women. Therefore, it is a challenge to show an interest in exploring women's life experiences and their ability to cope with the struggles of life.

2.6 Migration

As early 1982, Tantiwiramanond and Pandey (1996) noted the "feminisation" trend in the migration stream during 1976-1978. The trend of women outnumbering men in migration continued until the early 1990s. During 1976-1988, all regions saw more women than men heading to Bangkok, and the largest portion was from the poorest region, the Northeast. This has been increasing. Women who migrate to big cities are mostly

employed in retail and service sectors. The majority of women work in the informal sectors—as vendors, hawkers, maids or subcontractors—where returns are small and uncertain. In the export industry, the majority of the labour force are women (70% of all workers) working in electronic, textile, food processing, lapidary, footwear, and leather industries (Thompson, 1990).

Urbanisation and rural-urban migrations receive great attention as far as mental health is concerned (Elkeles and Seifert, 1996; Pick and Obermeyer, 1996; and Anson, Pilpel, and Rolnik, 1996). Two forms of migration in Thailand are identified: a single move (long-term migration) and a seasonal or repeating move (temporary migration). Long-term migration is highly selective among young adults, females, and more highly educated people (Archavanitkul, 1988; Richter et al, 1997; and Chamratritthirong et al, 1995).

2.7 Health of the Urban Poor

The World Health Organisation (1988) states that there are many kinds of disease patterns among the urban poor population, infectious diseases, malnutrition, and social diseases. Moreover, it is clear that the urban population is experiencing a high rate of depression and anxiety (Harpham, 1994). The six low-income communities studied here also face problems common to the urban poor population, (as stated by WHO) where people live in heavy populated areas, where there is polluted water and refuse dumps full of mosquitoes and dust.

These common problems of the urban poor usually have a direct effect on women who value their roles as caregivers (Gelfand and Mc Callum, 1994). These women face major demands as caregivers, but because of their low socioeconomic status, often have no

access to health care. They also face problems due to low levels of income, limited education, and fewer available health resources (Bechtel, Shepherd, and Rogers, 1995). At the same time, the study shows that Thai families on low-incomes are more inclined to purchase drugs for self-medication than families on higher incomes (Prasartkul et al, 1995). With the limited access to health services, buying drugs by themselves from drugs stores has become their alternative health service.

2.8 Impoverished Women and Work

Thai women have vital roles in finding money for supporting the families in both rural and urban economics (Archavanitkul, 1988; Chamratrithirong, 1979, 1995; Nouwarat, 1991; Pupaibul et al, 1991; Richter and Havanon, 1995; Suntornchai, 1996; and Richter, et al, 1997). Thai women contributed to the economic development of the country more than women in other Asian countries (Tong-uthi, 1990). The reason is because of the social, economic, and cultural characteristics of Thailand which draw a great number of women into the labour force. Women can be seen using minor farm machinery in rural areas, as well as being involved in a great number of small-scale businesses in the industrial and service sectors. Women are frequently found doing domestic and unpaid work within a family enterprise (Richter and Havanon, 1995). In addition, a Thai family is usually proud of a wife who assists in earning a living. Women, thus, do housework, look after the children, and are employed (Tong-uthi, 1990).

In 1990, it was reported that the labour force in Thailand amounted to 31.5 million from the total population of 56.4 million, or about 56% of the population. From this number, women accounted for 47% of the total labour force. This was 52% of the whole female population of the country (National Statistical Office, 1993). The statistical figures of

women and men working in different sectors are given below (Table 2.2). From the data, it can be noted that there are high percentages of women working in service and commerce sections than men. Since women can do housework, take care of children, and at the same time run their small-scale businesses.

Table 2.2 Distribution of Employee by Sex in the Whole Country (1993)

Work	Female		Male		Total
	No	%	NO	%	
Agriculture	8,449.9	46	9,794.6	54	18,244.5
Handicrafts	1,929.5	49	2,031.4	51	3,960.9
Services	1,936.7	53	1,735.8	47	3,667.7
Commerce	1,968.3	53	1,735.8	47	3,704.1
Construction workers	260.3	18	1,214.4	82	1,474.7
Transportation	109.3	12	770.0	88	879.3
Public service and Health workers	23.3	16	121.4	84	144.7
Miners	12.1	21	45.0	79	57.1
Others	10.8	61	6.9	39	17.7
Total	14,701	46	17,451.5	54	32,152.5

Source: National Statistical Office (NSO), 1993: 11
(To base of 1000)

2.8.1 Poverty

The meaning of the word 'poverty' is "a relative term based on living standards prevailing in the community" (Kosa, 1976: 2). However, poverty can also be considered as the relationship between the local environment and people's health. Several studies found a consistent relationship between women's poor health status and low income (Arber and Ginn, 1993; Asthana, 1995; Caputo, 1995; Dowler, 1996; Harpham, 1994; Millar, 1996; Pill, Peters and Robling, 1993; and Williams, 1994). Women are more likely than men to be poor, to work longer hours and earn less income (Kettel, 1996). Poverty results in inadequate housing and creates health hazards for women. Over 50% of urban dwellers in developing countries live in slums or squatter settlements. These urban dwellers face air and water problems amongst other health hazards. Squatters and slum residents have to

face overcrowding, inadequate sanitation and waste conduit, inadequate water supply, and other social welfare problems (Asthana, 1995; Chung and Kagawa-Singer, 1993; Chung and Spears, 1992; and Harpham, 1994).

2.9 The Meaning of Work

Work is important for the lives of individuals for several reasons (Steers & Porter, 1987; and Mc Lean, 1979). First, work is considered beneficial because it offers structure and form to an individual's life. Whether we are talking about a corporate executive, an assembly-line worker, or a volunteer, each receives some form of reward in exchange for his or her services. These rewards may be primarily extrinsic, such as money, or they may be purely intrinsic, such as personal satisfaction. Secondly, work commonly helps social interactions between workers and others. Thirdly, an individual's career is often a source of status and power in society. Fourthly, by the aspect of motivation, the personal meaning of work can be many; it can be an important source of self-esteem, and self-actualisation. On the contrary, it can also be a cause of frustration, boredom, and feeling of meaninglessness to someone when he or she feels dissatisfied with the job. For many, work is a vital part of the process of coping with life stress. This has two aspects: firstly, without work, the potential for boredom and meaninglessness is immeasurably increased. Secondly, work is often a form of coping and refuge. Work can provide psychological haven against problems that otherwise would be invincible, or against loneliness and depression (Mc Lean, 1979).

2.10 Women's Health Status in General

In Thailand the strategies to improve women's health status including nutritional health, family planning and health education for farmers' wives groups have been implemented for a long period. It can be seen that the life span of women increased when compared to 1960 when it was only 52 years. In addition infant mortality rate has decreased significantly (UNDP, 1993 cited in NCWA, 1994: 141). In general statistics relating to the following morbidities sexually transmitted diseases and mentally illness have been of concern to the Ministry of Health in Thailand (Sittitrai, et al. 1992).

As regards the use of health services by women, it was shown that most of the women living in municipal areas chose to give birth at the hospital, whereas most rural women gave birth at home with the help of traditional midwifes who were trained by health officers (UNDP, 1993 cited in Bureau Of Health Policy And Plan, 1997).

It can be concluded from official epidemiological data that ever since 1980, health and hygiene services and women's access to services generally has been improved. (Sittitrai, et al. 1992). Mortality rates during pregnancy or labouring have declined (Bureau of Health Policy and Planning, 1997). The life spans of both men and women have also increased. However, it is apparent that the spread of AIDS has not been prevented, and is awaiting urgent attention (Sittitrai, et al. 1992) and that the mental health of women is still of concern (Bureau of Health Policy and Planning, 1997).

2.10.1 Women's Occupational Health Problems

The occupational health and safety issues that affect women only, or affect them disproportionately or differently from men are the questions under concern. The

ergonomic situations which impact on women's health commonly found among the women at work could be divided into 7 types:

(1) Women's work has some particular characteristics, i.e. repetition of work requiring the same posture for a lengthy period, static effort, and simultaneous responsibilities for numerous tasks. (2) Spaces, equipment, and schedules have, for most cases, been designed for male physiology rather than for women. (3) Segregation may become a health risk by causing task fragmentation and thus increasing repetition and monotony. (4) Sex-based job assignments with an aim to protect health for both sexes often distract from more effective occupational health promotion practices. (5) Discrimination against women is stressful (6) Part-time workers do not receive health care service from any working units (Messing, 1997). (7) In developing countries, women working in informal sectors such as sub-contracting, working at home, working in small factories, or holding small-scale personal businesses are not under any health care program by any unit (Cooper, 1991a and Pupaibul, et al. 1990).

2.10.1.1 Labour Welfare for Women

According to the Notification of Labour Protection for Women Workers announced in 1972, women workers are allowed to take maternity leave with full pay for 30 days under the category of sickness leave. They are entitled to maternity leave without pay for another 30 days and are also entitled to regular holidays (Archavanitkul and Pramualratana, 1990). Female workers in the government sector and the state enterprises can take maternity leave with full pay for 60 to 90 days. However, this is in contrast to working conditions in small or illegal factories. The Labour Department reported (1996) that 99 percent of small-scale factories did not allow maternity leave. Some employers would rather choose to pay lower wages. Experiences indicated that most female workers in smaller illegal factories are not protected under the labour law, especially those who work in non-formal

occupations which are beyond the regulations, including domestic servants and waitresses where working hours are dictated by employers (Labour Force Protective Office, 1996).

Women's occupational health problems discussed hereunder will include those related to musculoskeletal disorders, reproductive health problems, emotional and psychological problems and chronic diseases.

2.10.1.2 Acute Episode due to Occupational Problems

(1) Musculoskeletal Disorders

Global statistics show women have a longer life span than men. However, although women live longer, they are nearly twice as likely to suffer disabling conditions than men (Messing, 1997; and Ponzer, et al. 1997). The major cause of disability amongst women is musculoskeletal disorders (Knutsson, and Goine, 1998). These problems range from arthritis, inflammations of various joints, and backache (Cooper, 1991a; Pupaibul, et al. 1990; Messing, 1997; Collin, et al, 1997; Tausig and Fenwick, 1999; and Bureau of Health Policy and Plan, 1996).

The causes of musculoskeletal disorders among workers is understood to be: Repetitive Work and Static Muscular Effort (Messing, 1992 and 1997, Dennerstein, 1995; and Messing, 1997, Collin, et al, 1997, Paul et al, 1994; and Messing, 1997, Repetti, et al, 1989; Dennerstein, 1995; and Messing, 1997).

(2) Reproductive Health Issues

The process of developing countries becoming industrialised results in a rapid changing of production structures. Introduction of new technology in the production sector often overlooks workers' health. This is particularly true in countries where the laws protecting

labour are not strictly enforced. Workers are exposed to chemicals and toxic substances such as cotton dust, lead, manganese and cyanide, all of which are carcinogenic substances. Women are known to be more susceptible to these toxins, which has serious implications for reproductive health (Baksh, et al, 1994; Franc, et al, 1996; Messing, 1992; and Collin, et al, 1997).

(3) Emotional and Mental Issues

Emotional and mental problems are secondary problems of musculo-skeletal disorders of women at all age ranges (Knutsson and Goine, 1998; and Dennerstein, 1995). Statistical surveys often reveal that women suffer greater stress than men working in the same workplace (Messing, 1992 and 1997; Collins, et al. 1997; Dennerstein, 1995; and Bird, 1999). According to technical reports, family-related roles of women constitute the major source of stress and suffering for women.

From a study by Karasek (1979), a stress-management model of job strain was discussed with an emphasis on degree of job control and level of demand. He found that combination of low decision latitude and heavy of demands caused mental strain. Conversely, any jobs with high decision latitude and low job demands would bring about satisfaction.

Stress is not caused only by the individual and the environment, but also from a complex relationship of factors that influence each other. When there is demand, people will utilise all their resources, and they will be free from stress as long as they are in equilibrium (Lazarus and others, 1980). When a person is in distress, the capacity of an individual to cope with crisis and return to an equilibrium is dependent on the following factors: stressors, existing resources and perception of relevant stressors (Mc Cubbin & Patterson,

1983). Stressors, causing an imbalance, create a set of problems that have to be solved. The problems could be either big or small depending upon how the person interprets this stressor. If the person believes the situation represents a small problem, stress can easily be overcome. On the contrary if one believe that the problem is a big one, but there are existing resources such as an adequate social support system to encourage them to solve problems, they can overcome stress (Friedman, 1992: 321). Therefore, the Crisis Theory of Mc Cubbin and Patterson could be applied as a framework in analyzing the family problems of low-income women who face daily problems and work-related problems.

It was noted that the occupations usually require workers to please their consumers and have lack of control over the work, which often leads to boredom. Lack of career progress can also cause stress, reducing job satisfaction (Burke, 1996). Work schedules and work overload causes physical and emotional exhaustion and effects both family life and women's health (Burke, 1996). Women of course face a double workload due to job demands in addition to their role performing housework and care of children. Because of this, there needs to be an intensive study on women's occupational stress to find a solution to this problem (Szalai 1972, Messing, 1997, Lee and others 1994).

There have been a great number of studies indicating that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with marital status, work, and roles in society (Russo cited in Dennerstein, 1995, Collins, et al. 1997, McBride, 1988). Nevertheless, women in low socioeconomic groups who have jobs are found to have positive feelings toward themselves. They feel valuable and have self-esteem (Messing, 1992).

(4) Occupation and Misuse of Alcohol and Drugs

In Thailand, alcohol is a major health problem, causing liver disease, peptic ulcer, mental infirmity and road traffic accidents. Moreover, alcohol consumption has increased. In 1986, the average alcohol and liquor consumption was 30.21 litres per person, whereas that of beer was 34.34 litres per person. Surveys also revealed that Thai people reporting to drink every day totaled 1,315,969 persons (Bureau of Health Policy and Plan, 1996).

After alcohol, the most frequently misused drugs amongst workers were opiates (30%), barbiturates (24%), benzodiazepines (21%), and amphetamines (15%) (Guppy and Marsden, 1996). Substance use disorders were found to be closely related to the low-socioeconomic class (Wohlfarth and Brink, 1998 & Amodeo, et al, 1996).

The Thailand Development Research Institute (IDRI) (the Bureau of Health Plan and Policy, 1996) estimated that there are at least 1.27 million drug addicts in Thailand. 0.41 million people of this figure (32.3%) use solvents, followed by marijuana (25.6%), amphetamines (20.3%), heroin (16.8%), and opium (4.9%).

Amphetamine has been under government control as of 1975 as a substance it has an impact on both the mind and the nerves and the selling and buying of the drug is illegal. However, there is still illegal production and selling on the black market. Consumers of this drug include the labour force who uses it to relieve tiredness and to enable them to work long hours (Sriluecha, et al. 1993).

It can be seen that misuse of substances is found among workers of nearly all occupations and is the major problem of every society. Besides influences from people in the same

occupation or availability of the substance/drugs, there is also another important factor leading to such misuse, i.e. high stress of work.

2.10.1.3 Chronic Disease due to Occupational Problems

It is difficult to attribute chronic disease to occupation, since a disease usually takes a long period to occur, often only after the person has quit the job. Sometimes, although a disease may emerge during the employment period, the severity may only gradually increase. Some health problems are not easily detected, such as chemical exposure. This often affects restaurant workers or food venders.

Most chronic diseases manifest after a person reaches his or her middle age. The prevalence of chronic disease affecting women is higher than in the past, both in developed and developing countries (Elliot, 1995; Baksh, et al. 1994; Arnstein, et al. 1996; Repetti, et al. 1989; Knutsson and Goine, 1998; Legato, et al. 1997; Bresinka and Kittel, 1995; and Collins, et al. 1997).

Previous studies have shown that chronic diseases relating to work include lung cancer and lung diseases (Supanchaiyamat, et al, 1993); byssinosis (cotton dust disease) (Bureau of Health Plan and Policy, 1996); arthritis (Collins, et al. 1997); chronic back problems (Skovron, 1992); heart diseases and osteoporosis (Collins, et al. 1997).

In Khon Kaen itself, statistics of the Office of Provincial Health in 1993 showed 83,529 persons showed symptoms indicating diseases of bones and muscles. Statistics from Srinagarind Hospital, Khon Kaen University in 1993 reported 4,920 patients receiving service at the Out Patient Department because of lower backache.

2.10.2 Informal Sector Works and Women's Occupational Health in Thailand

In many developing countries there is a dual economy; the first economy, "the formal sector", is that of the modern, capitalist and technological economy. The second, "the informal sector" is that of a traditional market economy. This market economy is defined as a system of production under which work is carried out by worker at a place of his or her own choosing. It includes manufacturing of small machines, clothing, furniture, trade street vending, food hawking, domestic work and illegal activities (Sirisambhand, 1995: 63).

Few studies have been concerned with occupational health for Thai women working in the informal sector (Chirawatkul, 1998). However, problems are known to exist because of the pressure to work in a climate with a lack of information, poor education, poor income, and absence of legislative protection. Health problems from excessive noise, poor lighting, poor ventilation, long working hours, poor workplace design and ergonomics, and uncontrolled use of chemicals can be expected to lead to occupational health problems at least as frequently as those in similar 'formal' industries.

The agricultural sector in Thailand is classified as an informal sector. Complaints from women in the agricultural sector include abnormalities in alimentary system such as stomachache, diarrhoea, flatulency, and peptic ulcer; as well as respiratory complaints including having a high temperature, cough, sore throat, pneumonia. Women also complained of waist and backache, as well as muscle pain due to hard work. In addition, there are skin abnormalities, physical abscesses, eczema, infection and various parasitic diseases (Supunchaiyamat, et al. 1993). Women working in the non-farming sector include private employers, followed by entrepreneurs who are most likely engaged in the informal

sector, which include street venders, hawkers, petty traders, and food stall operators. Many of these women are young, uneducated, and inexperienced.

It has been estimated that four out of five women working in small-scale industries are liable to face work that can lead to health problems. They are prone to long shift hours, noise from machines, dust from production processes, heat from operating machines, insufficient illumination, repetition, abnormal working postures, and machine-related accidents. In 1989, Kusol and Sureeporn (cited in Pupaibul, et al. 1990) conducted a study on common illnesses of 957 women labourers who worked in small-scale textile factories. Their study revealed the following health complaints of these women during a consecutive three-month period: 17.4% had problems related to respiratory tract, with symptoms of convulsive breathing, and difficult breathing. Another 18.4% were found to have difficulties in hearing and ear distension. 52.6% had eye irritations. 11.7% had abnormal eyesight and 6.7 percent had some eye pain, all of which could be attributed to cotton dust and chemicals used in the production processes.

In 1990, Pupaibul and others conducted a comparative study between women's health status in old style agricultural communities and newly industrialised villages in Khon Kaen Province. The findings revealed that the higher-income women in the newly industrialised group had poorer health status compared to the other group. The women in the newly industrialised group had a rode of higher abortion. Moreover, women in the newly industrialised group frequently reported illnesses such as eye problems and work-related injuries.

In 1991, Cooper and others performed a study of the occupational health of women who worked at home in Khon Kaen Province. The principal workers' groups studied were

artificial gem polishing and fishnet repairing groups. The occupational-related health problems of the two groups were similar and included a high rate of musculoskeletal problems. Other problems such as eyestrain and drowsiness were common.

2.11 Health Seeking Behaviour in Thai Culture

Health seeking behaviour refers to what people do in order to prevent current health problem (Weiss & Lynne, 1996: 108). Chrisman (1977) also defined the nature of self-health behaviour as also included the integration of local culture and each individual's perception. Beginning with a definition of health abnormality, they are able to measure how serious symptom is and what possible causes may be. This may lead to a discussion regarding treatment, or indeed cause the patient to. This concept is in accordance with the work of Mechanic (1986) relating to human's illness behaviour, which concluded that when a person is ill, their body would reflect that illness externally. The Health seeking behaviour was dependent upon these factors: 1) the illness's outside appearance, 2) the estimation of the seriousness of the illness, 3) the frequency of the illness, the greater the frequency of an illness, the more aware a patient would be, 4) the threshold of suffering of an illness; how much one could endure the pain, 5) how the person defines symptoms.

Existing data shows that feature of self-care amongst poor people in Thailand include purchasing drugs themselves, using the services of folk healers, going to the health volunteer office, and going to the hospital for immediate and emergency illnesses. However, if they still do not recover after receiving hospital treatment, they would turn to folk healers for treatment, including "magic" healers (Keskowit et al, 1993). This study was in compliance with the others (Muangman, 1987; Osana, 1993; Bureau of Health

Policy and Planning, 1996, Supunchaiyamat and others, 1988 and Le Grand and others, 1993).

In the Thai context, women are more likely than men to seek health care, and to be reported as having poor health (Kanungsukkasem, 1993). However, it is evident from the study that women are either not counseled at all or are inadequately counseled about their susceptibility to some diseases (Legato et al, 1997). This finding is of course in contrast to the fact that women are responsible for the health of all members of the family (Fuller et al, 1993). The health of women is of concern as it is influenced by gender socialisation. Also there are issues which required be further understood about why women place themselves and their health as the lowest priority within the family. This conforms to gender socialisation.

Singhakachen (1982, cited in Predasawast, et al, 1987) reported that Thai drug buyers were influenced from; advertisements (67.3%), drug sellers (42.2%). The remainder (29.8%) received recommendations from their neighbours. Most of the investigated population (67%) bought their own medicine from village groceries.

Predasawast and others (1987) studied the health care behaviours of villagers, in the Northeast. They found that villagers usually did nothing when they were ill. They would later purchase medicine on their own. If they failed to obtain medicine, they would visit a health service centre. This study indicated that such health seeking behaviour was dependent on certain factors, including self-evaluation as to whether the illness is severe or if the illness had a natural or super-natural cause. If the patient was less than 13 years of age, the decision depended on the mother or older relatives. If the patient was aged over 20 years, they were able to make their own decision. If the patient was elderly health

seeking would be decided by the children (Chadbunchachai et al, 1990). When people concluded that the cause was super-natural, traditional healers would be sought, such as "*Mor Phee*", "*Mor Lam Phee Faa*" (spirit doctors who contact with spirits), or "*Mor Dhamma*". If the case is a broken bone or bone dislocation then "*Mor Namman*" or "*Mor Nammon*" (quacks using consecrated oil or water) will be chosen. If the illness relates to abnormalities in the womb or eating bad food, villagers will see herb doctors. In cases where the patients do not recovered after seeing a western doctor they will usually visit a traditional healer (Chusil, et al, 1989; and Kanungsukkasem et al, 1993).

Chanpothisri et al (1990) and Ketkowit and others (1998) identified factors determining potentiality of self-care were: (1) the influence of modern medicine accessible to the community, (2) culture inherited from ancestors, (3) influence of relatives/kin, (4) education, (5) economic status of individuals and communities, (6) psychiatric needs and (7) each illness episode

Chadbunchachai subsequently studied the behaviour of the people in the Northeast of Thailand in 1997 relating to medicine for self-treatment. It was found that *Yaa Chud* (a set of several medicines together in a small plastic bag) for musculoskeletal pain was often used as alternative treatment for pain. The findings showed that the prevalence of *Yaa Chud* users in rural areas was higher than in urban areas. People had the perception that *Yaa Chud* was a potent drug, cheap and had beneficial effects.

Self-medication is the most preferred method of health care for Thai people. However, some medicines are not only unnecessary but also dangerous.

Analysis of Thai people's health behaviours can be carried out in three aspects: health behaviours as antecedent, health behaviours as target, and health behaviours as consequence. Health behaviours could be viewed as an antecedent or cause of illness because low-income people health behaviour involves the use of painkillers, alcohol and stimulants on a regular basis. These are risk behaviours that could lead to illness. In viewing health behaviours as target, health professionals may consider what strategies may help people change their health behaviours to lessen risk behaviours. These are questions to be answered in further research. However, in reality, people's behaviours do not develop in isolation. Indeed behaviours also relate to other social factors such as financial situation, society, politics and environment. Therefore, the behaviours of low-income group are viewed only as the outcome of the above-mentioned conditions. This is especially true of poverty, a social phenomenon which appears to have a direct effect on health. Researchers need to understand a comprehensive study on health behaviours in order to understand the crux of health behaviour problems and make systematic connections, according to the Buddhist Doctrine of the Four Noble Truths (*caturaiyasaccani*). These are, the Truth of suffering (*dukkha*), the Truth of the Cause of Suffering (*samudaya*), the Truth of Cessation of Suffering (*nirodha*), and the Truth of the Way leading to the Cessation of Suffering (*magga*).

2.12 Analytical Reflections

This chapter discussed literature relating to the surrounding conditions of women in the target group of the study in the Thai context. The Holistic Nursing Model, provided guidelines to discussing the health and experiences of women in this study. Buddhism has a great influence on the worldview of *Isaan* women and their attitude toward health and illness. Moreover, through socialisation *Isaan* women place higher value on family

happiness and peacefulness than on gender equality and politics. The framework and outline of the study are also given. This will be used to guide this study including aspects of environment, women, health status and nursing system.

Referring to the framework and the outline of the study, there are four components; environment, women's experiences, health status and the nursing system.

Environment is an important part of being human. People manipulate it to extract what they need to survive. Environment is also the place where the person is nurtured and grows, forms and breaks relationships and acts out roles with other people at work and play (Wright, 1990: 21).

The living environment of women indicates that women in Thailand are unequal to men, particular those women from low-income families. There is data however which
shows that there are a rising in number of women who have high status work and have finished higher education. These are women in the middle and higher soco-economic brackets. As for women in low-income families, high illiteracy rates exist. Most disquieting is the fact that there are more illiterate women in the north and north-east of Thailand than in any other region. This reflects the deprivations of the population in the region; the poor educational attainment and conversely, the contribution of economic plight to poor levels of education.

Previous studies also indicate that women enter wage labour at a very young age. The work force in the informal sector is dominated by poorly educated female labourers. At the same time, they have the responsibility of housework and childcare which means that they have a double role of both earning a living and taking care of their families. Working

in the informal sector, they lack welfare and protection, training opportunities, promotional privileges and reasonable wage rates. There are still no officials to oversee conditions in the informal sector.

Many families from rural areas migrate to urban areas due to the country's economic crises and create new slum settlements. A high proportion of these families come from northeast Thailand. Economic migration and poverty contribute to many health problems for urban populations. A number of studies have analysed aspects of Bangkok's urbanisation. However, there is still a lack of substantive information on other urban slums such as those in Khon Kaen in terms of resource usage, health of the population, the environmental and quality of the city. The impact of the growing city, of environmental problems on its inhabitants, and how people adapt or adjust to the changing environment, have not been studied in the Khon Kaen context. It remains to be seen how people's economic and living conditions are taken into account in the process of solving their living problems. At the individual level, how is both the physical and mental health of the population at risk.

In reality, nursing service system in Thailand is embedded in the health service infrastructures. The majority of services provide health care which focuses on curative activities rather than health promotion to prevent health problems. The nursing care activities like family visits and community health promotion are temporarily carried out according to government health promotion schemes and university student practices. The health service setting for people living in the low-income communities has not been set. Consequently, there are limited studies which explain the inappropriate environmental situations related to those low-income people's health and the application of nursing care.

Women's Experiences: Women who have good health can maintain their families' health (Archavanitkul & Pramulratana, 1990). Women can protect the family in terms of environment, disease prevention and health promotion. Unfortunately, previous research has not been concerned with these issues. In addition, a lack of professional nursing involvement in terms of health provision has limited the efforts of these women and communities. Some research has been concerned with women's experiences in various sectors such as education, commerce, services, politic sectors, and traditional rituals (Kabinlsingh, 1984, Keyes, 1984, Lapanun, 1993). Generally these previous studies have provided pictures of improvment in the status of Thai women in terms of educational achievement and economic contribution but in general Thai women are still submissive to the patriarchal society (Kabinlsingh, 1984, Iawsriwong, 1995). Previous studies also indicated that Thai women have a few roles in political and economic decision making. A few studies (Chirawatkul, 1998) have payed attention to their social integration, marriage and family formation in terms of housework with out pay, autonomy, privatisation, mothering, and their struggle of working. As for Thai women's experiences, the literature indicated that a huge number of low-income women are migrating for employment in retail and service sectors (Lapanun, 1998). They are responsible for sustaining traditional ritual child socialisation and ethics (Wongpohm, 1998). Regard to their values, women place a major concern on family happiness and less value on their own quality of life (Sindhu, 1992). There are limited studies which have focused on women's perspectives. Thus this current study is timely and required.

Health Status:

> "That health is something more than the absence of disease, has been suggested by the notion of good health as the power of overcoming disease which is actually present;...although health is sometimes the absence of serious disease, it is also

> possible to refer to someone as healthy even though serious disease is said in the same breath to the present" (Haughey, 1995: 208).

It can be seen, therefore, that health status is a state that people themselves recognise due to their health knowledge. Previous studies on Thai women's health focus on reproductive, nutritional and maternal health with AIDS. These studies indicated that women's health, hygiene and mortality rate have been better than in the past. The country's major health concerns are moving towards sexually transmitted diseases, particular AIDS.

Health status is the interest of the present study particularly that of women in the informal work sector in Thailand. Previous studies payed attention to occupational health analyse workers in the formal sector. They focused on segregated groups, different kinds of work and factories. Limited studies focused on women's health problems related to their work in the informal sector (Thanachusil, et al, 1984; Pupaibul, 1990, Cooper, 1991; and Chirawatkul, 1998). Numerous studies on women occupational health in the formal sector in Thailand are methodologically weak (Cooper, 1991, Chuprapawan, 1996, Pumisinsit, 1995, Supanchaiyamat et al, 1993 and Tantiwiramanond & Pandey, 1996). As for low-income families living in urban settlement, there is limited research concerned with their health condition, health behaviour patterns, service accessibility and awareness of health risks.

The fact that data on health status of people, particular low-income women is basically needed for nursing professionals to do their nursing process, especially at the assessment and planning levels (Wright, 1990: 56). Adequate health condition data will help nurses establish base-line data indexes for nursing care and health monitoring. I am interested in the disadvantaged group, particularly low-income women in urban slums. I therefore aim

to uncover the voices of low-income women as they attempt to give meaning to significant relationships in their lives in terms of experiences in caring for family members' health, the health delivery issues such as availability and accessibility of services. Finally, concepts of health and illness and awareness of their health risks are also described.

Nursing System:

> "The patient is a complex person having physical, social and psychological elements contributing to the whole..." (Wright, 1990: 19).

The nursing professional has a role to focus on caring for the person, namely individual, family, community and society (Friedman, 1992: 22-23). In using these skills a nurse needs to have both a beadth and depth of knowledge with regard to her clients in a context of social, psychological and physical phenomena. In doing so, nurses need to build up their body of knowledge. The present study invites the Holistic Nursing model as the key concept to understand the target of study, low-income women in urban settlements. As "*poverty is a significant risk factor for certain health problems and is associated with lack of access to care*" (Glick, 1999: 23). Low-income communities in Khon Kaen Municipailty are at the centred of this study. Since Holistic Nursing is not a procedure, but the values and interpretations of holistic nursing may dictate appropriate methods (Barnum, 1987: 28). Thus nursing process is the recommended approaches to caring and nursing activities.

Unfortunately, limited studies have paid attention to the application of nursing perspectives on the health care of low-income women or communities. There are some studies in health seeking behaviours of Thai farmers, labourers and segregate groups. Limited studies focused on women's backgrounds in terms of social and working life. For

the present study the importance of the clients background is of concern when pursuing an holistic nursing perspective on the health of women. (Vessey & Richardson, 1993: 14-19).

The present study considered personal social and working life information is important for health promotion and nursing care for women who live in the low-income communities as the views of Holistic nursing perspectives. The delivery issues related to these women will be examined in terms of their availability, accessibility, and acceptability of services. In addition, their health beliefs, behaviours and awareness of their health risks will be described. All regards of client factors such as culture, developmental stage, gender, personality, health beliefs, coping strategies of the women will be also explored.

Results of the present study are able to generate basic data about low-income women thereby helping nurses to better understand their clients and to formulate the explicit nursing care plan and implementation. All nursing processes begin with client assessment, which forces one to think in terms of components or of linkages between parts. The Holistic view is comprehensive and encourages nurses to think of all aspects of clients need, behaviour and health. Hence, Holistic nursing encourages the nurse to keep an inseparability of mind, body and culture foremost in her mind.

2.13 Conclusion and Directions for Research Methodology

In reality, women live in the society. Consequently, women's lives, work and health are related to other social factors including environment, economics, education, work conditions and politics. Moreover, environment could affect women's experiences in terms of health behaviours, health risk and health status. As mentioned earlier we know very little about the impact that specific work stressors have on the physical and mental

health of women. For an understanding of the working experiences of low-income women in terms of the impact on health, the interpretation of their experience should be grounded from an insider's view-point in order to provide their insight concepts. This is because work and health problems are related to social and cultural structures. How a woman perceives and responds to the experiences of her own physical and mental health throughout her life in relation to social constraints is a matter that should be of concern to health care providers. The method of investigation chosen, in the present study therefore is distinctively different from the designs adopted in the studies reviewed herein, in terms of content, context and international perspectives (Archavanitkul, 1988; Collins, et al, 1997; Chanratrithirong, 1995; Chirawatkul, 1998; Kabilsingh, 1984; Messing, 1997; NCWA, 1985; Pupaibul, 1991; and Wongphrom, 1998;). Conducting this particular research involves using both quantitative and qualitative research techniques. Quantitative data gives insights into the magnitude and extent of women and their health problems in general, while a qualitative study lends insight into understanding the processes and reasons for women's experiences beliefs and behaviours. Consequently, it provides in-depth explanation for women's experience in working, health problem and health seeking behaviours. The following chapters will describe the research design adopted to understand the experiences of Thai low-income women's health problems and their work.

CHAPTER THREE

METHODOLOGY AND RESEARCH PROCEDURE

3.1 Introduction

This chapter is concerned with the methodological theory upon which the present study is based. The strengths and weaknesses of the approach to methodological selection are also identified. The research design and procedure adopted for the study are finally described.

Although women's health has been of concern to the nursing profession for a long time, the focus of concern has been limited to reproductive health and family planning. Studies on women's health related to work, particularly in Thailand, are very few. Generally studies on occupational health in Thailand do not differentiate between men and women, although in reality, the situation, opportunities and problems facing men and women are very different. Key findings from the literature reviews in the previous chapter can be summarised on the following issues.

(1) After women leave school, they are likely to enter the labour force. They often have to engage in unskilled jobs which may lead to exploitation of their wages or to being over-burdened with work. An interesting question is "What are low-income women's concepts of being healthy, work-related health problems?"

(2) Cultural factors, namely social values and norms of Thai people seem vital in determining roles for women as daughters and members of society. An interesting question is "How do social values and social norms influence women to maintain their roles?" The fact that the family system in Thailand is still strong invites questions

such as "What role do women have for retaining their families?"; and "How do women balance their twin roles of work and family?"

(3) Previous research regarding health seeking behaviours in low-income people has shown that Thai culture is unique. They prefer self-medication and traditional health services. Formal western medical services are the last choice for them to use. This requires investigation especially amongst low-income women. In particular "What are their concepts of health and illness"; and "How does work impinge women's ability to care for family members?"

This study, which aims to illuminate, the interconnections between gender, poverty, work and health and the contribution of a community nursing service in enabling health care for women in low income communities can be divided into levels. Firstly at the macro level by employing 'health status surveys' from six communities in the Khon Kaen municipality. The six low-income communities were recognised as registered municipality members in 1991. As members of the municipality, people living in these communities sought health services from the municipality health centre. In addition, the members can also seek health care from the local government hospital. The health status surveys will generate on the basis of health data from women living in the low-income areas a community profile, demographic details, migration experiences, women's work and health under adversity. This macro data will answer some parts of the research questions: to understand the meaning of the concepts of health and wellness for low-income women; and to explore the work and family roles of these women. This macro information will help to select the appropriate qualitative site for in-depth study in micro level. In particular "Which community is the most imformative and obtained the most

suitable criteria for conducting field research?" Secondly, at the micro level, this approach will investigate the experiences, opportunities and health problems facing women in the low-income community. The case study approach aims to give a rounded and in-depth picture of the following: to understand the meaning of the concepts of health and wellness for them; to explore the work and family roles of these women; and to understand their perspectives on health, work and their caring ability within the family. By helping nurses who are working with low-income communities to better understand their clients's context and health problems.

One of six communities which is suitable and informative will be selected for micro level study. The criteria for choosing the community are both its profile and its residents' choices in terms of community establishment, women's empowerment and their coping strategies. It is concluded that knowledge gained from this community can be transfered to others.

3.2 Research Design

3.2.1 Introduction

The purpose of this study was to understand women's health and work in the socio-cultural context of poverty. To do so requires an understanding of many issues. Rich descriptions are needed which enable life processes to be understood fully in terms of the cultural context, gender, religion (Buddhism), family relations, position of poor women and their survival in an urban context.

To explore these issues the study is framed within a *constructivist paradigm*. According to Guba and Lincoln (1989: 128-129) the 'constructivist paradigm' is a 'naturalistic inquiry', which attempts to make sense of or to interpret the experiences of people. The nature of the construction that can be held at the end of the study depends upon 'the range of information available' to a researcher and how this is dealt with. This kind of study usually relies on a large number of diverse tasks, ranging from interviewing to observing, to interpreting events, to intensive self-reflection and introspection.

The present research is inherently multimethod in focus, and attempts to secure an in-depth understanding of the phenomena in question. The combination of multiple methods, empirical materials, perspectives and observations in a single study is understood, then, as a strategy that adds rigor, breadth, and depth to the investigation in order that an understanding may be constructed (Denzin & Lincoln, 1994: 128).

The key to this research, therefore, is holistic discovering and understanding the context in which decisions, actions and events occur. In particular the study particularly focuses on persons from disadvantaged sectors of Thai society. It allows the voices and thoughts of women who have been ignored by society and policy makers to be heard.

The research builds knowledge by combining methodologies, step by step. In doing so the researcher can eliminate the weakest characteristics of either method, whilst at the same time gaining greater insight into the phenomena. The researcher thus utilised an ethnographic approach as a part of the research process in the present thesis.

Constructing an Ethnographic Understanding

Ethnographic studies enable the cultural systems within societies to be understood. Within this approach the researcher can trace historical events, their causes and consequences and derive insightful explanations for all of these. It enables socio-cultural principles, which have an influence on the behaviours of the people in a specific group to be investigated (Parese, 1996; Fetterman, 1989). Ethnography provides a framework to incorporate historical accounts of social behaviours and hidden beliefs. The researcher is the important tool in such research (Franklin & Jordan, 1995 and Schatzman & Strauss, 1973).

Working within the constructivist paradigm an ethnography of women, health and work has been carried out from a nursing perspective. The remainder of this chapter provides detailed information on the design, the range of methods deployed and the analytical and interpretative processes which were followed (Atkinson & Hammerseley, 1994 and Lipson, 1989).

When a given problem is studied, different approaches to research present different questions, involving the collection of different data and the use of different frames of analysis (Baum, 1995: 463). Of course, different methods have different strengths, and it is tempting to believe that research projects combining the strengths of two or more methods will produce more than those methods could offer in isolation. This is especially true of health research reports, which frequently combine qualitative and quantitative methods (see discussion in Carey, 1993; Goering & Steiner, 1996; Miller& Crabtree, 1994; and Morse, 1994). The most likely reason for mixing research methods in health reports is the multi-factorial nature of health and health seeking behaviour. Hence,

employing multiple methods enables researchers to understand more factors relating to the health problem.

The two phases of the present study contains four separate stages. In phase 1, the first stage is the stage of *familiarisation* where qualitative data collections are carried out by 12 focus group interviews to gain necessary background information that will be valuable for developing later research stages and questionnaires. Such a qualitative approach will help the researcher to familiarise herself with the communities as well as identifying the actual and most recent problems found within the communities. Through this stage, the researcher can then identify appropriate approaches, target groups and questions to be asked.

The results of the first stage can then be used to develop the second stage of the study (in Phase 1), that is, *the stage of investigation.* With insight gained through the health survey of the six low-income communities. Results from this stage will provide basic health data and will help in selecting the site for in-depth study. In gaining more data about women's health and their work conditions, the researcher will also use the terms in developing the guidelines for the case study approach in next stage. This then makes the interview guidelines more sensitive to enable reliable and valid data to be gathered.

Phase 2 includes stages 3 and 4. Stage 3: *the case study approach* using the qualitative methods in-depth interviews, participation, observation, and field notes. Qualitative data generated at this stage can be used to understand patterns in the survey results. Emerging data from the qualitative stage will be verified by the last stage of the study (4), *focus group discussions.*

It is still very difficult to combine qualitative and quantitative methods in research projects. Conflicts are present between different paradigms involved in these two methods of research. These two paradigms have different origins and make different assumptions about the nature of knowledge and how knowledge can be generated. The quantitative approach comes from a positivistic paradigm, whilst the qualitative approach is located within the naturalistic paradigm. Hence, these two paradigms can present significant difficulties during the process of merging. However, in the midst of these arguments, scholars have stirred up ideas of combining the strength of these two paradigms in research related to people's health experiences. "It was time for the social science researchers to give up false attempts at distinguishing qualitative research from quantitative research and time for combining of the strength of both methods to answer research inquiry" (Merton and Kendall,1946 cited in Cohen & Manion, 1994: 40).

A combined design used in the present study to dismiss bias in two areas, 'slices of reality' and 'researcher's personal bias'. 'Slice of reality' argues that resource data might lead into fallacy, which might in turn lead to incorrect conclusions. The combined design would help researchers to be certain about the conclusion of results by comparing data obtained using different means. This might be similar to replication in experimental research, although in this case different data was obtained from different sources to confirm conclusions. Denzin (1970:313) repeated that triangulation would help researchers to exclude the intrinsic bias which could arise when research was carried out using one paradigm. Personal research bias occurred when researchers held on to a single paradigm and gave attention to the research question and the most suitable paradigm for obtaining research data. This leads to a drop in the validity and reliability of research results.

This study employed combined qualitative and quantitative methods to construct data. Focus group interviews were conducted as the first step using the qualitative method. Twelve group interviews were conducted in six communities. The aim of conducting focus group interviews before the quantitative survey was to identify and explore common problems women faced in low-income communities. The interviews also assisted in designing the questionnaire so that questions could be presented in a language easily understood by the target group. The second step involved conducting a pilot study after an analysis of the findings from the focus group interviews. The questionnaire used for the pilot study was formulated by utilizing relevant literature on questionnaire design and the findings from the focus group interviews. After the pilot study was completed, the desirability of formulating a second questionnaire was discussed with Thai scholars. Finally, the questionnaire was refined in terms of content and redundant questions. Then, a quantitative survey of six communities was conducted by random sampling of 209 households. From the survey, demographic data of social background, family characteristics, economic and employment status, health status, and lifestyle information was collected. This data, after being analysed by the SPSS program, contributed to the qualitative study. The qualitative phase employed a combination of major techniques in the gathering of field data, such as case studies, in-depth interviews, participatory observation, focus group discussion and field-note records. The data explored women's life experiences and work habit, as well as their family role in relation to their health status in a low-income context. Hence, qualitative studies often utilize a number of methods to crosscheck the reliability and validity of the descriptive and subjective data (Boonchalaksi, 1995: 50). Because of the use of this qualitative method, data collection and data analysis occurred simultaneously throughout the research, suggesting subsequent approaches to sampling and data gathering (Powers & Knapp, 1995: 134).

Therefore, this research was divided into two principle phases, quantitative and qualitative. The first phase of quantitative research investigated general experiences of women living in low-income communities. Following this, the qualitative phase provided an in-depth study focusing on women's occupation, life style, health problems, health-seeking behaviours, and health status related to their workload. These combined methods were carried out as follows.

(1) Combining of sources; data collection involved seeking multiple and varied information sources (Lincoln & Guba, 1985: 307). Interviews were conducted with municipal officers, related hospital personnel, non-government organization officers, respondents' co-workers, villagers, women's family members, and the women themselves.

(2) Combining methods; this research used a multiple strategy approach (Powers & Knapp, 1995: 177), incorporating documentary research providing a historical perspective and a holistic view of the study, in-depth interviews of key informants, survey research providing information on socio-economics, general portrait of the women living in low-income communities, community mapping, case studies, participatory observation and field notes. Data was obtained by using both qualitative and quantitative means, and was analysed and concluded together.

(3) Combined-level analysis; this was a two-level analysis, macro-level and micro-level. The macro-level analysis of this research was performed to provide a general portrait of the study. Following this, an in-depth micro-level analysis was conducted until themes emerged, prior to the conclusion of the study.

Thus overall it can be agreed that from within the constructivist paradigm, this study has utilised ethnographic approaches to paint a socio-cultural picture of women, health and work in poor communities.

3.3 Research Procedures

The discussion has so far been concerned with the design of qualitative and quantitative studies with a view to combining methods in a single study. A summary of the research methods is given in table 3.1.

3.3.1 Procedures for Data Collection

Data collection was initiated following the review and approval of the study by the Research Degrees Committee of the Robert Gordon University of Aberdeen, Scotland and the Institutional Human Subject Committee of Khon Kaen University, Thailand. Health volunteers were contacted in the six communities and meetings conducted so that I could familiarise myself with community conditions and the lifestyle of those living there.

3.3.1.1 Data Collection-Phase 1

Phase 1 of the study comprised **the quantitative survey,** which involved three stages: the focus group interviews for formulating the questionnaire, the pilot study of the questionnaire, and the quantitative data collection using the health status survey.

Table 3.1 Summary of research methods

Phase-Time	Method	Site	Number of Participants	Objective
Phase 1	**Quantitative**			
-Feb-Mar '97	*Stage 1:* Focus group interviews	Six communities	12 groups; 50 female, 52 male	Formulating the questionnaire
-April '97	Pilot study	*Tra* community	36 households	Testing the questionnaire
-May-Aug '97	*Stage 2*: Health status survey	Six communities; Guardian, Rental, Stranger, Temple, Railway and Joss communities	209 households	Basic health data of women & selective qualitative site
Phase 2	**Qualitative**			
-Mar-Oct '98	*Stage 3:* The case studies Participant Observation&In-Depth interviews *Stage 4:* Focus group discussion	Railway community (one of the six communities in Phase 1	18 families 19 general informants, 12 key informants 2 groups; 7 Females, 10 Males	Deriving answers to the research aim.

The Focus Group Interviews

The aim of conducting focus group interviews before the quantitative survey was to identify and explore common problems facing women living in low-income communities. This information contributed to the design of the questionnaire, especially in relation to the wording of questions, in language which could be easily understood by the target group. In all, twelve group interviews were conducted. All participants had lived in the same low-income community for more than six months. There were two groups in each community which included men and women over 20 years of age. Each session comprised six to ten informants. Guidelines for conducting focus group interviews were also formulated, and each group interview lasted approximately 90-120 minutes (Appendix 4, Guideline for focus group interviews). All participants were guaranteed absolute confidentiality and were informed that the interviews and findings would be used simply to formulate a structure for the questionnaire. The results of the group interviews

Plate 3.1

Men participating in focus group interviews

Plate 3.2

Young men participating in focus group discussion

Plate 3.3

Women participating in focus group interviews

introduced issues concerning living conditions, migration experiences, living arrangements, child rearing, household work and jobs, social behavior and health care. The interviews also offered an opportunity for learning the specific language or terminology used in the communities, in addition providing an opportunity to observe the environment.

Pilot Study

After analysing the findings from the focus group interviews, a questionnaire was formulated by utilizing the relevant literature on questionnaire design and the findings from the focus group interviews. The investigator also established measures, including general information on all household members and on women's health histories and physical health examinations. An interview guide was also formulated to provide direction for the six graduate nursing students who assisted with the data collection. The questionnaire was approved by four Thai scholars and one local advisor. Thai language study instruments were evaluated for cultural relevance by six nursing students prior to the procedural pilot study. A discussion was held with these colleagues to clarify words or terms in these instruments. After the pilot study was completed, the idea of formulating a second questionnaire dealing with mental health was discussed with one of the four Thai scholars, who indicated this was desirable.

As it turned out, little refinement in terms of content and removal of redundant questions was made following the pilot study. The pilot study also helped to improve techniques for interviewing the target group. These findings included the following:

(1). All 36 subjects preferred to be questioned verbally.

(2). The subjects felt reluctant to discuss consumption of over-the-counter drugs and other chemicals obtained without a prescription, fearing criticism. Participants were reassured that their information would not affect the investigators' feelings and that telling the truth would be of great use to the study. Some subjects also felt reluctant to discuss gambling habits. They were afraid that the information would be reported to the police, but were again reassured that all information was confidential.

(3). The initial questionnaire used in the pilot study consisted of four separate forms: (i) household demographics; (ii) women's bio-data; (iii) women's health history; (iv) physical examination. Subsequently, some redundant questions were eliminated, and the four forms were consolidated into Form One (work and life style information) and Form Two (physical examination and health status).

Following suggestions by Thai scholars, an evaluation of women's mental health status was added using a thesis questionnaire developed by a former graduate student. Her study examined the mental health status amongst the head of families in slum areas, the same communities using during this research. The reliability value of this questionnaire as tested by Cronbach's alpha coefficient was 0.92 (Thongbor,1996). This questionnaire was adopted because it was short and easy to understand. It was designed to fit with the population who lived at the same research sites.

After the pilot stage, a final version of the questionnaire was produced and this is described in detail below.

Plate 3.4

A woman participating in a household survey whilst doing housework

Plate 3.5

Young women participating in a focus group discussion

Plate 3.6

Mrs. Boon gardening on the land belonging to the State Railway of Thailand

Health Status Survey

A survey was designed to obtain basic information. It was necessary for this study to identify key issues of six low-income communities. It focused on the contribution of women's activities to the household economy, household labour, labour migration, and health status of women and their families. An exploratory survey was scheduled to elicit the answers to the prior questions concerning women's way of life relating to their well-being (Cormack, 1984; Parahoo, 1997; and Power & Knapp, 1995).

Population and sampling: phase 1 of the study

The population used in this research comprised low-income women who live in Khon Kaen Municipality, Northeast Thailand. This setting was chosen because the Northeast region of Thailand is the most economically disadvantaged part of Thailand and has a long history of labour migration. (Research and Development Institute, 1996).

In Khon Kaen Municipality there are six low income communities: the Guardian Community, Rental Community, Stranger Community, Temple Community, Railway Community, and Joss Community. A community-based survey of women's lifestyles was developed, piloted and administered to 209 low-income women aged over 15 living in the six designated communities.

Sample Size: In Phase 1 of this study, the sample size was calculated using the following formula (Petchnoi, et al, 1992: 141; De Vaus, 1986: 117-118),

$$N = \frac{S.D.^2}{S.E.^2} \quad \text{or} \quad \frac{P.Q}{S.E.^2}$$

When N = sample size of study

P = the percentage in one category of the variable; the pilot study having indicated that approximately 75% of the women studied were employed (27 from 36)

Q = the percentage in the other category of the variable; 25% of the studied women were unemployed (9 from 36)

S.E.= standard error for the confidence level=.03, the sample size within 3 percentage points of the true value with a 97 percent confidence level was calculated.

S.D.= standard error of the mean

So $$N = \frac{.75 x .25}{.03 x .03} = 208.33$$

The target area had a total of 831 households. Therefore, a sample size of 208.33 or 209 households, or 25% of the total households, was obtained. This sample size was regarded as an appropriate number for a survey design where the total population was smaller than 1,000 (Van Dalen & Meyer, 1966: 131 and Petchnoi et al, 1992: 141).

The population comprised 831 households in six communities. The sample size of the study was 209 households sampled from the six communities. See details in Table 3.2.

Table 3.2 Population and survey sample size

Communities	Total numbers	Size of Sample	%
Guardian	289	72	24.92
Rental	114	29	25.44
Stranger	129	33	25.6
Temple	125	31	24.8
Railway	120	30	25.0
Joss	54	14	25.93
Total	**831**	**209**	**25.15**

Interview procedure: Six low-income communities in Khon Kaen Municipality were recruited for the study. For the census data collection, people in each community were

coded and numbered. Every fourth person from each list was selected by systematic random sampling. If a selected household was habitually absent, the household on its immediate right was interviewed instead (see Appendix 6, the interview guide for quantitative survey). The structured interview was conducted by six graduate-nursing students from the Faculty of Nursing, Khon Kaen University. All of them held a Bachelor's degree in Nursing and had experienced conducting surveys for government officers. In addition, they were trained to be well informed of the research objectives and understand the interview guide. Prior to the training, these graduate students participated in group discussions to resolve any problems.

The health status survey was conducted during May and August 1997. Then numerical data of women's biographies were calculated into frequencies and percentages by using the SPSS programme. Reasons, opinions and activities related to women's health, illness and work were shown. Throughout this survey, women's health status was identified as the key factor to shape the direction for the next phase of the study. Respondents were asked to respond to a one-hour interview regarding women's household demographics and information on health histories, physical status, and mental status. The interview and physical examination took place in the women's houses.

One advantage of the survey was that large amounts of data could be amassed, the flow of information could be effectively controlled, and conversation was directed to particular topics. However, certain disadvantages could not be avoided, such as fairly superficial actual information content and the respondents' feelings of being threatened and frustrated by some questions (Fetterman, 1989; Powers & Knapp, 1995; and Yin, 1994).

Instrumentation

Four instruments were used in this phase: the guidelines for group interviews (Appendix 4-5), the interview guide for the questionnaire (Appendix 6), the questionnaire 'Form One' (Appendix 7-1), and the questionnaire 'Form Two'[1] (Appendix 7-2).

3.3.1.2 Data Collection - Phase 2

Data collection in Phase 2 of the study was conducted in order to achieve the following research objectives: to understand the meaning of health and wellness for women living in poor communities; to explore the work and familial roles of these women; and to understand the women's perspectives on health, work and their caring ability within the family. Phase 2 consisted of an in-depth collection of data. **A qualitative research** approach (case study method) was used because it was the most appropriate research method for the study of women's experience and to achieve the research goals.

Qualitative research methods: Case Study

Building knowledge of human behaviour through qualitative research

Qualitative research is conducted as a means of seeking knowledge through observation of social phenomena and environmental conditions as they actually occur. This is in order to find relationships between a phenomenon and its environment. This method is interested in data which relates to feelings or thoughts, definitions or meanings and values or ideology of the people concerned with such phenomenon. The investigation is long-term and applies participatory observation and informal in-depth interviews as the principle

[1] The mental status component of this Form was devised by Siripom Thongbor (1996). Respondents who achieved mean scores of more than 2.5 were grouped as optimists; respondents with a mean score of less than 2.5 were grouped as pessimists.

means of data collection. Data analysis is performed through interpretation and understanding, and finally conclusions are drawn using an inductive technique (Denzin, & Lincoln, 1994; Chantawanich, 1997; Strauss, & Corbin, 1990; Rubin, & Rubin, 1995; and Parse, 1996). Qualitative research has the capacity to collect holistic data. The study of a phenomenon or problem condition has to be conducted through the understanding of such phenomenon and its context. The researcher becomes the most important person and a key research instrument. (Pongsapich,1993; Parse, et al. 1985; and Van Maanen,1983). The researcher must possess a clarity. He or she must understand the meaning of human experience and must participate in the item under study. The researcher must perform documentary research in order to be able to explain, interpret, and describe the event arising in that context. (Miles, & Huberman, 1994). Meanwhile, the inductive analysis from the data collected should be compiled so as to make sense of and interpret the data. (Patton, 1990; Silverman, 1993; Walcott, 1994; Coffey, & Atkimson, 1996; and Riessman, 1993).

The use of qualitative research in nursing has become more and more popular. The conceptual philosophy of qualitative research seems to be in line with the nursing philosophy which aims to treat patients holistically (Streubert & Carpenter, 1995; Downe Wamboldt, 1992; Porter,1996; Carbonu & Soares, 1997; Scannell-Desch, 1996; Mc Murray, 1997; Letvak, 1997; Drew, 1993; and Catwright & Limandri, 1997). Moreover, qualitative methods also enable nurses to understand the context of their clients which has a direct influence on their health status. This reveals the clients' problems and needs (Swanson, & Chenitz, 1982) which in turn enables the nurses to improve their nursing practices and to create a body of knowledge.

There are many approaches and strategies involved with qualitative research. The research strategy must be determined by the nature of the research question. (Field & Morse, 1991) The research strategy is close in meaning to a "*tool*" which the researcher uses to find answers to research questions. Each qualitative strategy provides a unique perspective which enables the researcher to find the essence of truth for each type of research question (Morse, 1994). For this research, a case study approach was employed in an attempt to understand women's health and work in the socio-cultural context of poverty.

In Phase 2 of this study, a qualitative research procedure was the principle method of data collection. I classified myself as the research instrument performing long-term investigation, applied participatory observation, carrying out informal in-depth interviews, and conducting the case studies. Hence, phenomena were analysed by interpreting and understanding women's experiences concerning their work and health status. More than one method of data collection were employed simultaneously, (triangulation) to obtain different types of data and to check the accuracy of the information. The next few pages describe how these methods of qualitative research were used to obtain data, and strengths and weakness of each method are discussed.

The Case Study: Methodological Approaches; a case study is an intensive in-depth investigation of a single subject or a single unit, which could be a small number of individuals who seem to be representative of a large group or very different from it (Powers & Knapp, 1995:18). It is also typically undertaken to elucidate a particular problem requiring reflection (Franklin & Jordan, 1995: 285). While the case study is primarily an exploratory research approach, it can be used to describe, or less often explain results. This part outlines the purpose, advantages and limitations of the case

study approach. It is meant to serve as an introduction to this methodology. This research is an example of case study research, which combined quantitative and qualitative methods. Yin (1989: 14) defined the case study as:

> "....an empirical inquiry. It investigates a contemporary phenomenon with its real life content, when the boundaries between phenomenon and context are not clearly evident, and in which multiple resources of evidence are used."

As such, this definition attributed the case study as the focal research strategy for phase 2. Not every case study incorporates a qualitative perspective, and qualitative investigation can but does not always produce case studies (Yin, 1994:14). However, the case study of my research employed various qualitative methods, including interviews, participant observation and field studies. My research goals were to reconstruct and analyse a selected community from a socio-cultural perspective in order to try and provide an in-depth explanation of some critical findings from the survey (Hamel, 1993:1).

Hence, I employed the case study strategy to undertake data collection that incorporated a qualitative research design involving the detailed description and analysis of an individual case and the community (Dempsey & Dempsey, 1992:154). It focused on the holistic examination of the phenomenon, and it sought to avoid the separation of components from the larger context to which these matters might be related. Besides, the case study provided an opportunity to examine culture, society, community, organization and contemporary phenomenon in terms of beliefs, practices and social interaction of residents (Powers & Knapp, 1995).

Case study research has the following strengths: the target is directly focused from the topic, the insight is provided from causal inferences perceived, reality covers events in real

time, the context of events is covered, and interpersonal behaviour and motives are insightful. However, many have criticised the case study approach for its tendency to be subjective and contain bias from poorly constructed questions and the investigator's manipulation of events. Inaccuracies may occur due to poor recall or reflexive discourses during the interview process. Case studies are time consuming, reflexive or cause event difference (because observation is taking place), and are costly due to the number of hours needed by human observers (Yin, 1994:80).

Case studies have been built around women and their families, through participant observation and continuous home visits (Hamel, et al, 1993:1). In order to present case studies that were filled with thick description, I took detailed notes of my interviews and observations (Yin, 1989 & Franklin & Jordan, 1995). Five guidelines for keeping detailed notes for a case study are presented below. First, key pieces of information were recorded whilst interviewing and observing the respondent. This was in the form of key words or jotting of exact phrases, differentiated impressions from what the respondents' said, and verbatim and empirical observations. Second, the amount of time I came into contact with a respondent was limited. A home visit was limited to one to two hours so that stimulus overload would not occur and the information track could be maintained. Third, notes about the sequence of events and context in which behaviours occur were made. Fourth, detailed case notes were written that included a narrative account of the interview, observations, and my immediate impressions after contacting the respondents. Finally, case notes were written, reflected upon and interpreted for the assessment. Then the qualitative analysis method was used to examine the case notes in order to identify suitable themes (Franklin & Jordan, 1995:285).

Using case studies of women enabled me to understand a contemporary phenomenon within a real-life context. To answer the questions 'how' and 'why' women had different experiences of workload and health status, I conducted 18 family-case studies. I selected these families from the unstructured interviews, the survey, and the in-depth interviews. They involved a woman who was the primary breadwinner of the family. These interviews were confined to one neighbourhood, which yielded the greatest number of women expressing that work had an effect on their health. This qualitative information was obtained from interviewing successive respondents until the answer to key questions reached a level of repetitive redundancy, at which point sampling was terminated. I started to conduct the case studies in June 1997 and continued this actively along with other activities until the completion of fieldwork in October 1998.

Participation-observation is a significant qualitative assessment which originated from social and cultural anthropological research in which there is the use of a specialised form of observation referred to as non-structured and participant observation (Franklin & Jordan, 1995). While observing, a hypothesis is postulated from the arising event and the observed phenomenon. This is the perception of the event from the perspective of the insider, referred to as *emic* perspective, rather than the perspective of the outsider, called *etic* perspective (Schatzman & Strauss, 1973). As such, participant observations vary along a continuum that encompasses two dimensions—observation and participation. Participant observation accents the understanding of how the activities of a group and the interactions in a setting give meaning to certain behaviours or beliefs (Jorgensen, 1989). By this method, it is certain that the researcher must obtain permission from key informants or clients (in nursing) to observe them over a prolonged period during the study process (Franklin & Jodan, 1995).

In conducting participant observation in this research, the researcher applied three types of observation (Franklin & Jordan, 1995), namely: descriptive observations, focus observations, and selective observations. The descriptive observation is less systematic; it represents a shotgun approach whereby everything about people in the target community and their situation is observed in order to get an all-inclusive impression. The focused-observation is observing only the matter of specific interest to the key-informants. For example, I participated in a "*Het Wiak*" ritual (averting of a catastrophe by magic power) for people in the community, recorded (under permission), observed, and took notes. This type of specific observation enables me to learn the specific characteristics of the key-informants so that the event and its meaning can be explained. I followed the participants to make observations in their work places at the bus station, the market, or at the place where they sell refuse, in order to assess the events. Therefore, specific situations could be observed between participants or key informants, colleagues and other units of the society, so as to better understand the conditions present during their working time.

During observations, I produced *field notes, photographs* or *audiotapes* to keep track of what was seen. Field notes emphasised answers to the following questions: Who is present? What is happening? When does the activity or behaviour occur? Where is the activity or behaviour happening? Why is the activity or behaviour happening? How is the activity or behaviour organised? (Franklin & Jordan, 1995) Each day after observation, I made notes of the behaviours and activities observed, and included feelings or impressions toward the events. Primary meanings were coded and the sequence of events and emotions being expressed were kept track of in order to gain insight into the key informants attitudes and feelings towards the items they reacted to.

However, while participant observation could not be fully used on all occasions, observation alone was still effectively employed for obtaining information on issues such as gender differentiation within the workplace and the allocation of jobs by gender in the household. In using both participant observation and observation methods, I could usually re-confirm the validity of data gained from my informants on occasions when I was not sure that I had fully understood them. Also, I used observational techniques to recheck information from the informants.

Nevertheless, this method had both weaknesses and strengths for gathering data. The weaknesses of this method ranged from being time-consuming to there being a possible bias due to investigator's manipulation of events. In addition, an event may have proceeded differently because it was being observed. On the other hand, the strengths of participant observation itself are brought about by the natural social setting, natural interaction and high internal reliability and validity. Moreover, insight into interpersonal behaviours and motives were advantages of this method (Fetterman, 1989; Yin, 1994).

Interviews are actually purposeful conversations conducted in order to elicit data, working parallel to participant-observation which takes place during the qualitative research method. Interview data helps explain more clearly the things seen or observed, but not fully understood (Schatzman & Strauss, 1973). The interviews conducted in this study applied an unstructured form of questioning, following the interview guidelines. However, questions are not always asked according to the guideliness, and modification could be made depending on the situation. I used the guidelines as the frame for the question direction, and allowed the respondents the freedom to express their ideas without interruption (Field & Morse, 1985).

In this research, I applied the technique of the informal interview in which an atmosphere of everyday informal dialogue is created. There were no strict rules in ordering questions and procedures (Rubin & Rubin, 1995; and Chantawanich, 1997), so that concepts, manners, attitudes, culture and interpretation of participants towards various events in the contextual culture of the community could be elicited. The use of informal interviews allowed the researcher to create good relationships with people in the community and develop rapport. During informal interviews I also applied the research techniques from the open-ended interview, in-depth interview, and probe technique (Chantawanich, 1997, and Schatzman & Strauss, 1993). An open-ended interview is flexible. The respondents have freedom to go on explaining their experiences and concepts. I might direct the interviewee and then allow the interviewee to relate her experience freely. Data was then completed and interpreted to extract meaning. During the in-depth interview, I aimed to scrutinise certain behaviours related to the research objectives, while not creating a sense of unease for the interviewees. Appropriate freedom and time was also given. In the *probe-technique interview*, the questioning was used to elicit the thought lying deep inside the person, so as to obtain the truth as much as possible. Hypothetical questions might be necessary so that the interviewees would show their opinions. Sometimes, a supposition is related so as to evoke some reaction from the interviewee.

Therefore, the strengths of the interview are that it is suitable for probing for detail, for clarification or for getting significant ideas. Interview methods enable researchers to elicit insight, providing perceived causal inferences. For example, in the fieldwork, I attended the ritual '*Het Wiak*' (removing difficulties' ritual) for Mr. Koh, who was ill and was a waiting a visit from '*Laung Por*' (old monk). I did not understand why '*Laung Por*' asked

if Mr Koh had ever done anything wrong to a ghost? And how did it relate to Mr. Koh's illness? Later I could interview '*Laung Por*' for his reasons and the meaning of the ritual.

Thus the interview method provided an opportunity to ask for clarification when an answer is vague, or to provide further clarification if a question is not clear (Tashakkori & Teddlie, 1998: 102). On the other hand, the interview method is time consuming, the interviewer has a control over topics and interactions, and inaccuracy can occur due to poor recall (Fetterman, 1989 & Yin, 1994).

Focus Group Interview or Discussion is a form of evaluation in which groups of people are assembled to discuss potential changes or to share impressions (Rubin & Rubin, 1995; and Denzin & Lincoln, 1994). In this research, I conducted group discussion as a means for triangulation (Denzin, 1970) with two groups of young men and women, whose ages ranged from 16-27 years. The interview group consisted of 10 men and 7 women. This group discussion was conducted during the final stage of data collection in order to triangulate data already collected. The discussion was related to women's way of life, women's workload, men's and women's family responsibilities and health status of people in the community. This was done in order to study the reactions of these youth groups towards the researcher's data. The group discussion atmosphere was pleasant and informal since the members are all acquainted with each other and the moderator was familiar with the groups. The discussion took nearly two and a half hours for both groups.

In addition, focus group interviews were conducted as a feasibility study of the community during the first stage in order for the researcher to become acquainted with the community (Denzin, 1970). Thus, in this research, focus group interviews were conducted initially so

that I could familiarise myself with the low-income communities. Consequently, questionnaires were formed and key informants sought as already mentioned in Phase 1.

The advantage of focus group interviews/discussions was that valuable data could be obtained quickly and cheaply. Some participants felt comfortable in voicing their opinions with the presence of their friends or their colleagues more than they did when giving their opinions alone, with an interviewer. Moreover, focus group interviews gave opportunity for participants to reflect on and react to the opinions of others. In addition, participants had an opportunity to exchange experiences.

However, the disadvantage of focus group interviews or discussions was that dominant personalities or factions could monopolise the discussion and express their views at the expense of others. Moreover, some group members might be ashamed, unassertive or unable to articulate their opinions. Therefore, the suitable management of a group process conducted by a skilled moderator was necessary. However, focus group interviews are not suitable for sensitive or personal issues and behaviours that do not conform to the norm (Fetterman, 1989 & Yin, 1994).

Field Work

The qualitative data collection period of Phase 2 lasted 8 months from March 1998 to October 1998. Prior to this, I had visited the community several times since the beginning of 1996, at which time the community was part of a family visits programme, in which the researcher cooperated with a graduate student from the Faculty of Nursing. The community was selected for qualitative data collection in Phase 2, owing to reasons discussed in Chapter Five. However, in order to observe research ethics and to preserve

informants identity, the community was pseudonymised as "Railway Community" in reference to its location by the railroad.

The research field work comprised five stages (Schatzman &Strauss, 1973; and Chantawanich, 1997), namely: (1) Field selection, (2) Researcher identification, (3) Creation of rapport, (4) Data collection (5) Conclusion and exit.

Field Selection : Following the first phase of study which comprised data collection using focus group interviews, pilot study, and quantitative survey in 6 low-income communities, the data were analysed and the "Railway community" (an invented name) was selected as the site for the qualitative study in Phase 2. A detailed analysis of the selective process is given in Chapter 5.

Researcher Identification : I was known at a certain level in the community because of my involvement in family visits and health promotion since 1995. Nevertheless, I formally identified myself as a researcher by showing the introductory letter from the Dean of the Faculty of Nursing to the Lord Mayor of Khon Kaen Municipality and the officers in charge of community development of the municipality, in order to make a formal request to conduct research in the community. Another introductory letter from the Dean of the Faculty was presented to the community leader and community administrators, also to request their permission and to identify myself before formally conducting the study. The permission was made verbally on the part of the Lord Mayor and the community leader. Subsequently, I was introduced by the community leader to household heads in order to inform them of the objectives of the research. This was done at the community meeting. Hence, the researcher's role as formerly realised by

the people was extended from an "*Ajarn*" (or a clinical nurse instructor) to a "researcher". However, the people still called me "*Ajarn*" until the end of the field study. One thing that was changed was the way I dressed. During the research study, I avoided dressing in a community nurse gown which was worn while family visits were carried out, and began to dress like the people, i.e. wearing trousers, T-shirt, and sandals, in order to become part of them and so that they would not feel uneasy as could be with a typical "client" and "nurse" situation.

Creation of Rapport : I had entered the community and had a relationship with the community at one level. When Phase 2 of the research started, I asked the community leader about the possibility of renting a house in the community. However, it was impossible at that time because all of the rental houses were rented out, and no one would invest in building a new house for rent, and there was no vacant area left anyhow, except to landfill a wasteland area. The leader then suggested that I stay overnight at the leader's house during nights when data collection was to be made. I chose to stay there during the weekends or when there were festivals like *Songkran* day, the end of Bhuddhist Lent, in order to develop trust and establish relationships which are crucial to my involvement in the research site. For other days, I arrived at the community in the morning and returned at night or very late, which was not difficult for my house was only about three kilometres from the community. It was believed that with this approach, I could make myself known to the community people and develop rapport and relationships with them. Moreover, as most of the villagers knew that I lived nearby, my staying in the community would demonstrate my willingness not to stay in my own house which was conveniently located. I also had other roles to perform as a nurse lecturer, a maternal figure and conjugal role. During the data collection stage, I was often asked questions by participants, as if they

were conducting an in-depth interview themselves, about my family, husband or housework. Thus, if I deserted these roles and demonstrated only the role of researcher, the women in the community would find it hard to accept, perhaps feeling that I was negligent of my own responsibilities to my family, husband and work.

The increased sense of rapport with the villagers could be further developed by joining them for meals or supper. If, when walking by, the villagers were having a meeting and eating "*Som Tam*"[1] together, I would join and chat with them, especially if they were women or girls. Sometimes I bought "*Som Tam*" to eat with them. Chatting was not a problem because I can speak the *Isaan* dialect as a mother tongue. In Thai tradition, people address other people with certain titles which are usually based on position, kinship or seniority. Initially, the villagers called me "*Ajarn*" (meaning a lecturer at a school or university), this gradually changed as time passed. Younger people began calling me "*Pee*" (an elder sister), children used the term "*Paa*" (an elder sister of one's mother) or "*Naa*" (a younger sister of one's mother), while the elderly used "*Ee-Nang*" (a girl). I tried to approach the children so that the elder members in their family could in turn be approached. I also bought products sold in the grocery store in order to be aware of movements in the community, as a grocery can be a gathering place for housewives and drinkers. And when "*Boon Prapenee*" (merit making ceremonies) were held by the community, I would participate in order to get to know people, to converse with them and in doing so get more information.

Data Collection: Informants and Access to the Informants: The selection of key informants was essential in the finding of new information concerning the ways of living

[1] A kind of Thai hot and spicy salad made of sliced green papaya, dried shrimps favoured with chilli, fish sauce, garlic and lemon juice.

or the various changes the community had experienced in the past. The data would then be analysed together with the observation data (Fetterman, 1989). The key informants selected in this study consisted of a group of community administrators, an elderly group, an health volunteer group, a governmental worker and a non-governmental organisation officer who had been working in the community for a long time. General informants and participants comprised men, women and children in the community aged between 8 and 92 years who provided data relating to ways of living, women's workload, family responsibilities, and the people's health experiences. The samples were divided into 12 key informants, 19 general informants and 18 family case studies. Most participants were women because of the research objective to study women's way of life. Participants were obtained through introduction of one community member to another, assuming they met the required criteria. For example, Mrs. Tom aged 72 years said:

> *"If Ajarn wants to know about the illnesses of women, you should go to Mrs. Nang. She's sick from many diseases. She has been working very hard."*

This networking sampling or *snow balling* is a strategy used for locating participants. This strategy takes advantage of social networks and the fact that friends tend to have common characteristics (Lo Bionodo-Wood & Haber, 1994: 302).

In addition, conversations with other villagers besides the key informants and participants also allowed the researcher to obtain information and further investigation leading to clearer answers to the research questions. Reliability checks and validation of data was also based on conversations with other community people.

As regards the production of mapping, which is generally carried out at the commencement of qualitative research, I adapted and updated the map used in the survey

of this community from 1997, during the first phase of the study. Kin mapping of the community people was also produced in order to clearly investigate the kinship relations and patronising systems of this community.

Field Work Records; were produced during the data collection period. The records assisted in ordering the cultural scenes studied and in compiling details of events. This is called "*field notes*" and photograph compilation.

Field notes

Field notes are the recording of observed data. Noting is an essential means in data collection which leads to the utmost completion of the research work (Schatzman & Strauss, 1973). Noting is usually conducted to protect against forgetting information. It enables researchers to postulate temporary hypotheses in the analysis of field work data, assists in the organisation of thoughts for the planning of the next study, and helps to conclude data at various stages.

In this research study, field notes were an essential item in the provision of a detailed portrait of observable working situations and the health status of women. Noting involved a description of behaviours and events arising alongside each situation, and of the wording used in the course of the conversation. The field note form included the date, place, people involved and events which occurred. It helped in eliciting the ways of life of the community people, their working behaviours and their health seeking behaviours. In addition, records were also made of the interview data, interview plans and guides, and the researcher's feelings and reflections which would be used as an index and for cross

checking. When an event took place in the community, I would return home to make a field note of that day. This continued throughout the 8-month period during which the qualitative data was collected. Analyses of field notes and interviews were done every week in order to plan for activities taking place in the coming weeks. All of the field notes were made in Thai, which is my mother tongue. The words in local dialect used by the participants and key informants were given so as to retain the meaningful expression of the language used. The analytical process was also in Thai and was subsequently reported in English.

Photography

Photography helps describe observed events better than any lengthy written description. I therefore utilised photography alongside data collection, especially when rituals or ceremonies were held. Although photography assisted greatly in data collection, a problem arose when holding a camera to take photographs at each event, for it attracted children who wanted to be photographed. The children unintentionally obstructed the scenes and deprived the event of its natural backgrounds. Nevertheless, when the photographs were distributed to the children and villagers, it helped to further develop rapport. I was careful to observe research ethics when photographs were taken.

Data analysis

The analysis of qualitative data was conducted and compiled together with the results from the qualitative data analysis. The objective was to understand women's health and work in the socio-cultural context of poverty. The analysis of qualitative data was classified into two types, analysis during data collection and overall analysis.

Analysis during data collection was conducted after the daily field note was made (See Appendix 11, 12 and 13). I reread the field notes and re-listened to the recorded tapes to seek the meaning and significance of the observed events relating to women's way of life, their occupations, health and health behaviours. Following this, key words or concepts could be established which would in turn be used to create further questions.

The analysis of data integrated Colaizzis and Van Manen's phenomenologic methods (Beck,1994; and Streubert and Carpenter, 1995) to analyse the audiotaped interviews and written transcripts. In addition, analytical procedures were created with qualitative records (to be discussed later). Methodological triangulation (a research strategy which compares information sources to examine the quality of the data) was also employed. The procedure used in the analysis of data with the tape recorders is described below:

1) Tapes recorded from each participant were transferred into word-by-word scripts.

2) The researcher listened to each participant's recorded tape once more to grasp the feeling and better understand the meaning of each participant's words.

3) The scripts were revised to enable additional notes to be added.

4) The script derived from each participant was read again to extract significant statements and thematic descriptions emerging from the data.

5) Significant statements and thematic descriptions were classified.

6) After Steps 1-5 were completed, the tape scripts were revised once more to confirm significant and thematic descriptions obtained, and to compare each participant. In the case of any unclear statements, the researcher would return to ask the participant for clarification.

7) Descriptions of essential themes were written and rewritten, organised and reorganised several times.

8) A statement of the formulated structure of the findings was written based on descriptions of the essential themes.

9) The themes were brought to be discussed with municipal officers, non-governmental organisation officers, and some key informants in order to elicit opinions and feedback from the data.

Table 3.3 Formulated Meanings

Significant Statement	Formulated Meaning and Themes
"I don't know what learning in school is like. I only know I have to work, to sell things so that I can earn money for our survival"	Life is work and effort
"I don't know what to think about. My future couldn't be any better. I just live from day to day until I die."	Living from day to day
"I don't understand why we're in so much trouble. I'm not lazy. I work all the time without stopping. But I can't do any better. I'm so tired."	Feeling the impact
"I just bear the whole world by myself. I want to run away to live alone by myself, so I don't have to worry about anyone."	Escapism
"I used to think of running away from him. But that's useless. I'm worried about my little son. If I was not here he wouldn't be able to continue to M.1 I have to live with it."	Resolving / coping

Here is an example of a field note and analysis during the data collection:

"**May 27, 1998.,** 18.40 hours, at Mrs. Maew's house, 35 years…
……Mrs. Maew. related her personal account. Khon Kaen is her hometown. She used to live in a rental house until she was forced to move out. Her father and mother moved the family to their hometown in *Mahasarakham*. Mrs. Maew was 16 years old then. Every day she and her elder sister took a bus to the bus terminal to sell beverages. In fact, she earned her living after finishing Primary 4, at the age of 11-12 years. She put paper boxes together and tied them in bales for a Chinese trader who paid her 20 *Baht* a day. She has earned her living all her life. When they lived in *Mahasarakham*, her father couldn't see. He used to earn a living by boxing and was once attacked until his optic nerve was affected. Therefore, her father could not work. The children had to earn a living for the family while her mother did some farming. After some time passed, when they were tired

of having to commute by bus, she and her sister then moved to rent a house in Khon Kaen and sold grilled chicken. They taught themselves how to grill chicken......."

From the field note, informal conversation was conducted but not tape recorded. I made a written note instead whenever there was a chance for doing so after the conversation. After reading the field note, a question arose related to the field note, "*What does earning a living for a woman's father and mother mean to her? How does this relate to their work and health status? And is it true that earning a living for the family starts when a woman becomes a teenager?*

The questions which emerged during data collection were subsequently used to ask other participants in order to crosscheck and for ensuring triangulation to provide consistency and validation. The overall analysis involved sorting analysed data into group, such as women's ways of life, women's work, health status, self care, etc. Following this, an analytical card was produced for data collection and analysis. (See Appendix 11, 12 and 13)

Conclusion and Field Exit

I formally informed the community leader and the villagers that the data collection period was finished. Conclusion of primary analytical aspects were made and explained to the community leader, health volunteer members, some participants, and the non-governmental organisation officer working in the community. Feedback was provided. However, owing to its being a venue of clinical instruction for nursing students, the completion of data collection was not a termination of relationships with the villagers and the community committee members. The relationship will continue. And it is expected

that the research results will lead to the initiation of new research projects that aim to develop the health of women, children, family, and the community.

3.4 Translation Process

Since this research was conducted in Northeastern Thailand with Thai-Lao speakers, all instruments and documents were produced in Thai by myself. Therefore, this study dealt with two levels in translating reports; from local dialect to Thai and then Thai to English, or from local dialect directly to English. I am competent in both Thai and local language (Lao). The English reports, translated from Thai into English by myself, were edited by a Thai English lecturer and a native English speaker. Moreover, the report of the study was also edited by a native English speaker, the director of the studies. Discussions between the researcher and the English editors were completed throughout the thesis writing period to ensure that the most accurate interpretations were obtained.

3.5 Protection of Human Subjects

Researcher ethics are essential, since in qualitative research, the researcher is the most important research tool in data collection. Prior to understanding the study, the proposal, interview guide and subject consent form were reviewed and approved by the Ethics Committee, Faculty of Medicine, Khon Kaen University. The Ethics Committee of the Faculty of Medicine is the unit assigned by Khon Kaen University to be responsible for human subject approval for all research projects under Khon Kaen University. (see Appendix 10)

Prior to data collection from participants and key informants, the method, potential risks, and benefits from participating in the study as well as protection of confidentiality were explained. All participants were provided with a chance to ask questions and were free to decline to participate in the study. Initially, I planned to ask those who had informally consented to sign a consent form. However, in Thai tradition it is not usual for a person to sign his or her name because it can imply too many obligations. So people are reluctant to sign names, especially those from low socio-economic groups. However, participants and informants gave verbal consent, which was informal, implied no obligation, and participants felt happy to do so. Hence, for the last cases, there were no signatures. Names have been replaced by pseudonyms. Code numbers were used to replace names from case studies. Tape recording and photography during data collection required permission. Following completion of the research all tapes were erased.

It was explained to all participants that this research study would be conducted at no cost to them. No payments would be made to participants except for the provision of light food and beverages during focus group interviews. Participants were also informed that they could immediately stop the research at any time. They could also refuse to answer any questions.

3.6 Summary

This research has attempted to understand women's health and work in the socio-cultural context of poverty in Northeast Thailand. To explore the research questions, the present study combined quantitative and qualitative methods. Main methods including surveying and case studies were used to understand women's concepts of health and wellness, as

well as to explore the familial roles of low-income women, and to understand the women's perspectives on health, work and their caring ability within the family. The research procedures were divided into two phases. Phase 1 involved focus group interviews to assist in formulating the questionnaire, the pilot study of the questionnaire and the health status survey in six low-income communities. Twelve group interviews were conducted with those who had lived in the same low-income community for more than six months. There were 102 participants in total. Two hundred and nine women from six low-income communities were interviewed and physically examined in their homes on at least one occasion during the health status survey. Following this quantitative data was calculated into frequencies and percentages by using the SPSS programme.

'Railway Community' was selected for the qualitative venue. I employed qualitative methods and case studies to obtain data. Twelve key informants, 19 general informants and 18 family case studies participated in this phase. Interviews were conducted in Thai-Lao dialect and tape-recorded by myself. The confidentiality of participants was of major concern throughout the process of data gathering. Data collection and analysis were simultaneously conducted until data saturation was achieved. Checking and comparing sources of data, times, and places throughout the process was also done to construct an understanding. Tentative themes were written in Thai and then translated into English. A bilingual translator was asked to confirm the accuracy of the translation. Detailed descriptions of the findings are given in the following chapters.

CHAPTER FOUR

FINDINGS FROM THE HOUSEHOLD SURVEY OF SIX COMMUNITIES

Chapter four presents the findings of data analysis[1] conducted during Phase 1 of the study and is divided into four sections. The first section presents the main characteristics of the study site and the second focuses on the general characteristics of the respondents. The third section discusses migratory experiences of the respondents and the fourth section discusses women's work and health status.

4.1 Community Profile

In Khon Kaen Municipality there are six low-income communities; Guardian[2], Rental, Stranger, Temple, Railway and Joss communities (names changed). All of these communities are located near the center of the city along the railway line. Although they are accessible to the city, the roads within some slum areas are in a poor condition. There is an elected person who is the head of the local council for each community. Stranger and Joss communities both have women as the elected heads, while the remaining four communities have elected men. The council is responsible for community development activities such as requesting assistance from external organisations for environmental and livelihood development, and performing activities as agreed with the donor agencies.

[1] Where fingings are derived from Focus Groups this is designated in the text as FGI. Appendix 4 provides the Guidelines for FGI.
[2] Pseudonymes have been used for these communities.In choosing the pseudonymes attributes of the community have been captured.

The determinants of the low-income communities have been defined as disorderly and temporary residential buildings or shelters with a housing density of more than 15 households per 1 *rai* (1,600 square metres), or a residential density of over 80 persons per 1 rai. In addition, there are normally problems of lack of drainage, stagnant water retention created by uncollected garbage and refuse, bad ventilation, and inconvenient walkways.

The average household size is about 5. Their average population in each community ranged from 300 to 1400. Extended families are common in low-income communities, and comprise three to four-generation households. Many of the multiple generation households included not just one but two or three married couples and their offspring. The Guardian, Rental, Temple, Joss communities started to develop between 1970-1980. The Stranger and Railway communities started to develop around 1987 with families coming from other slums and later from surrounding rural areas. In 1991, the communities were admitted for supervision by the municipality, and the people became recognised as registered municipal members. The community lands are owned by the Railway Authority, except in the Joss Community which is not owned by anyone. There are 9-10 shops in each community.

> *"Our quality of life is better than in the past because the communities have been developed by the local council. After they were recognized as communities, infrastructure improvements were made. Before the establishment of the formal communities, there were a lot of problems such as brawls, larcenies, and glue sniffing. Now these problems have decreased since there are community committees overseeing the regulations"* (FGI).

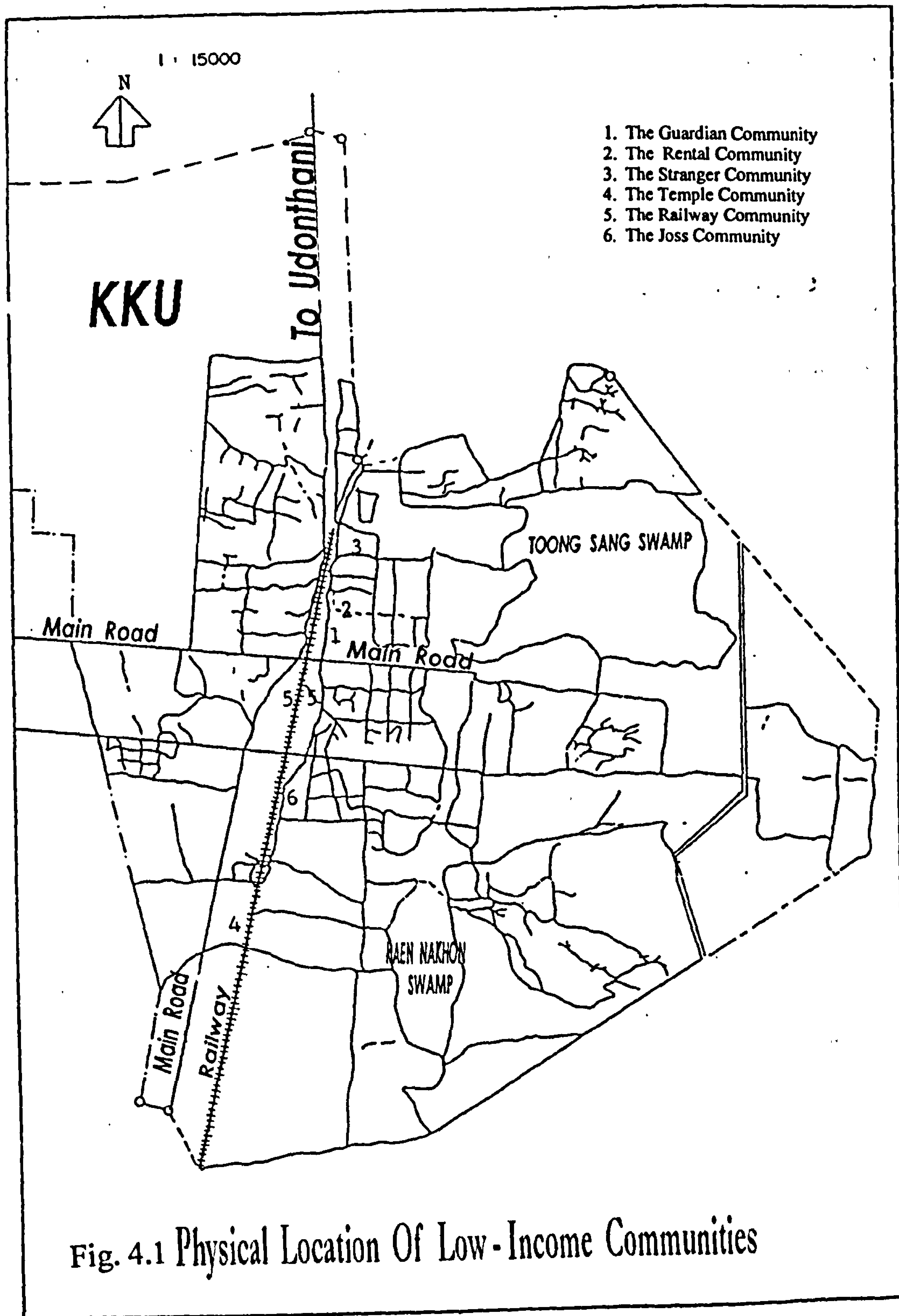


Fig. 4.1 Physical Location Of Low-Income Communities

4.1.1 General Information about the Communities

Most of the villagers in the communities are wage earners. There are some elderly persons who are unemployed and stay at home to look after children. The reasons for their living in these communities are primarily economic (FGI).

At first, these communities did not get any public utility assistance from the state, but since 1996, Khon Kaen Municipality has provided these communities with temporary addresses and census registration so that they can make requests for utilities and to enable their children to enter schools (Appendix 2 provides a Map of the six communities).

Water:

Most of the households in the six communities are supplied with tap water courtesy of a charitable project, which is run by the Thai government with aid from the Danish Cooperation for Environment and Development (DANCED). However, not all households have been supplied with tap water, and some continue to buy water from neighbouring households.

Electricity:

The majority of households have an access to electricity. However, since the people in these areas do not own the land and are considered temporary inhabitants, they have to pay twice the normal rate for electricity compared to there living elsewhere.

Drainage:

Drainage is carried out by the inhabitants themselves. Stagnant water is a major problem for all. There is generally a lack of access to adequate waste water drainage systems.

Community roads are usually flooded during heavy rainstorms. The majority of households have their own toilets but some share a toilet with neighbours or relatives. Some of these are unhygienic due to poor drainage.

Garbage:

Garbage is collected by the municipal workers three to four times a week. Villagers buy their own bins to store garbage, and each household pays 20 *baht* a month for the garbage collection service.

Organisations:

There are many kinds of community organisations including a community committee, health volunteers, informal savings and loans organization, elderly club, planting for increased income group, and a Christian study group. The community committee, under the leadership of an elected headperson, is responsible for community development activities and for formulating and enforcing community rules. There are about 10-20 health volunteers in each community who are responsible for running the community health centers and seeking support from the municipality in terms of drug and health care information.

The elderly club is for inhabitants who are over 60 years of age. They usually get free health care treatment at government hospitals. This club gets support from the municipality and provincial hospital in terms of health education. A gardening group has been developed in the Temple community and is supported by the provincial hospital, municipality and Khon Kaen University. The gardening group provides extra jobs for inhabitants who want to increase their income. Initial support in the forms of seedlings,

fertilisers, and expertise was provided at the beginning of the project. After that, the residents were responsible for maintaining the market gardens themselves. A Christian study group has been established at the Stranger community supported by the Church of Khon Kaen and teaches weekly bible lessons.

4.2 Demography

In the six low-income communities of Khon Kaen Municipality, 209 households (25.2%) were surveyed in order to investigate the economic status and health problems facing women (Table 4.1.1) from across these communities.

Table 4.1.1 Distribution of households in household survey 1997

Community	1997 Survey No. of Households	Total No. of Households	Percent	Percent of Survey
Guardian	72	289	24.9	34.44
Rental	29	114	25.4	13.9
Stranger	33	129	25.6	15.8
Temple	31	125	24.8	14.8
Railway	30	120	25.0	14.4
Joss	14	54	25.9	6.7
Total	**209**	**831**	**25.2**	**100.0**

(1) The Classification of Households

Households were classified by type using the national statistical office classification (1994), namely unrelated individual family, nuclear family, stem family, joint family and stem-joint family. The largest type of classified household were nuclear families (57 %) with unrelated individual families (6 %) (Appendix 3, Table 4.1.2) constituting the lowest number.

(2) Women's Marital Status

More than eighty percent of the subjects were married (81 %). 10 % of the women were widows, 5 % were divorced, 2 % single, and 1 % were separated. The results showed that the highest percentages of married women were living in the Guardian community (85 %) and the lowest in the Joss community (71 %) (Appendix 3, Table 4.1.3).

(3) Education

The majority of women in the communities had primary education (72 %). The findings also showed that only 0.5 % of the women who lived in the Rental community graduated from university. Only 14 % of the women finished secondary school, and 6 % had received no formal education (Appendix 3, Table 4.1.4).

(4) Socio-Economic Status

Occupation:

The most common categories of occupation for women included self-employed small business (stationary) (28 %), dress maker (21 %), labourer (14 %), self-employed small business (mobile) (9 %), garbage scavenger (6 %), private business employee (5 %), temporary government service (1 %) and government service (0.5 %). Only 14 % of the women worked at home as housewives and had no pay. However, the results also showed that 43 % of women in the Railway community and 40 % in the Joss community had self-employed small stationary businesses (Appendix 3, Table 4.1.5).

Income:

The results of the study showed that 29 % of women in the communities had a monthly income of between 1500-3000 *baht* (£ 23-47), 27 % had a monthly income of less than

1500 per month (£ 23), and 23 % had a monthly of income 3000-5000 *baht* (£ 47-78). The results also showed that 50 % of women in the Joss Community had a monthly income of between 5000-10000 *baht* (£ 78-156), and more than 60 % in the Railway Community had a monthly income between 1500-5000 *baht* (£ 23-78)(Appendix 3, Table 4.1.6).

In response to the questions about income and expenditure balancing, only 43 % of women reported having balanced income and expenditure. The majority, (55 %), stated that their income was not enough to pay for their daily expenses and they had to get extra money either from relatives or borrow from other sources. The women who lived in the Guardian Community had the highest occurrence of imbalanced budgets (Appendix 3, Table 4.1.7). When asked about balancing their budget, one respondent said :

> *"I couldn't make a balance between income and expenditure. I solved this problem by borrowing money from the shop owners. I had to pay 5-20 % interest on a loan" (FGI).*

Women as the primary income earners in the family:

In response to the question asking about who were the primary breadwinners in their families, nearly half of the women (49 %) identified themselves as the primary breadwinners, and only 37 % (Table 4.1.8) of the women reported that their spouses were. The highest percentage of women who were the primary breadwinners lived in the Joss community (64 %). Many key informants also commented that :

> *"The majority of women here have a vital role in the household economics because men are often alcoholics or often drunk when they are more than 40 years old. Men often stop working because of hangovers" (FGI).*

The respondents specified the age when women become wage earners as over 18 years

(21 %), 15 years (18 %), and 13 years (14 %) respectively. However, it should be noted that 30 % of women in the Railway Community became wage earners when they were less than 10 years old (Appendix 3, Table 4.1.9). A food vender who was 48 years old said:

> *"I started to find a job when I finished my six years of compulsory education because my family had no money to support me any further" (FGI).*

Family life

Most women married at the age of 21-25 years (23 %), while19 % got married at the age of 17 years. About 3 % of women who lived in the Guardian, Rental, and Temple Communities were married at age 17. Similarly another 3-4 % of women who lived in the Guardian, Rental, and Temple community married at the ages of 11-13 years (Appendix 3, Table 4.1.10).

65 % of women had married only once, 28 % for a second time, and 5 % a third time. Women living in the Temple Community had the highest incidence of remarriage (36 %) and the women living in the Railway Community had the highest incidence of remarriage three times (7%) (Appendix 3, Table 4.1.11).

29 % of the women had 2 children, 16 % had only one child and 15 % had 3 children (Appendix 3, Table 4.12). Most of them had children aged between 8 and 15 years (45%), aged 1-5 years (25 %), and aged 6-8 years (23 %). The results showed that 50% of the women who lived in the Guardian Community had children aged between 8-15 years (Appendix 3, Table 4.1.13).

There are child care centers at the Guardian and Temple Communities, with enrollment of 12 and 20 children respectively. One teacher is employed by the Provincial Social Worker Office to teach at both centers, and a janitor employed by the community committee. Children attending the centres must bring their own lunches (FGI).

Some communities have no child-care centers. So, some parents take their children with them to their workplaces, or hire the neighbours to look after while they are at work then, or leave them with relatives at home. Some older school-age sisters take care of and cook dinner for their younger siblings while their parents are at work. The children are sometimes left alone until midnight (FGI).

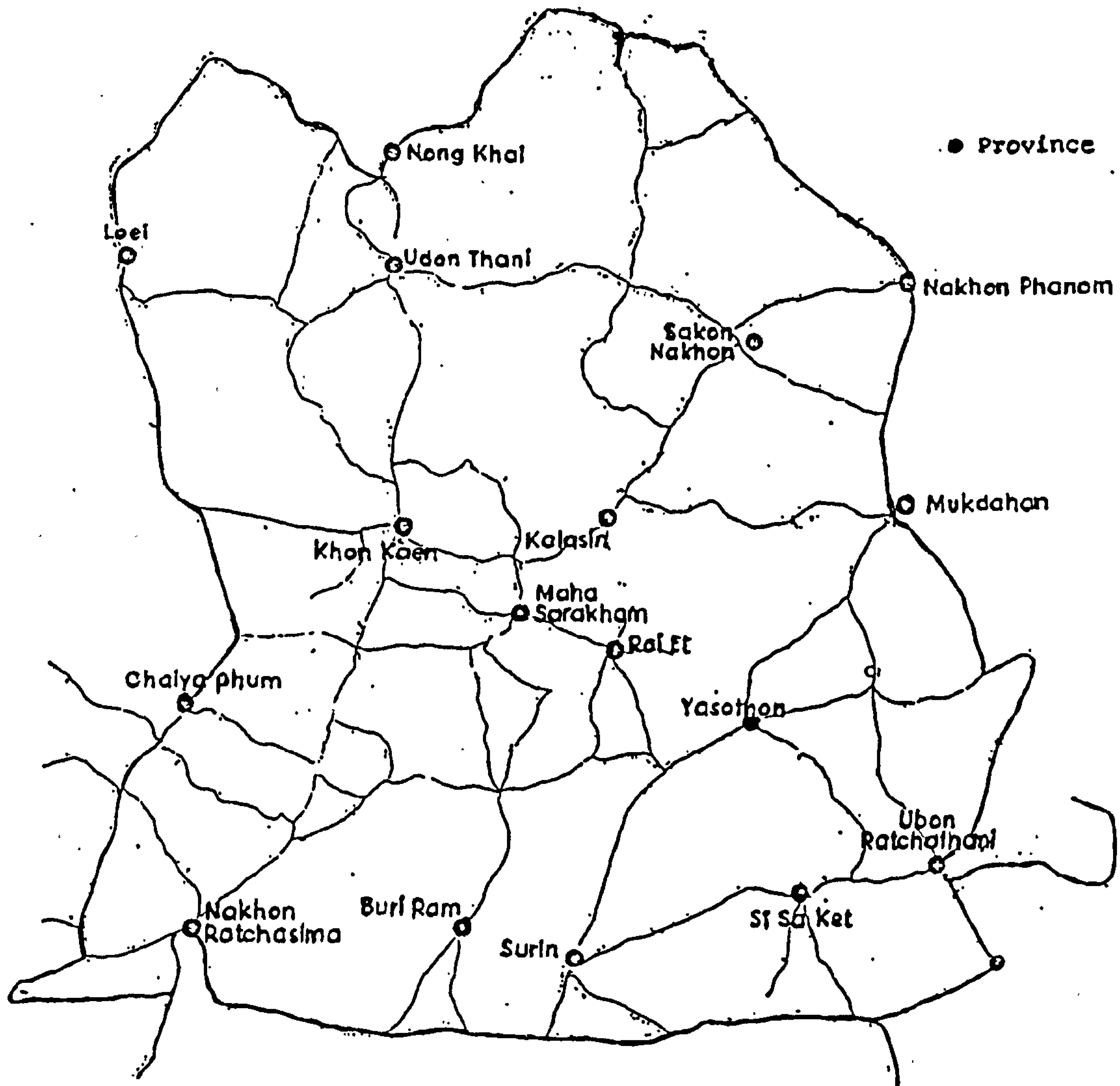
4.3 Migration Experiences

Most of the respondents had lived in these areas from 1 to 15 years. They came here to look for employment. Some followed their relatives when they moved into the city due to farming failure. Most came from Northeastern provinces, Loei, Udonthani, Sakon Nakhoh, Maha Sarakham, Kalasin , Chaiyaphum, Nakhon Ratchasima, Buriram, Sri Saket, Yasothorn, Roi Et, and the rural areas within Khon Kaen Province itself (refer to figure 4.2) (FGI).

Over one-third experienced moving once (35 %), 25 % twice, and 12 % 3 times. It was noted that respondents living in the Temple Community had the highest percentage of moving residence once (42 %), the Railway Community twice (47%), the Rental Community three times (21 %), and the Guardian Community more than four times (15 %) (Appendix 3, Table 4.1.14).

Figure 4.2

Places Of In - migration Origin



It is remarkable that the samples that live in the Guardian and the Rental Communities have high percentages of people moving house. This may be because these two communities have a lot of tenement houses; tenants often move in order to seek houses at a reasonable price, and which are closer to work within a better environment. In addition, when some people could earn a living and save some money, they would find a new place of their own to live by buying the right of habitation from others in the same community or nearby.

The Temple Community is an old community. With a number of tenement houses, where descendants takeover the house of the elderly or decreased parents. Because of this, there tends to be less shifting occupants than in other communities. Though the Guardian community is as old as the Temple Community, it differs from the Temple Community as it has more houses to rent. As the foremost occupants save some money and acquire permanent residences outside the community, they move out from this heavily populated area. However, when they move out, they still maintain the rights to property and keep the houses to collect rent. The Railway Community, is a new community. The new settlers migrated collectively from a private land settlement, whose owner drove them out in order to construct a department store. They occupied this public land because there were no other places to live. This is the second time that this community has been forced to move.

For all the communities involved in migration there were varying degrees of "cultural shock" experiences. However, the causes were often the same. The greatest problem for many was food acquisition. In villages, food was easily obtained from the environment (vegetables, fish, small wild animals, etc.), or from long standing friends or relatives.

However, in the urban environment these food sources were not readily available, making it necessary to purchase food items. Non-availability of natural fibers for making clothing at home was also a cause of stress.

Loss of a social support system available in their village was frequently cited as a negative change in lifestyle. The emotional and financial support enjoyed in the villages was no longer available. Because of their business commitments many had no opportunity to contact their relatives in their original village community (FGI).

4.4 Women's Work and Health

4.4.1 Work Experiences

Table 4.1.15 (in Appendix 3) illustrates household activities undertaken by men or women. The activities were sorted as follows: daily food/meal preparation, making beds, dish washing, house cleaning, garbage management, clothes washing, carrying water, child rearing and toilet cleaning. Across the 6 communities as a whole, women carried out the majority of household activities. For women these were, in rank order: House cleaning (99 %), making beds (98 %), dish washing (97 %), clothes washing (97 %), daily food preparation (94 %), garbage management (92 %), toilet cleaning (91 %), child rearing (89 %), and carrying water (79 %). While the activities that men carried out ranged as follows: carrying water (19 %), garbage management (8 %), daily food preparation (5 %), toilet cleaning (5 %), dish washing (3 %), clothes washing (3 %), house cleaning (1 %), making beds (1 %), child rearing (1 %).

When the activities were sorted by each community, it was also found that the pattern of household activities are still the same. Women carried out the majority of household activities while men were likely to carry out the more energetic activities such as carrying water and garbage management. Household activity sharing between men and women was dependent on women's working out side of their home. Men would not share those activities if their spouses had not to go away for work. In addition, if there were other females in extended families helping with the housework men did not give help with housework.

A participant in the focus group interviewed commented that:

> *"Usually men do not do house keeping because they think that it is the women's responsibility as housewives" (FGI).*

The opinion of one man was

> *"I don't make beds or wash clothes because those are female chores. I don't want to appear effeminate in the eyes of my neighbors. Some say that men will have bad fortune if they do unmanly activities" (FGI).*

Another woman

> *"I am under stress because I take full responsibility for managing my family while my husband has free time after work. I have to plan to do everything for the family all the time. Women must 'Tam Chai' (accept things as they are and don't think too much about it) (FGI).*

Work time:

Daytime was the most common time for women to work (64 %). It was noticeable that the respondents who lived in Stranger community had the highest percentage of women night workers (15 %) and the respondents who lived in the Railway community did day and night work (13 %) (Appendix 3, Table 4.1.16). A 48-year-old food vendor explained that :

> *"I sell grilled chicken. I get up at 2-3 am to buy chicken and grill it until 6-8 am. Then I sell it all day' (FGI).*

Sleeping:

It was found that more than half of the women slept for 6-8 hours (66 %) per night. The data showed that more women in the Railway Community slept for less than 3 hours (7 %). See Table 4.1.17 (Appendix 3). A 54-year-old woman explained her activities as follows:

> *"I live in the Temple community. I have three jobs: as a gardener, a road sweeper, and soft drink vendor. I get up to sweep the roads at 3 am until 7 am. I then water the gardens between 8 am to 10 am. After that I sell soft drinks from a mobile cart until 9 pm. The working hours are too long, and I don't get enough sleep (FGI).*

Vacation:

Table 4.1.18 (Appendix 3) shows the number of days women had off per month. By calculating figures for the whole community, the highest number of days off per month was just over 5 days (47%). By considering each community, a similar pattern was found with regard to vacation.

Two of the participants in the focus group interviews explained their activities :

> *"I am a food vendor which is my own small business. I earn a high income but I work seven days a week and longer than 10 hours a day" (FGI).*
>
> *"I am a worker in a fish-net factory, and I work eight hours a day six days a week. I think I am very lucky because I earn the minimum wages as prescribed by law" (FGI).*

Holiday pay:

More than two thirds of women received no pay for holidays (72 %). Two of the participants stated that :

"I run my own business (food vendor), so I get no money when I stop my work" (FGI).

"I am a worker in a fish net factory. I earn the minimum wages as prescribed by law and some other fringe benefits including holiday pay and health care" (FGI).

Activities:

For recreational activities, women preferred to chat with family members (19 %), watch television (17 %), chat with neighbours (16 %), listen to the radio (12 %), drink alcoholic beverages (8 %), shop (7 %), exercise (5 %), watch traditional concerts (5 %), gamble (5 %), and go to public parks (2 %). Among the respondents living in the Joss Community, the most popular form of recreation was chatting with family members' (30%), whereas the women in the Railway Community indicated "drinking alcoholic beverages" as their most popular recreational activity (10 %) (Appendix 3, Table 4.1.20). Moreover, some participants noted that :

"I think sleeping is the best recreational activity for me. My husband usually drinks after work"

"Talking with family members, gambling, watching TV, and participating in the illegal lottery are the most preferred recreational activities for my family" (FGI).

Community activities:

Women are more active in community activities than men, especially in the numerous traditional community affairs. Two of the participants in the focus group interviews explained :

"Normally, we don't trust men for community activities because they are usually drunk before the affair is finished" (FGI).

"We usually assign women to be in charge of money management because of their honesty and responsibility" (FGI).

4.4.2 Health, Illness and Self-Care Behaviour

From Table 4.1.21 (Appendix 3) women's health was compared with last year, and the following results were obtained regarding the health status of all communities combined: the community health status was reported to be: 'worse than last year' (28 %), 'as last year' (27 %), 'better than last year' (19 %), respectively. However, when considered by community, it was found that the first community, the Guardian Community, claimed their health status to be 'worse than last year' (35 %). Other responses included 'same as last year' (28 %), 'much worse than last year'

The results of study found some different patterns in the remaining communities. Most of the women who were housewives stated that their health status was 'same as last year' (Rental, Stranger and Temple Communities). While most of women living in the Railway and Joss Communities who worked outside the indicated home that their health status was 'worse than last year'.

From Table 4.1.22 (Appendix 3) showing women's frequency of getting sick compared with last year. The study found that nearly half the answers from all six communities showed they were 'more sick' (47 %), followed by these claiming to be 'less sick' (27 %) and 'uncertain' (25 %).

When we compared each sample, we discovered that the Joss Community answered 'more sick' the most (57 %) followed by the Railway Community (53 %), the Guardian Community (53 %), the Temple Community (42 %), the Rental Community (38 %) and the Stranger Community (36 %). It is noteworthy that the three communities who

answered 'more sick than last year', were the three communities that have the highest percentage of women working outdoors.

Common illnesses:

In the last two weeks 31 % of the respondents reported being ill. The most common answers having "acute illness in last two weeks" were from the women living in the Stranger community (52 %). The second highest was from women living in the Joss Community (43 %)) (Appendix 3, Table 4.1.23). Most of them had uncertain illnesses (84 %). The other common causes of illness were muscle pain (14.4 %). It was found that the highest percentage of women getting "muscle pain" were those living in the Stranger Community (30 %), while 3 % of the women from the Railway Community had "allergies"(Appendix 3, Table 4.1.24).

Nearly half of the respondents had suffered from skin allergies (46 %). Women who lived in the Guardian Community (52 %) suffered most frequently from this problem. A relatively high proportion of the respondents had problems of chronic colds (19 %), being diagnosed for allergies (19 %), and having face or mouth oedema (16 %) (Table 4.1.25 in appendices). In addition, a health volunteer stated that:

> *"The most common problems reported are headaches, peptic ulcers, joint pain, lower back pain, limb pain, and neck pain. I think that these problems are work-related. However, some men complain of liver disease such as Cirrhosis because of their drinking habits" (FGI).*

According to the women in the commentaries however, the respondents specified diseases caused by workload as : muscle pain (55 %), uncertain diseases (30 %), womb disease (12 %), kidney disease (1 %), allergies (1 %), malignancy (0.5 %), and AIDS (0.5 %) (Table 4.1.26).

Health seeking behavior:

With regard to initial treatments for ill family members, more than two-thirds of the respondents did not seek treatment (72 %) and 9 % bought medicine from drug stores, 9 % went to the local health stations or went to the government hospitals, and only 1 % went to private clinics. It was noted that 80 % of respondents living in the Railway Community reported that they ignored medical problems (80 %) (Appendix 3, Table 4.1.27).

Table 4.1.26 Women's views on diseases caused by workload

Diseases	No.	%
Muscle Pain	115	55.0
Womb Diseases	25	12.0
Kidney Disease	3	1.4
Malignancy	1	0.5
AIDS	1	0.5
Uncertain	62	29.7
Total	**209**	**100.0**

Participants in the focus group interviews explained :

> *"I am a labourer. I have no time to see a doctor when I get sick. If I stop working it means no money that day. I then get worse and eventually have to go to the hospital".*
>
> *"I could get free treatment in government hospitals under the umbrella of the Ministry of Public Health when I bought the government health insurance service. This insurance service costs 500 baht a year for free treatment of five family members. However, the government hospitals are too over-crowded, and while the private hospitals are not crowded they're too expensive" (FGI).*

With regard to treatments for long term illness of family members, more than two-thirds (75 %) of respondents went to government hospitals, 12 % went to private clinics, 6 %

bought medicine from drug stores, 5 % went to the local government service, and 2 % went to a private hospitals (Appendix 3, Table 4.1.28).

4.4.3 Health Risk Behaviour

One of the health volunteers in the community explained the risk behaviour of the villagers who commonly practice self-medication. Most of them bought pain relief, analgesic drugs, antibiotics, and especially mixed medicine (*Yaa Chud*) to treat themselves. Most respondents were unaware of the danger of drugs such as analgesics; antibiotics, and *Yaa Chud* (FGI).

Another health volunteer explained that the most commonly used drugs were combinations of analgesics and caffeine and were used either as analgesics or stimulants. Other stimulants widely used were vitamin-nutrient drinks, *Yaa E* (Ephedrine), *Yaa Maa* (Amphetamines), and Sudafed (Pseudoephedrine). These stimulants were available illegally. *Yaa Maa* is no longer legally available, although vitamin-nutrient drinks are easily available at any shop.

Analgesics:

As shown in Table 4.1.29 (Appendix 3), it was found that 74 % of the respondents took pain killers when prescribed, 18 % took them when doing hard work, and 9 % took them daily. Analgesics were taken for many work-related problems such as back, neck, limb, and joint pain as well as headaches. A 44-year-old woman said.

> *"Every day we take Tam Chai for muscle pain and some take Yaa E to stay awake" (FGI).*

Stimulants:

Most respondents refused to take stimulant tablets (81 %). The rest of the respondents specified that they took them when doing hard work (9 %), infrequently (7 %), and every day (1 %) (Appendix 3, Table 4.1.30).

More than half the respondents refused to take stimulant drinks (66%). The rest of the respondents took them infrequently (19 %). Women living in the Railway Community (13 %) represented the highest percentage of those who selected the answer "taking it every day" (Appendix 3, Table 4.1.31).

Smoking and Drinking:

The data indicated that more than two-thirds (77 %) of the respondents had never smoked cigarettes. Only 12 % of the respondents smoked ordinarily, 5 % smoked occasionally and 4 % used to smoke but had quit (Appendix 3, Table 4.1.32).

It was shown that more than half (59 %) of the respondents never drink alcoholic beverages, 24 % drank frequently, 10 % drank daily, and 6 % used to drink but had quit. It was noted that members from the Railway Community (13 %) had the highest rate of daily drinking (Appendix 3, Table 4.1.33).

4.4.4 Physical Health Status

The questionnaire for the physical health survey (Appendix 7, The quantitative questionnaire) uses the same criteria and methodology as the National Health Survey conducted by the Thai government in 1992 (Chuprapawan, 1992).

Arm, leg, and back pain:

History of illness and physical examinations were obtained from 209 women (Appendix 3, Table 4.2.1-4.2.7). The findings revealed that 48 % of the respondents described intermittent arm and leg pain. Additionally, 23 % of the respondents used to have pain in those areas and 75 % of respondents had a history of extreme pain (Table 4.2.2). It was found that 55 % of respondents had arm or leg pain from one to nine times per month (Appendix 3, Table 4.2.3). 67 % of respondents indicated pain lasting less than 1.5 months (Appendix 3, Table 4.2.4, Table 4.2.5, Table 4.2.6 and Table 4.2.7).

Vaginal discharge:

74 % of the respondents had never had abnormal vaginal discharge while 2.0 % used to have this complaint. 83 % of respondents indicated they never had abnormal vaginal bleeding and 4 % indicated they 'used to have it' (Appendix 3, Table 4.2.8-4.2.9, Table 4.2.10). 49 % of the respondents had never had a Pap smear check while 43 % had been checked (Appendix 3, Table 4.2.12 and Table 4.2.13).

Chronic disease:

Amongst the respondents a small percentage were found to have chronic illness (Appendix 3, Table 4.2.14 and Table 4.2.15).

Allergies:

31 % of the respondents had skin allergies, 13 % had chronic cold 13 % had been diagnosed as having an allergy, and 11 % had face or mouth oedema (Appendix 3, Table 4.2.16).

Cardiovascular disease:

30 % of the respondents indicated having chest pain, 20 % had chest pain when walking briskly/uphill. 66 % of the respondents had angina pain (for 10 minutes or more) when they walked/worked (Appendix 3, Table 4.2.17).

To criteria for diagnosing Angina pain are stated in the questionnaire. There are nine questions used to screen for chest pain. If the respondents answer 'yes' to the question on "whether they have ever had chest pain or chest congestion", the following questions would check for the area of disorder as follows:

- Having chest pain whilst walking, and must stop walking or walk more slowly, *and* the symptoms of chest pain/congestion *do not disappear* within 10 minutes. The area of pain or congestion is in area no. 4, 6, or 7 (see picture-location of chest pain in appendix 7), then it could be diagnosed as '*Angina pain*'.
- Having chest pain whilst walking and must stop walking or walk more slowly, *or* the symptoms of chest pain/congestion *disappear* within ten minutes. The area of pain or congestion is in no. 4, 6, or 7, it could be diagnosed as '*Probable angina pain*'.
- Having no prior history pain aforementioned, but the area of pain or congestion is in area no.4 or 6 or 7, it could be diagnosed as '*Possible angina pain*'.

4.4.5 Physical Examination

The findings of the physical examination showed that most respondents were within the normal limits for all items with a very small number having an abnormal physical profile. However, 7 % of the respondents had evidence of anaemia when their conjunctiva were examined and 5 % when their nail color was examined. It was noticeable that there were five cases (2 %) where respondents had evidence of an abnormal swelling in their breasts. 2 % of the respondents systolic blood pressures were higher than 160 nn.Hg. For diastolic blood pressures, 4 % of respondents had pressure of 95-105 mm.Hg (mild hypertension),

Table 4.2.18 The Physical Examination

Finding	No response		Normal		Abnormal	
	NO.	%	NO.	%	NO.	%
1. Finger count						
Right eye	-	-	208	99.5	2	1.0
Left eye	-	-	209	100.0	-	-
2. Hearing ability	3	1.4	206	98.1	-	-
3. Speaking ability	1	0.5	205	98.1	3	1.4
4. Cleft lip	1	0.5	199	95.2	9	4.3
5. Cleft palate	2	1.0	198	94.7	9	4.3
6. The test of arm, legs, and body movement						
- Raise hands and arms over the head						
• Right arm	-	-	208	99.5	1	0.5
• Left arm	1	0.5	208	99.5	-	-
- Bend the elbows, until fingers touch lips						
• Right arm	-	-	208	99.5	1	0.5
• Left arm	1	0.5	207	99.0	1	0.5
- Make a fist, with thumbs across the knuckles, hold the tester's finger tightly						
• Right arm	-	-	208	99.5	1	0.5
• Left arm	-	-	209	100	-	-
- Put a button through a hole 2 consecutive times						
• Right arm	-	-	209	100.0	-	-
• Left arm	1	0.5	208	99.5	-	-
- Squat down and let the palms touch the floor, then stand up						
• Right arm	-	-	206	98.6	3	1.4
• Left arm	-	-	205	98.1	4	1.9
- Walk straight ahead 10 steps and come back to starting point						
• Right arm	-	-	205	98.1	4	1.9
• Left arm	-	-	206	98.6	3	1.4
- Performing daily life activities unassisted	1	0.5	208	99.5	-	-
- Cirrhosis of the liver						
• Ascites	-	-	207	99.0	2	1.0
• Pitting edema	-	-	-	-	-	-
• Jaundice	-	-	205	98.1	4	1.9
• Spider nevi	-	-	208	99.5	1	0.5
• Palmar Erythema	-	-	207	99.0	2	1.0

Table 4.2.18 The Physical Examination (continued)

Finding	No response		Normal		Abnormal	
	NO.	%	NO.	%	NO.	%
- Breast examination						
Inspection : - Arm over head	13	6.2	195	93.3	1	0.5
Hands pressed against hips	13	6.2	195	93.3	1	0.5
Palpation : - At breasts	15	7.2	189	90.4	5	2.4
- At axillaes	62	29.7	14.7	70.3	-	-
- Evidence of anemia						
• At conjunctivas	6	2.9	189	90.4	14	6.7
• Nail color	6	2.9	193	92.3	10	4.8
- Blood pressure						
• Systolic pressure						
< 160 mmHg.	-	-	204	97.6	-	-
> 160 mmHg.	-	-	-	-	5	2.4
• Diastolic pressure						
< 95 mmHg.	-	-	193	92.3	-	-
95-105 mmHg.	-	-	-	-	9	4.3
> 105-114 mmHg.	-	-	-	-	4	1.9
> 115 mmHg.	-	-	-	-	3	1.4
- Body Mass Index (BMI)						
< 20	-	-	-	-	40	19.1
20-25	-	-	106	50.7	-	-
25.1-30	-	-	-	-	47	22.5
> 30	-	-	-	-	16	7.7
- Cirrhosis scoring						
0	-	-	2.3	97.1	-	-
1	-	-	-	-	2	1.0
2	-	-	-	-	2	1.0
6	-	-	-	-	1	0.5
9	-	-	-	-	1	0.5

2 % at the level of 105-114 mmHg (moderate hypertension), and 1 % higher than 115 mmHg (severe hypertension) (refers to Table 4.2.18).

Body mass index (BMI) was used to interpret adult malnutrition. Only half of the respondents were in the normal range of BMI (51 %), and 19 % of the respondents were lower than normal, 23 % who were better than normal, and 8 % were within the range of obesity. With regard to cirrhosis scoring, it was found that only 1-2 respondents had scores which indicated liver disease (refers to Table 4.2.18).

4.4.6 Mental Health Status

A mental health opinion survey was used to assess the mental health status of the women who were the primary breadwinners of the households. They were asked whether they had experienced any physical or mental symptoms which were caused by stress. There were 40 questions which were divided into two aspects of mental health status : optimist and pessimist. This produced a total score of 40-160. Mean score and standard deviation (S.D.) were employed to analyse the data. The respondents with a mean score of more than 2.5 were specified as optimists. Those who got a mean score of less than 2.5 were specified as pessimists.

The findings revealed that about 90 % of the respondents were optimists, and optimists were found in all of the communities.

There was a statistically significant correlation amongst the mental-health opinion scores of six communities ($p < 0.001$) by using the Pearson correlation test with 2-tailed

Table 4.2.19 Mental status

A mean score ($\overline{X}$)	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
< 2.5 (a pressimist)	8	11.1	2	6.9	4	12.1	4	12.9	2	6.7	0	0.0	20	9.6
> 2.5 (an optimist)	64	88.9	27	93.1	29	87.9	27	87.1	28	93.3	14	100	189	90.4
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100**	**209**	**100.0**
$\overline{X} \pm$ S.D. →	**2.97 ± .39***		**3.0 ± .35**		**3.03 ± .41**		**2.99 ± .41**		**3.16 ± .36***		**3.10 ± .29**		**3.02 ± .38**	

Note: 2 – tailed significant correlations amongst 6 communities ($p < 0.01$)

- The mean of women's mental status living in the Railway community was significantly higher than that of the Guardian community, by using the Least Significant Difference test (LSD) of one way ANOVA ($p < 0.05$)

significance. The mean of women's mental status of the Railway Community was significantly higher than that of the Guardian's residents ($p < 0.05$)(Table 4.2.19).

4.5 Overview of Key Findings

The study consisted of six low-income communities located along the railway and near the city. These communities had similar living conditions in most respects, and all occupied land (except the Joss Community which is no man's land) belonging to the State Railway Of Thailand (SRT).

Preliminary results indicated that the majority of women had a vital role in household economics and housework in the families. Most women remained married. The majority of them first married between 21 and 25 years of age. A higher percentage of the women had primary education. The most common type of principle occupation for women was self-employed small business (stationary). The annual income of the majority of women was higher than the poverty line (7870 *baht* per year).

There are two characteristics of migration : individual family migration and collective community migration. Reasons for individual family migration are economic, and the reason for collective community migration is lack of land and housing.

Nearly half the women specified themselves as the primary breadwinner because men were often drunk over the age of 40 years old (FGI). Women felt under stress because they had to take full responsibility for the family. A coping strategy that the women frequently used was *"Tam Chai"* (accept it and not to think too much about it).

Women often let their children work as wage labourers in order to cope with economic difficulties. They also fell into debt because they had to borrow money and pay a high interest rate of 5-20 %.

Women in these low-income communities also had vital roles in the communities as community money keepers, health volunteers, and other leading roles because of their high honesty and responsibility.

The findings showed a large number of health complaints including musculoskeletal symptoms, skin allergies, chronic colds, and psychological symptoms such as headaches and peptic ulcers. They generally did not seek health care. They preferred self-treatment by buying medicine from drug stores. Only when the symptoms became worse did they eventually went to the hospital.

Some women habitually used drugs such as pain relief medicine, ephedrine, and amphetamines or other stimulants.

However, the study showed that nearly all of the women were optimists and were happy. Statistically the mental status of women living in the Railway Community was significantly higher than those living in the Guardian Community.

4.6 Conclusion

To understand the six low-income communities, this chapter illuminated the issues of interest, namely gender, poverty, work and health in related to women experiences. This

is the stage of a macro investigation that employs 'health status surveys' from six communities in the Khon Kaen municipality. The findings from health status surveys generate initially information on basis health data of women living the low-income areas in terms of the community profile, demography, migration experiences, women's work and health. This macro data answers some parts of research question: to understand the meaning of the concepts of health and wellness for low-income women; and to explore the work and families roles of these women. The discussion of the findings of the survey will outline in the next chapter. This analysis will help to select the appropriate qualitative site for the next phase.

CHAPTER FIVE

DISCUSSION OF FINDINGS FROM SURVEY OF LOW-INCOME COMMUNITIES

The purposes of this chapter are 1) to compare the findings of this phase of the study to the findings of other studies, 2) to present the thematic findings which have informed the direction of the next phase, and 3) to address the limitations of research so far.

5.1 Environmental Living Conditions

Urbanization is said to be a worldwide phenomenon, which leads to the poor urban population forming crowded living zones where needy populations were ever increasing (Archavanitkul, 1988). Such is the case with there six communities in Khon Kaen. Poor environmental conditions led to many environmental problems such as lack of water improper drainage systems, waste strewn across living the areas, bad ventilation and inconvenient walkways similar to the findings of Lapanun (1999).

Urbanization also produces a greater magnitude of health problems due to residents often occupying land illegally or unofficially and are therefore under-enumerated in official statistics (Harpham, 1994). Moreover, the health of the urban poor was the source of many diseases due to poor environmental factors including infectious diseases, malnutrition, and other social diseases (WHO, 1988). For each of the six communities comparable environmental problems were evident in this study.

5.2 Context Poverty and Work

A high proportion of households classified themselves as nuclear families. This is consistent with findings from other studies (National Statistic Office, 1994).

According to the findings, most women (3/4) were married. The majority of women in the community first married between 21-25 years of age. The second age range at first marriage was 17 years old. This age range was highest amongst the women of the Railway community. According to Thai law, the minimum age for marriage is 15 years for girls and 17 years for boys (Chadchaidee, 1994: 108-9). Women's main reason for remaining married was to have men around as protectors (Boonjerm, 1993).

A high percentage of the women were educated to primary level. While some received no formal education at all. These findings corresponded with reports that the education rate in Thailand is around 90% ie. most people have some education (National Statistic Office, 1994). Women from poor families received less education because of families' monetary shortage and the family values of investing in the future of sons over daughters (Archavanitkul, 1988). Moreover, according to the Northeastern belief of '*women remaining while men leave*', daughters would be told to stay home, do housework or help doing jobs which could earn money for the family (Worasiriamorn, et al, 1990).

Previous studies have shown that the most common occupation for women was as a self-employed small business. In this study, this occupation proved most common for women living in the Railway and Joss communities. Noticeably, these people had few job opportunities because of their low level of education. They were largely dependent on their labour to find employment (cited in Lapanun, 1999).

The annual income of women was lowest in the Rental community, which was near the poverty line, (7870 *baht* or £ 123 per year in slums) as set for the Thai population. However, these results may contain inaccuracies in the overall estimation because 28 % of the women surveyed who worked as housewives reported having no income though they had remittances from their husbands and children. A wide gap can be seen between the rich and the poor in this study. According to COWI-CBI (1998), it was found that the per capita GPP of Thai provincial areas in 1995 was almost 34,000 *baht* (£ 531) while the average income of people in Khon Kaen province was roughly 15,000 *baht* (£ 234) annually (DANCED, 1996).

The findings indicated that there were two major types of migration, individual family migration and collective community migration. The reasons given for family migration from provinces in the Northeast and the rural areas in Khon Kaen were mainly economic ones. This conferred with the study on *Isaan*'s outward-migration in 1997 carried out by Richter, et al (1997). People have migrated into Khon Kaen Province since 1959 when the government specified Khon Kaen as the centre for development of the Northeast. Therefore, Khon Kaen has made the transition from an agricultural town to the business, service sector and financial centre of the Northeast region (Lapanun, 1999).

The development of the Railway community was a result of collective community migration when its residents were evicted from their previous location by the authorities. The residents moved and illegally occupied the property of the State Railway of Thailand (SRT) in an event which was similar to findings of most other studies of slum areas (Fuller, et al, 1993; and Payne, 1984).

The immigrants suffered from unsuitable and crowded living conditions. They constructed their houses over flooded land or uninhabitable wild areas. These migrants also had some degree of cultural and environmental shock because of the difficulty in acquiring food and clothing, which now needed to be purchased. They also needed to cope with different living arrangements to ensure family survival. These arrangements included adapting to new residences, coping with expenditure and adapting to the work environment and urban lifestyle. Similar results of migrants' adaptation to city residences were presented in several studies of migration (Chamratrithirong, 1979; Chung & Kagawa-Singer, 1993; and Frye & D'Avanzo, 1994).

The findings of this study support the traditional roles of husband and wife in Thai society. A dividing line exists between 'women's work' and 'men's work'. Women were highly represented in doing household work. They regarded husbands as 'breadwinners' and wives as 'homemakers'. However, these roles are becoming increasingly flexible due to the increased economic demands on the family, with women now becoming 'breadwinners'. But men still felt there were taboo duties they could not perform for fear of appearing effeminate in the eyes of their neighbours.

After Buddhism was introduced culture and beliefs in Thai society changed. Power and administration have come since been under the responsibility of men. Men stipulate social calibration, regulations and laws (Wongphrom, 1998). There have been studies on unequal distribution of homework and employment between men and women (Szalai, 1972). Szalai's study was conducted on men and women in 12 countries, and found that women with an occupation spared three hours of their time per day to do housework, whereas men spared only 17 minutes of their time. Moreover, it was also revealed that men took more recreational time than women. In addition, a study conducted in Canada,

found that women spent a total of 32.2 hours per week doing housework and looking after children while men spent only 18.2 hours per week on these family chores (Messing, 1997). Furthermore, *Isaan* women performed and observed '*Heet Kong* of being a woman': the traditional social regulations that women were supposed to behave themselves well on their 'women's jobs' including farming, handicraft, and housework; while men were assigned farming, handicraft, and commerce (Boonjerm, 1993; and Sohm-in, 1994). Women were also required to be reserved and to sacrifice their own contentment for their children and husbands well being (Thammawat, 1998). Thai society is concerned with upholding male roles in the eyes of society. Thus, men would refrain from things that were likely to make them lose their *Sak Sri* (dignity) or to appear effeminate in the eyes of their neighbours. This concept is encapsulated in the proverb 'A man's loincloth is always hung over women's underwear' (Iawsriwong, 1995).

In the present research nearly half the women specified themselves as the primary breadwinners because men were reported as either alcoholics or regularly drunk, especially if they were over 40 years of age. Men often missed work due to hangovers caused by drinking. The income of some male individuals did not contribute significantly to food expenditure because personal expenditure on tobacco and alcohol tended to increase proportionately with income.

Astonishingly, this finding that women were the primary breadwinners was opposed to the popular Thai idea that 'men are the breadwinners and women are the homemakers'. This finding was supported by the saying, 'men and women worked side by side', but while 'women earn a living, men keep drinking'. However, it is usually the case that in a period of capitalism, women acquire more roles related to earning money. Women also had more power in household decision making (Kaewteph, 1995).

Nearly one-third of the women who worked independently were vendors. They felt satisfied with this occupation because it offered autonomy. However, there were many women who were unable to sell things because they lacked capital to get started. Some were not satisfied with their low salary jobs, but they were limited by the level of their education at attainment (Grade 4-6) (Ritcher & Havanon, 1995). With limited education, the majority of women worked in the informal sectors as vendors, hawkers, maids, and sub-contractors (Thompson, 1990). Problems identified by those working in the informal work sector were: working in a climate lacking information, poor education, poor income, absence of legislative protection; health problems from excessive noise, poor ventilation, and long working hours (cited in Pupaibul, et al, 1990). However, few studies have been conducted on the issues of occupational health for Thai women workers in the informal sector (Chirawatkul, 1998).

In the present study the majority of the women worked in the informal employment sector. These women were under stress because they carried the full responsibility of supporting and providing for the family. A coping strategy that women frequently used was '*Tam Chai*' (to accept and not think too much about it), which coincides with the traditional Buddhist belief. Buddhist philosophy teaches people not to escape from suffering and that people should not attempt to escape the natural facts of life. They are instead encouraged to face problems and overcome them through their own efforts (Butr-Indr, 1995: 13). Thus the coping strategy, '*Tam Chai*' refers to people who face problems and try to overcome them by accepting the fact and adapting themselves as much as they can.

Although women have a vital role in household finances, the husbands were still the household authority figures and were responsible for the welfare of its members. The fathers or husbands took all responsibility for extra-household matters. The mothers or

women, on the other hand, were responsible for the house and its compound (Yoddumnern-Attig, 1992). Thus supporting the Thai saying that, 'women are the rear feet of elephants while men are the fore feet' (Kaewteph, 1995). This belief has been deeply rooted in Thai society for a very long time. Thai people have always believed that the man's role is as a leader while women are followers.

It became evident in the quantitative survey that women who faced an unreliable source of income from their husbands developed several strategies to cope with day to day hardships and economic crises. They coped with these problems by having children work as wage labourers, even though the children were as young as 9-10 years old. Some children left school after the compulsory level (Grade 6). The National Statistic Office (1993) reported that there were 2,145,900 male children labourers aged 13-17, and 2,068,800 female children labourers aged 13-17 were working in the whole kingdom. Loyalty to the family unit is another basic tenet and the duty of children to care for their parents in difficult times or in old age is accepted as entirely normal and correct. Children's loyalty to the family is based on Buddha's teaching. Respect and love towards one's parents is strongly emphasized in Buddhism. The reason for this is that parents sacrifice much for their children: they give life to them, nourish and bring them up, and introduce them to the world (Butr-Indr, 1995: 96).

Information obtained from focus group interviews revealed that women played important roles in the community. They were trusted to take care of the community and other people's money because of their honesty and responsibility. In addition, two of the six community heads were women and almost all of the health volunteers in the communities were women. This finding correlated with other studies in Northeast Thailand concerning women's participation in developing communities (RDI, 1996).

The overall findings in this quantitative phase suggested that a woman living in low-income communities had a large amount of work to be done is order to earn income including being a mother, a wife, a grandmother and a caregiver. Some women needed to work two to three jobs a day to earn enough money for their families. They complained of tough living and difficulties in finding money. This finding was consistent with Manmart's (1991) studies of women's role in earning money. Her study indicated that the difficulties faced by women were largely due to financial problems, demand for family facilities, and lack of a higher education. Moreover, children's needs were a significant factor in the decision-making process. However, the quantitative study was limited in this respect and a more specific study requires be conducted to explore women's views in order to gain a clearer understanding of the issues.

Although women were found to suffer from their hardship as breadwinners, the six focus groups of women still indicated that they were not really worried about their heavy workload. They unanimously said that they were quite happy if their families understood them and acted responsibly. Whenever they felt the demands of work were too great, they could seek pleasure from gambling or other activities. The most important thing to them was earning enough money for their families. This finding confirmed the nature of women that placed their family members, especially husbands and children as the most significant people in their lives (Duangpaktra, 1992; and Nichols, et al, 1995).

5.3 Women's Health

The use of a questionnaire and physical examination gave insight into the conditions of women's health status, which showed a high volume of complaints about musculoskeletal symptoms, skin allergies, chronic colds, and psychologically related symptoms such as

headaches and peptic ulcers. These findings parallel those in the literature. However, Collin and colleagues (1997) gave an observation on women's health status that the type work and the place of work were major sources of working women's health problems. This assertion may create the misunderstanding that women's work only had bad effects on women. In contrary, there is a large body of research regarding women, work and health which suggest that employment is also advantageous to women (Graetz, 1993 & Halfon, et al, 1991). Therefore, working hard could have either negative or positive effect on women's physical and mental health (Barnett, et al, 1991; Kotler & Wingard, 1989; and Kritz-Silverstein, et al, 1992). It should be noted that there are many respondents in the present study who filed health complaints for musculoskeletal pain and disorders. This may be because all the women studied were labourers, whose work was repetitive, required extremely fast work speeds and was done standing or sitting in a static position. This finding is in accordance with the study of other scholars such as Collin et al (1997), Dennerstein (1995) and Messing (1997). Furthermore, despite the fact there was a low percentage of factory workers in this present study and the problem of exposure to chemical substances happened rarely amongst these respondents, in reality, the risk of exposure to chemical substances and environmental pollution were potential problems. This is because some respondents were hired to attach lead-weights on fishing nets as subcontracted work at home, which had the risk of exposure to leads. Others planted vegetables to sell along the railway shoulder also risked exposure to pesticides. Even vendors along the road and at bus terminals also risked exposure to environmental pollution. Therefore, it is not surprising that respondents in this study complained of allergies such as skin rash and chronic colds.

Emotional and mental problems of respondents in the present study are not high in comparison to the rather high level of suffering caused by the economic difficulties they

were facing. Moreover, this group of respondents was women who were responsible for both the housework and outdoor work, and emotional distress was to be expected. They should have more emotional and mental problems than men who only worked outdoors and were not responsible for domestic work, as presented in other studies conducted in western countries such as in the work of Bird (1999), Collins, et al (1997), Dennerstein (1995) and Messing (1992 &1997).

From a mental health perspective many affective disorders could result in the use of substance abuse (Collins, et al, 1997). A Thai National Health Status Survey conducted during 1991-1992 found that 10.0% of the male sample drank everyday while 43.2% of the male sample drank occasionally. As for the female sample 1.5% drank everyday, and 21.4% drank occasionally (Chuprapawan, 1992: 87). The findings from this study are comparable.

Some studies found that women's reproductive problems could be related to their working conditions (Collins, et al, 1997; and Messing, 1992). Most focus group interview participants believed the cause of certain illnesses in women, especially womb disease, was related to work and environmental factors. This requires further research and is out of the scope of the present study.

Data from this survey revealed that 49 % of the respondents had never had a Pap smear check. When conducting in-depth interviews the reason they gave for not having this check was because they were shy to expose their bodies to doctors. Many Thai women are shy about going for internal exams or even about talking to health personnel about their symptoms. This is supported by other studies, in which women reported some form

of social stigma, fear of stigma or embarrassment about their reproductive problems (Boonmongkon, Nichter, & Pylypa, 1998: 25).

It was found that 6 % of respondents had a history of taking medication and being diagnosed for hypertension, which was close to the percentage of women being diagnosed for hypertension and living in the municipality areas of Northeast Thailand (7 %). However, 3 % of the respondents had a history of taking medication and being diagnosed for diabetes mellitus, compared to 4 % of women being diagnosed for diabetes mellitus in the wider Northeast region (Chuprapawan, 1992: 103, 110). It was found that 10% of respondents were taking medication for pain relief continuously for more than three months. Compared to other studies, 8.4% of urban pain relief users used the drugs for a period of about one-month, while 16.6% of people used the drug for about one year (Chadbunchachai, 1997: 111).

As for complaints relating to upper airway problems, There were the complaints with 15% to 32% of respondents reporting that they coughed more than four times a day, several days a week and felt exhausted while walking upstairs, respectively. Unfortunately, measurement of the peak expiratory flow rate could not be provided thus diagnosis of a chronic airway obstruction could not be made. However, it could be stated that one quarter of the respondents in this study was likely to have allergies.

Data also showed women seeking help for an initial illness and for a long-term illness. Women's health seeking behaviours are depicted in Figure 5.1.

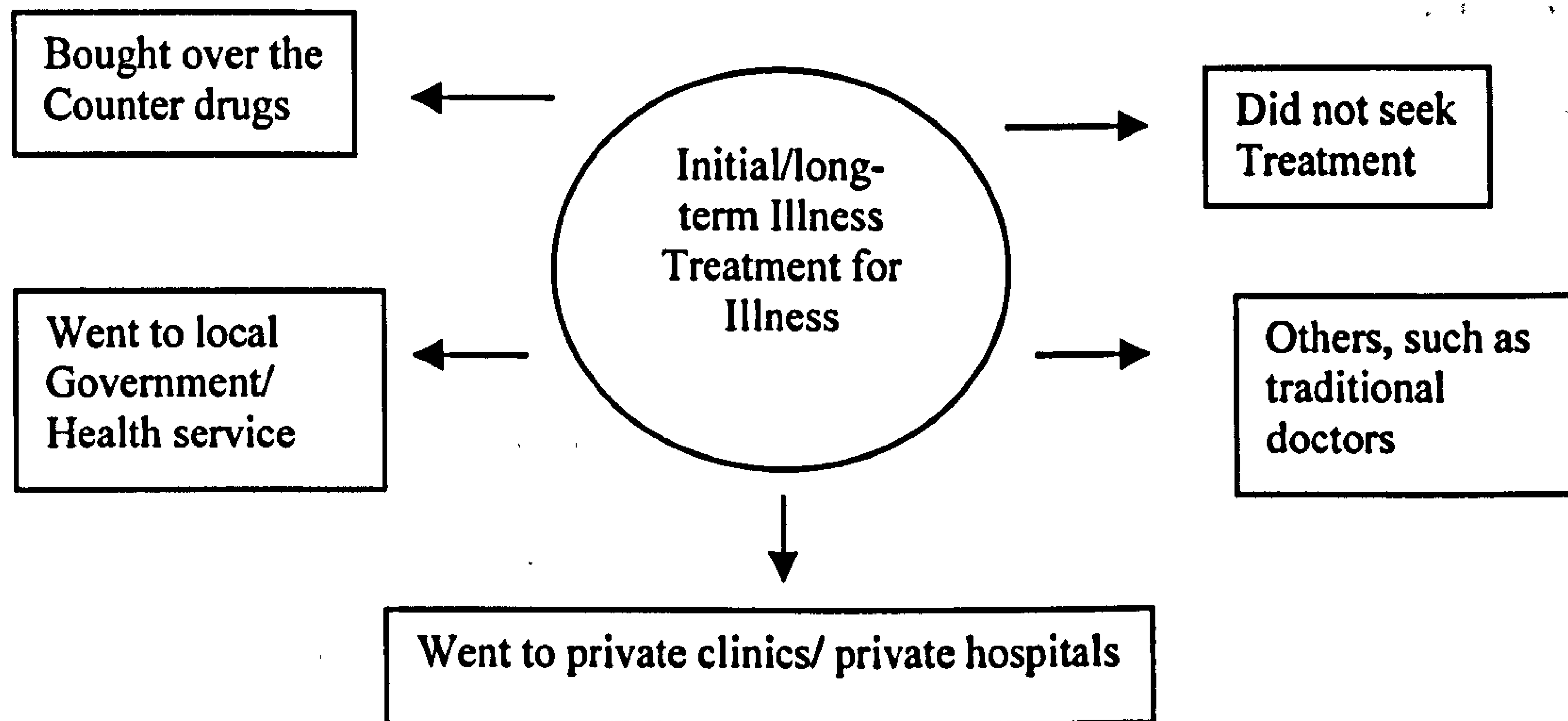


Figure 5.1 Health Seeking Behaviours of Women and Their Families.

The perceived severity of symptoms was an important factor in seeking medical care and complying with treatment (Kirscht, et al, 1976). The findings corresponded with other studies in the sense that (Chadbunchachai, 1997; Chuprapawan, 1992; and Kanungsukassem, 1993), most the women did not take action if their symptoms were not severe and preferred self-treatment by buying-over-the counter drugs. If symptoms increased, they eventually went to the hospital. However, women were also aware of the long waiting times at the hospital and preferred going to private clinics if they had enough money. From focus group interviews, it was noted that some also sought health-care from traditional doctors.

For these respondents, the difficulties in living with a shortage of public services (especially health care provision) were exacerbated not only by their own expectations as family providers but also by their poverty. They found themselves dealing with a life of economic struggle and hardship. Women had health care access constraints including the distance from their home to the hospital, time spent waiting for service and incapacitation due to illness and debt. These were consequences of structural constraints women

encountered. As revealed through open-ended interviews, respondents claimed spending more than one hour (one way) going to the hospital, then four to six hours waiting for a fifteen-minute physician appointment. After the hospital journey, the women had to rest and stop working for a few days to recover from their illness and exhaustion. The cost of travelling plus the lack of income for the days it took to receive medical care added more debt to their already penurious conditions. Therefore, buying over-the-counter drugs for self-treatment when they got sick was the cheapest option.

As is suggested by Rokeach (1968, cited in Rokeach, 1980: 261-304), 'Belief' is the personal postulation that man may feel or not. This directs man to do as he believes. Belief is a feeling, a thought, an understanding, and an expectation of people. Their belief may be reasonable or not and people will behave, as they believe. This belief will leave a deep impression and it plays a substantial role in personal behaviours. Belief occurs as a result of several causes, which are untouchable and might not be explicable. Belief occurs under the influence of passing on knowledge and experiences from generation to generation, which is socialized and reproduced by social norms and social circumstances. The individual's beliefs relating to health influences their health care seeking behaviour, illness, treatment, and compliance. Moreover, health beliefs also influence individual behaviours, which might not be grounded in knowledge of the facts (Rokeach, 1980: 112). Thus, it can be concluded that personal health behaviour is influenced by health beliefs.

There were many health risk behaviours identified amongst women living in low-income areas, especially drug use. Use of *Yaa Chud* (a mixed medicine), *Yaa Kae Puad* (pain relief medicine), *Yaa E* (ephedrine), *Yaa Maa* (amphetamines) was widespread. The findings corresponded with those of Chuprapawan (1992). Using these drugs was common especially the habitual use of stimulants by workers, which were bought in an

unregulated market. However, admission of use was likely to be underestimated. These points will be further investigated through in-depth interviews in the second phase of the study. Drinking was a popular activity, which the respondents living in the Railway community did for recreation (10 %), as compared to the figure for the whole (8 %). Based upon other research, daily drinking was found to be common amongst males in Thailand. The Thai National Health Status Survey conducted during 1991-1992 showed that 39 % of males sampled in the municipal areas drank often, whereas 21 % of females sampled in the same area often drank (Chuprapawan, 1992: 89).

After analysing this statistically, a significant correlation amongst the mental health status scores of women in six communities ($p < 0.0001$) by using the Pearson correlation test with 2-tailed significance was identified. The respondents studied in this research were women. These findings were in contrast to the findings from another study, which was conducted amongst men who were specified as the heads of families in the same communities (Thongbor, 1996). It was found that the mental health status of men was relatively low, while only 13.3% had a 'high level' mental health status.

Finally, the data showed the existence of low-income women's health and the substantial role which culture and environment played such as work conditions was more fully recognised in the health and illness episodes experienced. After the quantitative research phase, it was concluded that women in low-income communities faced many difficulties including living in crowded slums, which are unsuitable environments for healthy living. The inferior status of women in Thai society with their low education, and poverty meant that they worked hard in the informal sector as primary breadwinners with few holidays, and without social welfare or legal protection. Health problems included musculoskeletal symptoms, allergies, gastrointestinal symptoms and other chronic diseases. When they

were sick, their health seeking behaviours involved the sick person purchasing drugs for themselves. These are all factors that cause great suffering to them. However, the results showed that they did not worry about these difficulties as long as their families still had something to eat, they could earn a living and their husbands and sons behaved well. Furthermore, when they were in distress, they coped with problems by following the concept of '*Tam Chai*', in accordance with Buddhist teaching.

5.4 Potential Limitation of the Household Survey

This study focused on the experiences of poor women and was specific to a large city in Northeast Thailand. Had this study been conducted in one of the other cities in the North, South, or Centre of Thailand, the results might have been different.

The weakness of a quantitative method could be that it can provide fairly superficial information content as a result of respondents' frustrations at being questioned (Fetterman, 1989; Powers & Knapp, 1995; and Yin, 1994). In addition respondents may provide an incorrect answer due to an ability to recall facts clearly, or knowledge they may have gained during the period of the study or simply by an intentional desire to provide inaccurate information. However, in order to obtain good quality data it was necessary to establish good relationships with respondents by starting talking about general topics of daily life.

Due to the low prevalence of chronic diseases (Chuprapawan, 1992) and since diseases would take a long period of time for noticeable symptoms to occur, the health profile questionnaire might not be sensitive enough to indicate low-income women's health problems. In addition, this was the first ever survey of women's health status in these

low-income communities and should be viewed as providing baseline information. The restricted budget, lack of research assistants, equipment, and secondary data support contributed to the scale of the study. However, by integrating different research methods the weakness of a single approach can be reduced (Polit & Hungler, 1997: 205).

The research was designed to integrate different research methods as mentioned in Chapter 3, so as to avoid the limitation of using a single approach. The questionnaire part was also designed by using a variety of steps such as conducting focus group interviews with both men and women in all six communities. This helped to design a questionnaire with questions that are relevant to subject livelihood and also to ensure that the wording used was most consistent with respondent understandings. After the questionnaire was constructed, its content validity was reviewed by four Thai scholars who had experience in doing research with respondents in such the communities. Then, the revised questionnaires were a piloted in another community that had similar characteristics but was excluded from the main study.

Finally, the purpose of this phase of the research, was to initially understand the working and social life of women living in low-income areas and how work affects their health. This analysis of data answered some parts of the research questions including the nature of low-income women's health and their roles in both family and work. The remaining research questions intended to gain insight and understanding of women's perceptions and experiences in terms of the effects of work on women's health and their caring abilities will be explored in the next phase of the study. The results of phase one of the study also contributed to the selection of an appropriate research site for indepth study.

5.5 The Community Focus for the Second Phase

It was concluded that the Guardian community was too big to handle the field study. The residents appeared unwilling or unable to provide information. They were wary of strangers and police spies. Rental community was suitably sized to conduct qualitative research. However, residents were frequently on the move, largely due to the nature of the rental agreement. The majority of women living in the Stranger community were housewives with no income. They had experienced shifting the location of their home and preferred to keep themselves at a distance. The Temple community was a long-standing one however the majority of women living in this community were housewives with no income. They appeared to be in a good state of mind and kept themselves entertained by gambling and other pursuits. The majority of women living in the Joss community were primary breadwinners with self-employed small businesses. Unfortunately, the community was too small (54 households) to be representative of the type of phenomenon that will be discussed.

The following questions were posed.

Firstly, which community was the most informative in terms of transferability of findings back to other five communities, community strengthen and focus, and operational model of nursing services. Secondly was the community itself free of overly or unmanageable complex problem, such as crime or drugs as these would be likely to present obstacles to an effective study of women, health and work. Finally was the community of a suitable size for conducting field research (Chantawanich, 1997: 26). The 'Railway community' was selected as the research site as the above and the following refining criteria (see Table 5.1 for differentiating the six communities in abstract terms).

Table 5.1 Differentiating the six communities in abstract terms (based on data and observations)

Criteria / Community	Guardian Com.	Rental Com.	Stranger Com.	Temple Com.	Railway Com.	Joss Com.
1. Establish/Settlement	The oldest settlement & Individual migration	New Settlement & individual arrived	New Settlement & Individual migration	The Oldest settlement, 3-4 generations	New Settlement & Collective migration & Having settle for 3-4 generations	Old Settlement for 2-3 generations Individual migration
2. The Size of Community	The Biggest	Medium Sized	Medium Sized	Medium Sized	Medium Sized	The Smallest
3. Physical Environment	Good condition	Good condition	Faced Flooding, Stagnant Water & Poor Roads	Rural Style with green areas	Faced Flooding & Stagnant Water Gasoline run off & Poor Roads	Good condition
4. Women's Working Patterns	Self-employed with high percentage of primary breadwinners	Housewives & Self-employed	Housewives with no income	Housewives with no income	Self-employed & high percentage of primary breadwinners	Self-employed & high percentage of primary breadwinners
5. Women's Health	Good general & Poor mental health	Good general & Poor mental health	Good general & Poor mental health	Good general & Good mental health	Good general & Good mental health	Good general & Poor mental health
6. Women's recreation	Talking with family members & Gambling	Talking with family members & Neighbours	Talking with family members & Neighbours	Gambling	Drinking & Talking with Neighbours	Talking with family members & Neighbours
7. Family's Income when compared among low-income communities	Good income	The lowest income	Low income	Low income	Moderate income	Good income
8. Resources and Social Relationships	Keep silent in family, social problems	Keep silent in family, Migratory	Open and closed personality, Migratory	Open up & closed personality & Occupation networks & Strong kinship relations	Open & Occupation networks & Strong kinship relations	Open & Occupation networks

5.5.1 Respondent's Criteria

It was clear that most women living in this community met the criteria of representativeness.

(1) Most women were the primary breadwinners of the family (47 %).

(2) Most were optimists (93 %), although had worked hard.

(3) Most were married (83 %).

(4) The majority had primary education.

(5) 7% worked at home as housewives and received no payment.

(6) The most common of occupation was as a self-employed small business operator(40%).

(7) 30% of women became wage earners at <10 years.

(8) A large number got married at 17 years (23 %).

(9) Almost all had experience moving residence twice (47 %).

(10) 13 % drank everyday and 17% often drank.

(11) 53 % specified their health as worse than last year.

(12) Most did not seek medical treatment (80 %), and 13 % bought over-the-counter drugs for themselves and family members.

5.5.2 Community's Criteria

Railway residents revealed interesting experiences of collective community migration, as they were evicted from previous slums at other locations. After this time, more people moved into the community. Moreover, residents here had experienced some degree of hardship related to their community. Most houses in this community were built on water because it was located on low-lying land. Water from many parts of the city ran into this community and could not be drained out. The southern part of Railway was at the lowest level of elevation in the community. This part was much lower than the main road.

Coming with inflow water was rubbish and motor oil from gas stations and car garages along the main highway. In addition, the residents in the Railway community had sought help from outsiders in solving problems of infrastructure development, i.e. walkway construction, waste water ditches and community garbage bins. Besides the Railway community itself was a medium-sized community (120 households) suitable for conducting qualitative research (Chantawanich, 1997: 26). From observation it appeared, the Railway residents were open and willing to participate in data collection. They had strong kinship and occupational networks.

The following major themes emerged from the data and will be explored further through the case study of the Railway Community.

(1) How do women cope with poverty and problems encountered on a daily basis?

(2) How does their kin system assist them in developing effective coping strategies?

(3) What roles are taken both inside and outside the home?

(4) How do women on low-income perceive issues of work and health?

5.6 Conclusion

This chapter presented the discussion relating to the first phase of the study, which was helpful in initially understanding the general characteristics of women and families in impoverished communities. The outlines of the direction for next phase was also discussed. The Railway community was selected as the case study research site based on the criteria including the respondent's criteria and the community's criteria. Findings of the case study approach research will be presented in the following three chapters.

CHAPTER SIX

SOCIAL LIFE IN THE RAILWAY COMMUNITY: TOWARDS CASE ANALYSES

6.1 Community History and Activities

The Railway community is located on both sides of the main railway to Khon Kaen. The north region is situated next to the main road of the city, while the south region runs down to the bridge over the canal at the back of a middle-class community. The east border runs along a small lane parallel to the railway, which joins two main city roads. The border of the western region runs along the beginning of Railway road from North to South. The community border is a few hundred metres from the main Highway North.

The present area of Railway community is approximately 15 *Rai*[1]. All the land is the property of the State Railway of Thailand. This community occupies land belonging to the State Railway of Thailand, and land previously occupied by other slum communities (Appendix 2, Figure A 2-5).

Occupants built dwellings, there, avoiding land belonging to other community members. House owners had to develop their own land from lowland sewage dumps. Occupants used old motor cycle boxes and Zinc sheets to construct shelters and living areas. At this time, the State Railway of Thailand sent officers to warn people and instructed to move, however these failed to encourage people to leave. On the contrary, more families migrated into the community.

The Railway community quickly expanded when the families from *Soi Ha* [2] community migrated due to eviction from their former community. They arrived around 1989-90, and built permanent houses in the east, a former community vegetable-bed. In 1994, there were 68 houses in the Railway community with a population of 354.

The latest data (1998) shows 127 families in the Railway community, and a population of 764, (379 men and 385 women). On August 16 1994, the Railway community was declared as part of the jurisdiction of the municipality. An election was held for a community leader and managing committee comprising 14 community members.

6.1.1 Community Activities: Money Saving Group

This activity was established after advice from a private development organisation who worked in the community in 1994. The money saving group was open for members to deposit money with few regulations. The interest rate was 5 % per month, and the group shared the profits every three months. The regulations were as follows:

(1) Loan applications were assessed according to the appliance needs and their ability to pay the loan back;

(2) Consideration for a loan was given every 10 days;

(3) The community was divided into two zones. A member of the savings group would be allowed to borrow money following approval of an appointed committee. The zone leader guarantees the debt.

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[1] Unit of area equal to 1,600 square metres.

[2] This pseudonym has been used to refer to the previous settlement from which collective migration took place.

Plate 6.1

Housing in the Railway Community

Plate 6.2

Mrs. Pong repairing her household alongside her daughter

Plate 6.3

Grandmother Taew helps her children to keep things out of the rain

The money saving group was considering co-operating with a private organisation to strengthen the loan services. Although, it could be noted that this group provides lower interest rates on a loan, some residents cannot be a member of this group due to them lacking suitable qualification criteria. They needed to borrow money from other capital sources with higher interest rate.

6.1.2 Community Health Service Centre

This centre has support from the municipality, which provides drug supplies. The health service centre is physically located in the Railway community public hall. In the past, the municipality sent public health officers to check people's health once a month for free. If the officers were unable to treat particular patients, the chief of the community would send a referral letter to the Khon Kaen Hospital so that the patients would be treated without any charge. However this service has been discontinued, and Khon Kaen Hospital now distributes four health service units to four different parts of Khon Kaen City for people to attend.

6.1.3 The Housewives Group

Although this group has been established, they are currently no activities or projects in progress. This group was set up according to Department of Local Administration policy which aims to help members of a housewives group earn extra-money. Women in the Railway community were often primary breadwinners and also had spare time to earn extra money. This is the statement of the Head of the group.

> *"We don't have the time to run the group. The municipal officers forced us to have this group but we are too busy with our work.*
> *I think that this group will probably ran close because we too busy earning our own money"*, said Mrs. Korn, 58 years old.

6.1.4 The Group of Cultural Activity

Some groups gathered to develop their residence or the area around the community. The Southern Community was a lowland area with filthy water. 4-5 families gathered together to dig up the garbage. Most of the activities about community development were the responsibility of the community's chief and committee. The members in the community contributed labour.

In addition, community groups undertook community activity including *Tam Boon Pa Pa* (making merit by presenting robes to Buddhist monks), making merit on *Song Kran* Day, etc. Most of these activities, *Boon Prapenee* (traditional merit making) were supported by the people, according to the nature of the relationship between the family involved and other people in the community. Examples of traditional merit making activities are outlined below.

(1) ***Song Kran* Day** (ancient Thai New Year's Day) is held from 12th-15th of April each year. *Song Kran* Day is a very important part of life people amongst in the community. It is traditionally a time when descendants came home to visit parents and relatives, to greet and pay respect to the elders, etc. Celebrations would continue into the evening. The people also used *Song Kran* Day as a *Boon Koom* Day. The people in the same *Koom* (area) would join and make merit together.

(2) ***Other Traditional Merit Makings Activities:*** include the end of Buddhist Lent and *Loy Kratong festival a* Ceremony of floating miniature lotus plants made from banana leaves to thank the Goddess of the river and carry away sins and back luck.

Plate 6.4

Villagers participate in merit making (*Tam Boon*)

Plate 6.5

Grandmother Tom making a vapour bath of herb for her clients

Plate 6.6

Grandmother Lee and her grandchild

In sum, despite the fact that most villagers are poor and busy earning money, they try to follow the principles of Buddhism as much as possible. Although, some ceremonies have disappeared from the community because of economic factors and changing ways of life in town.

> *"Nowadays some* Boraan (ancient) ceremonies have disappeared, such as Boon Khaaw Chii (offering of roasted rice to monks and spirits), Boon Khaaw Pradabdin (ceremony for dead relatives), *and* Boon Khaaw Saak *(ceremony of sharing). Moreover, we now live in the city and our young generation is not interested tradition"*, said Mrs. Tom, 72 years old.

6.2 Religion

The religion to which most people adhere is the *Hinayana* sect of Buddhism; only one family followed Christianity. Religion also has an effect on people's beliefs regarding healing of patients.

Daily attendance at the monks' sermon is not a common behaviour for this community, as they lack time and there are no temples situated in the community. In contrast, rural villagers (especially the elders) attend monks' sermons very often (Nuntaboot, 1994: 85). Below is an example of one respondent's statement with regard to temple worship.

> *"I do not go to a temple everyday. I can remember when I was young and accompanied my grandmother to the monk's sermon every morning. Things have change. We have no time and need to find money. The temple is also too far from our homes. I am expected to go to the temple for every famous Buddhist ceremony day"*, said Mrs. Tom, 72 years old.

6.3 Education

Most people in the Railway community had completed compulsory education 82.0 % were able to read and write. However, a lot of women in the Railway community aged over 35 years were unable to read or write (Table 6.1), because parents in the past did not like or were to send children to school for a higher education.

Table 6.1 The number of people who were illiterate, or just a little literate (1996).

Age	Male (n=181)	%	Female (n=191)	%
Teenager (12-20)	3	1.7	4	2.1
Adult (21-35)	1	. 5	-	-
Middle-aged (36-60)	1	.5	17	8.9
Aged people (60 up)	3	1.7	5	2.6
Total (refer note)	**8**	**4.4**	**26**	**13.6**

Note:

(1) 13.6% of women were illiterate, excluding children in primary school.
(2) 4.4% of men were illiterate, excluding children in primary school.
(3) People's level of literacy was considered, regardless of the level of each person's education.

Some families had many children, and parents always chose to send a boy to school rather than a girl. They believed that a girl should help the parents work rather than go to school. Being unable to read and write affected the Railway community women in terms of the jobs that they were able to obtain. Women had no formal role in managing or developing the community. Officially only men dealt with aspects of community committees yet the women had key roles in the planning and organisation of events.

6.4 Occupations in the Community

Most people in the Railway community sold goods for a living while the second most common occupation was temporary, occasional employment as labourer, clerk in a store, or owner of a business. Popular occupations in this community are listed in Table 6.2.

Table 6.2 Men's and women's principle occupations (1996), n=375.

Occupation	Male (%)	Female (%)
Vendor at the bus station; for example, *Kaolam* (glutinous rice cooked in bamboo joints), Fermented pork, charcoal-grilled chicken.	5 (2.7)	26 (13.6)
Clerk in a store, shopping mall, gas station	13 (7.1)	19(9.9)
Painter	6(3.2)	-
Scavenger, buyer of junk	4(2.2)	3(1.6)
Tricycle or motor tricycle driver	20(10.9)	-
Plastic basket plaiter	-	2(1.1)
Temporary/occasional labour for general purpose	33 (17.9)	13(6.8)
Shop owner	4 (2.3)	10 (5.1)
Market vendor	9 (4.9)	10 (5.1)
Private business owner	3(1.6)	2(1.1)
Labour	6(3.2)	3(1.6)
Charcoal-grilled chicken wholesaler	-	3(1.6)
Laundress/laundry man	-	2(1.1)
Sausage maker	2(1.1)	2(1.1)
Government employee	3(1.6)	2(1.1)
Dress maker	-	2(1.1)
Miscellaneous(e.g. Clam seller, fermented pork wholesaler, fruit seller or barber shop owner)	-	4 (2)
Unemployed(including children, aged people, and housewives)	67(36.4)	88(46.1)
Delivery driver	9(4.9)	-
Total	**184 (100)**	**191 (100)**

6.4.1 Shop Owners

There are currently around nine groceries or food stores in the community. The groceries sold were bought from department stores or markets and resold. All family members helped one another, although mostly women were responsible for the selling. The women

Plate 6.7

Isaan sausage production

Plate 6.8

A recycle scavenger

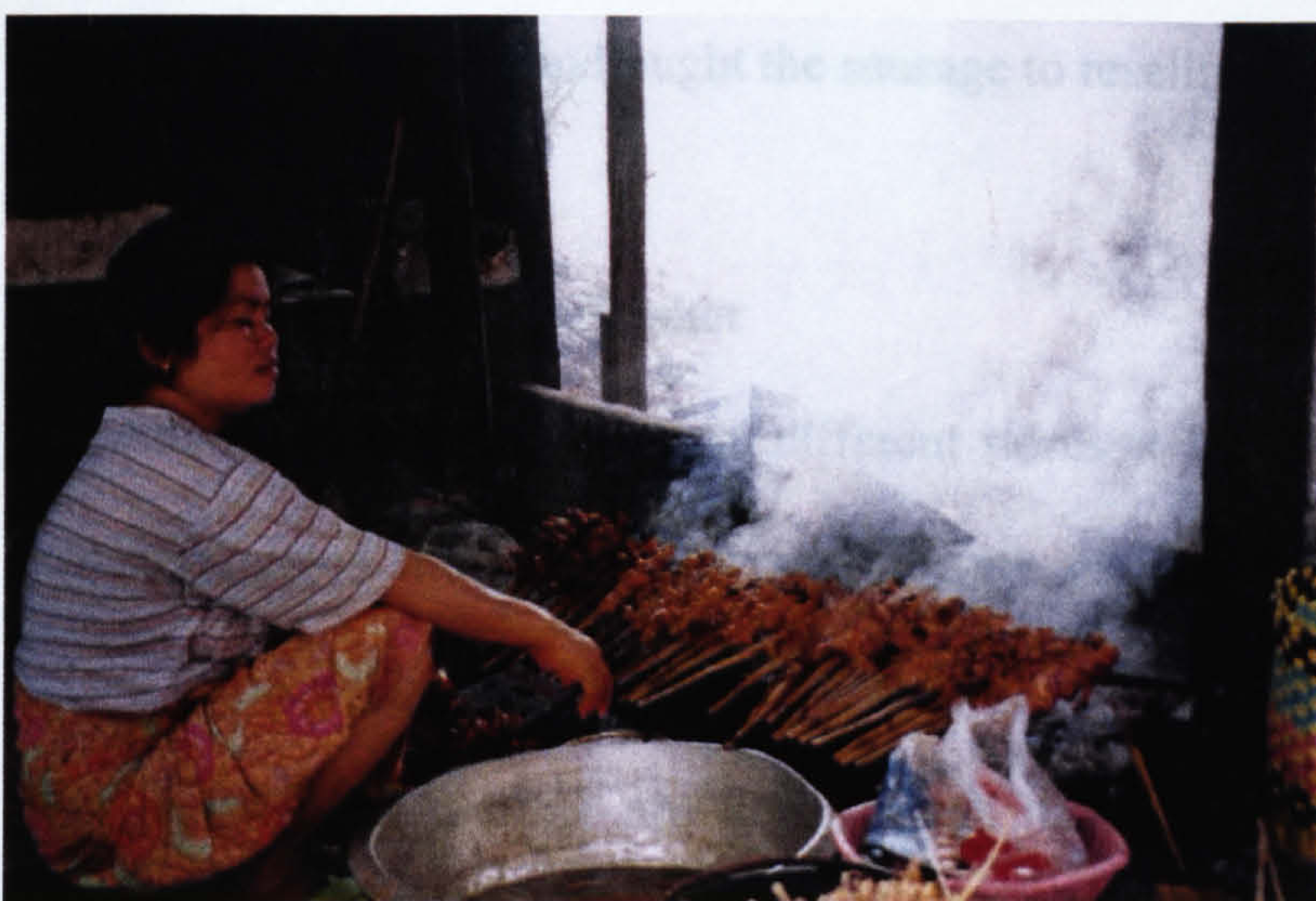

Plate 6.9

Charcoal grilled chicken production

also had responsibility for selling merchandise in the stores. Food cooked in food stores included noodles, *Som Tam* (papaya salad), vermicelli and sauce. This career paid relatively well, with the average income being around 50-200 *baht* (£ .8 - £ 3.1) per day[1].

6.4.2 Wholesaling Charcoal-Grilled Chicken

Most sellers grilled and sold chicken themselves, so got tired, sore and stiff. It was not a profitable use of time, so sellers shared duties, where the retailers would bring chicken and set the selling price themselves. Wholesaling charcoal-grilled chicken could earn 200-400 *baht* (£ 3- £ 6) per day for the wholesalers, and depended on how many chickens and entrails grilled.

6.4.3 Production of Northeastern Style Sausage

This work would start around 7 a.m. The process began by grinding meat (pork and beef) and then mixing this with streamed rice and other ingredients. The sausage would be sold at the market between midnight and 6 a.m. The average earning from sausage making was about 40-100 *baht* (£ 0.6-£ 1.6) per day. Most customers were tradespeople from other districts or villages who bought the sausage to resell.

6.4.4 Plaiting Plastic Basket

Plastic strips were bought from different stores at 10 *baht* (£ 0.2) per kilogram. Baskets plaited ranged from small to large and were sold at 10 (£ 0.2), 15 (0.23), and 25 (£ 0.4) *baht* respectively. Sometimes baskets were sold wholesale to market stalls. Or sometimes sellers traveled to other provinces to sell their goods directly. The career of plaiting

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[1] Where earnings are quoated these have been derived from observations and interviews.

baskets suited the lifestyle of people in the Railway community who wanted to get income by making the most of their free time.

6.4.5 Scavenging

Scavengers could sell many kinds of paper, glass bottles, plastic bottles, different kinds of plastic and metal. Scavengers would search for junk using a tricycle or cart. Work began at 5 a.m. when scavengers would search for junk from bins, garbage heaps, or would buy it from houses and stores. Junk would be sold to shops in the bus station. The average income was 50-150 *baht* (£0.8-£2.3)per day.

6.4.6 Labouring

A construction worker's duties included mixing cement, carrying cement, carrying pieces of wood, gathering chips of wood and scrap iron. All these things were done by women. Men would work in a higher position, as carpenters or masons. The average income for male labourers is 120-200 *baht* (£ 1.9-£ 3.1) per day, depending on the kind of work. The average wage for female labourers is 100-130 *baht* (£ 1.6- £ 2) per day. This work was temporary, and during the periods when there were no jobs labourers would find other work.

6.4.7 Taxi-Tricycle (*Samlor*), or Side-Carriage Driver

These workers are predominantly male. There are different kinds of vehicles, including tricycles with carrying tray, and covered tricycle. The average income per day was about 50-200 *baht* (£ 0.8 - £ 3.1). Most tricycles belonged to the drivers.

Plate 6.10

Mrs. Noi plaiting plastic baskets

Plate 6.11

Mrs. Rauy and her fresh fruit motor-cart

Plate 6.12

Mrs. Kai making Naem Klook, Northeastern style food

6.4.8 Bus Station Vendors

This was another popular career within the community and workers maintained an informal occupation network. Most workers were women. Vendors sold *Kaolam* (glutinous rice cooked in a bamboo tube), fermented pork with fried rice loaves, charcoal-grilled chicken, fruit and drinking water. The average income per day was about 50-200 *baht* (£ 0.8 - £ 3.1).

6.4.9 Occupations Undertaken Outside Khon Kaen Province

By and large, the people in the Railway community liked to work in Bangkok and other provinces outside the Khon Kaen area. Common careers were sales-clerks in a store or a shopping mall, workers in a factory or company, labourers, Housekeepers or car mechanics. Most income was paid monthly, with an average of 3,000-6,000 *baht* (£ 46.9 - £ 93.8) per person. Average periods of employment ranged from three months to over five months. Most of these workers were women between the ages of 17-37. People in the community also aspired to work overseas as housekeepers or waiters in European countries. The income for this type of work was about 15,000-40,000 *baht* (£ 234.3 - £ 625); and people would send remittances to their families.

People in the community are primarily employed as unskilled workers and earn a living on a day to day basis. It is noted that the majority of middle-aged women worked as vendors and sellers whereas girls and boys worked as sale-clerks in shops and petrol stations. Men worked as temporary employees.

Plate 6.13

A tradeswoman at a street

Plate 6.14

Food vendors at a bus station

Plate 6.15

Tradeswomen at a market

6.5 Strategies for Coping: Managing Money

Generally, the income of the people living in the Railway community fluctuated from day to day, and from year to year. If the country's economy was going well in any year, trades women or people involved in temporary employment would then have good incomes. Changes in economic conditions directly affect the poor, since these people usually do not have any savings or resources to draw upon when crises occur.

When the economy was going well, these people would keep real property in the form of electrical instruments, appliances for the home such as televisions, refrigerators, fans, stereos, electrical rice cookers, motorcycles, or gold ornaments. But when they lack money, some of these consumables or material possessions would be pawned to obtain ready cash.

In the Thai family, though husband and wife engage in separate productive activities, their income is pooled. Children usually contribute part of their income to the household and save some for individual expenses (Lapanun, 1993: 89). Such pooling of resources in this community were similar with a key difference namely: that husbands were unable to find enough money to provide for their families. They claimed they would give money to their wives if they had more. The main responsibility for household expenses fell on the women who found possible loan source in times of financial difficulty.

Some important expenses in this community are outlined below:

(1) Expenses for food and children's education was about 100-300 *baht* (£ 1.6 – £ 4.7) a day, this expense included all the household essentials and clothes for

family members;

(2) Expenses involved with food vending included purchase of raw materials and selling equipment.

(3) Electricity costs ranged from 200-1,500 *baht* (£ 3.1 - £ 23.4) a month;

(4) Water supply costs ranged from 50-500 *baht* (£ 0.8 - £ 7.8) a month;

(5) Expenses for debts such as refrigerators, fans, televisions, or stereos (and in this case there would be an agent from the company to collect the debt every month) could total around 500-2,000 *baht* (£ 7.8 - £ 31.1) a month, depending on the kind of electrical instrument.

(6) Expenses of previous debts usually involved a 20 percent interest rate, and creditors would collect between 20-100 *baht* (£ 0.3 – £ 1.6) per day.

(7) Expenses for a loan from the community money saving group, included an interest rate of 5 %. A borrower had to pay both the principal loan and interest rate in a one-month period.

(8) Other expenses involved unforeseen circumstances, and people would usually have small amounts of money in reserve to use for donations as part of merit-making activities (5-10 *baht* or £ 0.08 - £ 0.2).

6.6 Debt and Credit

Living on a low-income brought with it the threat of falling into debt and gambling. There were two forms of falling into debt: by borrowing money and by buying things on credit. With little or no real property it was almost impossible for the people in this community to borrow money from official money lending facilities.

A person could borrow money from a creditor both inside or outside the community. Besides the direct borrowing, which usually had a 20 % monthly interest rate, there was another form of borrowing called '*Len Chae'*. This means borrowing from a lending group to which one was a member. The word '*Chae*' comes from the English word 'share', and '*Len*' means 'playing'. For example Mrs. Mai was a 'banker in a *Chae* party', she would gather some members in a group called '*Wong*' (circle). Mrs. Mai set up a monthly *Chae* group with each share being 100 *baht* per person. There were 12 people in the group so that it could run for exactly a one year period.

In the first month the banker (Mrs. Mai) would get all the money which was 1,200 *baht* without any interest because she was the group administrator. In the second and subsequent months an auction was held to see who would get the next 1200 *baht* The auction was done by secretly by writing the interest rate each member was willing to pay on a piece of paper. The one who offered the highest interest would get the money. So when Mrs. Toy offered to pay interest at 30 % she got the money. At the next *Chae* meeting Mrs. Toy had to bring her own capital of 100 baht together with the interest of 360 *baht.* The interest was then divided among all the group's members except Mrs. Mai and Mrs. Toy. Next month those who had not received the money participated in the bidding and the cycle went on like this until 12 months had lapsed. Therefore, the group members were able to borrow money from one another and get some monthly interest as profit. But sometimes there was a problem of '*Nee Chae*' (running away from the *Chae* group). This was when a person got the money and ran away from the group, and never came back. The person who ran away from the '*Chae*' group might be the banker or a member. It meant that the banker had to take responsibility for a member who ran away. Additionally, many *Chae* groups collapsed when the banker ran away with the money.

Another way of incurring debt was to buy things on credit. Representatives from well known companies would bring many kinds of electrical appliances in the back of their pick-up vehicles. Using loudspeakers they would let the community know what they had to offer; usually televisions, fans, rice cookers, stereos, radios, or sometimes a washing machine. If anyone did not pay the installment on time, the merchandise would be reclaimed.

When people are very poor this pattern of credit buying is the only way they can purchase items for their homes. The merchants provided a necessary service but at a high cost.

6.7 Gambling

One result of poverty that led to further poverty was gambling. There is a government-sponsored lottery in Thailand and also an illegal lottery. The illegal lottery '*Hyua Ty Din*' (Underground lottery) is a kind of gambling in which the participants from the community, liked to participate. An illegal lottery number could be bought from agents in the community, there were two of them: a man and a woman. They sold two and three digit numbers. If the three numbers that a person bought were the same as the last three digits of the first prize of government lottery, even if the three-numbers were not arranged in the same order, the person won a prize. He or she would get 70 *baht* (£ 1.09) for each 1 baht he paid for the two-digit number, 500 *baht* (£ 7.8) for each 1 baht he paid for a three-digit-numbers, and 100 *baht* (£ 1.6) for each 1 baht he paid for the '*Tot*' any combination of the three-digit-numbers.

Buying a lottery was another condition that brought the housewives to '*So Ray*' (talk) about the lottery numbers they should buy. Generally people would buy illegal lottery numbers at more than 50 *baht* (£ 0.8) a time. The numbers they got were always from the interpretation of their dreams or the numbers might be from a monk who gave lottery numbers indirectly, or even from the numbers of a license plate of a car involved in an accident on the road. And they would tell others as an exchange.

When the participants were asked "*Why do you like to play the lottery?*", all of them would laugh either out of shyness or with shame, and reply "*I want to be rich.*" "*I might get lucky.*" "*It is a hope of the poor*". "*The poor play the lottery, the rich buy stock.*" "*It is fun, I can wait for the results with excitement.*"

The participants said that when it was close to the lottery announcement day they would feel very lively and hopeful that the number they bought would bring lots of money. While the field work was being done, there was very little news about people winning a lottery. Sometimes a person got only 1,000 baht from the lottery and spent 500 baht on a celebratory feast. It was part of their happiness and recreation to eat and drink as much as they wanted because it was 'free' money. They never thought that there had been many times when they invested in the lottery and had lost all their capital.

6.8 Alcohol and Parties

There were always drinking parties going on in the community. Drinking parties are not gender segregated, men and women with their friends drank together. Sometimes they ate dinner while drinking. The children in the community saw the drinking parties and were

used to them. They had a chance to taste alcohol on special occasions such as '*Songkran festival*' (Traditional Thai New Year). The children would join the drinking party and asked their parents if they could taste some *Shiang-Chun* (Chinese whisky), which was a 35 degree arrack. The adults poured some arrack for the children who waited in line to drink about 0.5 cc. each followed by water. When the first round had passed, the children would stand in line for a second and third round until their faces turned red. Then their parents would stop them from drinking. One mother said:

> *"Let them drink some, soon there will be a dance so and they will be alert. These children are good at dancing. They have been able to drink alcohol since they were young. When they drink alcohol, they become so happy and dance to the music vigorously"*, says Mrs. Mai, 35 years old.

The informants were asked why the people here like to drink a lot, They drink everyday, sometimes a lot, some times a little, depending on the occasion, both women and men. However, most of the alcoholics were men. Mrs. Peng, 66 years old, talked about this:

> *"We work hard, it is tiring work, so we take a rest by drinking alcohol. When there is a festival we will drink a lot of alcohol in order to have fun. If everyone gets bored and just sits still, the festival will not be fun. When there is no festival we still drink a glass or two of alcohol, just to eat well and sleep well and soundly. When we wake up we will not get sore and stiff, and we can keep on working. The cycle goes on and on this way".*

A question was asked in the focus group on how alcohol or having parents with alcoholism affected a family and the children in a family. The following answers illustrate some of their concerns.

> Mr. Tah, 25 years old, *"It had a big effect, when I was young my mother gave My father some money to buy food, it was about 40-50 baht. But when he got to the market he spent the money on alcohol. He had only 5 baht left and brought only some coriander back home. When he came back my mother scolded him. She was moody and hit us with an electrical wire".*

> Mr. Khiew, 25 years old *"It gives the children an inferiority complex, and we become sarcastic. We think that if our fathers can drink, why can't we children drink too? So we drank. I have been drinking since I was 15 years old, and I*

drank every day ".

A male NGO officer who had been working closely with the people in the slum for more than five years gave his opinion. He stated that these people drank alcohol and danced in order to compensate for their daily suffering. It looked like they were living a meaningless life day by day, but if we would understand, it was all a kind of strategy for coping with poverty. They were always looking for a chance to 'have a feast', such as a birthday, the day they win a lottery, the day they win a bet on a football match, the day of the railway spirit worship. These Thai people are 'pleasure loving', so when somebody comes back from somewhere, he would always be asked '*Muan Bor*' (Was it fun)?

People in the community relaxed by watching television together, talking in-groups, and having something to eat with friends or playing cards. They listened to radio music or tapes. Women and children loved watching soap operas on television. Men preferred sports programs like football and boxing which they also gambled on. As for going to a park, going to the movies, going shopping or going to a concert; these were not their usual habits, except on really special occasions.

Thus it can be concluded that alcohol was a main form of recreation which although potentially harmful to their health did provide a means of coping: by sitting together, talking, sharing problems and other activities as a community.

6.9 Family and Kin

Members of the Railway community had followed traditional views of marriage, in accordance with Northeastern Thai beliefs. After the wedding, the couple would stay with the wife's family for 1-3 years until they could afford a new house of their own. Most of the time, the new house was built close to the house of the bride's family. There were occasions when a bride had to move out and stay in the husband's house. The moving was related to work and the suitability of the place to live.

Most of the family structures in the Railway community were extended and nuclear families. An extended family could help family members to have a high level of support, including dependence in terms of income, expenses, labour, and other resources. The head of a family who was old and could not work would help with housework, taking care of and supporting children. The head of a family who could work would earn some income for the family. A housewife would work and earn money to help the family, find jobs for family members, take care of the family member's living conditions and raise the children. Children would work and earn some income from an early age. For nuclear families, all family members would help one another to work and earn an income. This was more common than in extended families, because members of an extended family were busy as labourers in the informal sector.

It was noticed that it trended to be less nuclear families than extended families due to the present poor state of the economy. Although living together in one area in the community is limited, it is difficult to expand and build new houses within the community because it is crowed and narrow.

In addition to previously mentioned marital situations, married couples had relationships with family members who were living in another province. Relationships between the relatives were made close by regular visits and helping with labour. As an example, a son-in-law from the Railway community would frequently help his wife's parents with farming. There would be financial assistance or exchange of goods or services when either side was in trouble. This would help keep the relationship of both sides close.
Lineage played an important role in developing the community in terms of the environment, health, and assets of the people and the economy. They provided help in finding jobs from different sources and developed the general condition of the community. They also played a role in politics and the control of the community. Because these groups had the power to elect group members to join the community's administration, they had the ability to manage almost all community affairs.

Relationships within wider family units were generally good with each member having a close relationship and a high level of dependency. They trusted one another, exchanged resources, talked, and gave advice to one another, and helped one another. When somebody was sick, relatives would give advice and suggestions related to healing, provide financial assistance, etc. When a group member was in trouble, they would help by lending money without asking for any interest, or with a very low interest rate and no due date. There were occasional problems, which did not last long, and people generally lived in harmony.

Besides the relationship within the extended family, there were other close relationships between other extended families in the community. The community members of each area had good relation, good unity, good harmony and helped one another more than they did

the members of another area. For example, the members of the east area had a close relationship with their group more than with the member of the north area and the south area, because they had known one another for a long time and their houses were close together. As for the north area, most of the members lived in *Soi Ha* before, so they had been close to one another before, and most of them had known one another for a long time. These were only some people in the south area who had lived closely together since they first came to build the houses in the community.

There were six large families in this community: LT, KK, PP, BJ, KP, and MS family. These six families migrated from *Soi Ha,* together, because they were driven away from land belonging to a group who planned to develop a shopping mall. They had been close since the time when their grand parents migrated to Khon Kaen to find a job, and mostly came from *Nakhon Ratchasima* province. The people in this community were from one of the oldest communities in Khon Kaen. Even though they had recently moved to the present place, they had been living in Khon Kaen for as long as half a century. They shared similar lifestyles, traditions and customs. Furthermore, five of the six families (except the KK family) shared a kinship through marriage amongst family members.

Isaan society is based on kinship. It can be concluded that kin relationships in the family and in the community are regarded highly according to religious teaching and culture.

6.10 Constructing the In-Depth Cases within the Community

To explore women's roles, health, work and family care, a series of in-depth studies were carried out. This section presents an overview of the respondents and key informants in

order to inform the case analyses in the next two chapters. Chapter seven and chapter eight presents and discusses the themes, which emerged during these case studies.

The following tables present an overview of the key informants, the families and women studied. Table 6.3 lists key-informants who had been working or dealing with the community. They know it very well but do not necessarily live in the community. They provided the initial information related to the women and the community and helped to locate case studies. They were also able to provide specialised information about the community culture. The key informants selected consisted of a group of community administrators, an elderly group, and health volunteer group, a government workers and a non-governmental organisation officer. Table 6.4 lists general informants. This group comprised men, women and children in the community aged between 8 and 67 years who provided data relating to ways of living, women's work, family responsibilities and the people's health experiences. The general informants also directed the researcher to particular families. Table 6.5 provides details of key family case studies including families of women who had experiences of hard work and health problems. They were able to provide detailed information as insiders about their own experiences of work and health. Participants were recruited by introduction via the key or general informants or even one community member, assuming that they met the required criteria.

Table 6.3 List of Key-Informants (n= 12)

Case Number	Age/ Sex/ Marital Status/ Educational level	Occupation
1. Luuk-orn (Id 06-07-98)	19: M: S: M3	Herbaceous shop keeper
2. Jod (Id 09-08-98)	25: M: S: P5	Undertaker
3. Di (Fn 26-05-98)	50: F: M: P4	Housewife
4. Kowit (Fn 28-05-98)	36: M: M: M6	Non-government officer
5. Orn (Id 02-06-98)	46: F: M: M3	Health volunteer
6 KruYai (Fn 26-05-98)	38: F: M: Bachelor	Principal/ Teacher in school
7. Mawyai (Fn 02-05-98)	48: F: M: M.D	Medical Doctor
8. Mawsu (Fn 26-07-98)	42: M: M: M.D.	Medical Doctor
9. Mawtia (Fn 26-07-98)	42: M: M: M.D.	Medical Doctor
10. Somkit (Fn 27-07-98)	46: F: M: Bachelor	Nurse
11. Mawnoi (Fn 26-07-98)	30 :M: M: Bachelor	Nurse
12. Jit (Fn 07-05-98)	33: M: M: Master	Municipal officer

Table 6.4 List of General Informants (n= 19)

Case number	Age/ Sex/ Marital Status/ Education Level	Occupation/ Birth-Place
1. Pew (Id 26/2-06-98)	55: F: M: No	Food Vendor/ Nakhon Ratchasima
2. Tum (Id 04-07-98)	36: F: M: No	Labour/ Khon Kaen
3. Ratri (Id 25-06-98)	48: F: M: P4	Housewife/ Khon Kaen
4. Lee (Id 13-07-98)	67: F: M: P4	Housewife/ Nakhon Ratchasima
5. Nui (Id 17/1-07-98)	38: F: M: P3	Labour/ Yasothorn
6. Sri (Id 19-07-98)	50: F: M: P4	Recycling Scavenger
7. Nang (Id 18-07-98)	17: F: M: M3	Unemployed/ Khon Kaen
8. Tien (Id 26-06-98)	46: F: M: P4	Wholesale for *Isaan* sausage/Khon Kaen
9. Jaab (Id 08-07-98)	56: F: M: No	Recycling Scavenger/ Buri Ram
10. Yainoi (Id 28-07-98)	56: F: W: P4	Grocer, Basket worker/ Khon Kaen
11. Little Kai (Id 18/1-07-98)	13: F: S: P6	Pupil/ Khon Kaen
12. Ormky (Id 10-08-98)	22: F: M: P6	Housewife/ Khon Kaen
13. Little Nong (Id 12/1-08-98)	11: F: S: P4	Labourer/ Khon Kaen
14. Pen (Id 17/1-08-98)	29: F: M: No	Recycling Scavenger
15. Taewtai (Id 03-08-98)	49: F: M: P4	Labour/ Kalasin
16. Pan (Id 26-07-98)	61: M: M: P4	Intermittent Labour
17. Duan (Id 27-05-98)	62: F: M: P4	Food Vendor
18. Little Joy (Id 12/2-08-98)	8: F: S: P2	Pupil/ Khon Kaen
19. Jek (Id 08-08-98)	22: F: M: M3	Private business employee/ Khon Kaen

Note: No = No formal education; P4 = 4 years in primary school; P6 = 6 years in primary school
M3 = 9 years in school; F = Female; M = Male / Marital
S = Single; W = Widow

Table 6.5 List of Family Case Studies (n=18)

Family case number/Original home town	Interviewees	Age/Sex/Marital Status/Education	Family member numbers	Occupation
1. Wiangtai/ Mahasarakham	Wiangtai (Id 02-07-98) Aom (Id01-07-98)	49: F: M: No 23: F: M: P6	4	Vegetable Vendor Former Prostitute
2. Chuli/ Khon Kaen	Nang (Id 13/1-07-98)	51: F: M: P4	4	Housewife
3. Palow/ Nakhon Phanom	Nib (Id02/1-07-98)	46: F: M: P4	4	Food Vendor
4. Wiangjun/ Khon Kaen	Wang (Id 24-06-98) Nangnoi (Id 05-08-98)	41: F: M: No 23: F: S: M3	9	Wholesale grilled chicken Employee
5. Rok Tub/ Nakhon Sawan	Pensri (Id 15-07-98)	51: F: M: P6	5	Recycling Scavenger
6. Noodles/ Khon Kaen	Peng (Id 26-06-98)	66: F: W: No	7	Chinese noodles/ Laundry
7. Baowan/ Khon Kaen	Koon (Id 27-07-98)	55: F: M: P2	5	Housewife
8. Yailom/Nakhon Ratchasima	Tom (Id 03-06-98)	72: F: W: No	3	Food Vendor
9. Pongmong/ Chaiyaphum	Pong (Id 25-07-98) Khiat (Id 25/1-07-98)	31: F: M: P6 35: M: M: P4	4	Food Vendor
10. Sawsod/ Mahasarakham & Samuthsakhorn	Maew (Id 27-28-05-98, 17-07-98) Daeng (Id 30-05-98, 07-07-98)	35: F: W: P4 46: F: W: P4	1/2	Food Vendor Tradeswoman
11. Fruits/ Khon Kaen	Ruey (Id 08-07-98)	34: F: M: P4	4	Fruit Vendor
12. Laow/ Khon Kaen	Korn (Id 20-07-98)	58: F: M: P4	3	Small whiskey shop
13. YaiYang/ Khon Kaen	Ari (Id 26/1-06-98) Wang (Id 17-08-98) Yang (Id 09-06-98)	43: F: M: P4 46: M: M: P5 65: F: W: P4	4	Tradeswoman Intermittent labour No occupation
14. Yam/ Nakhonsawan	Sa-ad (Id 22-06-98) Gium (Id 15-08-98) Miew (Id 12-08-98)	65: F: W: P4 37: M: M: High school 33: F: M: Vocational school	6	No occupation Government employee Government employee
15. Kaiyang/ Khon Kaen	Pui (Id 07/2-07-98)	44: F: M: No	5	Wholesale for grilled chicken
16. Sapai/ Mahasarakham	Tad (Id 09-08-98) Tui (Id 07-07-98)	20: F: M: P6 45: F: D: P1	5	Labourer Housewife

Family case number/Original home town	Interviewees	Age/Sex/Marital Status/Education	Family member numbers	Occupation
17. Jeng/ Nakhonratchasima	Jeeb (Id 01-08-98)	54: F: M: No	5	Tradeswoman
18. Taaloi/ Nakhonratchasima	Taew (Id 21-06-98)	60: F: M: No	7	Labourer

Case Analysis: An holistic analysis was applied to attain an understanding of the experiences of women with very high workloads who supported their family whilst still living in poverty. As mentioned in chapter three, in-depth interviews were audiotaped for transcription and analysis in order to gain an understanding of the experiences of these women. Data was analysed using procedures adapted from Colaizzi's and Van Manen's methods (Beck, 1994; and Streubert & Carpenter, 1995). Significant statements were extracted from transcriptions, and each unit of information was compared to previous units. As analysis progressed, distinct themes emerged and five broad themes were identified (Table 6.6).

Table 6.6 Themes and categorised clusters from the women in the Railway Community.

Themes	Categories
1. Life is work and effort	-Working from childhood to old ages -Health is the lowest priority in life -Living from day to day
2. Sacrifice to family	-Myself is belonged to family
3. Feeling the impact	-Loss -Hopelessness, or no hope for the future depression -Helplessness-no way to escape -Feeling inferior and luckless
4. Ideas of escape	-Burden of family and mother role
5. Resolving/coping	-Venting anger on children -Escaping- alcohol, humour and talking -Self-control for children's sake -Reliance on religion

As analysis continued, previous units of information were compared to new units in both similar and different categories. Moreover, theme clusters were further synthesized into categories. Findings were integrated into a comprehensive description of women's experience (Denzin, 1970). The themes were then validated by referring back to original protocols to note if the protocols contained anything not accounted for in the themes (Letvak, 1997).

The holistic approach had a significant implication for the fieldwork. Focusing requires that the investigator gained enough rapport and trusted from the participants. Preliminarily analyses were carried out in order to identify additional information to fill in any gaps. There were four reflected ways of sorting and interpreting data. Firstly, domain analysis, which addressed the following: "What and why do women demand this?" Secondly, taxonomic analysis, where questions such as: "What are the differences between each woman's experiences?"; "Who are those family members that respond to this activity?" and "Who are those that demand it?" were considered Thirdly, componential analysis, in which questions such as: "In which situation will they demand and not demand this?" Finally, thematic analysis, where the major question: "How important and significant are the relationships between those who demand and those who respond in terms of individual (woman), family and community mobilization in the past, present and future?" governed the analysis.

6.11 Conclusion

Basic information about people and their daily lifestyle in this low-income community illustrates their attempt to struggle to survive, having to work hard just to make ends meet.

They attempted to incorporate knowledge and experiences from the outside world to support their traditional knowledge. Above all, traditional values were highly respected in order to maintain relationships in the family and community. In fact, kin relationship was essential for community peace and existence. The next two chapters present detailed case analyses of women in the Railway community.

CHAPTER SEVEN

WOMEN LIVING AND WORKING IN THE RAILWAY COMMUNITY: FINDINGS FROM INTERVIEWS

This chapter is concerned with family women's way of life, as workers and family providers in a slum context. To explore the 'How' and 'Why' of women having different experiences of working and livng, I conducted case studies of a Railway community whose villagers have migrated together and lived together for four generations. Although there is a lack of written documentation, they share aspects of social and family structures of long standing.

7.1 Women and Family

Women in this lower-class community were in a state of poverty. They worked as either manual labourers in agriculture or factories and/or as self employed vendors. Their life was busy '*Ha Yoo Ha Kin*' (working and earning a living). The women's way of life was complex and involved responsibility for their children, their husbands, their extended family, their work and themselves. Most of the women lived their lives in an occupational network where they could share experiences with one another and provide support. The following themes are presented to illustrate this complex lifestyle in a low-income community.

7.1.1. *Lai Phua, Lai Mia* (Many Husbands - Many Wives)

All of the participants in this study had experienced a broken home. There were many levels of broken home: the informants themselves, the informants' parents, and the informants' grandparents.

Plate 7.1

Railway and houses

Plate 7.2

A railway: a place for rest and chat

Plate 7.3

Stagnant water after the rains

When asked "*What is the thing you want most in your life?*", the participants aged between 10-25 indicated that the thing they wanted most was 'family warmth'. Most of the women and also men then had had more than one spouse. It is customary in lower class Thai communities for men and women to live together as a married couple but without the formality or legality of the marriage ceremony.

The reason that a woman had to have a new husband when the first one passed away or left her was that she was pressured by her parents and society to find a new man to protect her and her children, in the participants' words :

> *"These two children are not from this husband, this one is his child. My former husband left me for a new wife, he said the new wife was richer than me,she is a dress maker. My husband left me when the second child was an infant, so he has never known his father. Then my parents made me marry a new husband so that the new husband can help me raise the children. But since I married him, he always scolds my children. I am sorry about it but I have to endure. "* says Mrs. Pen, 29 years old with three children.

> *"It is hurtful to talk about my husbands, the first was such a drunkard that we finally left each other. He never worked. The second one was even worse, he drank a lot and took amphetamine. He had another wife and had a child with her. He did not have a child with me because I had already been sterilised after my first two children. So now he lives with her. Now I am old, but I am afraid that I may be lonely without any companion when I am older. Actually I want to have another husband, there is a man flirting with me, but then again, he already has a wife.*" says Mr. Tui, 45 years old with two children.

As for the effect on the children in a family with a new father, such broken families affected the children very much. However, no family in this community consisted of a stepmother and stepchildren, because when a man left he went alone. Often children felt that a new father did not love them like he loved his own children as is reflected in the following statements:

"I want my mother and the new father to love me like they love their child, Ei Nang. My new father doesn't love me as much as he loves Ei Nang, and my Mother likes to hit me. She says that I am stubborn.", says Little Joy, 8 years old.

"When my mother had a new husband I and my younger sister had to live with our aunt. We cooked charcoal-grilled chicken to sell with our aunt when we were young, we were not close to our mother. But when I grew up, she came to live close to me. So I let her depend on me sometimes as it should be, because I am her child. But deep inside I feel that I have a inferiority complex", says Mrs. Wang, 41 years old.

Thus it can be concluded that '*Lai Phua, Lai Mia*' is a phenomenon which coexistss with poverty. Poverty and the struggle for family survival contributed to the need for women to get married again and again because they thought it would improve their lives. From the evidence gathered from the family groups studied it appeared that every marriage ended the same again and again. It was a cycle of poverty and the need for security and protection, the outcome of which effected all members of the family.

7.1.2 Women's Roles in Family

From the result of the study of slum women' s roles and functions, they played a crucial role in both the external social system and internal family functions. In the household the woman had the role of mother and wife. Each role could not be completely separated from the other, nor could it be separated from the external role of breadwinner and wage earner. All of them overlapped as is the nature of human subsistence in which everything is mixed harmoniously.

(1) '*Pen Mae*', Motherhood

The word '*Mae*" is considered a significant word in Thai society. '*Mae*' means a person who gives birth and life to others which is the highest kindness in Buddhist belief, and the *Isaan* moral precept that children must return this kindness (Intarakumhang, 1994).

From the evidence gathered it was found that 'love and warmth' from parents appeared to be what participants wanted most in their lives. Some interviewees said that they had experienced a lack of love and warmth from their parents and they did not know how to express love to children.

Past experience and memory of how they had been treated and acted towards, influenced the way they treated their children. They were very sorrowful that they hit their children, as implied by Mrs. Tad, who was 21 years old, that when she was young her step-father always hit her. Now she had a child who was 2 years old. She also felt sorry and guilty about hitting her child and said:

> *"I want to give my child everything as much as I can because I want him to be a good person and get a high education because I have a very low education. I try hard to tell him. As I have a quick temper, when I teach him I always get angry and unconsciously hit him ...After I hit him, I always apply ointment while telling him that I am sorry."*

In addition there were some participants who insisted that they were affectionate in the role of mother and grandmother as Mrs. Tom, 72 years old, said :

> *"I raised all of my seven children by myself. My husband died 20-30 years ago. My mother-in-law is now 92 years old. She has stayed with me since I was 20 years old. Can you imagine, it is 52 years all together that we have stayed in the same house ? All of my children have jobs and can help each other. At present I have to bring up my grandchildren because both of her parents died. I pity my grandchild, I don 't know who will take care of her when I die "*

'*Mae*' has to provide family members with basic requisites such as food, clothing, shelter and health remedies. In the past, according to traditional perspectives, the grandmother was considered to be the head of the family (Fein, 1978; Khannengsukkasem, et al, 1997; and Mc Adoo, 1993). In this community, wives played an important role as provider, and surprisingly, primary breadwinner of their family. The following was stated by a woman

who was 43 years old, had three children, and whose husband was a taxi-tricycle driver before he had an accident and got a serious injury on his shoulder. After he was completely cured he dared not ride a tricycle on the road anymore.

> *"I carry much burden indeed. It is me alone who takes care of everything. I have to support my family. If I died, the family would be broken and completely demolished. I support everything in this family. I have to borrow money from other people to invest in selling things. If my goods do not sell well and I do not have money to pay off my debt, I have to avoid meeting the creditors. I was born to pay back a sin. My life is so harsh."*

The role of mother extended into old age even when their children had their own family. They still came back home and asked for support from their mother, for example; Mrs. Duan, 62 years old, who was a food seller, talked about her children:

> *"I think I have supported my family long enough. However, I still have to sell food to support my children. If I don't sell food, my children will have no one to give assistance to them when they have (money) problems. Every child still comes to me to this food center. They are all poor and have never made enough money to support their families."*

As mothers of families, these women took the responsibilities in taking care of family members, to help them to be healthy. This involved vaccination, caring for the sick, allocating money for medical expenses, adapting ways of life to be more standard, and promoting family members' health. For example, Mrs. Di was 50 years old. Her husband had been sick from cirrhosis for several months. She had to stop selling food which she usually sold in order to take care of her husband. She talked about this:

> *"I stopped selling food to take care my husband who has cirrhosis. I do not think he will get better, but wait for the last day of his life. I have no money because I stopped selling things. In fact, my children give me some but I feel uncomfortable about that."*

(2) *'Pen Mia'* **or As a Wife**

The cohabitation of a man and a woman were mostly from their determination to stay together; they decided to stay together because they loved each either. From the study, It was found that there were 31 couples who indicated that they loved each other before living together, and only one couple mentioned that they met each other only one day before having sexual intercourse and have been living together for about 30 years. Three couples stated that they did not know or meet their husbands before the wedding ceremony. Matchmakers went to their house and ask for a hand of a girl in marriage.

Men talked about their wives being jealous, and did not want them to have a good time drinking. The nature of conjugality in this community was unique. Gender aggression came from the women rather than the men. The women chased and hit or slashed their husbands. Regularly men who had head injuries could be seen around the community. Some women said that scolding and hitting their husbands and children was one way to calm themselves down and to cope with stress.

Most of the household work fell to the wife who had to do everything before leaving to go to her paid work. Mrs.Ari said that:

> *"I have to do everything alone. In the morning, I have to get up very early and hurry to do house chores like cooking rice, preparing food, goods to sell at the bus station, and then go to sell at the workplace. When I get back home. I have to buy vegetables, meal or ready-to-eat-food to take back home. I have to do our laundry".*

In the families studied about a third of men (36 %) of all potential men (8 cases out of 27 cases) gave all the money they earned to their wives to manage the household and spend on the family. Other men occasionally worked as laborers and spent all the money they earned on their personal business, or they might give some money to their wives when

Plate 7.4

Cooking: a young girl's role

Plate 7.5

Women and families

Plate 7.6

Popular whiskey

asked for it. Normally the money their wives gave them was much more than they gave their wives. Mr. Pan who was 61 years old was in a good mood while talking about managing household finance said :

> *"I rarely go to work I sometimes ask for money from my wife, or if I am completely broke, I will work for hire. It 's sure that my wife would scold me when I ask for money from her. But if I stay claim and quiet, she will pity me, give me some money".*

(3) '*Pen Luk Sao*' or As a Daughter: Sacrifice to Family

> *"I belong to my family"*

A common trait of *Isaan* (northeastern) women is their loyalty to the family. From a young age, girl is taught to stay home, take care of the family, and be responsible for the housework. *Isaan* people believe that "*Women are to stay, men are to go*". *Isaan* girls learn this from her mother, older sister, aunt and grandmother, through things that are taught and by example. When the family was in trouble or lacked sufficient money it would cause a girl to feel guilty. An interview with Mrs. Wang, 41 years old, revealed:

> *"When I was young, I didn't know of the benefits of study. When I grew up, I knew how things were and I felt bad about myself, but it was too late. So I didn't study, I can't read, I can't write. My parents didn't study either, they might not know have known the benefits either. At that time I was baby-sitting and I gave all my money to my mother. During my childhood, I never knew what fun was, I never went to play. I only worked for money".*

These children did not have any aspirations to study, and did not understand why they had to study and what the benefits would be. *Nong* explained why she did not want to study:

"I don't want to study. E Mae (mom) took me to three schools to take a look because she wants me to change the school if I don't like my previous school. But I jumped out off the tricycle and ran away. I deplore E Mae's situation and deplore Ai Beer and Ai Earth's situation (the word 'Ai' is slightly impolite, but it is used before the name of anyone with a close relationship). No one takes care of them and I miss them too. Even though we have a different father, I love them. E Mae is not very strong, when I have time I will go out to see if someone wants to hire me to wash clothes or do the dishes. I can help my parents to get some money to buy food or candy for my brothers and sisters. If I went to school, no one would help mom. And she is indifferent, she only said 'if you don't want to go to school, it's your business, it's up to you....".

Nong gave reasons why she had to baby-sit children in spite of the fact that her mother was not employed:

"E Mae is not very strong, she always has a headache in the morning. On days when she gets drunk and fights with E Por (dad), she will have even less energy to take care of my brother and sister in the morning. I have to take care of them. If my brother and sister bother mom a lot, she will get upset and hit them which I deplore and take them out of the house for a walk".

When *Nong* was asked if she knew that a child of her age was required to study in order to be able to work and earn money for himself, she replied:

"That's fine, I will raise Ai Earth well, he will go to school and he will take care of mum and me. Mum is not very strong, if I went to school, no one would help her take care of all her children. I will raise Ai Earth very well, I won't let him be like my older brother. He graduated from M.3 (grade 9) but doesn't find work, instead he waits for mum to prepare dinner. My second older sister, graduated from P.6 (grade 6) and went out to live and work with Chinese people. She gets 2,000 baht a month and shares it with mum. My older brother and sister are the children of my mother's previous husband. E Yo, E Beer and myself ('E' is like 'Ai' but is used for female, 'E' sounds more impolite though) have the same father and Ai Earth is from mum's new husband. Mum has had three husbands, they left one another because they only drink alcohol and fight, so they left".

Although *Nong's* oldest brother was 15, *Nong's* mother did not ask him to take care of the children or do any housework. *Nong* responded to this:

"E Mae said let him go, he would soon find a job. But when I was hired to work, he came to ask for my money. I didn't give him any. E Mae said to me 'Let Aye

> *(older brother) borrows it, young girl. When he has money he will return it to you' but he never pays me back, not even a single time".*

Therefore, the only hope for *Nong* was the youngest brother *Earth*, since she raised him up by herself, *Earth* owed her this kindness. This brother would take care of his sister and mother in the future. It was common cultural practice in this community for an older sister to take care of her younger siblings. There the case of a five-year-old girl who had just begun to speak fluently, taking care of her younger sister. She would watch the younger child to prevent accidents and would call the mother if any problems arose, especially when the child went to play on the railway alone.

Consequently, these girls had learnt to be loyal to their family from a very young age. Society would judge girls according to how good they are at taking care of younger children, doing housework and working for money. These virtues would lead them to be 'good wives', taking care of the family, cooking nice food, raising the children well, working well and earning money. Every family wanted to have this kind of daughter-in-law. When a woman married she had to be loyal to her husband, his relatives, and her own descendants. This situation is clearly illustrated by the case of Tad, a 20-year-old woman who graduated from grade 6. She married and had two children, and had lived with her husband's family since the marriage. When interviewed, she said:

> *"I made a big mistake by moving to live with my husband. When I moved to live with him, I found out that he was not as good as I thought he was. He isn't absorbed in work, his job is as a temporary employee, driving a tricycle-taxi with a carrying tray. But he doesn't go out to work very often because he gets up late, when he goes out to work late no one hires him. So he just lies in the house, drinks alcohol, stays up late and wakes up late. The burden is now with me, I have to get hired to work in two houses in order to have enough to satisfy life's needs for my family members. There are my two children, mother-in-law, my husband, my husband's younger sister who is unemployed, and I. My mother-in-law takes care of the children in the daytime, sometimes I am so sad because I go out to work in the morning and come back in the evening to see my children wearing the same clothes they wore last night. I just wonder why, I go out to work for them, why*

don't they take good care of my children? I have to give it to my husband to drink, if I don't he will put on a fight, and I can't do anything...".

Some women were also willing to sell their own bodies in order to support their family. Mrs.Aom, 23 years old gave an interview, before passing away from AIDS, which she contracted from her first husband or through prostitution.

> *"My first husband died when I was 8 months pregnant, so my baby has never seen his father's face. He was killed in front of the railway station. When I gave birth, my family status-which was already bad-got even worse. I haven't sold any vegetables and got money from our family, but the income was just a little. My stepfather drank alcohol, took amphetamines, and didn't work. My younger brother and sister worked as temporary employees, with no certain working hours. I had no way out, so I went and worked in the sex in Srisaket province. They hid it behind a restaurant business. I am sorry to have done it, I know that I lost my dignity, but if trouble doesn't happen to you, you won't understand. It was necessary."*

Mrs. Maew, 36 years old, who started to work for her family when she was 9 to provide for her parents and nephew-a son of her older sister who committed suicide. When asked why women had to bear an unreasonable workload, she commented:

> *"Because our parents have shown us a lot of kindness. Think about it, my father didn't have any education but he tried to raise us by earning a living as a kick-boxer 'Ka Gum Pun'. My mother is a farmer, she has worked on farms since she was in the countryside. The farm didn't belong to us, we were simply employed as workers. We are so poor, and our parents were willing to do all kinds of hard work for us. My father boxed until he was blind and he couldn't work, I am their daughter and I have to return their kindness. I must work and earn as much money as I can. I don't care if I have to be hungry, but my parents must eat. If they are sick I will find treatment for them. We are very poor, no matter how much money we earned we couldn't have enough to heal our blind father. My older sister had an intestinal cancer, she pitied all of us being in trouble because of her, so she hung herself and left a child for me to rise. She didn't have any husband because he ran away since the child was born. Now my father is dead, there is only my mother left. She is living with my younger sister in the countryside, I send them some money every month. And my nephew is in prison, I sent him to school until he was in M.4 (grade 10) but he was terrible. He was addicted to Yaa Baa (Amphetamine) and he also sold it, so he was put in prison".*

Women are loyal to both their birth family and their family of procreation. To her original family a woman is a daughter, an older sister, or a younger sister. As for a relationship between a woman and her family of procreation, a woman had roles as wife, mother and grandmother. The behaviour of a woman to be loyal to her family was based on customs which have been influenced by Buddhism in Thailand (Keyes, 1984:223-241) and the traditional Thai maxim which stated that '*Ying Pen Kwai, Chai Pen Kon*' (a woman is a water buffalo, a man is a human being). The meaning of this law is: a woman's status was as a 'female slave' or a 'follower' and the property of her father or husband. She was not considered to be a subject, so she did not have any rights of her own. She had to work as she was ordered to, and worked for her owner. This brought to mind the image of a water buffalo which in Thailand was an animal that had to work very hard and plough the fields of rice, the main economic crop of Thailand from ancient times until the present (Kaewthep, 1995:10). Buddhism teaches that to be born a woman, you had less merit than a man. Peasants always said: in this life you are a woman, you should make a lot of merit so that you will be born a man in the next life.

7.1.3 Caring Ability: Impoverished Women's Experiences

Caring is defined as intentional actions that convey physical care and emotional concern and promote a sense of security in another (Greenhalgh, Vanhanen, Kyngas, 1998: 927). As a mother and a wife, low-income women had a key role, which clearly reflected their caring ability playing an important role in child care, and providing health service for family members.

(1) Caring Ability in Child Care

In this community, young girls quickly became initiated into domestic tasks and care of younger siblings. Children were bottle fed with sweetened condensed milk because this

kind of milk was cheaper than formula milk. This sweetened condensed milk is a kind of milk with 50% sugar and has low nutrition quality, since most of its protein and fat is extracted from whole milk and it is filled with vegetable oil and sugar.

Besides milk, a mother gave her children some supplemental food such as rice porridge, '*Tom Sen*' (clear vermicelli soup), and '*Guai Jub*' (round white noodles in thick soup) sold for 5 to 7 *baht* per bowl. Protein could be acquired from some little pieces of chicken in small amounts, the rest was water, flour and a few vegetables. Other kinds of food that the children had besides the food they ate with their parents were cheap 'Junk food'. They were ready-made, crispy snacks in packages, colourful instant toffees, and biscuit in shapes of fish or other animals.

Evidence from this study revealed that children in the low-income community were a group of people that was vulnerable to malnutrition and numerous heaths related consequences. Inappropriate or inadequate food intake was according to their parents' economic abilities and limited knowledge. Thus the situational data obtained from this study will provide community and family nurses awareness of low-income child health problems due to inappropriate nutrition. However, good understanding of the health problems and nutritional status of the children in these areas need to have further studies on a wider scale to investigate the nutritional status and health related problems of these children.

(2) Child Socialisation

Child socialisation is the process of developing patterns of behaviour, which continue throughout a human's life, in order to inculcate and contribute a virtuous disposition in children to be fine people in the future when they grow up (Sear, et al, 1957).

From the result of the study, women could not take care of their children all the time. Raising children varied depending upon family conditions. A person who took care of children might be a relative or neighbour baby sitter. Thus a way to decrease a mother's burden was training children to be able to help themselves as soon as possible.

Some participants were concerned about their quick tempers. They were afraid that their children might copy them. Emotional and physical responses to problems were often seen in this community, like fights and scoldings between spouses and fights between the community's teen boys and their enemies outside the community. Therefore children acquired the method of aggressive solutions from their parents. There was a fear that they would solve their life problems aggressively.

(3) Care Giver Role

The participants' role as caregiver continued until they were old, even when their children had departed and had their own families. A person who played a vital role in decision making on family issues was the primary breadwinner, because most of the family issues involved money; spending, borrowing money, purchasing utensils, and appliances. If women were the primary breadwinners or supporters, they always had power to make final decisions.

The study showed that women played a significant part as care givers to people in the family, taking care of sick children, husbands, grandchildren, parents, and the postpartum period of daughters or daughters-in-law as well as their role in promoting the health of the family. Women also played a crucial part in the coping function in the family. They could support the family and help it get through contingencies, crises and difficulties. The

research revealed that the women of this community could endure and tolerate enormous difficulties, adversity, and considerable suffering which passed through their lives.

Thus it could be concluded that the women in the study were capable in caring for their family members in terms of physical care, emotional concern and promoting a sense of security in each another even though they were living in deprived conditions.

7.2 Women and Work

7.2.1 Life Is Work and Effort: Working Life Patterns

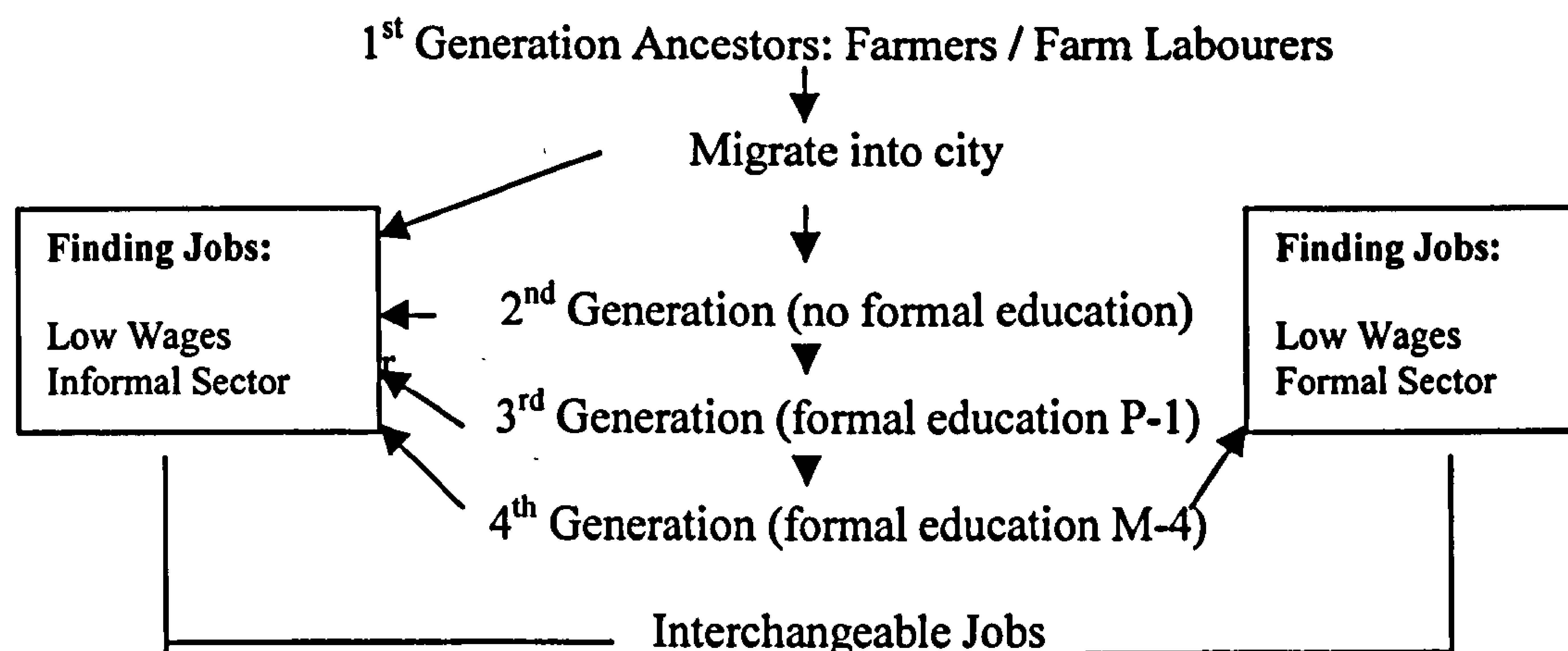
'*Het Ngan Tae Noi....*' (I've worked since I was so young....)

When all participants - both men and women - were asked about the experience of their working life, they gave the same answer with keywords such as '*Lumbaak Tae Noi*' (being in trouble since one was young), and '*Tum Ngarn Tae Noi*' (started to work since one was young). Their stories began similarly to those of their ancestors. Their grandparent's generation or their parents' generation migrated from rural areas where they were farmers or farm labourers. Then they settled down in Khon Kaen province, they had moved to many places in the province, all the places were on private land for rent. There were times when these people were driven away or the renting was canceled because the economic growth raised the land's price, and therefore it could be more profitably developed. Finally, the illegal occupation of the land which belongs to the State Railway of Thailand happened and this has developed into the current community of today.

The first and second generations started to work in the informal sector as labourers for general work. They would do whatever the employee wanted i.e. carry merchandise at the

train station, at the market, or at the bus station, transport drinking water and water from a large marsh at *Toong Saang Swamp* by cart to some houses in the city.

Figure 7.1 Showing the participants' working way of life



They started small businesses such as selling drinking water. Their businesses developed into sweet vendors or charcoal-grilled chicken vendors at the bus station. Others cooked food to sell at the market, some bought vegetables and retailed at the market, some worked as domestic servants, launderers and laundresses. Some were willing to be employed to do anything, for example, digging up the soil and carrying it away and loading it by hand on to a truck. These employees even dug up faecal matter from toilet septic tanks. All this information was told by the older participants who were over 60 years old and could remember migrating with their parents from rural areas.

As for the experiences of the lives of the participants in the third generation, they began their working lives when they graduated from the compulsory education which was *Pratom 4* (grade 4). Many of them started work as domestic servants in the houses of rich Chinese families. Some people continued this work until they got married.

Others had changed jobs from a servant in a house to a 'gunny bag factory girl'. That is making hemp bags to contain rice. If anybody had a relative working in a factory, and if they 'got good wages', the participants would change their jobs for more money. All the participants who had ever worked in a gunny bag-factory could not stand the dust from the gunny bags because it gave them a bloody cough and severe allergies. Many resigned and came back home to find a job 'selling goods'.

In the fourth generation there were more people graduating from *Matayom* 3 (grade 9) secondary school. The jobs they usually did were 'a salesclerk in a shopping mall' because a person with an M3 level education could be accepted to work in such a position. But when they worked as a salesclerk they earned 100-120 *baht* per day, (the income was no more than 3,120-4,500 *baht* per month if they worked overtime). This was not enough to live and support a family. Therefore they started to look for jobs in other provinces such as Bangkok, Pattaya and Hat Yai. In the beginning they sent some money home and visited their families regularly. Later, if they got married their lives would change with less contact with their family or some of them just disappeared without any clue. When the parents were asked about their daughters' work in another province such as Bangkok, Puttaya, Songkhla and Hat Yai, they did not always specify what kind of job their daughters were doing. They wanted to keep the nature of the work a secret as it may have involved sex services.

7.2.2 Satisfaction with Working Life

Most of the participants preferred jobs in the informal sector; for example, selling at the market or at the bus station. When asked about satisfaction with their current work the participants pointed out the good points of their jobs as follows.

(1) Have Freedom: A job in selling miscellaneous goods give the sellers freedom.

There was no employer to command them to do what they were supposed to do. The participants themselves could decide what they would sell, how much merchandise they would make, and where they would sell. They could also quit when they wanted to, even though they would not have money to use as capital for the next day. A recycle scavenger job: the people doing this job were very pleased with the job although they felt that other people looked down on them. They liked it because they did not have to invest anything. As for male participants, they liked taxi-tricycle jobs because they could go to work when they felt like it and could stop work when they wanted to.

(2) Work more, Get more money: If the participants were diligent in selling, collecting garbage, or looking for a passenger in the case of taxi-tricycle drivers, these jobs in the informal sector could make a good amount of money, unlike a job with a fixed salary.

(3) Receive the money right away: The most important point was that a person did not have to wait for the monthly salary, weekly wages, or fortnightly wages. Workers such as labourers or sales clerk had to wait for their income whilst work in the informal sector provided cash for the workers to use right away. Salaried workers could be sure that they got the money, unlike labourers on construction sites who sometimes were cheated and got less money than initially agreed.

The participants specified some bad points of jobs in the informal sector, for example there were no *fringe-benefits;* if they stopped selling or had an accident while working. If it was necessary for them to stop selling, it meant they would lose the income of that day. Some days there were no passengers hiring a taxi - tricycle at all, or a food vendor cooked a lot of food but it could not be sold, and she lost. When it rained, the garbage that a recycle scavenger collected would get wet and ruined.

Although most of the participants were doing work in the informal sector they could specify some good points of jobs in the formal sector as follows:

(1) Certain income: A labourer stated that he liked his job because he knew for sure that if he went to work he would get 100-200 baht per day, depending on the wages that he and the employer agreed.

(2) No investment needed: Many participants thought that a selling job might make more income than a labouring job. If the goods sold well the profit would be higher than 200 baht a day. But they did not do that job because it required capital and they did not dare to take a risk.

(3) Under the labour law: One good point in having a job that was under the labor law was if there was an accident at work, the worker would be taken care of, and received medical expenses.

Nevertheless, the living and working conditions of these poor people, in both the informal and formal sectors, was really like urban subsistence living. As one participant stated '*Haa Chao Kin Chao, Haa Kum Kin Kum*' (work in the morning, eat in the morning, work at night, eat at night). They had to struggle very hard to live.

7.2.2 Meaning of Work

(1) "Work is Money"

When being questioned about "*What is a job?*" and "*What does it mean to you?*" participants had definitions which obviously implied their attitude towards jobs : something which benefited themselves and their family's economy and motivation. Most of the participants' answers to the question "*What is a job?*" was "*Work is money. If they don 't gain money, they won 't work*". To get money had enormous meaning to their lives and families because it could help women run their family easily; having enough money to

buy food, to spend, to give children an allowance to go school, to pay for medical treatment when the family members were sick, and to buy drugs.

It was noticeable that participants did not mention clothes as an important thing in their lives at all. Although in traditional Thai society there are four requisites for living: food, drugs, shelter and clothing. One of the participants insisted that :

> *"I can wear any thing, it is not important. Having 2-3 sets of clothes are enough for me when they are worn out, I can repair them and go on wearing then. My children have only one school uniform each. When they arrive home, they wash it and wear it the next day".*

(2) "Work Makes People Valuable"

Most of the participants did not only give the definition of work as money but also stated that "*work makes people valuable*". "*If there were no jobs which you could earn money, there was no life*". Therefore, in the participants' opinion, working as a housewife or doing house chores means nothing to them, in other words it was not a valuable job because they did not get money from that job; even though they worked hard and spent a lot of energy on doing that job as well. The participants in the focus group discussion stated that :

> *"We will have our own money and stand on our own feet, we don 't have to depend on other people like husbands. We can buy what we want and feel free and comfortable about that and we don 't have to wait for our husbands to give us money*", said Mrs. Kob, 26 years old.

> *"I have 2 hands, 2 feet like him, I can work and support myself and my children. I feel more comfortable with this because I can stand on my own feet, "* said Mrs. Noi, 27 years old.

(3) *"Work Means to be Alive"*

Besides making them valuable and able to stand on their own feet and not have to depend upon their husbands or men, work stimulated their lives, as in the following statements:

> "*Working can show that a person is still alive and can move.*" said Mrs. Wang, 41 years old.

> "*A person who doesn't work and lives aimlessly, is dead*", said Mrs. Tom, 72 years old.

Work also made people stronger. As they experienced a range of problems which might be serious or tough or easy depending on the nature of the job that the women carried out, but they usually learned how to solve them.

In conclusion work is an important part of these people's lives. They seize opportunities to make as much money as possible by working hard during normal weekdays and also on special holidays. When work does not go well and they are unable to sell their wares then their health is affected in many ways. They need money to stay healthy.

7.3 Women's Emotional Reflections on Daily Living

7.3.1 'Living from Day to Day or Earning Day to Day'

This was a common finding. If 'something' could be sold they would sell it. They would vary specific, but always sold food and consumer goods. Vendors chose the same location to sell goods, usually the bus terminal, the market, or the roadside. If work involved labouring, people were generally employed by a regular employer who usually hired them to do housework. Women would also take occasional jobs, such as unloading goods from a truck, grass cutting, or carrying loads of soil. A participant said she was once paid to

slap a person's face at the bus terminal. If she had been sued for this, the one who hired her would take responsibility and pay the fine or bail her out.

7.3.2 Feeling the Impact: the Feeling of Hopelessness and No Way to Escape

The participants expressed the emotions they had towards the stress of being the primary breadwinners of the family and of having a husband who took no responsibility (*'Mai Aw Nai'*). These women had to work hard to earn a living for the members in their family. The feelings expressed by these women included: the loss of life's opportunities because of marrying this man, hopelessness felt in terms of their ability to improve the situation, helplessness, and the feeling of lucklessness in their fortune owing to an irresponsible husband.

Feelings of hopelessness and depression were expressed by participants in relation to their perceived ability to influence affaires in the house and their husbands' vices. It was considered a lost cause to encourage their husbands to become diligent and help to earn a living, or to lessen their burden and their struggle to earn enough money for the family. Hope had direct impact on a person's mental health as Parse, (1996:12) discussed:

> "The lived experience of hope meets the criteria of a lived experience of health in that it surfaces as a way of becoming in the human-environment interrelationship. Hope is a common human experience in that it is a way of propelling self toward envisioned possibilities in every day encounters with the world. Hope is the predominant mode of becoming for persons who find themselves anticipating the "will be" in critical life situations as well as a chosen mode of becoming, accompanying every day looking forward to something......".

The participants all mentioned their husbands' irresponsible behaviours. At first the women urged their husbands to improve. But despite saying this every day, no changes were made. The women then felt burnt out and frustrated and stopped trying to improve

their husbands' habits. The following examples demonstrate women's feelings of hopelessness:

> "*In the past my husband never took any responsibility, he would only drink alcohol. When he went out he said he was going to earn money by riding a tricycle taxi. But when he came home in the evening or very late at night he was drunk. So we were not able to talk things over. He was not responsible at all. I tried to tell him to improve himself. But he was too drunk to listen. When I got angry I beat him on the head with a wooden pole. His head was cut so I had to take him for stitching and that meant more money to pay. I got fed up and paid no attention toward him. Whatever he did I wouldn't worry. I just worked for the sake of my children... When he died, I felt the bad deed was gone*" (Mrs. Wang, 41 years)

The feeling of hopelessness also arose from fear that one would not survive infectious disease (AIDS), as in the case of a former prostitute who was infected with HIV. She felt hopeless and worried about her 5-year old son who had no father and was now living with a grandmother.

> "*I believe I'm going to die. I don't care if I die for I've been hopeless for the last 5 years since I knew I was infected. I just leave it to fate. But I'm worried about my son. You see, my mother sells vegetables she collects from around the fence which make a small amount of money. My sister isn't any better. I don't know how my son will live. I'm so sorry. I'm hopeless and worried about my son. He won't be able to survive....*" (Mrs. Aom, 23 years)

Some participants felt hopeless with events happening in their lives, such as bad health which prevented them from working hard, bad husbands who had other girls, and children addicted to amphetamines. There was nothing left in their life to be proud of.

> *"Touch my muscle. See! It's all softened. Whatever I do I feel tired and sore. I've got an ache all over my body and have to take some 6-7 pills I buy from the shop every day. My husband is rarely home. He has another girl. I think I'm dying soon, I won't live long. My body is over-deteriorated. The doctor doesn't know what I have, he couldn't tell me. So I stopped seeing him and buy medicine on my own. When my children grow up and are all gone and left me these grandchildren. I have six children, but none of them stay. There's one who I'm worried about so much. He takes amphetamines. Now he's living in the slum at Klong Taey (in*

> *Bangkok). They said he was caught 2-3 times already, but he never stops. I think my life is so sad. I'm hopeless. Nothing's going to be any better. All is finished. Now life is becoming worse and worse...."* (Mrs. Nang, 51 years)

The majority of participants felt a sense of helplessness and inability to the situation at home. It was a commonly expressed feeling that one did not know how to solve this unwanted situation. An example was a participant whose husband drank large amounts did not help to do housework or earn money for the family expenses. Her relatives did not want her to marry this man. Therefore, her relatives showed her little empathy. However, she believed her husband would change in time. It did not turn out to be like she hoped. She had no one to rely on, and could not discuss it with her relatives. The only thing she could do was cry to herself. This was what she said:

> *"My husband is bad. What he earns he spends on drinking with his friends and leaves nothing for our family. He doesn't help with housework either. What he earns he earns for himself alone. He doesn't care for the children either. I feel ashamed toward my relatives, for my husband takes no responsibility just like they predicted. I've been patient. I only cry to myself. Sometimes I discuss with the neighbour, but only parts because this is shameful. I just cry alone. I don't know what to do."* (Mrs. Ruey, 34 years)

Participants expressed the feeling of wanting to escape from their irresponsible husbands. They figured out how they could escape from the husband. Sometimes they dreamt of having a nice husband who helped to earn a living and helped to save up, and how they would be happy. These dreams never came true. When they woke up, they found the same adverse situations. If their husbands came home early, said nice things to them, and helped with some of the housework, they would be very happy. But usually the husbands talked nicely and helped them a little, only to ask for some money to go out again. These women said they were not silly like their husbands might think they were. Their husbands thought they were never aware that when the husbands showed kindness towards them, they actually wanted something in exchange. In fact, the women were aware of this but just

gave them money to ease the situation. If they refused, the husbands would not stop asking. Perhaps they might be too "*Jai Orn*" (submissive). However, the women were not easy every time. Sometimes they were too angry to stop themselves and ended up grabbing a pole or a knife to attack the men. This meant the neighbours had to interfere and stop them. When they were asked if they could really kill their husbands, they said, *"I was very angry and I would have stabbed him if I could reach him".* When they calmed down they sometimes regretted the situation not just because they could be caught, but because they would be in trouble for having to pay for the treatment. If the husbands died, the women would be imprisoned, and their children would have no one to look after them. However, it was a common occurrence for husbands to be beaten with a stick. It was also the wives who took their husbands to hospital and paid for the treatment.

7.4 Women's Health Beliefs

7.4.1 Meaning of Health

The participants in the group discussions gave a summary of their understanding of health as:

> *"Health or healthy means in the local term 'Yoo Dee Mee Haeng'. It means a state that a person is plump with firm flesh, strong and big, able to eat well and sleep well, not sick, able to work, and mentally comfortable."*

(1) Ways of Being Healthy

> *"A person can be healthy when he/she drinks alcohol everyday, drink a little bit just one Kong (1 tea cup, about 20 cc.). When you drink you will eat well, eat deliciously and sleep well and soundly.*", said the participants in the focus group discussion.

To summarise, the opinions of the participants about the way to make a person healthy contained behavior practices which could be grouped as followed:

Eat Well:

The participants put eating as their first priority, these participants always complained that they were poor and they were working from hand to mouth. They did not have good food to nourish their bodies, unlike the rich. Therefore, eating good food seemed to be what they wanted the most, and it was believed that they would be in good health if they ate good food.

Live in a Good Environment:

This group of people was living in a crowded place or slum. The slum was surrounded by stagnant, filthy, smelly water, garbage was embedded in the water and mosquitoes bred there.

> *"It is necessary for us, we don 't have anywhere else to live so we have to live in a slum like this. Even though it is illegal and everyday we have to be aware and be afraid of being driven away, we can 't live happily, we have to live here because it is close to our workplace."*

Have a Balance:

Many participants said that a balance in life, in terms of work and relaxation, would make a person healthy. For example:

> *"A man can be healthy when he has some relaxation, when he gets sore and stiff after work he must relax. When he gets some energy he can get back to work again. When he is sick he must quickly get himself healed, and take some medicine right then."*

> *"When it rains he should not go out in the rain, he may work in the sun moderately. But the sunlight makes people strong."*

Mental Well Being:

Mental condition was another thing that the participants were aware that affected their health. Everybody said that if they had mental well-being and if they were happy, even though they were poor, they could be healthy.

"To be healthy one must have mental well being; for example no matter how hard we are suffering we can just listen to music and we can forget the problems.", said Mrs.Tad, 20 years old.

"For a person to be healthy first of all they must have a happy mind, must be centred, and stable. Keep the Lord Buddha 's teaching in their mind. ", said Mrs. Tom, 72 years old.

It was noticed that this meaning of health was rather concrete. The definition reflected an easy uncomplicated way of thinking which was well within their own life-cycles and experiences. Moreover, the definition of health as understood by the people incorporated the body, spirits, souls, and social relationships. Buddhism had also a great influence on the worldview of Thai people and their attitudes toward health, illness, and death. An individual's relationships with all of these would be balanced and in harmony for good health. Finally, the meaning of health described above was distinctive of *Isaan* culture and was understood by people as a marker of their way of life throughout the generations. This such "perspectives" on health offers nurses an insight into another way of life. Thus it could be helpful to the provision of nursing services to be aware of such.

7.4.2 Meaning of Illness

Illness meant the following to the participants:

"Illness is a state in which a person is exhausted, tired, unable to work, having a headache, feeling of wind in their ears, and may faint. The word illness has the same meaning as the words in local terms spoken by us which are "Odd Odd Aed Aed". If the symptom is severe, we will call it "Puai " which means to have a disease, and if it gets much worse they call it "Puai Haeng " (fatal illness), summarised from the focus group discussion.

From the above meanings given by the participants, it could be seen that when they think about illness they would concentrate on the capability of a person to work and earn a living. That is the main purpose in living for the low-income people. When they were sick, many participants said that they must take some medicine very quickly in order to go back

to work, or else they would have no money to use as capital for the next day. The wording they always used was:

"*Fao Hai, Fao Pai Ha Kin*" (Get well fast, get to work fast.)

The participants had given the word illness 3 degrees of intensity:

(1) *Bor Mee Haeng, Bor Pen Lai* or Non-Severe Illness

This degree of illness was the one the participants mentioned most. It was the first recognition of feeling ill. The symptoms that were most mentioned as chief complaints were headaches, chills, sore throats, getting tired, inability to sleep well or eat well, loss of appetite and muscle pains. These symptoms usually happened to everybody and were considered to be common symptoms from hard work. Thus these people took a pain reliever everyday; for example, Paracetamol or Aspirin. Some people took '*Yaa Chud*' (mixed medicine tablets) everyday in order to relieve the pain. When people had the symptoms of '*Bor Mee Haeng*' or '*Bor Pen Lai*' they would not go to a doctor. They would practice self-medication by buying some over-the-counter drugs. These drugs were easy to find, both in community groceries and in drugstores downtown. The participants also preferred going to see an informal-untrained medical practitioner ('*Mor Sheed Yaa*' – folk doctor for injection medicine) in order to have an injection to relieve the symptoms of '*Bor Mee Haeng*'. These informal-untrained medical practitioners worked outside the community, and they did not have a clinic. Only the people who went there knew where they were and told others.

The following is an example of the field notes about the symptom '*Bor Mee Haeng*':

> *"The weather on the recording day is very hot, but the lay people still go out to work as usual. Today Mrs. Wang, 41 years old, whose career is wholesaling charcoal-grilled chicken, has a pain on her spinal bone, with a refer pain around the occipital area and the left temple of the head. She says that she has had these symptoms for 2-3 days, but she has not taken any medicine yet because it 's not*

very severe. She only made her daughter step on her back, and made Grandmother Noi massage her. Grandmother Noi says that Mrs. Wang symptom is pain from dislocation of her scupula tendon, and it needs to be turned back".

(2) *Bor Sumbai* or Severe Illness

The symptoms of '*Bor Sumbai*' are recognised by the people when the symptoms get worse after the feeling of '*Bor Pen Lai*'. If the symptoms still exist or worsen after a while without any sign of improvement despite the patient trying different kinds of medicine, as suggested by others, then the relatives would start to worry about the illness. The patient would be unable to work, and would just rest at home.

The appearing symptoms might be abnormal; for example, paleness, jaundice, edema, fainting, any severe pains in parts of their body, severe cough, extreme exhaustion, chest congestion, gasping for air, shortness of breath, or persistent high fever.

When the illness reached to this stage, the patient's relatives and close friends would discuss how to heal the patient, what the cause of the illness was, what kind of medicine the patient should use, whether he should see a medical doctor or traditional healer or use both of them. The discussion among the relatives always took a long time before they came to a conclusion. So, during this period the patient's relatives would contact and tell one another to visit the patient in order to cheer them up and help discuss the problem. Any relatives who knew something would offer ideas as much as they could. For example:

"Mr. Kae is 25 years old, thin, pale, hollow eyed, and looks weak He is lying in bed with his mother and relatives sitting around him. Mr. Kae has been ill for many days, Mrs. Jai, Mr. Kae's mother says that her son may have a kidney disease and a sexually transmitted disease but not AIDS. Mrs. Jai can't tell from whom she knows this, but insists that it's not AIDS. She has tried many kinds of drugs but the symptoms are not better, he is still pale, exhausted, "Bor Mee Haeng" just the same. When Mr. Kae is asked if he has ever done anything Pid Pee (immoral), he says that he has passed urine over the railway which may have made a spirit of the railway angry. So Mr. Kae's mother goes to invite

'Luang Poo' (an old monk) to set a ritual 'Hed Wiak' in order to release bad luck by magical power and cut the relationship with the spirit".

(3) *Bor Sumbai Lai* or Fatal Illness

The '*Bor Sumbai Lai*' symptoms continue from the '*Bor Sumbai*' symptoms, or might happen suddenly and cause a critical illness. If a patient and his relatives felt that the symptoms were very severe, and the patient might die if they did not do anything to help. The '*Bor Sumbai Lai*' symptoms stated were: unconsciousness, convulsions, severe abnormal pain, bloody vomiting, severe diarrhea, severe vomiting, numbness of the body, restlessness, stop breathing, or vaginal bleeding.

A person who had any of these symptoms needed to be sent to a hospital very quickly, or if they thought the abnormal symptoms were from supernatural causes they must find a monk or a spirit healer to set a ritual to save the patient's life as soon as possible.

A patient with a fatal illness was always surrounded by their relatives and friends who came to cheer them up and inspire them to fight with the illness. It was called *'Doo Jai'* (to take a look into heart), which was very important in *Isaan* culture. Therefore, if a patient was sent to a hospital, many of the patient' s relatives accompanied him to '*Doo Jai'*.

The following were some examples from the participants and the field notes related to the very sick:

"Mrs. Aom, 23 years old, had had abnormal symptoms for years. She began with decreasing weight, paleness, exhaustion, frequent fainting, and sores all over her body which couldn't be healed. She was told by a doctor that she had a disease which was unable to be cured at the present time when she went to an Ante Natal clinic. Therefore, she tried to seek other healing methods by traditional medicine and magical art. After that, her symptoms became more severe, she was serious,

talked semi-consciously and strangely, in shock, unconscious regularly, compulsive and tense, and smoked 2 cigarettes at a time. Her neighbor said that she was haunted by a spirit, so her mother and neighbors decided to take her to a temple where the monk was well-known for conquering spirits".

"Mother Peng, 66 years old, she said that 5 years ago she had an Uterovaginal prolapse but she did not do anything, just put it buck into place. It did not hurt, so she just bought some medicine to take. Then after that there was a wound on the prolapsed flesh and she bought some penicillin to take but it was not better, Now the blood came out of her womb and that meant it was terrible a fatal illness because the blood came out. So she told her adult children to take her to a hospital. She said there was a time when she almost died and she had to go to a hospital".

Thus it is concluded that illness was classified into three types: '*Bor Mee Haeng*' or '*Bor Pen Lai*' (not very sick), '*Bor Sumbai*' (severe illness) and '*Bor Sumbai Lai*' (very sick or fatal illness). In each of these types of illness the cause may be attributed to a cause within the body, a supernatural cause or a combination of both. So when someone is ill they will either wait for self healing to take place or begin a process of social support to seek help from traditional healers, monks or doctors.

7.4.3 Women's Reflections on Health Being: '*Health is the Lowest Priority in Life*'

"I'm not afraid to die"

"It's good to die, to be free from troubles"

"I'm not afraid to die, but afraid to starve"

These were common expressions amongst people in this community which clearly shows the low regard given to health. As a result, people led their life fully taking risks that often led to health problems, including regular alcohol abuse, stimulant abuse, not visiting doctors and self-medicating '*Yaa Chud*' (mixed medicine) to cure themselves. Therefore, workload increased health risks due to the use of stimulants, which enabled workers to work harder. The effect on physical health, resulted, in fact, from straining the muscular-

skeletal system which led to people self-prescribing medicines. This cycle caused side effects from the use of mixed medicines and stimulants. These effects ranged from heart disease and peptic ulcers to osteoporosis and liver disease. However, a constraint of this research was that it was not experimental research from which conclusion could be made about whether symptoms actually arose as a direct result of women's workload.

7.5 Conclusion

This chapter has provided an overview of the general themes and a picture of women's way of life in the Railway community and their working ways. Women in this study used many strategies to cope with their problems in living from hand to mouth. They tried to do their best without suitable advice and information.

They developed their own knowledge, and used trial and error in their struggle for existence. Work is a substantial function of these women' s lives. Work means every thing for them to be alive.

Women's ways of life and women's roles in various situations under slum conditions has been presented. Their lives are dynamic, affected by the major forces such as nature, history, culture and society. I believe that each person was born with the potential to be of benefit to society. The findings of this study have confirmed that these women have a crucial part in their places. They could endure and tolerate enormously difficulties, adversity. and sufferings, which passed through their lives. Moreover, they placed the highest value on family happiness. This chapter has also provided a picture of women's health beliefs. Women in this study used many strategies to cope with their problems in

living, working, and seeking health benefits in the context of living from hand to mouth. They tried to do their best without suitable advice and information.

They developed their own knowledge, and used trial and error in their struggle for existence. They described 'health' as a person's condition of strength, ability to eat well, sleep well, work hard and also be mentally comfortable. They classified illness into three types; not very sick, severe illness, and very sick. Abnormal bodies and/or the supernatural caused these illnesses. They placed 'health being' as the lowest priority in their life.

CHAPTER EIGHT

HEALTH PROBLEMS

This chapter discusses the health status of the women in the Railway community.

Women in this community were employed as merchants and food vendors at various places including bus stations, train station and markets. Women were invariably employed in the informal sector.

General working conditions of men and women in this community were studied. However, in this community women were the primary breadwinners and most of the men were either unemployed or occasionally employed. Although this group worked hard, they received a low-income due to their position as unskilled labourers. Women and children often begin working at an early age, therefore foregoing their education, and becoming unskilled labourers. As a result, women and children lack opportunities to improve their quality of life:

> *"I always work hard. I have been working hard since I was young without becoming rich. I am not lazy, and I don't know why I am still poor like this. My father and mother are poor. We are all poor. Is poverty a heredity disease?"* (Mrs. Maew, 35 years).

The health status of participants was obtained by conducting in-depth interviews and through observations. Participants indicated symptoms they believed to be derived from work-related health problems as shown in Table 8.1.

8.1 Musculoskeletal Symptoms

Six symptoms are grouped in this category; muscle pain and feeling stiff and sore, headache, back pain, bone pain, joint pain and swollen legs. Heart pain may be related to musculoskeletal complaints, but is believed more likely to be the result of stomachache, which was grouped with gastrointestinal symptoms. In addition, gastrointestinal symptoms were the most common complaints from working women (33%). Body pain was caused by working in one position for long periods of times, lifting heavy objects, and using bicycle transport to sell goods. For example, scavengers find goods to sell by walking and pulling a heavy cart long distances.

Secondly, staying in one position for long periods of time can cause severe musculoskeletal problems. Merchants reported sitting with the same posture for around 12 hours. Wholesale merchants selling grilled chicken often stay in the same position for around six hours a day, preparing and grilling chicken. Wholesale merchants who sell *Isaan* sausage usually stand or sit in the same manner making sausages for about six hours. These women have to sit and bend usually for around an hour at a time before changing to a new posture, involving about1-2 minutes rest. Limited working also results musculoskeletal problems. The working areas in the market, bus station, or houses are very small. Some workers have to sit on small stool, which is about 20 cm from the floor. The sitting space on the stall is so small that there is no support for their back, requiring women to bend forward and hunch their shoulders up. Limited working space leads to a postural rotation of the spine, which is predominantly one-sided. Some sit on the floor while working requiring constant neck reflection. Repeated

Table 8.1 Women work-related health problems (1998).

Groups of Symptoms	Symptoms	
	No	**Percentage**
1. Musculoskeletal Symptoms		
-Muscle pain and feeling stiff & sore	8	
-Headache	4	
-Back pain	3	
-Bone pain	2	
-Joint pain	1	
-Swollen legs	1	
Total	**19**	**27.2**
2. Allergic Symptoms		
-Skin allergy	4	
-Exposure to dust	3	
-Heat stroke	3	
-Eye irritation	2	
-Asthma	2	
Total	**14**	**20**
3. Gastrointestinal Symptoms		
-Peptic ulcer & stomach ache	5	
-Heart pain	3	
-Diarrhoea	1	
Total	**9**	**12.9**
4. Psychosocial problems		
-Stress	5	
-Being unable to sleep	1	
Total	**6**	**8.6**
5. Work accidents	**2**	**2.8**
6. Chronic Illness		
-Hypertension	5	
-Heart disease	4	
-Diabetes	3	
Total	**12**	**17.1**
7. Miscellaneous		
-Miscarriage	3	
-Prolapsed uterus	2	
-Dizziness	2	
-AIDS	1	
Total	**8**	**11.4**
Total	**70**	**100**

work patterns for long hours causes musculoskeletal complaints. However, this research will not offer a composition between informal working conditions and other working conditions since other research concerning this topic cannot be found.

"I have muscular pain because while making sausage I have to sit for many hours every day. I think you can imagine how painful it is. I have to pack sausages from 6 am to 1 pm about 7 hours all together. I have a small amount of time to take a rest from 1 p.m. to around mid night. After midnight I'll go to sell my sausage at the market until they sell out at around 6 pm. Then I'll buy ingredients, go back home and go on making sausage. I spend about 13-14 hours working. Whether making or selling sausages I have to sit all the time. Sometime I sleep while sitting because I am too tired", said Mrs. Tien, aged 46.

"I sit for a long period grilling chicken. I begin by getting up around 3 am, going to the market to buy fresh chicken, and then preparing the chicken. To prepare chicken I sit on a small stool for several hours. After that I sit to grill chicken which takes time. I usually finish all my jobs including cleaning the containers from around 11 a.m. to 12 p.m. I do all of them alone by sitting on a narrow porch for around 6-7 hours per day, so I have got a back and knee pain. Sometimes I can't stand up because of having sat down for such a long time, and I have a sore back and stiff legs", said Mrs. Pui, 44 years old.

"I walk all day long to sell food at the bus station I sell several things like Khaw Lam (glutinous rice with coconut milk grilled in bamboo joints), fruit and sometimes grilled chicken, depending on the season and which sells better at the time. I have to walk all day, or I can't sell my goods. I think I walk several kilometers each day. I walk around buses, in buses, or near the windows. I know that some people are bothered by me and others not, but I have to do it because I need the money. When I arrive home, I feel so much pain in my legs. My calves get bigger and bigger. I have to lie on the floor and put my legs on the wall because of the pain, I have to sell grilled chicken from around 6-7 am to 3 p.m. or 6 p.m. if they don't sell well, which means I have to work about 9-12 hours all together", said Mrs. Pong, 31 years old.

To heal body pain and fatigue women usually take '*Yaa Chud Kae Puad*' (painkiller medicine set) which is sold under various brand names, and also pain reliever in various forms. Women also reported stimulants use.

8.1.1 Drugs and Stimulant Use Patterns for Treatment of Work-Related Health Problems

To relieve *pain and fatigue*, women usually depend on commonly available drugs, such as analgesics. Some analgesics are combined with caffeine, which is used for its analgesic effect or as a stimulant. In addition, women may take other 'homemade' pain killers including '*Yaa Chud Mau Nuad*' (medicine for massaging) '*Yaa Chud Kra Jai Sen*' (medicine for relaxing muscle), *Yaa Chud Pradong Sen*, etc. These mixed medicines are usually composed of Dexamethasone, Prednisolone, Phenylbutazone, Idomethacin, Aspirin, Diazepam, Paracetamol, Caffeine and some Vitamins, (explained in the self-medication section). These 'combination' drugs are widely used:

Table 8.2 Drug and Stimulant Use for Women Workers (1998).

Drugs/Stimulants	Number	Percentage
Pain killer (any kind)	10	15.4
Mixed medicine (*Yaa Chud*)	9	13.9
Aspirin powder (*Tamchai*)	6	9.2
Ephedrine (*Yaa E*)	4	6.1
Amphetamine (*Yaa Baa*)	3	4.6
Stimulant drinks	10	15.4
Coffee can	10	15.4
Alcohol	7	10.8
Cigarettes	4	6.1
Chewing betel	2	3.1
Total	65	100

Although women's work may not affect women's health directly, overworking can cause pain, fatigue, and exhaustion, which often lead to serious health problems. Most relieve pain by buying drugs (especially *Yaa Chud)* in their community without having knowledge of the medicine or its effects. Negative health effects of the drug used to make *Yaa Chud* are presented in table 8.3.

Although *stimulants* such as *Yaa E* (Ephedrine) and *Yaa Baa* (Amphetamine) are illegal, they are widely used in Thai society, especially by secondary school students. There have been attempts made to suppress '*Yaa Baa*'. However, the problem is yet to be vanquished from Thai society, and there are currently a large number of factories producing this drug along the Myanmar-Thai border (Daily News, 1998: 7).

The side effects of drugs including *Yaa Chud* may be a cause for many diseases affecting women, e.g. Hypertension, Heart disease, Diabetes, and Osteoporosis

Table 8.3 Disadvantages of Drugs Commonly Used by Participants.

Generic Name	Disadvantages of Drugs
Dexamethasone / Prednisolone	-Hypertension, sodium and water retention, potassium loss and muscle weakness -Diabetes, osteoporosis, -Mental disturbances -Peptic ulceration, which may result in haemorrhage or perforation, etc.
Indomethacin	-Headache, dizziness, gastrointestinal discomfort, syncope, hypertension, hyperglycemia, etc.
Aspirin	-Gastric irritation, increased bleeding time
Paracetamol	-Liver damage in prolonged use or over dosage
Diazepam	-Drug dependence, confusion, toxic psychosis, etc.
Ephedrine	-Anxiety, tremor, restlessness, insomnia, arrhythmia, dry mouth, cold extremities, etc.
Amphetamine	-Wakefulness, exhaustion, excessive activity, paranoia, hallucinations, hypertension, convulsion, coma
Caffeine	-Gastric irritation, headache when withdrawn

Source: Pharmacy Department, 1990. *Srinagarind Hospital Formulary*. Khon Kaen: Khon Kaen University.

The following description comes from a woman who is typical of many women who took part in this research;

"I did all kinds of work, selling vegetables, Pla Som (salt fish with rice, garlic, and pepper), Moo Som (a kind of Thai condiment made from fermented pork), Isaan sausages and feeding pigs, I am a merchant of sorts. Sometimes I did several jobs at the same time. However I can't do these jobs anymore, instead I just stay home under my children's care didn't know about how to take medicine, so whenever I felt tired, exhausted, or fatigued I took Yaa Chud Mau Nuad (massaging medicine). Back then I was not afraid of taking drugs, so I took it every day. It made me feel better and I could go on working. Recently the doctor has told me that I have Osteoporosis because of taking too much 'Yaa Chud'," said Mrs. Sa-ad, 65 years old.

"Now I am disable and am taken care of by my husband, because I can't work any more. After my parents died, I had to do several jobs to support my children, sisters and brothers. My husband didn't support the family because he had a minor wife. I had to laundry for many people. I did all these extra jobs alone. There were a lot of things to do, so many clothes to wash, therefore when I felt tired I used 'Yaa Baa' (Amphetamine). I took 2 tablets every day which gave me the energy to continue working. I think you can imagine how hard I worked because right now I look much older than my age. I am only 51 years old but look older and weak because of my diseases; heart disease, diabetes, hypertension, and asthma," said Mrs. Nang, 51 years old.

Drinking coffee as a stimulant is widely practiced in Thailand, especially in the form of small coffee cans, which can be purchased at stalls along the road. Other beverages, which are similar to stimulant drinks such as *Kra Ting Daeng and Ranger,* are available which promote their vitamin content in order to give the false impression that these drinks are healthy.

People in the case study area buy cans of coffee in preference to jars of instant coffee because canned coffee is cheap and convenient.

In general Thai women do not like *smoking* and only four women studied were smokers. Women explained that they first began smoking when they worked as maids at a hotel, where customers would leave cigarettes in the room before leaving. They became addicted and although they did not have money and knew it was bad for their health could not stop.

Seven cases indicated that they developed alcohol dependence during the postpartum of delivery during what is known as '*Yoo Fai*' (lying by the fire during the postpartum of delivery). This required the drinking of medicinal liquor, and was believed to assist in the production of milk, as well as helping the uterus recover rapidly. Women claimed that drinking also increased their appetite. Women would normally drink about 30-50 ml., which costs about 10-20 *baht* per day. Women believed that it helps increase good appetite and help them to sleep. Seven participants do not believe that they are alcoholic. They said they drink every day in order to relieve fatigue and to relax. If they do not drink, they feel their lives lack something. They did not think it causes them problems because when they drink they are happy.

Musculoskeletal problems including swollen feet and legs can occur when people are required to stand, walk or remaining stationary for a long period of time. This causes the venous blood return, where blood remains around the peripheral extremities of the body. One overweight participant complained of swollen legs and feet. She sells fruit from a cart she pushes around the inner city. When she returns home she finds she has painful swollen feet and legs. To relieve the pain and swelling she takes painkillers and rests her legs by raising them up to the wall. She also has hypertension. To control her blood pressure she regularly buys drugs without a prescription from pharmacy. She is unaware of any other medical conditions she has as she has not visited a doctor for several months.

8.2 Allergic Symptoms

Allergic symptoms caused by exposure to dust, heat stroke are skin allergies from dust, exposure to polluted water in the work place, and polluted air containing carbon monoxide were reported by several women. These symptoms are commonly reported by women selling food at bus stations, which contain high levels of toxic chemicals.

Skin irritation was often reported Mrs. Ta, (35 years old), works as a labourer at a building site and is allergic to the cement used in construction. This caused papules and pustules and legs became covered with clusters of scales. Mrs. Taew is a 60 year-old employee who cleans chicken for wholesale merchants, who sell grilled chicken in the market. Both her insteps have papules and pustules caused by water used to clean chicken. Mrs. Jeeb is a 56 year-old refuse collector who complained of papules and pustules on her back caused by sunlight and sweat. Mrs. Ngeeb, a 56 year-old and Mrs. Maew, a 35 year-old, both complained of skin irritations. Mrs. Maew's face is heavily blemished, a common complaint amongst participants.

To heal facial blemishes, most women use antihistamine and Prednisolone cream which is recommended by the chemist. Mrs. Maew's face has been covered with grime for several years. She believes it has been affected by dust and the dirty atmosphere at her work place. However, women understood they had no choice and so have to accept the unhealthy work environment.

"I have blemishes all over my face, and pimples all over my body, which may be caused by the sunlight or sweat. I don't know what I would do if I stop selling grilled chicken because I only finished Pratom 4 (Grade 4). I have spent a lot of money treating it, sometimes it disappears but it usually comes back. I am lazy to go to see the doctor, so I just buy medicine to heal the blemishes myself. It's OK, I won't die because it's far from my heart...(according to a Thai belief state that the heart is the most important organ in a human being's body, and as long as the disease does not affect their heart it cannot cause them to die)".

Exposure to dust is commonly associated with respiratory problems including chronic bronchitis, asthma and nose congestion. Food vendors at the bus station and on the streets often have colds when exposed to dust. Dust is a major health problem in Thailand.

One participant, a merchant, talked about her respiratory problems:

"Once I went to see medical personnel at the Municipal Health Service. She suggested I cover my nose and mouth with a mask so I wouldn't have colds or asthma. But wearing a mask while walking and selling things along the road is very strange. It is not practical when I ask customers if they want to buy my goods. The nurse's suggestion of wearing a mask is easy to say but difficult to practice." (Mrs, Maew, 35 years old)

Two cases of eye irritation were reported. Those who commonly complain of eye problems are wholesale merchants who sell grilled chicken at the bus station. One explained that the large amounts of smoke from the oven irritated her eyes. She suffered from stinging eyes and had tears every day. However, she did not believe this to be a serious problem, as explained below.

"There is a lot of smoke covering this area every morning. I think others might feel it stinks, but they are probably used to it by now. They never complain because they understand that it is my livelihood, and we live in a slum. I know it stinks and I suffer from stinging eyes every morning. All can do is blow the smoke away. I have to wash my hair every day because of that bad smell. Even though I am afraid of having eye problems when I get older, I have to bear it since I do not know how else to make a living. I have been selling grilled chicken for 20-30 years, so I don't know how to begin to do other jobs. Besides, I don't have any other skills. (Mrs. Wang, 43 years old)

Heat stroke and fainting are physical hazards involved with working in high temperature (up to 40°C). Exposure to heat is a major problem in tropical countries and is compounded by high humidity. Common problems associated with heat are heat stress, prickly heat, heat cramps, heat exhaustion and heat stroke (Phoom, 1988).

Participants who suffer from heat stroke or fainting are commonly refuse collectors, street-food-vendors and grocery owners in the community. In the first two works, workers are required to walk along the road in scorching sunlight. Many grocery storeowners sit in stores roofed with corrugated iron, which become unbearably hot. Also the heat from making Thai noodle soup and *Isaan* fried noodle, together with repetitious raising and lowering of the head may be a cause of postural syncope.

Two participants reported having *asthma*. The 23-year-old participant no longer has asthma. The 54-year-old participant has had asthma since she was in her 30s. However, the symptom is not severe, and she worries more about the arrhythmia of her heart than asthma. Participants treat asthma by purchasing over-the-counter drugs. Medicine commonly used is *Coban* (Vandicoff) formally known as *Theophylline*. Participants have also used this medicine as a stimulant and are aware that this medicine can also help treat asthma. Participants also use Ephedrine, referred to by lay people as "*Yaa E*". Sedatives (pseudoephedrine), which are still available in pharmacies are also commonly used. However, *pseudoephedrine* doesn't have any effect on bronchodilatation, and is a treatment for sinusitis and congestion. 7.9% of Thai people are reported as having asthma. The study was conducted among people aged over 15 years and found the non-working elderly people

have the highest prevalence rate of around 4.5 %. This is followed by housewives, 2.1 %, labourers, 1.4 % and farmers, 1.2 % (Chuprapawan, 1992: 115-116).

8.3 Gastrointestinal Problems

Peptic ulcers, diarrhoea and heartburn are included in gastrointestinal symptoms. Heart burn or heart pain is usually associated with the reflux of peptic acid which can cause pain and stinging around the epigastrium area. Gastrointestinal complaints rank in the top third(14%) of problems cited by participants.

Women complained of gastrointestinal problems related to their usage painkillers and '*Yaa Chud*' between one and three times a week. '*Yaa Chud*' and most painkillers cause gastric irritation. These also contain caffeine and steroid which can cause gastric irritation.

Refuse collectors often eat foods found in bins because they believe the food to be fresh.

> *"I have health problems from collecting garbage. For example, during the Chinese New Year I found boiled chicken finely wrapped in a plastic bag. I brought it back home because it looked fresh and unspoiled and roasted it since we hadn't had boiled chicken for a long time. Usually we have only 'Nam Prig' (Isaan dipping made from chilies, garlic, lime juice and fish sauce) and parboiled vegetables. As a result, my family had diarrhoea for two days"*, said Mrs. Pen, 29 years old.

Stomachaches caused by use of stimulants and relaxant drugs were occasionally related to muscular problem as a result of long hours of sitting (Cooper, et al, 1991: 72).

Peptic ulcers amongst working women often result from stress and women's habit of self-prescribing drugs or taking *Yaa Chud* which contains steroids and other gastric irritants.

> *"I had black faeces and a stomachache. I also vomited blood. I was very frightened and went to see Dr. K. He said that I took Tamchai (Aspirin mixed with caffeine) too often. He told me to stop taking this drug or my stomach would be perforated by it. I tried to stop taking Tamchai, but I work very hard. I often have pain in my body and so need to have drugs. Also, I forget to have meals on time because of my work"*, said Mrs. Sri, 50 years old.

8.4 Psychological Problems

Stress and insomnia are grouped under psychological problems. Although, hypertension could also be grouped in this category (Leigh, 1991; and Ross & Mirowsky, 1995), it was grouped under chronic diseases. Stress and insomnia were grouped together because participants pointed out that the reasons they could not sleep at night could be due to worrying about earning a living and lack of financial resources. Those who could not sleep reported drinking two bottles of stimulant drinks per day. As a result, it was likely to be the caffeine that caused sleepless nights. Stress was a problem implied in five cases during the in-depth interviews.

Headaches could also be grouped in this problem but are instead categorised under musculoskeletal problems, due to the fact that headaches and musculoskeletal problems are very difficult to clearly separate.

Those who reported symptoms of stress reported feeling depressed and unhappy all day or at least once a week. The cause of their unhappiness was related to earning a living and lack of

funds to save or pay for debts. An interest rate on loans is usually 20%. Stress related to paying back loans with high interest rates was a common problem. Although all participants reported unhappiness many reported coping strategies.

Nevertheless, rapid changes in economic and social conditions have resulted in an increased incidence of mental disorders. A 1994 survey of Thai national health found that the prevalence rates of certain mental illness including psychosis, anxiety and depression were increasing compared with similar studies conducted in 1989 (Bureau of Health Policy and Plan, 1997: 85).

8.5 Accidents in the Workplace

In general accidents are the most common cause of work-related disability (El-Batawi, 1981). If an accident occurs in formal employment sectors, there is compensation for the victims. However there is no compensation for the self-employed or those who work in the informal sector, despite the loss of income. Some participants reported having to borrow money in order to cover debts. Two participants in this study reported accidents while working. Each of which resulted in a loss of earnings for two women.

Another participant had a motorcycle accident on the way to work, when she was practising riding it. The accident was very serious, and she had a long lacerated wound on her right leg. She had to stop working for two months, and because she had no insurance, she did not receive any compensation. She had to pay for her medical expenses by herself. She spent around 200 *baht* per day for cleaning and dressing her wound. After her savings were used up

she borrowed money with an interest rate of 20%. She was willing to spend this money: "*I don't care how much I have to spend. I want only I get well quickly so that I can go back to work soon*".

8.6 Chronic Illness

Amongst the respondents a small percentage reported having chronic illness. There were classified as hypertension, heart disease, and diabetes. The following quoted from Mrs. Jai illustrates the typical way in which the women manage their long-term illness.

> *"You can say that I have a firmly established disease, I have chest pain, soreness, and stiffness. But I don't have these symptoms very often, just once in a while, but I didn't do anything. I mix Yaa Hom powder in water and drink it, and the symptom is better. I haven't gone to see a doctor even once, I'm busy cooking the food to sell everyday, and my son is sick, too. I only have a local to healer heal my son, that's it."* (Mrs. Jai, 48 years-Grocery Store Owner)

8.7 Miscellaneous

The symptoms of miscarriage, prolapsed uterus, dizziness, and AIDS were health problems participants attributed to over working. Even though over work may not generally be considered as the cause of illness, participants insisted that overwork really does cause health problems.

Although there were only three cases of *miscarriage* attributable to overwork, several participants believed many of their acquaintances aborted due to overwork, especially during times when people were living in the rural areas and had to farm. The reason given for

miscarrying was "*Mod look Mai Dee Lae Tam Ngan Nak*" (those who miscarry have uterus problems and work hard).

> "*I have worked hard all of my life. When I was a young woman, I worked so hard that I miscarried twice. I did two jobs at the same time; taking laundry and cleaning dishes at a restaurant. After the abortion, I didn't go to hospital, I just stayed at home and waited until it stopped bleeding.*" (Mrs. Peng, 66 years old)

Women who have gynaecological problems are reluctant to see a doctor because they feel "*Yaak Eye*" (shameful and shy). They know that when they visit a doctor with a gynaecological problem, the doctor will give them an internal examination. When participants have to tell 'stranger' such as health professionals about these problems, they feel very reluctant and are unlikely to fully trust medical staff. This point is emphasised by the case of Mrs. Aom, 24, who has AIDS.

> *"Some people ask me what's wrong with me because now I have a lot of pustules all over my body where I didn't have before. I don't dare tell anyone but my mother that I have AIDS. No one would be sincere to me, I'm afraid they will gossip. Even when there were some nurses coming into the community to visit sick people, I wanted to ask them for their advice but I didn't dare. I only looked at them when they were passing by."*

However, if the participants trust health professionals who talk to them regularly, they will willingly talk about their problems. This was evident when women began discussing their problems much more openly after I had maintained regular contact for a period of time.

Dizziness affected two participants who sell grilled chicken and fruit at the bus station. The following is an example quote from a woman who is vendor at the bus station.

> "*Even though we suffer we have to bear it. The number of buses increases steadily, causing a greater amount of toxic smoke. We feel dizzy everyday, but we don't know*

where we can move to sell these things. I don't know where to go because I have been selling food here since I was around 14-15 years old. Now I am 42 years old. I don't know how to change things because I don't have a high level of education", said Mrs. Daeng, 42 years old.

8.8 Women's Health Behaviours

8.8.1 *Rak-Saa-Eang*: Self-Medication and Self-Care

Self-medication was the main method by which the people sought health care. From the evidence, it was found that every participant and family preferred to buy drugs from the drugstores instead of consulting doctors. Medicines that were purchased were both western and traditional drugs.

The crucial factor that drove the participants to buy one type of medicine instead of the other was the kind of disease. For example, if they had a cold, headache, fever, upper respiratory tract disease, toothache, diarrhea, skin allergies, peptic ulcer or physical pains, they would normally choose western drugs. However, problems concerning postpartum women, malnutrition in children, fever with rash, contusion, eating the wrong food (allergic foods), were treated with traditional medicines.

There were several factors concerning why these people bought drugs for themselves:

(1) If the illness was not severe, they believed it could be eased by self-medication.

(2) Experience taught them which illnesses were not severe and could be cured.

(3) Their neighbours who had had those diseases before suggested drugs for them.

(4) The values and beliefs about the effectiveness of certain medicine, especially herbal medicine, passed down from one generation to another.

(5) The drugs were not to expensive and considered cheaper than other health services.

(6) It was easy to buy these drugs because they were widely sold in their community.

(7) The media, which advertises the properties of drugs, had an influence over them. Moreover, the drug vendors advertised and sold their drugs in these regions themselves.

(8) Those who were acquainted with and believed in the drug sellers recommended the drugs to these people.

In this study self-medication was described according to the following categories:

(1) Availability and accessibility

(2) Choice of medication.

(1) Availability and Accessibility

One main reason why participants preferred buying medicines themselves was the convenience in purchasing it. When the illness was not serious, they preferred to observe the symptoms first without taking any action or medicine. But when they felt that it was getting worse, they took medicine without a prescription.

On the other hand some merchants or labourers said that whenever they got sick, they took drugs immediately to prevent diseases. Since they believed that they should take drugs immediately in order to recover and go back to work soon.

Plate 8.1

Preserved drugs in alcohol for a postpartum mother

Plate 8.2

Nuay Tai Bai: herbal medicine for traumatic relief

Plate 8.3

Yaa Horm: traditional powder for helping heart work

It was found that a child who was only 11 years old started self medication when he felt that he was sick. If children were sick, the first one they informed and asked for medicine was a mother or a grandmother. A mother or a grandmother would check their stock, and bought medicine from the grocery store if they did not have enough in their stock.

There were three grocery stores which offered many kinds of drugs. The owners of the shops bought drugs from downtown and sold them to their neighbours. At the time when this survey was conducted it was found that there were about 30 different brandname drugs available such as pain killers, fever relievers, anti-inflammatory drugs, gastrointestinal tract drugs, and *Yaa Chud.*

Yaa Chud were considered dangerous drugs, especially as they contained controlled drugs, and psychoactive drugs which are illegal to sell in groceries, or even in the drug stores. However, these drugs were widespread and can be bought easily at grocery stores in both rural and urban areas in Thailand.

Mrs. Noi, a shop owner who was 38 years old, said:

> *"Pain killers like Paracetamol must be kept at home, therefore, when we are sick, we can take it immediately. If the illness is not serious, my neighbours buy medicine here."*

Fifty-six year old Mrs.Yai, one of the owners of the grocery store talked about how she chose medicine to sell there:

> *"We always record and remember the kinds of drugs that our neighbors want to buy. If we don 't have the drugs they want we have to buy them from downtown in order to have it next time. At first we didn't intend to sell medicine, but when people kept asking about it and wanted to buy some, we decided to sell drugs*

Plate 8.4

Yaa Kae Kin Phit: drugs for treatment of wrong eating, both western & traditional medicines

Plate 8.5

Yaa Khiew: traditional medicine, to treats Chicken Pox

Plate 8.6

Chinese plasters: local pain reliever

here. It is also convenient for our neighbours to buy drugs here "

Drugstores in town and drug vendors were other sources of purchase.

> *"I buy medicine from Y Drugstore because they dispense medicine very effectively. The owners give useful suggestions. It is very convenient buying drugs there. I have never asked for the names of medicine he has given to me because I trust him "*, said Mrs. Pen, 31 years old.

Therefore, it could be concluded that the criteria of choosing drugstores were as follows:

(1) Generous disposition of the dispenser

(2) Acquaintances

(3) Useful suggestions

(4) Good dispensation

(5) Reasonable price

(6) Proximity to their residence.

(2) Choice of Medicine

Participants' methods of choosing drugs were based upon previous experience, advice from family, friends, shop owners and information from media advertisements. Nowadays, the people prefer taking western medicine over herbal medicine. The main reason was that it was very convenient to get western medicines in their community. The villagers believed that western medicines act quicker and are more potent than herbal medicines. At present western medicine is advertised frequently through posters, television, or free samples. Furthermore, traditional knowledge about medical plants is not widespread. This knowledge was generally transmitted among family members or villagers. Some knowledge disappeared when local herbalists passed away.

Table 8.4 Choice of Medicine

Kind of medicine/Trade name	**Generic names**
Antipyretic Drugs	
Yaa Vi-koon-Deg	81 mg. of Acetylsalicylic acid
(for children)	5 mg. of Saccharin sodium
	1 gm. of Dextrose monohydrate
	(3-5 *baht*/sachet)
Yaa Hau Singha	300 mg. of Acetyl salicylic acid
(for children)	145 mg. of Lactose,
	5 mg. of Saccharine
Yaa Tam-Chai	500 gm. of Aspirin
	(2-3 *baht*/sachet)
Paracetamol, Da Ga	500 mg. of paracetamol
Bura, Buad-hai	325 mg. of Aspirin
Pyrana	500 mg. of Metamizol
Cold Remedy	
Dee-Col-Gen, Nuta, Tiffy	500 mg. of paracetamol
	15 mg. of phenyl propanolamine HCl
	12 mg. of chlorpheniramine meleater
Sulidine	2.5 mg. of Triprolidine hydrochloride
	60 mg. of Pseudoephedrine
Apracure	10 mg. of Phenylephine HCl
	20 mg. of Clenizole hydrochloride
	150 mg. of Salicylamide
	200 mg. of Paracetamol
Iyafin	15 mg. of Dexa tromethorphan HCl H_2O
	25 mg. of Phenyl propanolamine HCl
	2 mg. of Chlorpheniramine meleate
	100 mg. of Glyceryl guaiacolate
Antibiotics	
Hero, T.C. Mycine	250 mg. of Tetracycline HCl
Gano	500 mg. of Tetracycline HCl
Yaa Pen	Penicillin G. Potassium, 500,000 units
Mycochlorin	250 mg. of Chloramphenical U.S.P.
Gastroenteral Drugs	
Antacil	960 mg. of Aluminum hydroxide gel
	Magnesium hydroxide
	60 mg. of Simethicone
Gelusil	250 mg. of Alum hydroxide dried gel
	500 mg. of Magnesium Trisilicate
Lomotil	2.5 mg. of Diphemoxylate HCl
	25 micrograms of Atropine Sulphate
Muscle Relaxant Drugs	
Yaa Chud	Unknown medicine sets
Yaa Mor Nuad (Masseur's drugs)	***Unknown medicine sets***
Antipyretic Drugs	
Yaa Chud	*Unknown medicine sets*
Gastro-enteritis, Peptic ulcers Sexually transmitted disease Hypertension, Heart disease General weakness	*Unknown medicine sets*

The kinds of medicines which the participant use were divided into 8 groups; Antipyretic drugs, Painkillers, Muscle relaxants, Antibiotics, Gastroenteral drugs, Drugs for chronic illness, Stimulants, and Herbal Medicines and *YaaChud.* These drugs were pre-packaged as a mixture of unmarked drugs, sold as universal remedies for a variety of complaints and often contained potent and potentially harmful medicines in small packets.

Table 8.5 Choice of Herbal Medicine

Kind of Medicine/Trade Name	Generic Name
Fa Ta Lai Chon Plants	Powder of *Andrographis, Paniculate Wall. Ex. Nees* dried leaves 350 mg. For relief of pharyngotonsilitis.
Bua Boak Plants	Leaves of *Centella Asiatica (Linn.) Urban.* Indications: Diuretics, Sore Throat, Used in Anaemias, and Metabolic Disorder.
Look Tai Bai Plants	Leaves and Stalks of *Phyllanthus Amarus Schum. & Thonn.* Indications: Diuretics, Allergic Disorders, Used in Diabetes, and Muscle Pain

Self medication is a cheap way for the women in this community to manage their own health problems. They can easily obtain the medicines without loosing working time.

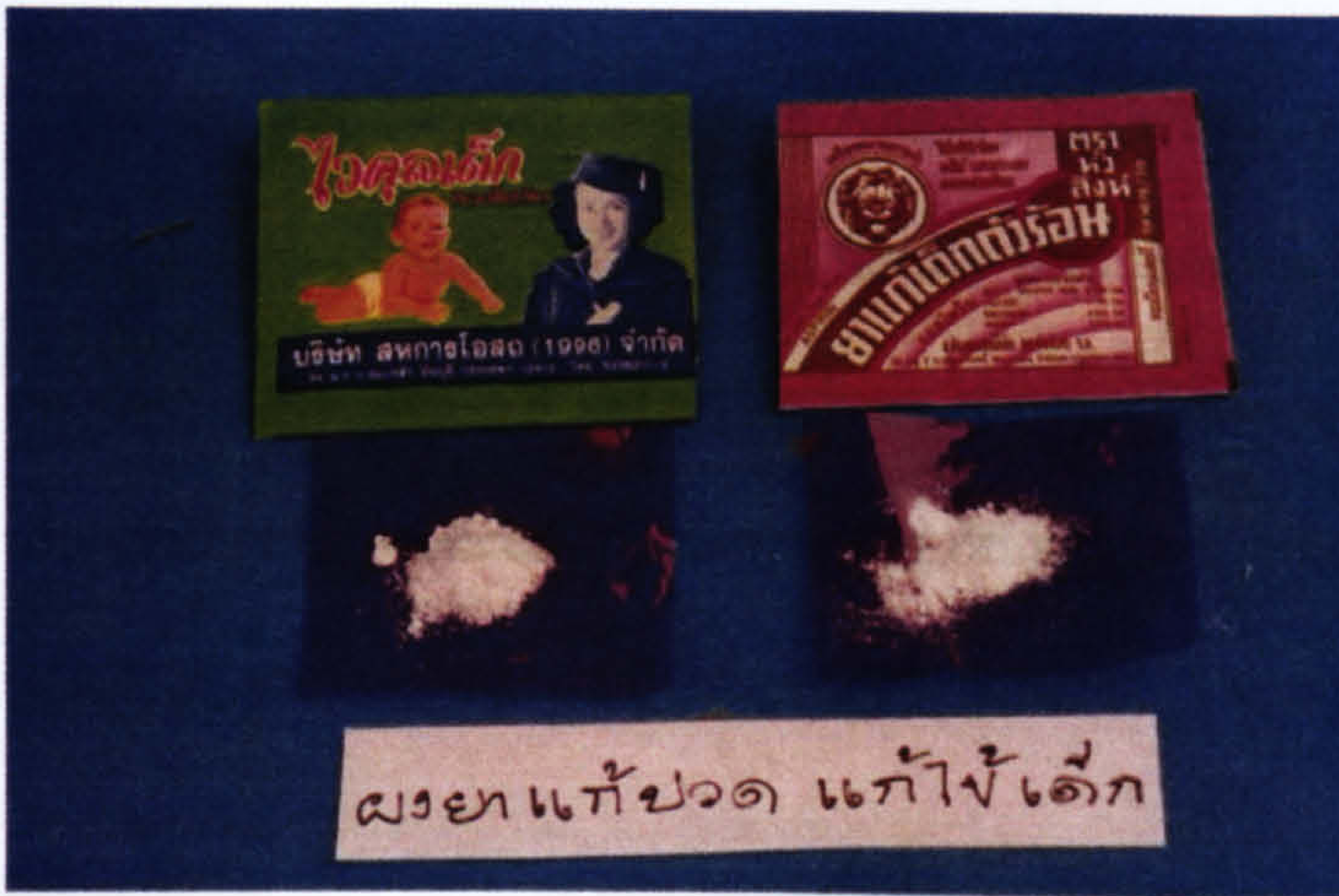


Plate 8.7

Painkillers and antipyretic powder for children

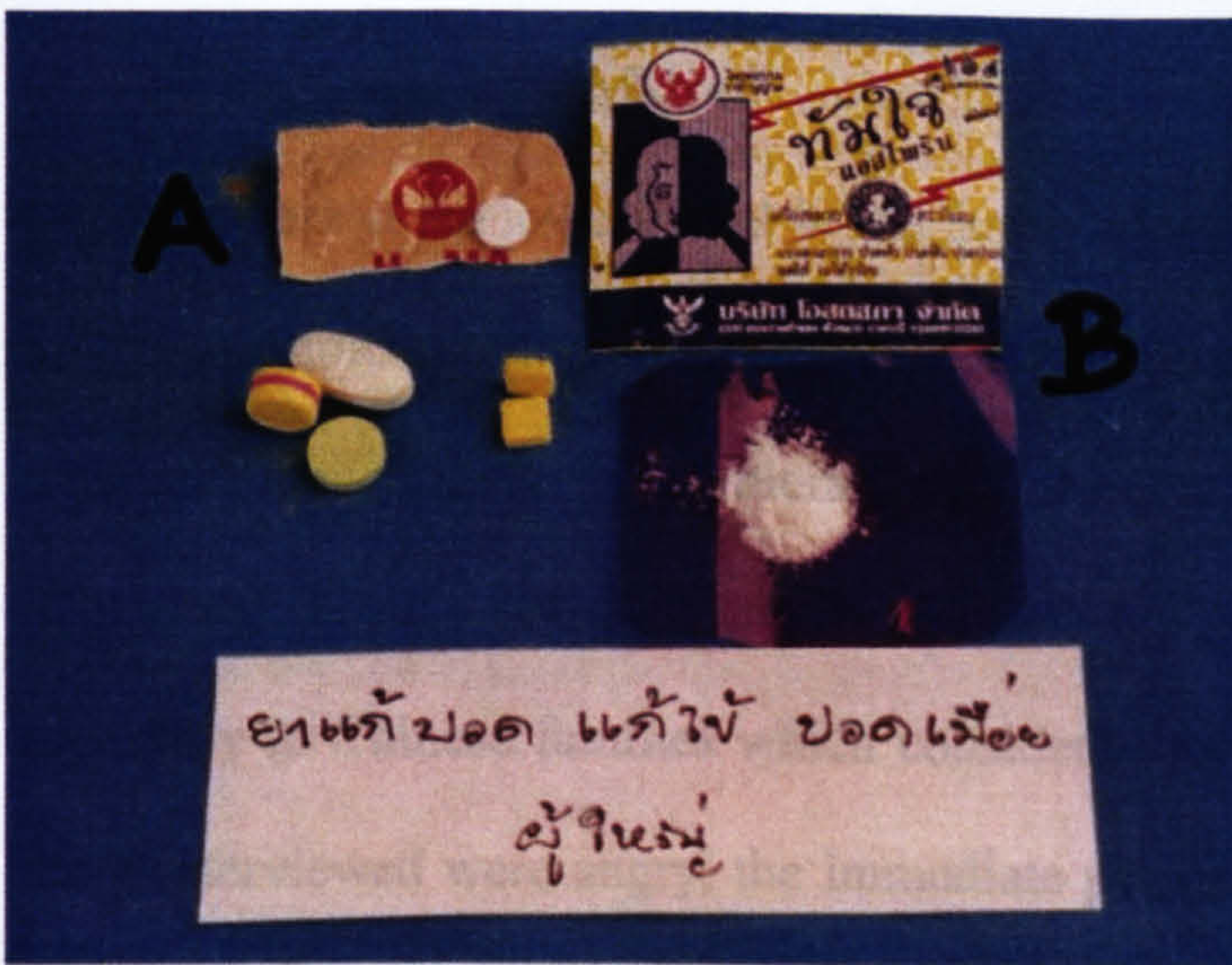


Plate 8.8

A: *Yaa Chud*, B: *Yaa Tam Chai,* both for the treatment of musculoskeletal pain

Plate 8.9

A: *Yaa Chud* for treatment of musculoskeletal pain,
B: Antibiotic drugs,
C: Traditional powder for helping heart work

8.8.2 Mental Coping: Venting Anger, Diverting Activities and Self-Reliance

Participants tried to get through family problems which included poverty and irresponsibility of the husbands, by using various means listed above: venting anger on their children, diverting their concern by depending on alcohol, using humour, restraining oneself for the sake of the children (so that they will not worry), and relying on religion to comfort themselves.

(1) Venting Anger on Children

Children were at the lowest level in the family hierarchy, and women took the children under her "possession". Some families comprised the husband's father and mother, the husband, the wife and the children. The hierarchical level of the wife was just above the children (Chayovan, et al, 1996). In some families, her level might be lower than the children, especially in Chinese families which considered the sons to be very important. Thus, when those interviewed were angry, the immediate person who was a target for vented frustration was the child. Women vented their anger on their children by grumbling, scolding and beating them, depending on the degree of rage. When asked about beating, they revealed that in the past when they were children they used to be beaten by their father and mother as well. People believe in a Thai proverb which says:

"*Rak Wua Hai Phook Rak Look Hai Tee*"
(Love your ox, tie it; love your child, beat him/her.)

Miss Nong, 11 years explained:

> *"My mom often beats me, for I'm a big girl now. She says if you're big, you must be beaten more than your younger sister and brother. When she gets angry with dad she'll beat me. I'm not angry. She says she loves me but that she's upset. I don't blame her. I pity her".*

Mrs. Tad, 20 years, said:

> *"I love my children so much. But when I'm angry I can't vent my anger on any one except them. The bigger one gets it often. The small one is too small. I'm afraid she'd get sick. When I beat them, I feel sorry, so I put some balm on them. Sometimes I cry also....Come to think of it, perhaps when I was small I was beaten before, so that's why I get annoyed easily. I just beat them so often. And after each time I feel sorry. I try to stop myself but I can't. I beat them because I love them. I don't want to kill them".*

Mrs. Jeeb, 54 years, related:

> *"If I'm angry I just grab a pole and beat my son, ...and I beat him several times. Especially when I return home from my job and find that he hasn't cooked the meal even though I'd told him to do so, I just beat and beat him. Now he's grown up. He runs away so fast I can't catch him. So I just scold him. I shout and curse him to death. This soothes me. My anger is appeased."*

(2) Diverting Activities: Alcohol, Humour and Talking

All participants over 35 years of age had a habit of drinking. The older they were, the more they drank. Some drank every day before dinner. Some drank at least 2-3 times a week, especially during festivals when they would drink every day. However, drinking would not prevent them from performing their jobs because they only drank in the evening and were able to work in the morning. When they returned in the evening they drank again. None

believed they were alcoholics, saying that they drank for these reasons: (1) to have an appetite for food, (2) to eat more, (3) to sleep well and not worry about family problems (Amodeo, et al, 1996). Drinking habits usually increased after the first child was born, partly as a result of a preserved drug containing alcohol they took during pregnancy. They commented that the taste was and it made them feel good. Drinking quickly developed in a habit. The alcohol of choice amongst these participants was generally a Chinese liquor called '*Siang Soon*', because it had herbal ingredients which believed good for one's health. Another reason given as to why women drank more was due to the period of time they had to cope with problems such as their husband being imprisoned or divorcing.

> *"Since I ran away from my husband and my children from Korat I've been so worried. I just believed that I should leave him before he left me. When I came to sell things in Khon Kaen I persuaded my friends to drink. I drank a lot and nearly became a bad girl. They nearly sold me to a prostitute's house. I was lucky "Pi" Daeng (the way to address an elder person) helped me. I drank alcohol to forget about the bad things. Now it's many years have passed and I'm not worried about it (separation from her husband) any more. But I still drink, 2 to 3 times a week, just to make me feel relaxed. That's my happiness".* (Mrs. Maew, 35 years)

> *"I drink a 'Gong' (30 c.c.) every day. Then I'll sleep well and have a large appetite. I believe I have energy to work because of alcohol. When I work hard and get very tired, I have my meal and drink. Then I won't think too much and can sleep well. In the morning I wake up fresh and can continue to work.. I started to drink with my father. Sometimes when he had white whisky, I stole some from him to drink. When I had my child I had 'Yaa Dong'(preserved herbal drug in alcohol) and felt good. That's why I've been drinking until today".* (Mrs. Peng, 66 years)

The use of humour and talking to release stress was observed throughout the period when qualitative research was carried out. At '*Som Tam*' parties, laughter could be heard continuously. They would exchange stories, especially dreams, so these they could be interpreted into numbers for the underground lotteries. The people in the group all had great fun doing this. The use of humour to solve problems was a unique characteristic of Thai

people. A major Thai characteristic is their love of fun and being able to turn depressing or stressful situations into enjoyable situations. At a funeral, for example, the guests would not show much sorrow. The atmosphere was informal, with guests chatting. Late at night people played cards in order to accompany the dead (Rabibhadana & Iawsriwong, 1999). Hence, the use of humour to reduce the stress of any given situation was very effective among participants (Scannell -Desch, 1996: 121). The following stories were related:

> *"When I get angry, I'll walk away, holding my child. I just stop at houses to chat with friends. If they gather around at a shop I'd stop and listen to them. If they have "Som Tam" together, I'd join them too. This makes me forget. If I have very hot "Som Tam", my nose runs and my tear runs down also. This makes me forget my anger, because of the spicy hot "Som Tam".* (Mrs. Tad, 20 years)

> *"In the evening I sit on the railroad tracks. There will be many friends. The wind also blows. We discuss our troubles and talk about funny things. So it makes us enjoy ourselves and we can return home to do more housework. I usually feed my child there, for there are lots of friends".* (Mrs. Aom, 23 years)

(3) '*Tam Chai*' or Self-Control for Children's Sake

Children were the most important factor which encouraged women to be patient about their family problems.

> *"No favour is as great as mother's favour"* The Buddha's motto

The Buddha's preaching emphasised women who were "mothers" to sacrifice their personal happiness for the children's happiness. This concept had always been taught to Thai women who are deeply affected by it. Therefore, all of the participants stated as an answer to the

question, "*What ties women to the trying situation which arises from the husband's irresponsibility?:*

> *"I'm patient ("Buen or Tam Chai") only for my children".*

The women did not want their children to be without a father, nor did they want the family to be broken. Another important thing viewed by *Isaan* people is that (Sohm-in, 1990: 53):

> "*Isaan* society praises married women. Unmarried women are considered as having an incomplete life. If a woman is a widow, she is called '*Mae Haang*', and is not respected by society. People will try to encourage her to get married again so that she has a husband to protect her".

Hence, both the Buddhist and old *Isaan* concepts have an influence on this group of women, rendering them incredibly patient:

> "*I was patient and Tam Chai because I didn't want the children to feel bad. I didn't want to be angry, and I didn't want to separate from him either. So I was patient until... he died... Men do not worry about their children as much as women do. We women cannot ignore this, that's why we become men's slave.... You may ask any woman, any family, what women all have to bear. If I didn't have any children, I would have run away to a far place. I wouldn't have been a slave to him and earned money for him. But how could I let my children grow up without a father. Bad as he was, he was still their father. So I had to 'Tam Chai' (accept and do not think too much about it, or control one's mind or restrain from it) and stopped myself from thinking too much. Let it be...just let it be...*", says Mrs. Wang, 41 years.

Thus, women used a variety of coping strategies, by venting anger on children, alcohol, humour and talking and self-control for the sake of the children to get through their problems in their life.

8.9 Conclusion

This chapter has provided a picture of women's health beliefs and behaviours. Women in this study used many strategies to cope with their problems in living, working, and seeking health benefits in the context of living from hand to mouth. They tried to do their best without suitable advice and information.

They developed their own knowledge, and used trial and error in their struggle for existence. They used 'alcohol' as the main form of coping with difficulties in their lives. Self-medication was a preference for these women because of its convenience.

In addition this chapter provides a picture of women's health problems which are related to working conditions. However, while women's health status, may be regarded as low by most standard measures, the women themselves placed health as a low priority. Although this qualitative research cannot conclusively argue that work directly affects health, there certainly appears to be a connection. Work allows women to live but their occupations are invariably physically and mentally exhausting, if not dangerous. The women surveyed observe the work being done by educated people and people of means, and think:

"Light-work is considered a privilege for the rich, the poor have no right to do it!"

CHATER NINE

INTERPRETATION AND DISCUSSION OF IN-DEPTH STUDY OF THE RAILWAY COMMUNITY

In this chapter, the relevance of the findings to related literature and professional nursing will be discussed and interpreted.

The study was conducted amongst Northeast Thailand's poor communities. The poor are defined as those living in households with an income 50 % below the average, as given in statistics relating to below average incomes (Caputo, 1995; Chaudhry, 1996; Dowler, 1996, Fuller, et al., 1993; Millar, 1996; Najman, 1993; and Thavar, et al., 1998) and those who have low socio-economics status. The way of life of the poor is dictated by poverty, resulting in many instances of hardship (Fuller, et al., 1993; Ronnou & Marlow, 1993; and Thaver, et al., 1998).

The objective of this study was to understand women's health and work in the socio-cultural context of poverty in Northeast Thailand by raising research questions including 1) How does this group of women define the words 'health' and 'illness'? 2) What part do these women play in work and family? 3) What are their perspectives on health, work and their caring ability within the family? This study does not intend to confirm or argue any particular theory. Various perspectives associated with the constructivist paradigm, the Holistic nursing model and Buddhist ideology were applied in order to understand the impact on low-income women on both a micro and macro level in the household at a local and regional level.

With the innovative design of this study, I was able to capture a diverse range of experiences about poor women in their work and health, and have provided a narrative richness and depth that has been lacking in previous research. In order to clearly discuss the findings, the chapter has been divided into five components; the role of women, women and family, women and work, women's health beliefs, and women and illness.

9.1 The Role of Women

This research has shown that not only do women need to be mother and wife, but also that they take responsibility for work and family roles, including being a provider, a care-giver, a decision maker and a kin-keeper (Friedman, 1992: 212-221). This is because among their roles as daughter, wife, mother and grandmother, women are also required to be a fully responsible mother until they are very old, due to the fact that they need to support their children until they are fully-grown up. Even after children have their own families, they are often still reliant on their mothers. Group of women in this study commented "your children never grow up". Some young mothers leave children in the care of their grandmother, often without providing any financial support. This study is in line with the work of Kannengsukkasem et al (1997) and Mc Adoo (1993), which shows that grandmothers usually take on the role as the head of the family, and take care of their grandchildren. Furthermore, these women perform a kin-keeping role by providing cohesion within the family. They believe they are intermediaries, whose children can come back home when in need of support. Despite the burden women face from providing continual support to their children and grandchildren, women believe it is a good chance for the whole family to reunite and assist each other.

The role of motherhood for these women is a heavy burden that they are willing to bear. It can be explained by the influence of Buddhist doctrine which states that "The Buddha's teaching emphasises that women who are mothers should sacrifice personal happiness for the sake of their children's happiness" (Sohm-in, 1990:53). Another of Buddha's teaching states that "Motherhood represents the highest kindness in Buddhist belief and an *Isaan* moral precept states that children must return this kindness" (Intarakumhang, 1994: 12). No matter how numerous their responsibilities are, women are capable of caring for their family members physically, emotionally and by providing a sense of security. They place the highest value on family happiness. Despite living as an extended family, and caring for their aged parents causing stress, some research has shown that an extended family provides a social resource, which supports women and helps to decrease stress. Though sources of stress (including carrying out multiple roles) have been well documented, future research should identify and include direct measures of the types of resources, which are meaningful in low-income Thai society to undue stress.

In this study, another theme which emerged relates to participants who face 'role overload'; 'Ideas of escape-the burden of maternal and familial roles'. Women are usually required to make decisions regarding money, including budgeting gambling and borrowing. This can cause conflict the feeling of being pulled apart by social demands. The more responsibility these women have to take, the more stress and frustration they feel. The stress of women as documented in this study is in line with other research, regarding women's roles (Cafferata, Kasper & Bernstein,1983; Facinone, 1994; Noor, 1995; Pleck, 1997; and Sorensen & Verbrugge, 1987).

However, to determine if role overload has a psychological impact on women, other factors such as women's personality should also be considered (Amatea & Fong, 1999). Their research showed that women's personality is a major factor associated with stress. It is interesting that women in this study showed a symptom of depression and their mental health status (as self-assessed during Phase 1) was good. This result may due to adaptation or a developed tolerance, since women are continuously exposed to high levels of stress for long periods of time. It is a pity that this current research did not evaluate personality. Another contrasting argument has been made that women who had multiple roles were likely to be in good health (Waldron & Jacobs, 1989:3). This argument is in contrast with some research, which shows multiple roles are harmful to women's health (Sorensen & Verbrugg, 1987:242). Indeed, it is possible that a favourable outcome of having multiple roles could be possible in Western society, where husbands often lightened the workload in the household and when both partners earn a living. However, in this study, husbands do not work regularly and the income earned providing only a small contribution to the family. An important question that should be raised here is whether work and family roles need to be modified (Pleck, 1997: 424).

These findings from the present study relate to women on low incomes in an urban context. Therefore, the inferences drawn should not be applied to low-income women living in rural areas. How this study relates to low-income rural Thai remains an open question. Economic difficulties in rural areas are not as severe as in urban areas owing to a constant and readily available food supply. However, in urban areas, a lack of money can mean malnourishment. In addition to alternative health care, the kin system also provides support during times of trouble. However, all participants mentioned that given a choice, they would not choose to

return as they no longer had any land to farm. Furthermore, people have often lived in cities for such a long time that they could no longer adjust to rural life. Thus, future research needs to validate these concepts and state differences between the urban and rural low-income population.

Women in this study have played an important role in maintaining good traditional, religious and cultural activities in the community. Though they are busy earning a living, they try to find time to make merit at temples on Buddhist religious days. When doing so they wish for their work to progress, and their products to sell better. They hope that the merit stored up in this life will reward them in the next life. Most of these women work trades, so it is possible that they see making merit as an investment that will bring benefit to them in the next life.

By researching these women's roles, I have discovered that they are important in taking care of the community, the family, in running the house, in raising children and in taking care of family members when they become sick, disabled or elderly. This study provides an understanding of the complex connection between socio-cultural concepts of gender, culture and religion operating within a particular society: Northeast Thailand.

9. 2 Women and Families

Family is defined as the primary group or the first human group, in the sense of being central and principle to the development and maintenance of self. Family membership is primary throughout life and constitutes the key social anchor at the end of people lives, as it did at the beginning (Friedman, 1992: 63 & Hagested, 1984: 37-38). A specific characteristic of this

group of women is the commitment they demonstrate to their families; having to work since a very age to support their families until they are aged or no longer able to work. This is in line with the statement of Hagested, (1984: 38-39) which comments on the way girls and boys are brought up; "It has been found that family obligations and preparation for family roles are stressed more in the upbringing of girls than boys". Buddhist teaching also places family above all else (Sohm-in, 1994: 32). Moreover, these women are living in the context of poverty. These factors have formed characteristics unique to these women. In order to focus on women and family, these themes will be covered: I) Family as stressors, II) Family as social support, and III) Family as a means of coping

9.2.1 Family as Stressors

Mc Cubbin et al (1983: 857) defined family stressors as "those life events or occurrences of sufficient magnitude to bring about change in the family system" Mc Cubbin explained that stressors are often created by the household, unemployment, not be able to work husband, and poverty. Mc Cubbin's findings are in accordance with this study; where we see husbands not taking responsibility for the family, especially in relation to earning an income. Moreover, this group lives in poverty and in overcrowded slums. There have been several research studies conducted in Thailand indicating that heavily populated areas have an influence on the inhabitants and that crowding is a chronic source of stress, i.e. Fuller et al (1993 & 1996).

The suffering of these participants is in part due to their poverty. As one participant said:

'Phuu Gin Gin Phoh Haak

Phuu Yaak Yaak Phoh Tai'

This is an *Isaan* proverb which reflects the hardship of women in the struggle to support their families. This proverb literally means those who have enough to eat, eat until their stomachs burst, and those who have little food do not eat to the point of dying. This proverb succinctly describes the ugly reality of the unequal distribution of wealth in Thai society. Participants' struggle is exacerbated by the hardship they encounter while trying to earn a living. Many complained of inadequate social services they received in comparison with developed countries which provide low-cost housing food and health care for their own people (Axihn & Hirsch, 1993; Caputo, 1995; Dowler, 1996; Millar, 1996; and Williams, 1994). Poor people have very little chance of obtaining similar services due to the following circumstances:

(1) Their communities were illegal. They have trespassed upon the government's land and thereby were under a constant threat of eviction.

(2) The use of public facilities such as water and electricity are unreasonably high. This was due to the fact that the specially designed temporary metres involved service charges twice or three times as high as regular rates.

(3) There was no free food available.

Another stressor identified in this study was suffering caused by marriage. Broken homes are a significant problem facing participants. Most have experienced divorce, or have had more than one husband and wife. This finding is contrary to other studies on Thai society (Yongkittikul & Chayutkahakit, 1989: 122), which have suggested that divorce is not prevalent among Thai families. Thai society regards divorced women as being defective, and women will usually try to sustain their families as long as possible. This concept has a strong influence on women, however, the stress of unhappy marriages often overcomes the social pressure to remain married. Even so, women often remarry, in part due to the belief that a

husband is a safeguard, who can also help by earning an income. However, it has been expressed that women's desire to seek a responsible husband usually remains unfulfilled.

The study is in line with other western research, which has suggested that, "marriage is more beneficial for men than for women" (Thoits, 1986: 271). The study of Fishel & Samsa (1993: 87-98) on 101 divorced couples in western society revealed the first four reasons to divorce as; husbands drink heavily, earn little income, do not share the housework, and are unfaithful. Unfaithfulness is only one factor that women in this study could not tolerate. Most divorces are not officially recognised because most marriages were not registered. Sharing a dwelling or elders from family acting as witness was usually enough to constitute a marriage amongst the community members.

Though women in this study earn more income than their husbands, they still remain 'powerless', even if in practice it appears women make all decisions in the household. Hagested (1984: 40) explains 'power': "Commonly, power is defined as a person's ability to carry out his or her will in relationships with others". This group of women maintained the power over decision making in household affairs. However, this level of 'power' does not include having influence over their husbands. Moreover, women in this study were generally compliant (*Jai Orn*) to all the requests of their husbands and children. When the women wanted anything, they would use indirect strategies to exert pressure on their husbands. However, the more they tried to influence their spouse, it seems the less influence they actually had. Furthermore, they experienced increased stress, a phenomenon previously discussed in studies by Bechtel, Shepherd& Roger (1995: 19) and Greaves, Zvonkovic, Evan & Hall (1995: 64). They each found that in a patriarchal social system, money earned by men

will often be used to purchase alcohol or other comfort, rather than for food or other necessities.

The vital role of women in this study was to take care of the extended family. The role of caregiver was not shared by women's husbands, causing it to become a major stressor for women. Husbands played only a limited role in the care giving process, as they believed women were able to handle all care giving duties. Husbands also maintained traditional beliefs that a caregiving role should not be performed by men. This finding is common to similar studies conducted with Greek, Jewish and Vietnamese men (Gelfand & Mc Callum, 1994: 49)

Aside from their role as caregiver, to their children and husbands, women were required to take care of their own parents, and her husband's parents, to pay back debts of gratitude. Thus, a theme emerged in this study entitled 'Sacrifice to family'. The concept has previously been discussed in the work of Ashley (1958: 107), which claimed that women are often self-sacrificing for the family. Women are often considered inferior because they tend to be gentle and unaggressive. This is especially true in *Isaan* Thailand, where the family still retains many traditional characteristics including a large, cohesive social network present in the extended family (Thammawat, 1998). This extended family could be viewed as a means of psychological support, but it can also be a cause of stress for women.

9.2.2 Families as Social Support

The word 'support' here means to have someone listening to one's concerns, providing assistance and mutual support (Harrison, Neufeld & Kushner, 1995: 858-864). In a Buddhist

society, and especially in *Isaan*, it is common for people to exchange help when needed. There are practical guidelines in a Buddhist society which emphasises reciprocal support and kindness.

The tight-knit nature of low-income communities ensures that people sympathise with others' plight and provide support for those in trouble. This is in agreement with the study of Campbell and Barett (1992) on neighborhood social networks where people of lower socioeconomic status were bound to their neighbors in long-standing reciprocal social contact. This point has important implications for the establishment of health promotion projects at a community level.

Kinship relations can sometimes be viewed as stressors when women are required to support a large number of family members. This is compounded by the fact that Thai society believes firmly in paying attention to seniority. Yongkittikul & Chayutsahakit's (1989: 114) study of Thai people aged 15-60 years found that 80 percent of them agreed with the practice of elder brothers or sisters taking responsibility for younger family members. For these reasons, the eldest sister in a Thai family plays a large supportive role in the family.

Women are reluctant to ask for support from outsiders. Patients with AIDS would not ask for help from nurses entering the community for fear of nurses of others learning they had AIDS. They will only reveal their secret to close and reliable relatives. Therefore, findings from this study will be beneficial to nurses who provide health care, to realise barriers caused by distrust, and the necessity to create trust among clients.

This study revealed that however difficult the lives of women are they still maintain good mental health. This is in part due to the presence of a Buddhist support system which believes in fate, and that acts performed in previous lives determine a person's fate in the next. A person has to expiate sin by making merit (Sohm-in, 1994: 120). Thus, there is an acceptance of one's predicament, and an unwillingness to criticise or envy those in positions of privilege or power. This is partly why the women involved in this study are still in good mental health even though faced with hardship. There has been much research carried out into the relationship between social support and health, with the general agreement that individuals with high levels of social support are more likely to have better mental and physical health (House et al, 1988: 540-544)

9.2.3 Families as a Means of Coping

An important question remains as to why women remain in relationships with irresponsible husbands. Possible reasons may be that women have greater interpersonal skills and social competence (Greenglass, 1991: 570). These skills are particularly important in protecting women from burnout. There were no cases of mental illness or psychosymptomatic syndromes amongst the women in this study. The findings contrast greatly with studies of low-income women in Puerto Rico, which found that one third of women had high levels of depressive symptoms, especially those women who were heads of households (Jimenez, Alegria, Pena & Vera, 1997: 15).

Lazarus et al (1980: 90-117) stated that humans have two main ways of coping: problem-focussed coping and emotional-focussed coping. The former means to manage the source of stress, while the latter means to regulate emotional response. The coping strategy used by

women in this study was emotional-focussed. Consumption of alcohol was a common response to stress. The consumption of alcohol was viewed by the researcher as a means of coping with their anxiety and depression, as argued by Parry et al (1974, cited in Cafferata, Kasper & Bernstein, 1983: 134). Furthermore, this study is contrary to the work of Meleis, et al (1989) because it shows that female workers used a systemic problem-solving approach to deal with stress at their work.

According to the USA national survey, 73% of married men and 63% of married women drink alcohol. Alcohol is often cited as a cause of marital dissolution (cited in Roberts & Leonard, 1998: 515). This study found that both husbands and wives drank alcohol, with men drinking more than women. Excessive drinking can have a great impact on relationships within the family. Conflict arose between sons and fathers because fathers did not provide support for the family. However, the study also found that sons often imitated their fathers and in these cases, there was a high possibility that children would become alcoholics. This is in accordance with the work of Chenitz and Granfors (1989: 477), who found that children of alcoholics became alcoholics at a higher rate than children from nonalcoholic families.

Reports on the misuse of alcohol could be found amongst labourers (Guppy & Marsden, 1996). Alcohol use was also related to psychosomatic complaints and absenteeism amongst working women (Collin, et al, 1997). Drinking has become a significant feature of Thai society. According to the statistics of the National Health Statistics Survey of the Ministry of Public Health (1997), 1,315,969 people (a rate of 22.2 per 1,000 persons) drank alcohol daily. The Northeast had a drinking rate of 14.7 per 1,000 persons, the fourth highest in the country (Bureau of Health Policy and Planning, 1997: 79). Alcohol consumption causing family and

social problems is a worldwide phenomenon (Bogenscheneider, et al, 1998; Cafferata, et al, 1983; Calva1996; Morissette & Debobbeleer, 1997; Ratner, 1998; Sandmairer, 1992; Simon, 1998; and Wohlfarth & Vanden Brink, 1998). The findings of this study concurred with other studies where drinking caused the following problems:

(1) It can severely affect the family finances;

(2) It can destroy peace and warmth in the family;

(3) It can cause the family to break up;

(4) Children can develop an inferiority complex and are more likely to develop alcoholism.

The latter is in line with studies by Ogur (1986) and Ratner (1998). The above-mentioned consequences have been summarised from group discussions with male and female children whose fathers are alcoholics.

Apart from using alcohol as a coping mechanism, women in this study also vented their anger and frustrations on their children. This is in agreement with studies of the coping strategies used by women (Douglas, et al, 1996: 501) and Smyth & Yarandi (1996: 25-29). These studies indicated that women liked methods of coping including talking with someone about their stress, venting anger on other people, and using avoidance strategies. It has already been noted that concepts of interdependence, cooperation, and mutual respect are expressed in extended family networks. The kinship family is instrumental in transmitting the true feelings and experiences of these women. '*Tam Chai*' is a specific practice in Buddhist teaching, aimed to teach a person to be lifted out of suffering by self-restraint. Buddhism considers that suffering can be ended by overcoming the cause of suffering, if one can not find or resolve the cause of suffering, then re-defining of the meaning of suffering is necessary.

The Lord Buddha once said:

"This verily, is the highest, holiest wisdom: to know that all suffering has passed away...

This verily, is the highest, holiest peace: appeasement of greed, hatred and delusion......"

There is a duality to *Isaan* women's characters: one part which is oppressed by social norms and the other which sees women acting as a leader in informal activities. The women in this community took major roles in informal activities such as the occupational network, merit making, preservation of traditions, co-ordination of relatives, community development, and providing occasional support to formal activities. This is in accordance with studies conducted in relation to *Isaan* social phenomena (Pumisinsit, 1995; Soonthorndhada, 1992 and Suntornchai, et al 1995). The increasing role of women in Thai society has created stress for women, where they maintain the same responsibilities in the household, yet have to earn more income to support their family without support from their husbands. However, the study found that Thai women could cope with stress by using Buddhist philosophy '*Tam Chai*' and other coping strategies such as talking about their stress, venting anger on other people and using avoidance strategies.

9. 3 Women and Work

To them, work is very important, and most have developed a work ethic since a young age. Elderly people continue to work to earn a living and there is no retirement period, except for when they become physically disabled. The topics to be discussed here include the meaning of work and participation in employment; division of work; accessibility, employment opportunities and social support; and physical effort and responsibility.

9.3.1 Meaning of Work and Participation in Employment

Women defined the concept of 'work' as follow: 'work is money', 'work makes people valuable', and 'work means to be alive'. This view is supported by the work of Mc Lean (1979: 12), who indicated that work is a vital part of the process of coping with life stress and life would be meaningless without work. In addition, the work of Steers & Porter (1987: 575-584) has indicated that work is important for people because it provides one with the means for livelihood and established social networks. Work is not only a reward in terms of money or the pleasure derived from work, also displays one's social status (Dirksen, 1994: 468). However, work is more than just a livelihood, social network or status. It means food for the whole family, education for their children, payment of their debts and the remedy for their illness. This contributes to a sense of pride of having their own income, and not being dependent on their husband. Women believe that their own income enables them to stand on their own legs in line with the Buddhist teaching of "self-reliance". Therefore, women's work provides a psychological base and independence (Mc Lean, 1979: 14). In relation to the definition that 'work is money', Kasl (1974 cited in Dirksen, 1994: 468) claimed that we do not work only for money as work also offers status, regulates life activities, permits association with others and makes available a meaningful life experience. However, this view can not be applied to this group low-income women to the same extent as it can in developed countries. This is because an income in this community meant survival to a greater extent than in developed countries. It usually meant the difference between eating and not eating (Bisgrove & Popkin, 1996: 1484).

Most of women's income earn is spent on meals for their children and other members of the family. Some money is also given to their unemployed husbands to drink or gamble. Even

their adult children, who already have their own families, still come back to ask for money to buy food or pay debts. This study is in line with the work of Bruce & Dwyer (1988, as cited in Garcia-Moreno, 1997: 26).

Work is significant to women in this community because it provides sustenance for the whole family. The many hardships these women have gone through have strengthened them; they generally feel they can perform any kind of work in order to get money.

9.3.2 Division of Work

Work can be divided into 2 categories: family work and paid work. In this community family work is the work of women. It includes all household responsibilities for bearing and rearing children. However, the majority of work that women perform is unpaid. Furthermore, women in this community perform both unpaid family work, and occupational work to support their families.

The work of Bird (1999) provided strong support for the differential exposure theory of gender differences in psychological distress. Gender difference in depression is associated with differences in men and women's contributions to household labour. Interestingly, neither men nor women think that this is an unfair division of work. They both believe that it is the women's responsibility to keep house and cook, regardless of additional paid employment. In Thai society, girls are brought up to take these responsibilities, while men believe it is acceptable for them not to contribute to housework. This idea is supported by Brannen & Moss (1991: 5), who states the division of work between men and women as

natural and part of the process socialisation. Women's domestic contribution is seen as functional for the family and as complementary to the activities of the male worker. However, women also have had to earn an income or even be the primary breadwinner. Should there be a reconsideration of the division of family work? If so, how can the traditional practice of shifting all the family responsibility to women be changed? Furthermore, how can women not subordinate their own potential work role by accepting such an extensive role in the family?

Women in this study have indicated that domestic work is overlooked and lacks reward. This is in agreement with the view of women in Brazil (Spindle, 1987: 63), which states that domestic work is work "you never see" and "is irritating". Though women are in paid employment, they are also expected to take good care of the children and the house.

9.3.3 Accessibility, Work Opportunity and Social Support

The special characteristic of the group of women in this study is that they work in similar occupations, and also live in the same community. This leads to a building of close relations which can evolve into career networks. Thus, they can support each other, which agreed with the other study (Henderson & Argyle, 1985: 229-239).

In this study, a work network doubles as a social network for women. This is in line with the work of Henderson & Argule (1985: 238) and Lapanun (1994), which indicates that a work network could lessen stress because work could provide emotional support, increase self-esteem and create a social network. Work includes activities such as asking or giving personal advice or discussing feelings or emotions. A network support would include such low-

intimacy social activities as chatting casually or having drinks or meals together. It is possible that such support is used primarily as a coping mechanism, while instrumental and network support can provide those aspects of social support that operate directly on stress in the work setting. By going out to work, women have friends to talk to and discuss problems. They could alleviate their problems. That is why this group of women could maintain a balance and continue to take the road of self-reliance and hard work.

This study found that women had less opportunity to obtain a good job which is highly paid and provides welfare similar to jobs found in the formal sector. With their limited education and work skills, needed in the formal sector, these women could only work in an informal sector where welfare was non-existent and wages were low. The study found that a lot of women in the Railway community aged over 35 years were unable to read or write. The literacy rate amongst the women in this community was 86.4% in 1996 whereas the figure for general average Thailand 93% in 1990 (Bureau of Health Policy and Planning, 1996). These women do not enter school because they have to work since a young age. As a result when they enter the labour market, they are part of the unskilled and low education group in the labour force, i.e. domestic servants, wage labourers, street vendors, market sellers, and sex workers. A major difference between the formal and the informal sectors is the lack of effective forms of protection, legislation, or any benefits for those in the informal sector. Informal work provides only a basic salary to use for clothing, transportation fees, health care clinics or dormitories. This phenomenon is common in other Southeast Asian countries including Malaysia (O'Brien, 1983: 201). Though women do not receive the types of benefits mentioned, they are satisfied in their work. These women prefer self-employment because it involves the freedom of deciding when to start work or how fast to work. They also accept

that they have little choice. Most agreed they would stay in this job until they retired or find a more beneficial means of employment.

9.3.4 Physical Effort and Responsibility

Women's work is labour intensive and therefore time-consuming. Woman peddlers have to walk up to ten kilometres to find customers, and carry loads of 20 kilograms or more on their shoulders. A high prevalence of back pain is not surprising. This is also true of women who prepare food for the wholesale market. Food production and processing, which is all performed manually requires large amounts of energy and women often take painkillers every day. During pregnancy, women continue working, which has obvious implications for both women's and children's health. There are risks relating to reproductive health including miscarriage, premature labour and prolapsed uterus. These all are problems that have occurred with the respondents of this study. A study of the relationship between work and health will be discussed in detail in the section discussing women's health.

It is common for women to work irregular hours or shift work. Tradeswomen sell goods from 4 a.m. until 6 or 8 p.m. The traditional *Isaan* sausage maker will produce sausages during the daytime and sell their products to the retailers in the market from midnight until 6 a.m. There is little time left for resting. The findings from this study are in line with studies by Baksh, Neumann & Paolosso (1994: 345-354), which concluded that low-income women in the Third World spend large amount of time in subsistence work.

The work analysis of Karasek (1979) on work as a cause of stress considers work as one of women's stressors because it has high demand with low control. During work, woman

provide services, take care of their customers and rarely on their own. The study of Noor (1995: 87-106) has also indicated that women in higher positions have less stress in contrast with lower positions which are reported to have higher stress involved with work. The responsibility of women is great, and women have to produce both mental and physical effort to complete their work. Every *baht* earned is the result of hard toil and a strong will.

9. 4 Women's Health Beliefs

Participants in this study defined health in specific terms. They believed health was based on one's ability to earn a living and whether one slept or ate well. The consumption of alcohol was also believed to be a necessary factor in the attainment of well being. They believed alcohol enable them to sleep soundly and wake with the necessary energy to complete a full days work. This view can found in other studies, such as the work of Amodeo et al (1996). The people in this community equated well being with the eating of good food, living in a good environment, having a balance between work and leisure, having good mental health, and following the Lord Buddha's teaching. This line of thought reflects their *Isaan* beliefs, which define a health person as one who is strong physically, mentally and socially (Sodsuchat, 1993:24). This definition is in line with that of many nursing scholars, where health is a state of the balance amongst the subsystems of the human system, including body, mind, social and cultural systems (Neuman, 1982; Capers & Kelly, 1987: 20). Johnson, on the other hand, stated that health was a state in which an individual maintained a balance in terms of eating, eliminating, having sexual intercourse, anger control and pleasure in success (Johnson, 1966). Furthermore, the definition of health and well being of the people in this community can be considered as a holistic one. holding to the principle that to be healthy is to

have an appropriate balance of physical, mental, psycho-social and spiritual perspectives (Bockmon & Riemen, 1987: 72).

The health and well being of each person is linked with the religious and cultural philosophy of each society. In this study, the participants had developed their own view of health based on Buddhism, which considered life, death, health and illness as a continuous process. These Buddhist beliefs had become interviewed with culture as a result of natural social evolution (Pulchaloen, 2000: 41). Aside from cultural influence, a person's health is also governed by people's lifestyle. Thus, participants could be found to have neglected their health because the desire to make a living, took priority over health care. This group of people was obliged to earn more income and overlooked safety by taking stimulants or painkillers on a daily basis in order to be fit for work. The consumption of alcohol was also popular as a means of relieving stress, in contrast to the Buddhist precepts, which forbid drinking alcohol. Thai Sociologists have in the past commented that Thai people do as they like (Rabinbhadana & Iawsriwong, 1999). Since people's health behaviour could not be understood by isolating health factors, body, mind, as well social and spiritual health become key elements in ensuring the efficient performance of the health system. Eventually, this would ideally lead to improvements in the well being of people (Bockmon & Riemen, 1987: 71-75). Therefore, health professionals should considered people's health by using an Holistic approach.

The overriding theme relating to health-seeking behaviour of participants in this study was "self-medication". This concurs with the study of Muangman (1987) which showed that nearly 55% of those studied chose to self-medicate by buying their own medicine from drugstores. This is also in agreement with a survey made in 1998 by the Household Socio-

economic Organisation which reported that in Northeast Thailand a person paid on average ground 105 *baht* a month for purchasing drugs without a prescription. This represented around 3.5% of the family income. A study on drug use in 1993, conducted by the Working Group on Drug System Analysis in Thailand, concluded that the wholesale value of drug consumption was about 27,000 million *baht* per year, while the retail price was estimated to be 50,000 million *baht* or about 35% of the overall national health expenditure. By comparison, in the U.K. only 11% of the overall national health expenditure was for drug consumption, whereas in Japan and the USA the figures were 18.4% and 8.2%, respectively (comparative data from 1990-Bureau of Health Policy and Planning, 1997: 81).

According to Kleinman (1984) the most common method of health care behaviour found extensively among villagers in every culture was self-medication or self-treatment (Le Grand & Sringernyuang, 1989; Chadbanchachai, 1990). This study revealed several factors associated with self-medication. One factor is the influence of Buddhist teaching, which emphasised self-reliance. In the past people usually cured themselves by using a family remedy. However, as time passes and circumstances change, inherited family remedies are gradually lost. This loss is compensated for by the import of drugs from western countries. With the advent of the mass media drugs can be advertised freely, and as people began to use and trust the drugs, traditional local medicine replaced by western drugs. The practice of self-reliance and self-treatment was still evident, but self-treatment using traditional medicine was replaced by self-treatment using western drugs, which used effective and varied forms of promotion. People began using over-the-counter drugs, which they could be purchased without a prescription. Therefore, problems of over-consumption, unnecessary drug use and the misuse of drugs were becoming major problems in Thailand. These issues can be

explained by the fact that the way ordinary people (or the popular sector), especially in developing countries, took care of their health is influenced by economic, political and cultural factors (Kleinman, 1984). In Thailand, it is time for those in charge of public health to urgently review weaknesses and build intellectual potential and provide strategies to solve these problems.

Furthermore, this study found that women and their families are able to use Thai folk beliefs to strengthen or replace the areas where health care providers are unsuccessful. An example of AIDS patients are withdrawn from modern medication and treated by the use of sacred water, or by curing chronic fatal diseases through driving out the threatened spirit. This type of treatment is considered unacceptable if viewed from a purely western scientific background. Also, if nurses are not aware of the Holistic-nursing model, they may reject traditional beliefs, which would in turn widen the gap between nurses and clients. However, if they view patients and their families holistically, they will have a better understanding of the options acceptable to patients. It is therefore necessary to bridge the gulf between popular beliefs and the scientific nursing world. Participants have grown up in a culture which believes in the supernatural, therefore nurses should not reject this belief, rather they should acknowledge and respect its mutual benefit, such as allowing patients to receive sacred water if it will ensure the nurse has the opportunity to make a follow up visit. In addition, they could take advantage of spiritual values of the patients by using them to lessen the feelings of stress.

Weiss & Lynne (1996: 108) concluded that a person acts in accordance with their health beliefs to prevent health problems. Furthermore, the work of Gochman (1988: 169) defined

health behaviour as those "personal attributes such as beliefs, expectations, motives, values, perceptions and other cognitive elements; personality characteristics, including affective and emotional states and traits and overt behaviour patterns, actions and habits that relate to health maintenance, to health restoration and to health improvement". Health behaviours or health seeking behaviours of the participants in this study consisted of the purchase of drugs for self-treatment, or seeking a Traditional Healer, such as Buddhist monks who will attempt cure their disease by sacred water, magic spells and herbs. Participants sought out traditional healers when they believed that the sickness had a supernatural cause. This behavior is similar to that studied in the work of Mechanic (1986), which explained that illness occurred logically and chronologically. However, Alonzo (1984) also discussed questions relating to what made patients decide how to care of their health when they became sick. He explained that it depended on people's situational perspective to adapt themselves to daily circumstances with the assistance of their relatives for their health's sake. This explanation can be applied to participants in this study.

The phenomenon in this study on the health-seeking behaviour of participants is in accordance with the concept of health-seeking behavior as discussed in the work of Chrisman (1977) where he explained the nature of illness in terms of a whole popular sector, in which the sub-culture of each region and the beliefs of each individual were integrated. For example, when some participants felt unwell, they would normally define the symptoms, either possible causes based on experience, and then estimate the impact of the illness on themselves and their families, in order to make a decision as to whether they would seek health treatment. The participants further classified human sickness into 3 levels: minor illness, severe illness and very sick or fatal illness. Participants would wait to observe

symptoms, and normally purchase drugs themselves, or find more information regarding possible further treatment. In this study, women, who were primary breadwinners, indicated that the major effect due to sickness was the loss of income. Women were required to earn at least 200 *baht* per day in order to buy school lunches for their children, a meal for the whole family and repay debts. Therefore, women generally bought medicine to eliminate risk of illness. They believed this could reduce the risk of serious illness or cure minor illness. However, due to a lack of medical knowledge, this practice was not only costly but also hazardous to health. Participants believed that their health system was similar to an engine (Mc Kinlay, 1976: 239); when it went wrong or did not work properly, it could be fixed by "flushing out", "unblocking", or "cleansing". Therefore, people in this community were likely to take medical 'sets' to cure any number of ailments. These sets were easy to find and could be bought with a small sum of money from drug stores or general stores. A 'set' would typically contain many kind of unidentified drugs, making it impossible to ascertain the potential risk to the body.

Community members interviewed in this study complained of extremely long waits at public hospitals or health stations. This wait means the loss of a day's income gained from selling goods or working as a labourer. To avoid such situations, the participants usually purchase medicine on a day to day basis, a common experience for poor people in developing countries (Calva, 1996; Ferraze, et al, 1996; Morissette & Dedobbeleer, 1997; and Seaman, 1995). The Thai government has recently passed a health care insurance system, to be administered by the Ministry of Public Health, which requires a 500 *baht* payment for a health insurance card. The card entitles the buyer and four other family members to free medical care for a year. However, only 20% of the people in the Railway Community were able to afford it. Those

who could not afford the card explained that managing to get enough food to sustain their family members and to pay for their children's schooling expenses was already an insurmountable task for them. This predicament was further exacerbated when 1998, the government announced that the card would no longer cover expenditure relating to childbirth. It could be said that at present, the health service system in Thailand does not cover those in low-income groups, and as yet fails to provide quality social security for all members of Thai society.

9.5 Women and Illness

Using the findings from this research, women's illness can be divided into two categories: poverty and environmental associated illness and work related illness. The first category relates to the group of poor living in a heavy-populated area, where the environment creates a low equality of life. The second part is the discussion relating to illness caused through and will be discussed further in the section titled 'work related illness'.

9.5.1 Poverty and Environmental Associated Illness

It is certain that the group involved in this study are poor. As a result of poverty, these people are exposed to a greater number of diseases. Poverty was leads to stress and causes psycho-biological change that affected women's health and well-being (Williams & Umberson, 2000: 553). Most participants received a low-income, had a low level of education and few employment options. They had to work as unskilled labourers, which provided no long term security. These factors contributed to the aforementioned psychological conditions

(Thiralaph, 1990). The relationship between poverty and mental health in Thailand is confirmed by figures released from Psychiatric Hospitals in Thailand. In 1992, 87% of patients in Psychiatric Hospitals were poor labourers with a low level of education (cited in Chuchart, et al, 1992). Poverty and illness are inextricably linked, meaning problems of illness in Thailand are very hard to solve. One possible remedy would be to allow poor people more opportunities to make a living, by creating employment schemes and training programmes. Also, there is a strong need for increased access to medical treatment.

Various group analysing poverty in Thailand have stated that it is not as widespread or severe as in similar countries facing economic difficulties, is as there has been no insurgent activity in Thailand. However, on absence of rebellion cannot be misconstrued to mean there are no serious problems. Religion, culture, beliefs and the strong kinship system of Thailand have helped to prevent uprisings and violence. The Buddhist principle of 'self-reliance' promotes kinship as a way of reducing common problems.

There is still no precise answer on what the government should do in order to solve the problem of the poor. Many have spoken about good governance and equitable distribution of economic resources. His Majesty the King has promoted the concept of maintaining a self-sufficient economy, where people can conduct integrated farming for local consumption and sell the surplus. This would ensure people had food to eat. As a nurse, I am unable to provide economic solutions. However, I can discuss the most effective way to help lessen the impact of poverty in relation to illness and health care services.

9.5.2 Work Related Illness

9.5.2.1 Physical Health Problems

Key Health problems, participants claimed were caused by a heavy workload, included musculoskeletal symptoms, allergic symptoms, gastrointestinal symptoms, and psychosocial problems.

Musculoskeletal symptoms: This study found that women performing highly physical work are likely to have musculoskeletal problems. This is in accordance with the work of others, including Houtman, et al (1994), Messing (1997), Paul, et al (1994), Travell (1976), and Watts & Siziya (1997), who indicated that daily activities or repetitive movement and static muscular effort while working were some of the precipitating factors which could cause a range of low-level pains, to excruciating aching and /or burning pains. There is substantial clinical, biomechanical, and epidemiological evidence supporting the relationship between musculoskeletal disorders and ergonomic factors in the workplace, including high repetition and high manual forces (Punnett & Herbert, 2000: 486). In this study, both men and women were facing neck and upper back disorders, shoulder disorders, elbow disorders, hand and wrist disorders, lower-back disorders and problems with the lower extremity. More research is needed to elucidate whether musculoskeletal disorders risk varies between women and men working in jobs with the same work exposure, and whether work-related musculoskeletal disorders have similar outcomes for both men and women.

Allergic Symptoms: The majority of work completed by participants in this study included selling grilled chicken and peddling goods at bus stations and other places along the road.

This type of work required high temperature charcoal fires and contained high levels of smoke, which caused eye irritation and problems with the respiratory system. Furthermore, walking all day in the sun could also cause heat stroke and prickly heat syndrome.

Exposure to dust is a common allergic symptom for some participants. Associated respiratory problems of many types include chronic bronchitis, asthma, nose congestion and sniffles. Participants suffering from dust allergies were food vendors at the bus depots and on the streets. These workers reported frequent colds due to the exposure to dust.

Another area of working with potential health problems was food production. Many participants complained of chronic skin ulcers at their insteps as a result of preparing grilled chicken, caused by the slicing and washing of chicken for many hours a day. This finding is in accordance with the work of Lewenhak (1992: 119), which analysed the negative health effects of working in the food production business, especially in relation to animal-borne infectious diseases, and those associated with molds, spores and other organic dusts.

Other physical hazards related to food production included heat and smoke irritation (Lewenhak, 1992:119) from grilling chicken. An extremely common complaint from participants in this study is glum face from malasma caused by heat from the grills. Faced with this women seek self-treatment by buying malasma-curing cream to apply on their faces. However, this often caused negative effects, with some participants being allergic to the chemical ingredients, resulting in their becoming reddish, peeled, dark and filled with rash. After consulting a doctor, they were only able to cure the rash, while the glum face remained.

The doctor assumed that they were allergic to mercury mixed in the malasma-curing cream. This product may not have passed the standards set by the Ministry of Public Health.

Gastrointestinal Symptoms: Acute diarrhoea is still an important health problem with increasing incidences in both children and adults in Thailand, but recent declining death rates are due to better health service coverage and the practice of oral re-hydration therapy on a wider scale (Bureau of Health Policy and Planning, 1997: 64). This study found that diarrhoea was such a common problem that every household had instant salt powder at home. The knowledge of drinking salt to compensate for fluid and electrolyte lost is very popular in Thailand after campaigns for more than 10 years. So, participants believed that "*For the common diarrhoea, just drink electrolyte, then every thing will be OK*". If vomiting was involved, participants were required to be given intravascular electrolyte fluid at the hospital.

One of the most commonly occurring problems found was chronic peptic ulcers, which participants themselves believed was due to not having meals on time, because they were busy trading and preparing food to sell. If they had not finished work or been very busy selling their produce, they would not have time to eat. Or, sometimes, they did not have time to prepare the food and pack to eat, they would take some snacks, that were easy to find. Shop assistants and construction workers who had to hurry to work in the early morning admitted that they did not have time to have breakfast before going to work. When they arrived at work they would work until noon. This may be one of the causes of peptic ulcers. Furthermore, they did not realize that taking painkillers continuously could also cause peptic ulcers (Cooper, et al, 1991: 72 & Roth, 1988). Other factors including the relationship between strain and the secretion of gastric acid in the stomach that causes a wound (Collin, et

al, 1997 & Karasek, 1979). This sickness seemed to be a major problem in Thailand for workers who had high physical demands, as found in a study conducted in 1993, which found that peptic ulcers is the second most commonly occurring health complaint after back pain (Koses, 1993).

9.5.2.2 Psychosocial Health Problems

Mental Health Problems: When participants from this study were asked what major difficulties they were facing, they often mentioned distress related to poverty, made worse by the economic crisis of 1997. Some had lost all their capital and had to borrow to invest. Difficulties in earning a living were a major factor related to mental health problems. Rapid changes in economic and social conditions have resulted in rising incidence of mental disorders. In a 1994 survey conducted in order to evaluate the Thai National Health Development Plan, it was found that the prevalence rate (case per 100,000 persons) of certain mental illnesses such as psychosis, anxiety and depression were on the increase since 1989.

Self-Medication: Aside from painkillers and medical 'sets', stimulants are frequently used by the subjects in this study. In Thai language, stimulants are referred to as *Yaa Bum Roong* (or a tonic). Using this title of '*Yaa*', believe that it is able to help maintain good health. Stimulants commonly used by participants include caffeine in the form of tonic beverages, containing water, sugar, caffeine and some vitamins. Many stimulant brand names are available and cost about 12-15 *baht* for a 150 c.c. Each bottle contains 22 gm of sucrose, 0.05 gm caffeine and 80.2 gm of various vitamins. Several studies have been conducted on the unfavourable effects of taking too much caffeine. Side effects include gastric irritation,

wakefulness and headaches when withdrawn. It can also cause cancer of the urinary bladder and cancer of gastroenteritis (The Pharmacy Department, 1990). Drinking stimulants containing caffeine involves both negative health effects and the loss of income upon purchasing these expensive drinks. Also, many participants liked to drink it with alcohol. Furthermore, the beverages contain synthesised caffeine, which can be more harmful than natural caffeine.

The drug that the participants liked to take most was *Yaa Tam Chai* (5oo mg of aspirin powder). *Yaa Tam Chai* was very popular amongst participants in this study. Some took it every in order to relax muscle strain. There were also causes of overuse causing peptic ulcers while required operations to treat the peptic perforation. *Yaa Tam Chai* costs about 3-5 *baht* per case. In the past, *Yaa Tam Chai* contained caffeine, which had caused addiction for regular users. The Ministry of Public Health therefore prohibited the mixing of caffeine in *Yaa Tam Chai* (cited in Whittaker, 1994).

Besides *Yaa Tam Chai*, the most popular drug, participants also liked to take *Yaa Chud* (a medicine set). In 1991, a study revealed 51 brands of *Yaa Chud* sold on the market which consisted of painkillers and muscular relaxants.

However, there is still no clear cut evidence of the side effects of taking *Yaa Chud* over a sustained period of time, as this study was only able to obtain data over a one year period. To understand the full impact of drug use, it is necessary to perform a longitudinal study. Retrospective information from participants, revealed the majority had a history of peptic

ulcers, but could not identify specific causes. Further research is required to determine the long-term effects of these drugs.

In order to effectively promote awareness of the dangers of over-use of antibiotics, it is important that any such campaign targets medical staff as well as the general public. It is suggested that this information be included in the medical curriculum

In conclusion, this study found that illness was caused by two major factors: the characteristics of the participants themselves, and work. Participants were poor and living in heavily populated areas, and this had an impact on their mental health. Poverty brought with it major problems for these participants, who were required to work extremely hard in order to survive. Work is a major factor causing health problem. These health problems can be divided into 2 categories, direct impact problems such include musculoskeletal, allergic, gastrointestinal, psychosocial and chronic illness. Indirect impact problems such as work accidents, miscellaneous symptoms and undesirable drug use. Unfortunately, a constraint of this research was that it could not clearly identify which work caused which health problems. This is because it dealt with the subjective accounts given by participants. Despite this, based on issues discussed here, concrete recommendations, will be made which will be practical and beneficial to the development of government policies, nursing education and health care practices.

9.6 Conclusion

This chapter has indicated the importance of women's labour force participation to the household economy and the way in which domestic units manage income. Women are the primary breadwinners for their families. 'Work' is considered as something that provides the money to help them and their family to survive. Finally, I have examined the issue of decision making within the household and indicated that the household, rather than the individual, is wholly responsible for decision making. However, it has also been uncovered that women are the prime decision-makers regarding small-scale market trade or labour force participation. Women, who live in the same community, have similar characteristics, they take concerted action, working as a network, which in turn becomes another social support mechanism, apart from their family.

It was discovered that Buddhism and the Thai way of living were the major factors influencing women's views on health and well being. By examining health or other problems via Buddhist philosophy, women were able to cope with problems more easily, and maintain a state of equilibrium. Indeed, the Buddhist teaching of "self-reliance" has a great impact on self-medication in Thai society.

This chapter has discussed the relationships between women and work, the economic and social processes of the household, and women's health status relating to their role within the domestic context. I have also indicated that women's participation in the labour force can and do change according to their family situations. Women's ability to participate in income generating activities is related to the circumstances of the household.

Therefore, the structure of the household also affects women's labor force participation since it influences the pattern of division of labour by labour in the domestic unit. Furthermore, it determines the extent to which women receive assistance in lessening their primary burden. In addition, the relationships between the income generating activities of a wife and a husband also affect women's participation in the labour force. In fact, these factors are interrelated and it is the dynamic interaction of these factors that women have to juggle in order to earn a living strive for a better life and maintaining health against adversity.

CHAPTER TEN

CONCLUSION AND RECOMMENDATIONS

The overwhelming life experience of the women in this study has been one of struggle since early childhood. Nearly half of the women were primary breadwinners for their families and held down several jobs in order to earn enough income to support their families. Despite being the primary breadwinners, their main perceived cultural responsibility was still domestic work. This is because Thai society maintains that domestic work is the unavoidable role of women.

In addition a remarkable characteristic of men in low-income communities is their alcohol dependence, especially amongst men aged over 40. Therefore, the women took on most responsibilities within the family in place of men. However, with limited education, working in the informal sectors as vendors, hawkers, maids, construction labourers or sub-contractors. The women were often available are such jobs offered: no legal protection, no welfare for health or income security, low income, and high competition among vendors and sub-contractors

Definite conclusions from the health status survey could not be reached. However, many participants had described associated with work included denying ill health, drinking, gambling, talking with relatives or neighbours and following the principles of *Tam Chai,* the Buddhist teaching of downplaying stressful events.

Within the communities women were usually responsible for the work related to money, and were the community's money keepers because of their high level of responsibility and sobriety during religious ceremonies.

Families are important to the social structure of Thai society. The characteristics of Thai family are cohesion and strength with tight-knit families. Family for these women has two dimensions: it can be a stressor, as they have to be responsible for the familial role and financially supporting their families, while it can also be an important social support network that help women maintain their life balance until they are able to cope with the problems.

Women's health beliefs have been influenced by Buddhist cultural beliefs. The latter places an emphasis on self-reliance. Self reliance included combining work and familial roles; self-medication; constructing social networks within the communities and '*Tam Chai*'.

10.1 Implications of the Findings

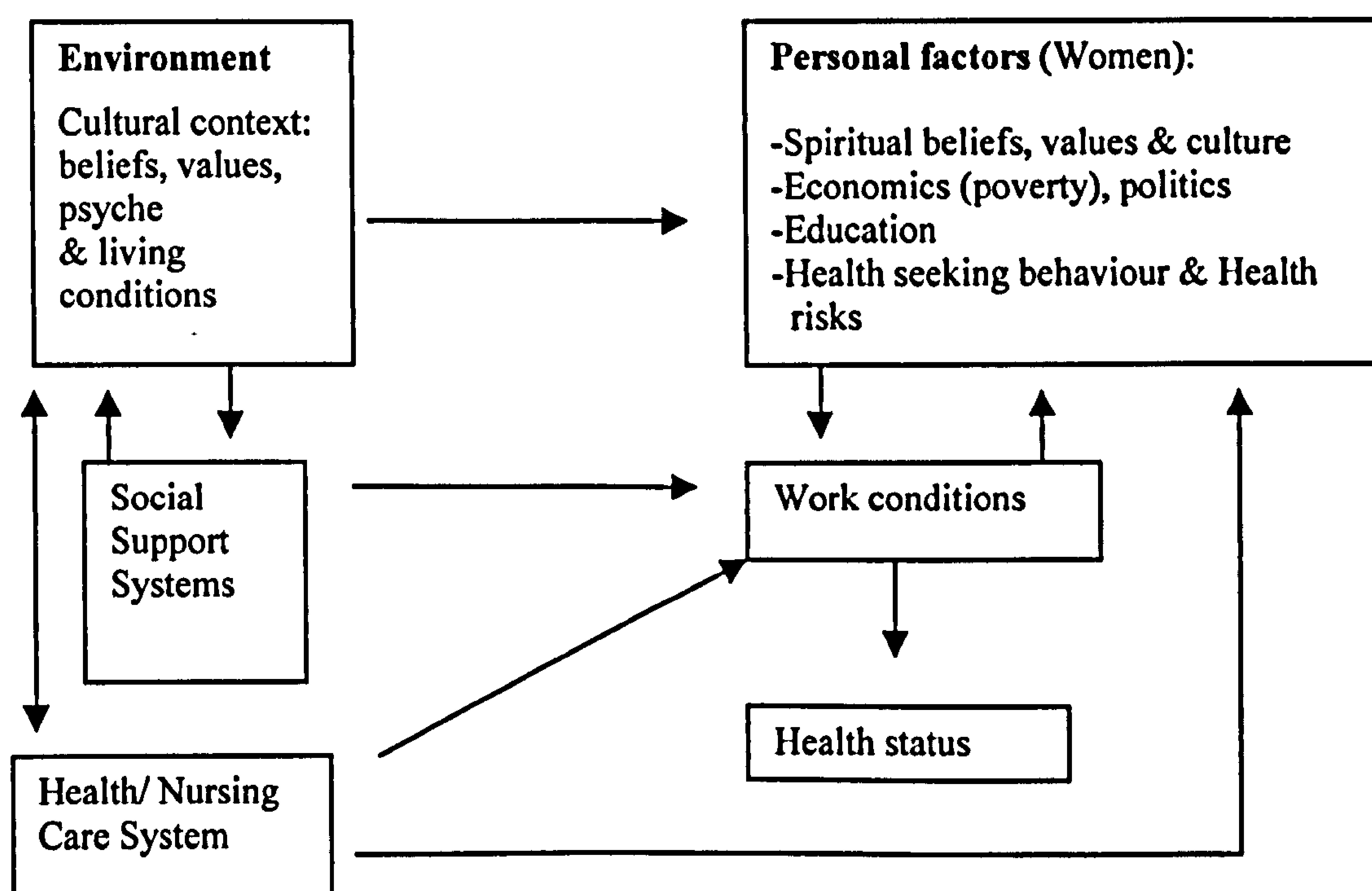
The findings from this study are beneficial to the nursing profession because they offer nurses a new understanding and insight into the difficulties and stresses facing hard working Thai women in low socio-economic groups. These findings can provide us with a better understanding of women's way of life, common characteristics defining women in this study include patience, sacrifice to family, faith in Buddhist beliefs, optimism, struggle to keep family intact and a determination to survive despite extreme hardship. Aspects concerning health seeking and risk-taking behaviour have also been dealt with. All parties concerned, especially health professionals and women's groups, need to recognise, that many poor women experience work-related stress while attempting to manage major family problems. The thrust of nursing practice should be based on increasing coping skills for women so that they can find solutions to problems effectively and creatively, for the sake of themselves and their families.

10.1.1 Implications for Nursing Philosophy

This exploratory study discloses pertinent conceptual information relating to the socio-cultural background of poor women and their health experiences. These concepts provide specific portraits about women, work and health in the context of poverty in Northeast Thailand.

At present the nursing profession still needs to develop its body of knowledge for directing nursing practice in Thailand. Nursing science by definition pays great attention to the whole of humanity and attempts to develop knowledge relating to this. The nursing profession is attempting to develop the principles of holistic health care. This means that not only one physical, mental and social aspect of health care are important, but spiritual aspects including values, beliefs and cultural factors of people are also relevant.

Figure 10.1 Nursing perspectives on women, work and health in the socio-cultural context of poverty.



From figure 10.1, we can further define the meaning of the following factors, personal factors, environments, health and nursing.

Personal factors: self-health responsibility; spiritual factors including values, beliefs and culture as relates to self-care behaviour. This is dynamic and changeable. This behaviour will be related to the social context including aspects of culture, politics and economics. Above all, they have their own attitudes and beliefs relating to health seeking behaviours.

Environment refers to the internal and external circumstances of a person. These are related to and influence a person in creating his/her life experience, health and well being. The data from this study indicated that low-income women could not separate themselves from their environment. This environment including factors such as family, work place and community were significant elements influencing their way of life.

Health is the process of individual change that incorporates his/or her environment. Health is an individual's perception related to his/her well being. The data showed that low-income women related their health to their work, in so far as the idea of good health required having money to support their families.

Nursing: Although no direct investigation of nursing strategies was conducted during this research, knowledge obtained through the course of study provided a set of data based on low-income women, their work, health and family roles. Nursing is the process of looking after people's health and promoting their longevity. Nurses relate to their clients by focusing on human aspects and promoting their potential. This study used a holistic approach, regarded the whole person rather than specific parts. The study paid great attention to people's beliefs, values and culture relating to health behaviour, I believe that

this study is not only be useful in providing guidance for nursing care of poor families in Northeast Thailand, but also contributes to the development of transcultural nursing concepts (as indicated in Figure 10.1), and thereby strengthens the body of knowledge in nursing science.

Information which emerged during the course of this study relating to women and low-income families, their health seeking behaviours and health risks, can provide a foundation for nursing. It can help provide a conceptual model for guiding future research and nursing development.

The findings from this research have led to the development of a primary conceptual nursing perspective for the health of poor women. The relationships between factors are described below.

The preliminary nursing perspective comprises six major components: personal factors, environment, work conditions, social support system, nursing care system and health status. Economic problems represent a primary factor affecting health. Economic problems limit opportunities for education. Economic problems have a clear impact on living conditions and force people to take on heavy workloads. These constraints have related health risks and create inappropriate health behaviours. This causes a cycle where health problems cause an inability to work and this inability to work leads to poverty and increased health risks. Nurses can intervene in aspects relating to the social system and nursing system in such communities. Nurses can help to promote appropriate health behaviours, which will in turn promote better health. Nevertheless, whether the direction of each component will be one-way or two-way still awaits findings of further studies that aim to develop and clarify this concept. It should be pointed out here that these concepts

have been sketched on the basis of only one component of research study which is not adequate. Social support systems and environment are mutually important as they have an influence on each other. This study found that in the social support system, both kinship and work networks play an important role in maintaining a state of equilibrium. Nurses should take into account how they can integrate or strengthen the social support systems of these women because it can indirectly help strengthen environments, personal factors and work conditions, which would in turn help improve women's health status.

The above-mentioned nursing perspective gives general guidance on how to provide nursing care to low-income women by paying attention to all aspects of human life. It does not isolate specific components, and emphasises a complete bio-psycho-social-spiritual system.

10.1.2 Implications for Nursing Practice

Many low-income women need information about self-health care and the skills required to take responsibility for themselves and their family members. Due to stress and other difficulties, women struggle to attain a status of well being. These women take care of themselves and their family members in a holistic manner, by incorporating their values and beliefs. There is a saying that women's health status often indicates the health status of their family members, since women are in the position of care giver to all in their family (La Rosa, 1997). Thus, a holistic nursing approach and family nursing care should be considered as the most effective method of health care for women and their families (Puavilai, 1996).

To perform holistic nursing care, nurses should adopt a holistic health perspective to focus their minds on the wholeness of a person (Johnson, 1990). In addition, it would help

nurses to understand family responsibilities with the theoretical-based family help nursing concepts (Friedman, 1992). As such, a significant strategy in implementing nursing care must be to build rapport with clients. When a good relationship has been developed, the client will genuinely express their health concerns. A finding of this study is the great reluctance of clients to approach nurses with health complaints. An underlying reason is the class difference, between a government official and village people, which prevents an open relationship. Therefore, the approach takes by each nurse to every household in the community is very important, and is of special importance for a family nurse working in small communities. The purpose is to build a trusting relationship and to gain rapport. Moreover, it is necessary for educators to assist the nurse in gaining an insight into a client's lifestyle, as well as the unique context of each individual.

Another significant strategy for nurses working with poor people is to be a coordinator between available economic or other resources and the clients. Although this is not the direct duty of the nurse, if our clients' economics status is improved, their health services are supported, or their occupational skills trained; then the clients' family health care can also be improved. For example, a nurse may coordinate with non-governmental officers (NGO) who train people with occupational skills so they can find jobs and earn money. NGO workers may locate occupations for HIV / AIDS infected people, or contact provincial social workers to assist in tuition for needy children. These are not nurse's direct duties, but nurses are able to make contact with or provide access to helpful resources. Community researchers also have a role to play for they are able to act as a coordinator providing beneficial resources or helpful advice. Therefore, I perceived my role in this research project as researcher, nurse, nurse teacher and as a coordinator between agencies and the community. This can also be a limitation in a context where there are limited resources.

In addition to building rapport between a nurse and the clients via the above-mentioned strategies, nurses can also adhere to the following guidelines. The nurse should assess the clients at the same time as providing them with opportunities to talk and express their problems. This will enable the nurse to gain an understanding of the client and share the cultural and personal values with them, which will in turn, have an impact on their way of life and health. Clients should be encouraged to utilise adaptive tasks and coping skills in a creative manner. To assess clients effectively, the nurse should not only talk with them but must incorporate an attentive listening strategy. Two-way communication will allow the nurse to learn more about the clients' experiences and health problems. The nurse should recognise the clients' importance and discuss appropriate ways of solving problems. Hence, the use of a holistic approach to nursing would help nurses better understand the clients' life situation.

Furthermore, information obtained about the importance of support systems which are favourable to helping solve health problems, could warrant a further major case study. Clients should be grouped in order to create a network of those who share similar problems, so all involved may have an opportunity to share their problems, consult, and exchange experiences. Nurses could act as coordinators or facilitators for such groups. This form of self-help group would provide mutual psychological assistance, and nurses would provide constructive health information when required.

It is critical that nurses must have an understanding of the complex factors that shape the professional practice of nursing and recognise that the profession of nursing exists within a larger sphere. By allowing nurses to recognise socio-economic and political factors which influence the health care system, they can gain a practical education to support their theoretical base. Thus, family, community or occupational nurses should focus on

relevant social factors affecting health care. This would enable nurses to gain a better understanding in providing a health care as promoters, caregivers, guides, facilitators and educators.

10.1.3 Implications for Nursing Education

The implications of this research for nursing education can be categorised into three aspects. Firstly, the findings suggest that women's health have not been effectively promoted in Thailand, especially in families of lower economic status. Generally speaking a healthy woman will promote a healthy family, therefore nursing educators should be aware that at present, there are many women who have limited access to resources needed in order to provide health care. As previously mentioned, these women have to take care of themselves, their families and provide financial resources. The majority of this group of women is excluded from the political and educational process and so suffer from a lack of health care resources. A vital role to take by nursing educators is not only through their words as a classroom teacher, but also by modeling in their role as a clinical instructor. This is particularly true in family and community areas.

Secondly, nurses in Thailand compose the largest group of health professionals in the country, and are scattered throughout the health care delivery system. In the past, traditional nurse training and learning emphasised the care of patients only. This study however helps to confirm that nursing education in Thailand should focus on knowledge and skills, and increase the potential of Thai nurses in the wider community. They should move in a new direction of health care delivery by simultaneously emphasising illness prevention and promoting well-being, as well as caring for clients.

Thirdly, the nursing syllabus should stress a culturally sensitive approach to the nursing care of women in low socio-economic groups, as these women have limited financial resources, time and knowledge of health care. Besides, the syllabus should allow students to understand the cultural issues of people in various contexts, since this would guide them to institute effective integrated nursing practices. The discoveries in this study could also be used to illustrate the limited access to health care, limited knowledge of important health issues, and the specific health and cultural characteristics commonly found in low socio-economic groups.

10.1.4 Implications for Research Design

Although the research methods employed were intended to be as rigorous as possible, there are three limitations that should be noted here. Firstly, the findings from this study provide portraits of women in specific low-income communities. The results reveal important information about the needs, concerns and strength of these women. A qualitative research study aims to elicit meanings in a given situation and to develop a reality-based theory. Although a qualitative approach cannot create exact replication (Morse & Field, 1995), the knowledge obtained from this study may be applied to Thai women in other low-income families, or even women in other poor countries for it is contended that many of the contributory factors are global in their application.

Therefore, this study represents one of a limited number of efforts to examine the relationship between women's work and their own welfare. This analysis uses models which allow us to model differentially the work performed at-home and away-from-home and to consider the potential endogeneity of many of the work and consumption decisions.

Secondly, this research did not look at the male viewpoint in an attempt to provide answers to why they were irresponsible and what they thought the underlying causes might be. The information gained from men was only used to verify, whether the informants' information was true or not. However, as the objective of this research was only study women work and health, it would be the aim of a further study to look at the perspective of men in this community, their personality development, their responsibility and their socialisation.

Thirdly, in the present research health status as related to work was part of a short-term study. Longitudinal research would be helpful to examine the change over time in the interrelationships of family variables. Studies of family functioning throughout phases of illness would cast light on these issues. A larger sample size is recommended to understand how women's work conditions are affected by their health and how they respond to illness.

In summary, findings from this study support the combining of quantitative and qualitative approaches in conceptualising family life and poverty and women's experiences of participation in the labour force. Further studies are requires which expand sample size, study the perspective of low-income men, and take a longitudinal approach. Finally a longitudinal study based on the holistic nursing model could provide a clearer understanding of lifestyles, earning a living, hardship, what women define as priority health problems and causes, and the effective information on what is necessary for this group of women and their families in order to care for themselves and their families.

10.2 Recommendations

From the results of the study, this section presents the recommendations for health care delivery and policy and recommendations for Thai health care reform. In addition, the recommendation for further research is also presented.

10.2.1 Recommendations for Health Care Delivery and Policy

The following recommendations are proposed for government and non-government organisations.

1. There are several dimensions of discrimination against women in the workplace, such as lack of training opportunities, promotional previleges, and wage rates (Archavanikul & Pramualratana, 1990). According to the data, poor women mostly work in the informal sector. These women include street vendors, food stall operators, domestic servants, and waitresses. Many of them are young, uneducated and inexperienced. With regard to the informal sector, they are not under the protection of the labour law. **Thus, I suggest that the Ministry of Public Health pay greater attention to promote the occupational health for workers in the informal sectors; in terms of the development of simple occupational health assessment strategies, development of occupational health education modules, and inclusion of occupational health in the preventive and promotion responsibilities.**

2. At this time, self-medication is still necessary particularly in the Thai community where the health care professionals are not numerous enough to support the people's health service requirement. I, therefore, recommend that The Ministry of Public Health should develop the education programme for both lay people and the dispensers to have appropriate knowledge in the use and selling of medicines. Moreover, development of

standard treatment guidelines for common self-medication should be provided as well as the disadvantages and dangerous of misused chemicals.

3. Municipality health services reported by this study and Srithumma (1994) have been found to be very low, at an average of only ten visitors per day. Furthermore the types of visits are more for curative than preventive purposes. Preventive services would include maternal and childcare, family planning, and communicable disease control. The lack of attractive service contributes much more to their under-use. The causes of under-utilization consist of lack of faith that lay people have upon health personnel, inconvenient location, high expense, and limited health services offered. Thus, there is enough ground for considering service improvement.

4. In most developmental programmes, many projects suggest the idea of the top down approach in which government officials introduce various training programmes, teaching women how to develop their daily household activities, which preserve their immediate environment. This approach emphasizes the '*etic*' approach. I, therefore, suggest that the ground up approaches are probably more appropriate or perhaps a combination of '*emic* and *etic*' approaches would be more fruitful. Thus the organisers should blend in external and internal sources of information for the ultimate outcomes of each programme.

5. Low-income female youth should be promoted and supported to receive equal foundation education as do middle-class and high-class female youths. Training and promotion of skills should be addressed so that they can work in different fields.

6. Funds should be established to support and develop occupations and skill training amongst poor women in order to upgrade them to become skilled labours.

7. Networks of women's occupations should be established amongst communities in the vicinity in order that they can rely on and exchange information with each other, and finally can negotiate with the employers and obtain more chances of occupations.

8. There should be thorough governmental external social services and welfare in every aspect for poor women.

9. Free welfare support, disseminate information on health care and feminine disease prevention should be arranged for the right target groups, i.e. poor women and old women who cannot earn a living and have no one to take care of them.

10. Funds should be established for low or free interest loaning for women heads of family so that they can invest in their business.

11. The potential of women heads of family in education and occupational skill development should be promoted and strengthened so that they can work and earn enough for their living.

12. An organisation responsible for alcohol and drug addiction among low-income people should be established. Information should be provided, and efficient and personal approach programmes arranged that call for addiction stoppage. The strategy used should incorporate politics, psychology, public health, and education together.

13. Child day care centers should be established in every communities in order to release women's responsibilities in dual roles, domestic task, and occupational task.

10.2.2 Recommendations for Thai Health Care Reform

Since the Asian crisis, arising from the devaluation of the Thai currency in 1997, there has been a great impact on all the countries in this area (Siamwala, 1998: 3). In Thailand, the impact has been of all levels of Thai society, especially the poor. Due to pre-existing economic difficulties, the crisis further increased the impact on all aspects of livelihood, including health problems. The health service units also have practical problems such as the overcrowding in public hospitals, patients falling ill with preventable diseases, higher cost of medical expenses caused by the devaluation of the *baht* (The Provincial Health Office, 2000: 1). Therefore, many health scholars including Pulchaleon, et al (2000) expressed that it was time to reform the public service system in Thailand. However, the reform needs to consider the composition of the Health Care System: Client Focus, Health Care Financial Support and Health Care Delivery System and especially the construction of a health infrastructure for the urban poor.

Client Empowerment

Client empowerment provides knowledge to lay people by outlining the rights to which they are entitled to receive, their potential to be self-reliant, focussing an traditional Thai wisdom, the ability to take care for themselves and their family, and knowing their duty and how to ensure health promotion for themselves and their families. This is the point of entry that should be used to approach each community. Since each community has the capacity to unite on health, they could effectively protect and promote public health and a better community environment. This could reduce the reliance on health products and technologies from foreign countries. In addition, the government should also provide an opportunity for all the people to participate in setting up, monitoring and administrating community policies so that people could really be a part of their country, as ruled in the Constitution of the Kingdom of Thailand 1997.

Health Care Delivery System

The system should place an emphasis on developing effective primary care services. The Health system must be a mechanism which can administrate health promotion, disease prevention, curation, nursing care and rehabilitation by using a holistic approach. A person would be considered as a whole: by considering physical, psychosocial and spiritual dimensions, irrespective of status, economic position, education, sex, age or disabilities. This is the philosophy which should be the basis for health care. Furthermore, wisdom based health systems are also needed to promote intellectual potential to develop the body of knowledge within the Thai context by using scientific methods as an educational approach and as a policy with strategies to manage a national health care service system.

In addition, the health care service system should consider efficiency and the affordability of the country to make the system worthwhile, in order to bring the greatest benefit. Furthermore, it should also have good quality and standards that emphasise the greatest benefit for the people. Therefore, the processes to develop and conduct quality control at all levels of the health system should be promoted, and the dissemination of health information is needed to provide quality health services to all people, regardless of the level of education. Finally, people need to have sufficient knowledge to make their own decisions about health care.

10.2.3 Recommendations for Further Research

This research is a study conducted only on a relatively group of small disadvantaged women group, but in fact, women comprise a big disadvantaged group in the social world and half of the world population. Although women's right and women's equality in society are an increasingly attentive issue at present, the interest is still not adequate in

less-developed countries. On top of this, there exists the economic problem, which deteriorates the situation even more. I would like to propose the following recommendations as regards research on women and women in low-income groups:

1. There should be an increase in research interest on topics concerning different women's groups, especially the low-income opportunity groups, so as to increase knowledge and find the means to problem solution and women's development.
2. A study should be conducted to establish a model for information transmission and perception suitable to ways of living of needy women in order to be applied as basis data in any campaign for knowledge and concepts on self-care of needy women and their families.
3. A study should also be made to produce a health service model suitable for women in low-income communities and their families, which is in accordance with their large number of life limitations.
4. An in-depth study and further research should be conducted for the testing or cross-validating to reaffirm and clarify the empirical validity of this conceptual nursing model of health status in women in the low-income context.

10.3 Epilogue

In this study, I have devoted all my physical energy, time and thought in order to achieve and obtain the clearest answers to the research. Different research methods have been combined. I have accordingly achieved one level of benefits from this research, which could be applied as basis knowledge in conducting nursing practice and clinical teaching for poor people in urban areas. I have a hope that this research will also be useful for other interested people, and can be used as basis data for future research. Although the

findings are not any breakthrough, I still believe that at least, it will be a step towards an understanding of ways of living, women's different limitations, and the truth of life in slums. Understanding these will lead to more appropriate health promotion, disease prevention, and enhanced health care services for this group of people in the future:

'Changing the slums, as valuable as a pearl
For a new society of slum in a beautiful world'.
(Thai slum people's song - My translation)

REFERENCES

Allan, G. 1994. *Family Life: Domestic Roles And Social Organisation*. Oxford: Basil Blackwell.

Allen, O.E. 1981. *Building Sound Bones And Muscle*. Alexandria: Library Of Health / Time-Life Books.

Alonzo, A.A.1984. An Illness Behavior Paradigm: A Conceptual Exploration Of A Situation Adaptation Perspective. *Soc.Sci Med.* 19(5): 449-501.

Amatea, E.S. & Fong, M.L. 1999. The Impact Of Role Stressors And Personal Resources On The Stress Experience Of Professional Women. *Psychology Of Women Quarterly*. 15, 419-430.

Amodeo, M. et al. 1996. Adapting Mainstream Substance-Abuse Interventions For Southeast Asian Clients. *Families In Society: The Journal Of Contemporary Human Service*. 77(7) : 403-412.

Anderson, N. & Armstead, C.A. 1995. Toward Understanding The Association Of Socioeconomic Status And Health: A New Challenge For The Biopsychosocial Approach. *Psychosomatic Medicine*. 57 (3): 213-225.

Aneshensel, C.S. 1992. Social Stress: Theory And Research. *Annu.Rev.Sociol.* 18: 15-38.

Anonymous Writer, 1993. *Our Lives- Our Stories*. Bangkok: The Foundation For Women (FFW).

Anson, O., Pilpel, D. and Rolnik, V.1996. Physical And Psychological Well - Being Among Immigrant Referrals To Colonoscopy. *Soc. Sci. Med.* 43(9): 1309-1316.

Arber, S. and Ginn J. 1993. Gender And Inequalities In Health In Later Life. *Soc. Sci. Med.* 36(1) : 33-46.

Archavanitkul, K. 1988. *Migration And Urbanisation In Thailand, 1980 : The Urban-Rural Continuum Analysis*. Paper presented in the International Conference on Thai Studies At The Australian National University, Canberra, 3-6 July, 1987.

Archavanitkul, K. And Pramulratana, A. 1990. *Factors Affecting Women's Health In Thailand.* Unpublished Paper.

Armentrout, G. 1993. A Comparison Of The Medical Model And The Wellness Model: The Importance Of Knowing The Difference. *Holistic Nurs Pract.* 7(4): 57-62.

Arnstein, P.M. et al. 1996. Women And Heart Attack: Prevention, diagnosis, And Care. *Nurse Practitioner*. 21(5): 57-70.

Ashley, M.M. 1958. *His First Million Years*. Now York: The New American Library.

Asthana, S. 1995. Variations In Poverty And Health Between Slum Settlements : Contradictory Findings From Visakhapatnam, India. *Soc. Sci. Med.* 40 (2) : 177-188.

Atkinson, P. & Hammerseley, M. 1994. Ethnography And Participant Observation. In Denzin, N.K. & Lincoln, Y.S. (eds). *Handbook Of Qualitative Research*. London: Sage Publications.

Atwell, C. 1996. Health In The Workplace. In Twinn, S.et al (eds.) *Community Health Care Nursing-Principles For Practice*. Oxford: Butter Worth Heinemann.

Austin, G.A. & Gilbert, M.J. 1989. Substance Abuse Among Latino Youth. *Prevention Research Update, Spring, 3*. Portland: OR: Western Center For Drug-Free School & Communities.

Axihm, J.M. and Hirsch, A.E. 1993. Welfare And The "Reform" Of Women. *Families In Society : The Journal Of Contemporary Human Services*. 74(9) : 563-572.

Baksh, M. et al. 1994. The Influence Of Reproductive Status On Rural Kenyan Women's Time Use. *Soc. Sci. Med.* 39 (3) : 345-354.

Barnett, R. C., Davidson, H. & Marshall, N.L. 1991. Physical Symptoms And The Interplay Of Work And Family Roles. *Health Psychology*. 10(2): 94-101.

Barnett, R.C., et al. 1993. Gender and the relationship between job experiences and psychological distress : a study of dual-earner couples. *J-Pers-Soc-Psychol*. 64 (5) : 794-806.

Barnum, B.J. 1987. Holistic Nursing And Nursing Process. *Holistic Nurs Pract*. 1(3): 27-35.

Baum, F. 1995. Researching Public Health : Behind The Qualitative-Quantitative Methodological Debate. *Soc. Sci. Med.* 40 (4) : 459-468.

Bechtel, G.A., Shephred, M.A. And Rogers, P.W. 1995. Family, Culture, And Health Practices Among Migrant Farm workers. *Journal Of Community Health Nursing*. 12 (1) : 15-22.

Beck, C.T. 1994. Phenomenology: Its Use In Nursing Research. *Int.J.Nurs.Stud.* 31(6): 499-510.

Bennett, L. 1991. Adolescent Girls' Experience Of Witnessing Marital Violence: A Phenomenological Study. *J. Of Advanced Nursing*. 16: 431-438.

Bennett, S. & Tangcharoen Sathien, V. 1994. A Shrinking State? Politics And Private Health Care In Thailand. *Public Administration And Development*. 14: 1-17.

Benson, E.R. & Mc Devitt, J.Q. 1989. Home Care And The Older Adult: Illness Care Versus Wellness Care. *Holistic Nurs Pract*. 3(2): 30-38.

Bird, C. E. 1999. Gender, Household Labour, And Psychological Distress: The Impact Of The Amount And Division Of Housework. *J.Of Health And Social Behavior*. 40(1): 32-45.

Bisgrove, E.Z. and Popkin, B.M. 1996. Does Women's Work Improve Their Nutrition : Evidence From The Urban Philippines. *Soc. Sci. Med.* 43 (10) : 1475-1488.

Bhuntong, T. 1990. Thought Relating To Health And Nursing Care. *Thai Nursing Council Bulletin*. 5(March):12-14. (In Thai).

Blattner, B. 1981. *Holistic Nursing*. Englewood Cliffs (NJ): Prentice Hall.

Blum, H.L. 1976. *Expanding Health Care Horizons: Form A General Systems Concept Of Health To A National Health Policy*. Oakland Calif: Third Party Associates.

Bockmom, D.F. & Riemen, D.J. 1987. Qualitative Versus Quantitative. *Nursing Research*. 2(1): 71-75.

Bogenschneider, K. et al. 1998. Other Teens Drink, But Not My Kid: Does Parental Awareness Of Adolescent Alcohol Use Protect Adolescents From Risky Consequences? *J. Of Marriage And The Family*. 60 (2): 356-373.

Boonchalaksi, W. 1995. The Reliability And Validity Of Qualitative Research Methods. In Yoddumnern-Attig, B. et al (eds.). *Qualitative Methods For Population And Health Research.* Nakhonprathom: institute For Population And Social Research, Pp 49-57.

Boonjerm, S. 1993. *Isaan Heritage.* Ubonrachathani: Isaan Heritage Print (In Thai).

Boonmongkon, P. et al. 1998. *Understanding Women's Experience Of Gynaecological Problems: An Ethnographic Case Study From NE. Thailand.* Bangkok: The Ford Foundation.

Brannen, J. and Moss, P. 1991. *Managing Mothers-Dual Earner Households After Maternity Leave.* London : Unwin Hyman.

Brezinka, V. And Kittel, F. 1995. Psychosocial Factors Of Coronary Heart Disease In Women: A Review. *Soc. Sci. Med.* 42(10):1351-1365.

Brown, D. 1994. *The State And Ethnic Politics In Southeast Asia.* New York: Routledge. Pp 158-205.

Buchberger, J., Nemeck, J. & Fahrni, M. 1978. Occupational Medicine Insight Into The Problem Of Occupation Stress In The Construction Industry. *Soz-Praventivented.* 32(4-5): 263-265.

Bukkyo Dendo Kyokai, 1996. *The Teaching Of Buddha.* Tokyo: Society For The Promotion Of Buddhism.

Bureau Of Health Policy And Planning, 1996, 1997. *Health In Thailand 1995-1997.* Bangkok: Ministry Of Public Health Thailand.

Burg, J.A. & Gist, G.L. 1997. The Potential Impact On Women From Environmental Exposures. J. Women's Health. 6 (2): 159-161.

Burke, R. J. 1996. Work Experiences, Stress And Health Among Managerial And Professional Women. In Schabracq, et al (eds.) *Handbook Of Work And Health Psychology.* New York: John Wiley & Sons.

Bushy, A. 1994. Women In Rural Environments: Considerations For Holistic Nurses. *Holistic Nurs Pract.* 8 (4): 67-73.

Butr-Indr, S. 1995. *The Social Philosophy Of Buddhism.* Bangkok: Mahamakut Buddhist University.

Cafferata, G.L., Kasper, J. and Bernstein, A. 1983. Family Roles, Structure, and Stressors In Relation To Sex Differences in Obtaining Psychotropic Drugs. *Journal of Health and Social Behavior.* 24 (June) : 132-143.

Calva, J. 1996. Antibiotic Use in A Periurban Community In Mexico: A Household And Drugstore Survey. *Soc. Sci. Med.* 42 (8) : 1121-1128.

Campbell, K.E. & Barrett, A.L. 1992. Sources Of Personal Neighbour Networks: Social Integration, Need Or Time? *Social Forces.* 70, 1077-1100.

Capers, C.F. & Kelly, B. 1987. Neuman Nursing Process: A Model Of Holistic Care. *Holistic Nurs Pract.* 1(3): 19-26 .

Caputo, R.K. 1995. Income Inequality And Family Poverty. *Families In Society: The Journal Of Contemporary Human Services.* 76(10) : 604-615.

Carbonu, D.M. And Soares, J.M. 1997. Forensic Nursing In Pakistan Bridging The Gap Between Victimized Women And Health Care Delivery System. *Journal Of Psychosocial Nursing Mental Health Service.* 35 (6): 19 - 27.

Carey, J. 1993. Linking Qualitative And Quantitative Methods: Integrating Cultural Factors Into Public Health. *Qualitative Health Research.* 3: 298-318.

Carper, B.A. 1978. Fundamental Patterns Of Knowing In Nursing. *Advanced In Nursing Science.* 1(1): 13-23.

Cartwright, J. And Limandri, B. 1997. The Challenge Of Multiple Roles In The Qualitative Clinician Research - Participant Client Relationship. *Qualitative Health Research.* 7 (2) : 223 - 235.

Cassel, J. 1979. The relation of urban environment to health: Toward a conceptual frame and a research strategy. In Hinkle, L.E. & Loring, W.C. (eds). *The Effect Of The Man-Made Environment On Health And Behaviour.* London: Castle House.

Chadbunchachai, S. et al. 1990. *Resources and Decision Making For Drug Usage Of Rural Northerners.* Khon Kaen: Khon Kaen Karn Pimp (In Thai).

Chadbunchachai, S. 1997. *The Behaviour Of The People Of NE Thailand Towards Medicines For Self-Treatment.* Thesis Of The Degree Of Doctoral Of Philosophy, The Robert Gordon University, Scotland, UK.

Chadchaidee, T. 1994. *Essays On Thailand.* 5th ed. Bangkok: Thanapol Vitayakarn Co. Ltd.

Chamratrithirong, A., 1979. *Recent migrations in Bangkok Metropolis : a follow up study of migrants' adjustment, assimilation, and integration.* Bangkok : Institute for Population, and Social Research, Mahidol University.

Chamratrithirong, A.et al.1995. *National Migration Survey Of Thailand.* Bangkok : Mahidol University.

Chanawongse, K., Kamnuansilpa, P., Wongtanavasu, S. & Techamanee, Y. 1999. Khon Kaen: Heart Of The Northeast. In *Five Cities: Asian Urban Population- Environment & Dynamics.* AUICK & UMPEDP, Oxford Press Of Singapore.

Changkwanyaeu, P. 1998. *Women In Eastern Perspectives.* Bangkok: Chulalongkorn University Press.

Chanpothisri, W. 1990. *Potential Of Isaan Rural Communities In Self- Care.* Khon Kaen: CIDA & RDI, KKU.(In Thai).

Chantawanich, S. 1997. *Qualitative Methodology.* Bangkok: Chulalongkorn University Press (In Thai).

Chaudhry, F. 1996. Race And Poverty. In *Strathclyde: Issues And Opportunities.* Strathclyde Poverty Alliance.

Chayovan, N. et al. 1996. *A Study On The Status Of Women And Fertility In Thailand.* Bangkok: Institute Of Population Studies, Chulalongkorn University.

Chen, V.T. 1997. Asian And Pacific Island Women. In K.M. Allen And J.M.Phillips.(eds). *Women's Health Across The Lifespan.* Philadelphia: Lippincott.

Chenitz, W.C.& Granfors, W. 1989. Alcoholism And The Family. In Gillis, G.L. et al (eds) *Toward A Science Of Family Nursing*. New York: Addison E-Wesley Publishing Company.

Chirawatkul, A. et al. 1995. *Social And Health Problems Of The Construction Workers In The Northeast*. Khon Kaen: Khon Kaen University (In Thai).

Chirawatkul, S. 1998. Research On Thai Women's Health During 1983-1995. *Health Systems Research J.* 6(1): 66-76 (In Thai).

Chrisman, N. 1977. The Health Seeking Process: An Approach To The Natural History Of Illness. *Cul Med Psychi.* 1: 351-377.

Chuchart, A. et al. 1992. *Research On Psychosocial Factors Related To Psychosis Patients In Psychosis Hospitals.* Nontaburi: Sripanya Hospital (In Thai).

Chunchamnong, S. 1997. *Faith And Belief Toward Philosophy And Religion*. Bangkok: Mental Health Press. (In Thai).

Chung, P., and Spears, G., 1992. Psychiatric Morbidity Amongst Dunedin Chinese Women. *Aust-N-J-Psychiatry*. 26 (2) :183-190.

Chung, R.C.Y. and Kagawa-Singer, M. 1993. Predictors Of Psychological Distress Among Southeast Asian Refugees. *Soc. Sci. Med.* 36 (5) : 631-639.

Chuprapawan, C. 1992. *Health Examination Survey, Round 1, 1991-1992.* Bangkok: Ministry Of Public Health. (In Thai).

Chuprapawan, C. 1996. *The National Health Examination Survey Of 1992.* Bangkok : NEBT, THRI, And HSAI (In Thai).

Chusil, k. et al. 1989. *Situations And Problems Of Traditional Medicine And Development Strategies In Primary Health Care*. Khon Kaen: USAID & RDI, KKU (In Thai).

Coffey, A. And Atkinson, P. 1996. *Making Sense Of Qualitative Data*. London : SAGE Publications.

Cohen, L. & Manion, L. 1994. *Research Methods In Education*. 4th ed. New York: Routledge.

Collin, B.S. et al. 1997. Women, Work and Health : Issues And Implications For Worksite Health Promotion. *Women & Health*. 25 (4): 3-37.

Cooper, A. et al. 1991. *Occupational Health In Homeworkers: A Study Of Homework In Two Village In Khon Kaen Province, Northeast, Thailand.* Unpublished Thesis Of The Master Degree, The University Of Queensland.

Cooper, W. et al. 1991a. *The Impact Of Development Policies On Health-A Review Of The Literature*. Geneva: World Health Organization.

Cormack, D.F.S. 1984, 1996. *The Research Process In Nursing*. London : Blackwell.

COWI-CBI. 1998. *Khon Kaen Province: Its Economic Profile*. Khon Kaen: COWI-CBI Joint Venture.

Craddock, C. and Reid, M. 1993. Structure and Struggle : Implementing A Social Model Of A Well Women Clinic in Glasgow. *Soc. Sci. Med.* 36 (1): 67-76.

Creswell, J.W. 1994. *Research Design: Qualitative And Quantitative Approaches.* California: SAGE.

Cummings, J. 1996. *Thailand: A Lonely Planet Survival Kit.* Melbourne : Lonely Planet.

Daily News. 1998. *Yaa Chud. Matichon.* 7420 (21) : 7 (In Thai).

DANCED. 1996. *Municipal Environmental Plan For Khon Kaen.* Khon Kaen : COWI-CBI Joint Venture.

Data & Statistics, 1998. *Health Systems Research Journal.* 6(1): 83-84 (In Thai).

De Vaus, D.A. 1986. *Surveys In Social Research.* London: Allen & Unwin.

Dempsey, P.A. & Dmpsey, A.D. 1992. *Nursing Research With Basic Statistical Applications.* 3rd ed. Boston: Jones & Bartlett Publishers.

Dennerstein, L. 1995. Mental Health, Work, and Gender. *International Journal of Health Services.* 25 (3) : 503-509.

Denzin, N.K. 1970. *The Research Act In Sociology: A Theoretical Introduction To Sociological Methods.* London: The Butterworth Group.

Denzin, N.K. And Lincoln, Y.S. 1994. *Handbook Of Qualitative Research.* London : SAGE Publications.

Donohue, J. 1982. Facts And Figures On Urbanisation In The Developing World. *Assignment Children.* 57: 21-41.

Dossey, B.M., Keegan, L., Guzzetta, C.E. & Kolkmeier, L.G. 1995. *Holistic Nursing.* 2nd Maryland: An Aspen Publication.

Douglas, M.K. et al. 1996. The Work Of Auxiliary Nurses In Mexico Stressors, Satisfiers And Coping Strategies. In *J.Nurs .Stud.* 33(5): 495-505.

Dowler, E. 1996. Women, Food And Low Income : A Cause For Concern. *Health Visitor.* 69 (9): 359-360.

Downe, P.J. 1997. Constructing A Complex Of Contagion : The Perceptions Of AIDS Among Working Prostitutes In Costa Rica. *Soc. Sci. Med.* 44 (10) : 1575-1583.

Downe-Wamboldt, B. 1992. Content Analysis : Method, Applications, and Issues. *Health Care for Women International.* 13 : 313-321.

Drew, N. 1993. Reenactment Interviewing : A Methodology For Phenomenological Research. *IMAGE : Journal Of Nursing Scholarship.* 25 (4) : 345 -351.

Duangpaktra, J. 1992. *Analysis On Esarn Women's Pole, From Kampoon Boontawee's Short Stories.* Khon Kaen: Faculty Of Humanities And Social Science (In Thai).

Duncan, M.E. et al. 1994. A Socioeconomic, Clinical And Serological Study In An African City Of Prostitutes And Women Still Married To Their First Husband. *Soc. Sci. Med.* 39(3): 323-333.

Eisner, E.W. 1981.On The Differences Between Scientific And Artistic Approaches To Qualitative Research. *Education Researcher.* 10(2): 5-9.

El-Batawi, M.A. 1981. Special Problems Of Occupational Health In The Developing Countries. In R.S.F. Schilling (ed). *Occupational Health Practice.* London: Butter-Worths.

Elkeles, T. And Seifert, W. 1996. Immigrants And Health : Unemployment And Health Risks Of Labour Migrants In The Federal Republic Of Germany, 1984-1994. *Soc. Sci. Med.* 43 (7) ; 1035-1047.

Elliott, S.J. 1995. Psychosocial Stress, Women And Heart Health : A Critical Review. *Soc. Sci. Med.* 40 (1) : 105-115.

Facione, N.C. 1994. Role Overload And Health : The Married Mother In The Waged Labor Force. *Health Care For Women International.* 15: 157-167.

Farr, K.A. & Wilson-Figueroa, M. 1997. Talking About Health And Health Care: Experiences And Perspectives Of Latino Women In A Farming Community. *Women & Health.* 25 (2): 23-40.

Fawcett, J. 1989. *Analysis And Evaluation Of Conceptual Model Of Nursing.* 2nd ed. Philadelphia: FA. Davis.

Fein, R.1978. Research On Fathering: Social Policy And An Emergent Perspective. *Journal Of Social Issues.* 34(1): 123-125.

Ferraze, M.B. et al. 1996. Availability Of Over-The Counter Drugs For Arthritis In Sao Paulo, Brazil. *Soc. Sci. Med.* 42 (8) : 1129-1131.

Fetterman, D.M. 1989. *Ethnography Step By Step.* Newbury Park: SAGE.

Field, P.A. And Morse, J.M. 1985, 1991. *Nursing Research: The Application Of Qualitative Approaches.* London: Chapman & Hall.

Fishel, A.H. and Samsa, G.P. 1993. Role Perceptions Of Divorcing Parents. *Health Care For Women International.* 14 (1) : 87-98.

Franc, E.L. et al. 1996. Working Women's Sexual Risk Taking In Jamaica. *Soc. Sci. Med.* 42 (10): 1411-1417.

Franklin, C. and Jordan, C. 1995. Qualitative Assessment : A Methodological Review. *Families In Society : The Journal Of Contemporary Human Services.* 76 (5) : 281-295.

Friedman, M.M. 1986, 1992. *Family Nursing : Theory And Assessment.* New York : Appleton-Century-Crofts.

Frye, B.A. And D'Avanzo, C. 1994. Themes In Managing Culturally Defined Illness In The Cambodian Refugee Family. *Journal Of Community Health Nursing.* 11(2) : 89-98.

Fuller, T.D. et al. 1993. Housing, Stress, and Physical Well-Being : Evidence From Thailand. *Soc. Sci. Med.* 36 (11) : 1417-1428.

Fuller, T.D.et al. 1996. Chronic Stress And Psychological Well-Being: Evidence From Thailand On Household Crowding. *Soc. Sci. Med.* 42 (2): 265-280.

Garcia-Moreno, C. 1997. Gender Issues In Women's Work And Health. In *Gender And Women's Health Part I.* Asian-Pacific Resource & Research Centre For Women (ARROW), Pp 25-29.

Gelfand, D.E. and Mc Callum, J. 1994. Immigration, the Family, And Female Caregivers in Australia. *Journal of Gerontological Social Work.* 22 (314) : 41-59.

Glick, D.F. 1999. Advanced Practice Community Health Nursing In Community Nursing Centers: A Holistic Approach To The Community As Client. *Holist Nurs Pract.* 13 (4): 19-27.

Gochman, S.D. (ed.). 1988. *Health Behavior Emerging Research Perspectives.* New York: Plenum Press.

Goering, P.N. & Steiner, D.L. 1996. Reconcilable Differences: The Marriage Of Qualitative And Quantitative Methods. *Canadian J. Of Psychiatry.* 41: 491-497.

Gottschalk, J. and Teymour, L. 1993. Third World Women Call For A Balanced Perspective On Women's Health. *Health Care for Women International.* 14 : 111-116.

Graetz, B. 1993. Health Consequences Of Employment And Unemployment : Longitudinal Evidence For Young Men And Women. *Soc. Sci. Med.* 36 (6) : 715-724.

Greaves, K.M. et al. 1995. Economic Resources, Influence, And Stress Among Married Couples. *Family And Consumer Sciences Research Journal.* 24 (1) : 47-69.

Green, J.C., Caracelli, V.J. And Graham, W.F. 1989. Toward A Conceptual Framework For Mixed Method Evaluation Designs. *Educational Evaluation And Policy Analysis.* 11 (3): 255-274.

Greenglass, E.R. 1991. Burnout And Gender: Theoretical And Organisational Implications. *Canadian Psychology.* 32 (4): 563-572.

Greenhalgh, J., Vanhanen, L.& Kyngas, H. 1998. Nurse caring Behaviours. *J. Of Advanced Nursing.* 27(5): 927-932.

Guppy, A. And Marsden, J. 1996. Alcohol And Drug Misuse And The Organization. In Schabracq, M. J. (eds.) *Handbook Of Work And Health Psychology.* New York: John Wiley & Sons.

Hagested, G.O. 1984. Women Intergenerational Patterns Of Power And Influence. In Stamm, L. & Ryff, C.D. *Social Power And Influence Of Women.* Washington: AAAS Selected Symposium.

Halfon, S.T., Kodama, A.M. & Arbeit, W. 1991. The Health Working Women In Health. *Hawaii. Med. J.* 50 (1): 18-23.

Hallqvist, J. et al. 1998. Is The Effect Of Job Strain On Myocardial Infarction Risk Due To Interaction Between High Psychological Demands And Low Decision Latitude? Results From StockholmHeart Epidemiology Program (SHEEP). *Soc. Sci. Med.* 46(11): 1405-1415.

Hamel, J. 1993. *Case Study Methods.* Newbury Park: SAGE.

Handerson, M. and Argyle, 1985. Social Support By Four Categories Of Work Colleagues : Relationships Between Activities, Stress And Satisfaction. *Journal Of Occupational Behaviour.* 6 : 229-239.

Hanna, J.M. 1998. Migration and Acculturation Among Samoans: Some Sources Of Stress And Support. *Soc. Sci. Med.* 46(10): 1325-1336.

Harpham, T. 1994. Urbanization And Mental Health In Developing Countries : A Research Role For Social Scientists, Public Health Professionals And Social Psychiatrists. *Soc. Sci. Med.* 39 (2) : 233-245.

Harrison, M., Neufeld, A. & Kuskner, K. 1995. Women In Transition: Access & Barriers To Social Support. *J. Of Advanced Nursing*. 21(5): 858-864.

Haughey, A. 1995. Contemporary District Nursing Practice. In Sciences, D. (ed.) *Community Health Care Nursing.* Oxford: Blackwell Sciences.

Henderson, D.J. et al. 1992. Toward Culturally Sensitive Research In A Multicultural Society. *Health Care For Women International.* 13: 339-350.

Herlich, C. 1993. *Health And Illness*. London: Academic Press.

Hochschild, A. 1989. *The Second Shift*. New York: Avon Books.

Hodges, D. 1997. The Role Of The Occupational Health Nurse. In Oakley, K. (ed.) *Occupational Health Nursing*. London: Whurr Publishers Ltd.

Hoffman, M. et al. 1997. Women's Health Status And Use Of Health Service In A Rapidly Growing Peri-Urban Area Of South Africa. *Soc. Sci. Med.* 45 (10): 149-157.

Holm, K. And Scherubel, J. 1997. Coronary Heart Disease. K.M. Allen And J.M. Phillips. *Women's Health Across The Lifespan*. Philadelphia: Lippincott: 125-143.

House, J.S., Landis, K.R. & Umberston, D. 1988. Social Support And Health. *Social* Relationships And Health Science. 24: 540-544.

Houtman, I.L. et al. 1994. Psychosocial Stressors At Work And Musculoskeletal Problems. *Scan. J. Work. Environ. Health.* 20(2): 139-145.

Iawsriwong, N. 1995. *Ideology Of Loincloth, Sarong And Underwear.* Bangkok: Matichon Printed. Pp 90-100 (In Thai).

Infante-Rivard, C. et al. 1993. Pregnancy Loss And Work Schedule During Pregnancy. *Epidemiology.* 4(1): 73-75.

Intarakumhang, R. 1994. *Women's Right In Buddhist Ways.* Bangkok: Gender Press. (In Thai).

Jambunathan, J. 1992. Socio-cultural Factors In Depression In Asian Indian Women. *Health Care For Women International.* 13 (3) : 261-269.

Jimenez, A.L. et al. 1997. Mental Health Utilization In Women With Symptoms Of Depression. *Women & Health.* 25 (2) : 1-21.

Johnson, D.E. 1966. A Philosophy Of Nursing. In B. Bullough And V. Bullough (eds). *Issues In Nursing.* New York: Springer.

Johnson, M.B. 1990. The Holistic Paradigm In Nursing : The Diffusion Of An Innovation. *Research In Nursing & Health.* 13 : 129-139.

Jongudomkarn, D. 1995. *Low-Income Women: Aspects Of Health: Case Studies In A Khon Kaen Slum.* Khon Kaen: Faculty of Nursing, KKU (In Thai).

Jorgensen, D.L. 1989. *Participant Observation: A Methodology For Human Studies.* Newbury Park: SAGE.

Kabinlsingh, C. 1984. Buddhism And The Status Of Women. In Terwiel (ed.) *Buddhism And Society In Thailand.* Ranchai (India): South East Asian Review Office.

Kaewthep, K. et al. 1995. *Idealism, Belief, Values, Society, And Culture.* Bangkok: Mimeo. (In Thai).

Kanungsukkasem, U. 1993. Determinants Of Health Service Utilization In Rural Thailand. In Yoddumnern-Attig, B. et al. (eds). *Qualitative Methods For Population And Health Research.* Bangkok : Institute For Population And Social Research, Mahidol University.

Kanungsukkasem, U. et al. 1997. *Child Care Pattern Among Male Factory Workers.* Nakhonphathom: Mahidol University.

Karasek, R.A. 1979. Job Demands, Job Decision Latitude, And Mental Strain : Implications For Job Redesign. *Administrative Science Quarterly.* 24 (June) : 285.

Karasek, R.A., And Theorell, T. 1990. *Healthy Work: Stress, Productivity, And The Reconstruction Of Working Life.* New York: Basic Books.

Kasemmanat, N. et al. 1991. *The Health Survey in Slum People: A Study in Khon Kaen Municipality.* Khon Kaen: KKU (In Thai).

Keskowit, K. et al.1993. Folk Healers And Self-Care Of *Isaan* Villagers: Case Study. Khon Kaen : Khon Kaen University (In Thai).

Ketkowit, K. et al. 1998. *Health Seeking Behaviour Of Rural Villagers: Case Study In Three Villages In The NE.* Khon Kaen: KKU (In Thai).

Kettel, B. 1996. Women, Health And The Environment. *Soc. Sci. Med.*42 (10) : 1367-1379.

Keyes, C.F. 1984. Mother Or Mistress But Never A Monk: Buddhist Notions Of Female Gender In Rural Thailand. *American Ethnologist.* 11(2): 234-241.

Khon Kaen Provincial Health Office, 1991, 1996, 1997. *Report 1991, 1996, 1997.* Khon Kaen: Klangnanavithaya Press (In Thai).

Kirscht, J, Becker, M. and Eveland, J. 1976. Psychological And Social Factors As Predictors Of Medical Behaviour. *Medical Care.* 14 : 422-431.

Kiange, H.M. et al, 1996. Outlook For Survivours Of Childhood In Sub-Saharan Africa: Adult Mortality In Tazania. *BJM.* 312 (7025): 216-220.

Kleinman, A. 1978. Concepts And A Model For The Comparison Of Medical Systems As Culture System. *Soc. Sci. Med.* 12: 85-95.

Kleinman, A. 1980. *Patients And Healer In The Context Of Culture.* London: University Of California Press.

Kleinman, A. 1984. Indigenous Systems Of Healing: Questions For Professional Popular And Folk Care. In Warren Salmon (ed.), *Alternative Medicines.* London: Tavistock Publication.

Klinsong, P. 1993. Prescription For Danger. *The Nation.* March, 4:C1

Knutsson, A. and Goine, H. 1998. Occupation And Unemployment Rates As Predictors Of Long Term Sickness Absence In Two Swedish Counties. *Soc.Sci.Med.* 47(1):25-31.

Kosa, J. 1976. The Nature Of Poverty. In Kosa & Zoba (eds.) *Poverty And Health: A Sociological Analysis.* Cambridge: Harvard University Press.

Koses, P. 1993. *Health Status Of Aging And Family Factors Related.* Bangkok: Lerd- Sin Hospital, Ministry Of Public Health.

Kotler, P. And Wingard, D. L. 1989. The Effect Of Occupational Marital And Parental Roles On Mortality: The Alameda Country Study. *American Journal Of Public Health.* 79: 607-612.

Kritz-Silverstein, D. et al. 1992. Employment Status And Heart Disease Risk Factors In Middle-Age Women: The Rancho Bernado Study. *American Journal Of Public Health.* 82: 215-219.

La Rosa, J.H. 1997. Women's Health Policy And Research. In K.M. Allen And J.M. Phillips. *Women's Health- Across The Lifespan.* Philadelphia: Lippincott.

Labour Force Protective Office., 1996. *Report Of The Labcur Force : Housework Subcontractors.* Bangkok : Ministry Of Labour Force And Social Welfares (In Thai).

Lai, G. 1995. Work and Family Roles And Psychological Well-Being In Urban China. *Journal Of Health And Social Behavior.* 36 (March) : 11-37.

Lapanun, P. 1993. *Women And Household Economy: Women Market Traders And Traditional In Northeast Thailand.* Thesis For The Degree Of Master Of Arts, The University Of Guelph, Canada.

Lapanun, P. et al. 1998, 1999. *Development Of Slum And Slum Organization: Case Studies Of Khon Kaen Province.* Khon Kaen : RDI. (In Thai).

Lazarus, R.S., Cohen, J.B., Folkman, S., Manner, A. & Schafer, C. 1980. Psychological Stress And Adaptations: Some Unresolved Issues. In Selye, H. (ed.) *Selya's Guide To Stress Research.* New York: Van Nostrandt Reinhold.

Le Grand, A.L., Sringernyuang, L. and Streefland, P.H. 1993. Enhancing Appropriate Drug Use : The Contribution of Herbal Medicine Promotion-A Case Study In Rural Thailand. *Soc. Sci. Med.* 36 (8) : 1023-1035.

Leclere, F.B. et al. 1998. Neighborhood Social Context and Racial Differences In Women's Heart Disease Mortality. *J. Of Health And Social Behaviour.* 39(1): 91-107.

Lee, C. et al. 1994. *Employed Mothers: Balancing Work And Family Life.* Ottawa: Canadian Centre For Management Development.

Leigh. J.P. 1987. Estimates Of The Probability Of Job- Related Death In 347 Occupations. *J. Of Occupational Medicine.* 29:510-519.

Leigh, J.P. 1991. A Ranking Of Occupations Based On The Blood Pressures Of Incumbents In The National Health And Nutrition Examination Survey I. *J. Of Occupational Medicine.*33(8): 653-860.

Legato, M.J., Padus, E. and Slaughter, ED. 1997. Women's Perceptions Of Their General Health, With Special Reference To Their Risk Of Coronary Artery Disease : Results Of ANational Telephone Survey. *Journal Of Women's Health.* 6 (2) : 189-198.

Lennon, M.C. 1994. Women, Work, And Well-Being : The Importance Of Work Conditions. *Journal Of Health And Social Behavior.* 35 (September) : 235-247.

Letvak, S. 1997. Relational Experiences Of Elderly Women Living Alone In Rural Communities : A Phenomenological Inquiry. *J. Of The New York State Nurse Association.* 28 (2) : 20 -25.

Lewenhak, S. 1992. *The Revaluation Of Women's Work.* London: Earthscan Publications Ld.

Limanonda, B. 1995. Families In Thailand: Beliefs And Realities. *J. Of Comparative Family Studies.* 26(1): 67-82.

Limprasutr, P. 1991. *Functions And Education Of Community Health Nursing In Relation To Primary Health Care.* Bangkok: Assumption University. (In Thai)

Lincoln, Y.S. & Guba, E.G. 1985. *Naturalistic Inquiry.* CA: SAGE.

Lipson, J.G. 1989. The Use Of Self In Ethnographic Research. In Morse, J.M. *Qualitative Nursing Research: A Contemporary Dialogue.* London: Sage Publications. Pp 73-89.

Lo Bionodo-Wood, G. & Haber, J. 1994. *Nursing Research.* 3rd ed. St. Louis: Mosby.

Manmart, L. 1991. *Women's Role In Earning Money: A Case Study On Women Sellers Of Agricultural Commodities In The Market Place, Amphur Muang.* Khon Kaen: KKU. (In Thai).

Mc Adoo. 1993. The Roles of African American Fathers : An Ecological Perspective. *Families in Society : The Journal of Contemporary Human Services.* 74 (1) : 28-35.

Mc Bride, A. B. 1988. Mental Health Effects Of Women's Multiple Roles. *Image-Journal Of Nursing Scholarship.* 20: 31-47.

Mc Cubbin, H.I. & Patterson, A. 1983. *Stress And The Family Vol I: Coping With Normative Transition.* New York: Brunner Mazer.

Mc Kinlay, J.B. 1976. The Help-Seeking Behavior Of The Poor. In Kosa, J. & Zola, I.K. (eds.) *Poverty And Health: A sociological Analysis.* London: A Commonwealth Fund Book Harvard University Press.

Mc Lean, A. A. 1979. *Work Stress.* London: Addoson-Wesley Publishing Co.

Mc Murray, A. 1997. Violence Against Ex - Wives : Anger And Advocacy. *Health Care For Women International.* 18 : 543 - 556.

Mechanic, D. 1986. The Concept Of Illness Behaviour. *Journal Of Chronic Disease.* 15, 289-294.

Meleis, A.I. & Bernal, P. Domestic Workers in Columbia as Spouse: Security And Servitude. *Holistic Nurs Pract.* 8 (4): 33-43.

Meleis, A.I., Norbeek, J.S. & Laffirey, S.C. 1989. Role Integration And Health Among Female Clerical Workers. *Res. Nurs. Health.* 12, 355-364.

Messing, K. 1992. Introduction: Research Directed To Improving Women's Occupational Health. *Women & Health.* 18(3): 1-9.

Messing, K., Dumais, L. and Romito, P. 1993. Prostitutes And Chimney Sweeps Both Have Problems : Towards Full Integration Of Both Sexes In The Study Of Occupational Health. *Soc. Sci. Med.* 36 (1): 47-55.

Messing, K. 1997. Women's Occupational Health : A Critical Review And Discussion Of Current Issues. *Women & Health.* 25 (4) : 39 - 67.

Millar, J. 1996. Women, Poverty And Social Security. In Hallett, C. (ed). *Women And Social Policy : An Introduction.* London : Prentice Hall.

Miller, W.L. & Crabtree, B.F. 1994. Clinical Research. In Denzin, N. & Lincoln, Y. (eds.).*Handbook Of Qualitative Research.* CA: Stage.

Miles, M.B. and Huberman, A.M. 1994. *Qualitative Data Analysis.* 2nd ed. London : SAGE Publications.

Ministry Of Public Health, 1998. *Health Development Plan In Thailand.* Bangkok: Bureau Of Health Policy And Planning, Ministry Of Public Health.

Mongkolsmai, P. 1996. *The Social Security Scheme and Private Health Sector Growth In Thailand.* Manila: Asian Development Bank.

Morgan, D. G. And Stewart, N. J. 1999. The Physical Environment Of Special Care Units: Needs Of Residents With Dementia From The Perspective Of Staff And Family Caregivers. *Qualitative Health Research.* 9(1): 105-118.

Morissette, P. and Dedobbeleer, N. 1997. Is Work A Risk Factor In The Prescribed Psychotropic Drug Consumption Of Female white-collar Workers And Professionals? *Women & Health.* 25 (4) : 105-121.

Morse, J.M. 1994. Designing Funded Qualitative Research. In N.K., Denzin And Y.S. Lincoln. *Handbook Of Qualitative Research.* London : SAGE Publication.

Morse, J.M. & Field, P.A. 1995. *Qualitative Research Methods for Health Professionals.* 2nd ed. London: SAGE Publication.

Muangman, D. 1987. Review Of Some Health System. In Poom, Wand Chen, P. (eds). *A Textbook Of Community Medicine In Southeast Asia.* Singapore : John Wiley And Sons.

Najman, J.M. 1993. Health And Poverty : Past, Present And Prospects For The Future. *Soc. Sci. Med.* 36 (2) : 157-166.

Nayar, K.R. 1999. Housing And Health. In Oommen, M.A. (ed). *Karala's Development Experience II.* New Delhi: Institute Of Social Sciences, Concept Publishing Company.

National Commission On Women's Affairs (NCWA).1985. *Women's Development in Thailand.* Bangkok: Office Of The Prime Minister (In Thai).

National Commission On Women's Affairs (NCWA). 1994. *Family Matters: Forms And Function*. Bangkok: Office Of The Prime Minister, Thailand. (In Thai).

National Commission On Women's Affairs (NCWA). 1996. *Planning For Women's Development Of The National Development Programs In The 8th National Economic And Social Development Plan, 1997-2001*. Bangkok: Office Of The Prime Minister, Thailand, pp.14-16.

National Economic And Social Development Plan, 1997-2001. Bangkok: Office Of The Prime Minister, Thailand, pp.14-16.

National Statistical Office (NSO), !985. *Report On Fertility Of Thai People*. Bangkok : Office Of The Prime Minister.

National Statistical Office (NSO), 1986. *Report Of The Labour Force Survey. Whole Kingdom (Round 1) February*. Bangkok : Office Of The Prime Minister (In Thai).

National Statistical Office (NSO), 1987. *Report Of The Labour Force Survey. Whole Kingdom (Round 1) February*. Bangkok : Office Of The Prime Minister (In Thai).

National Statistical Office (NSO) 1989, 1991, 1993. *Survey On Labour Force Participation*. Bangkok : Office Of The Prime Minister (In Thai).

National Statistical Office (NSO), 1993. *Report Of The Child Labourers*. Bangkok: Office Of The Prime Minister (In Thai).

National Statistical Office (NSO), 1994. *Reports Of Changing Population 1994*. Bangkok : R.S.P. Printed (In Thai).

National Statistical Office (NSO), 1995. *Report Of The Labour Force Survey. Northeastern Part (Round 1) February*. Bangkok : Office Of The Prime Minister (In Thai).

Neuman, B. 1982. *The Neuman System's Model: Application To Nursing Education And Practice*. Norwalk: Appleton-Century Crofts.

Newham, D.J. et al. 1994. Skeleton Muscle Pain. In P.D. Wall And R. Melzack (eds). *Textbook Of Pain*. Edinburgh: Churchill Livingstone: 423-428.

Nichols, L.S., Wanamaker, N. And Deringer, N. 1995. Needs And Priorities In Balancing Paid And Family Work : A Gender And Social Class Analysis. *Family And Consumer Sciences Research Journal*. 24 (1) : 71- 86.

Nieman, L.Z. et al. 1997. Designing Evaluations For A Women's Health Education Program. *Journal of Women's Health*. 6 (1) : 63-71.

Noor, N.M. 1995. Work And Family Roles In Relation To Women's Well - Being : A Longitudinal Study. *British Journal Of Social Psychology*. 34 : 106.

Nouwarat, N., 1991. Virtue, Order, Health, And Money : Towards A Comprehensive Perspective Of Female Prostitution In Asia. *J-Education*. 16 (2) : 47-57.

Nuntaboot, K. 1994. *Cultural Perceptions Of Illness In Rural N.E. Thailand*. Unpublished Doctoral Thesis, Massey University.

O'Brien, L.N. 1983. Four Paces Behind: Women's Work In Peninsular Malaysia. In Manderson, L. (ed.). *Women's Work And Women's Roles*. New York: The Australian National University.

Office Of The National Economic And Social Development Board. 1990. *Population With AIDS And HIV Positive 1987-2005: A Situation Analysis.* Bangkok: Mimeo.

Office Of the National Economic And social development Board. 1997. *Unemployment In The National Economic Crisis In 1997: The Situation Analysis.* Bangkok: Office Of The Prime Minister.

Ogur, D. 1986. Long Day's Journey Into Night : Women And Prescription Drug Abuse. *Women & Health.* 11 (1) : 99 - 112.

Osana, K. 1993. *Health Services Utilisation And Pattern Of Health-Seeking Behaviour Of North-East Villages Thailand.* Khon Kaen : Khon Kaen University.

Paolisso, M. and Leslie, J. 1995. Meeting The Changing Health Needs Of Women In Developing Countries. *Soc. Sci. Med.* 40 (1): 55-65.

Parahoo, K. 1997. *Nursing Research/ Principles, Process And Issues.* London: Mac Millan.

Parse, R.R. et al. 1985. *Nursing Research Qualitative Methods.* Bowie, M.D.: Brady Commits.

Parse, R.R. 1996. Building Knowledge Through Qualitative Research : The Road Less Traveled. *Nursing Science Quarterly.* 9(1) : 10 - 16.

Patton, M.Q. 1990. *Qualitative Evaluation And Research Methods.* 2nd ed. London : SAGE Publications.

Paul, J.A., Van Dijk, F.J.H.& Frings-Dresen, M.H.W. 1994. Workload And Musculoskeletal Complaints During Pregnancy. *Scand.J.Work.Environ.Health.* 20:153-159.

Payne, G.K. 1984. *Low-Income Housing In The Developing World.* New York: Wiley.

Petchnoi, S. et al. 1989, 1992. *Nursing Research: Principle & Process.* Songkhla: Prince of Songkhla University (In Thai).

Peracca, S. et al. 1998. Can Prostitute Marry? Thai Attitudes Toward Female Sex Workers. *Soc.Sci.Med.* 45: 255-267.

Phoom, W.O. 1988. *Practical Occupational Health.* Singapore: P.G.Publishing.

Pick, W.M. and Obermeyer, C.M. 1996. Urbanisation, Household Composition And The Reproductive Health Of Women In A South African City. *Soc. Sci. Med.* 43 (10) : 1431-1441.

Pill, R., Peters, T. J. and Robling, M.R. 1993. Factors Associated With Health Behaviour Among Mothers of Lower Socio-Economic Status : A British Example. *Soc. Sci. Med.* 36 (9) : 1137-1144.

Pintong, P. 1988. *Isaan-Thai-English Dictionary.* Ubonrachathani : Siritham printed.

Pischat, N. et al. 1995. *Behaviours Of Drug Use Among Old Age Group.* Ubolratchtani: Collge Of Nursing Ubolratchatani. (In Thai).

Pleck, J.H. 1997. The work-Family Role System. *Social Problems.* 24:417-427.

Pocket Thailand Figures. 1996. 2nd ed. Bangkok : Alpha Research Co. Ltd.

Polit, D.F. And Hungler, B.P. 1997. *Essentials Of Nursing Research-Methods, Appraisals, And Utlization.* 4th ed. Philadelphia: Lippincott.

Pongsapich, A. 1993. Definitions Of Qualitative Research.In A. Dulayakasaem (ed.) *Handbook Of Qualitative Research For Development Field.* Bangkok : Dan Sutha Press. (In Thai).

Ponzer, S. et al. 1997. Women And Injuries-Factors Influencing Recovery. *Women & Health.* 25(3): 47-62.

Popay, J., Rogers, A. and Williams, G. 1998. Rationale And Standards For The Systematic Review Of Qualitative Literature In Health Services Research. *Qualitative Health Research.* 8(3): 341-351.

Porter, S. 1996. Qualitative Research. In D.F.S. ,Cormack. *The Research Process In Nursing.* 3rd ed. London : Blackwell. Pp.114-122.

Powers, B.A. And Knapp, T.R. 1995. *A Dictionary Of Nursing Theory And Research.* 2nd ed. London : SAGE Publications.

Prasartkul, P. et al, 1995. *Assessing Household Use Of Commercial Medicine : A Pilot Study Of DATA Collection Methodology.* Bangkok : Mahidol University.

Provincial Health Office, 1986. *General Informations In Thailand and Khon Kaen.* Khon Kaen : Public Health Ministry (In Thai).

Predasawast, P. et al. 1987. *Self-Care: Attitude Toward Cultural-Sociology.* Bangkok: Mahidol University.

Puavilai, A. 1996. *Life Quality And Life Experiences Of Thai Women With Diabetes.* Unpublished Thesis Of Ph.D. In Nursing, The University Of Texas At Austin.

Pugboonmee, R. 1996. Women And Chronic Illness. *Health Systems Research Journal.* 4(1): 67-75 (In Thai).

Pulchaloen, W. 2000. *The Ways To Health Care Reform.* Bangkok: Desire Co. Limited (In Thai).

Pumisinsit, W. 1995.*Women In Village Society.* A Supplementary Paper On Seminar, Body Of Knowledge Related To Villages. Chiang Mai: Faculty Of Social Science, Chiang Mai University (In Thai).

Punnett, L. & Herbert, R. 2000. Work-Related Musculoskeletal Disorders: Is There A Gender Differential, And If So, What Does It Mean? In Goldman, M.B. & Hatch, M.C. *Women And Health.* San Diego: Academic Press, Pp.474-491.

Pupaibul, P., et al, 1990, 1991. *A Comparative Study On Women's Health Status Between Agricultural And Newly Industrialized In Nong-Ruae, Khon Kaen Province.* Khon Kaen: Khon Kaen University (In Thai).

Rabibhadana, A.1998. *Different Views On Law, Economic Principle, Political Science, Justice, Compassion In Relation Between Landlords And Trespasser.* Khon Kaen : RDI. (In Thai).

Rabibhadana, A. & Iawsriwong, N. 1999. Thai Nature. In *Symposiums on Television Programme Channel 9.* 'Khaw Khid Duay Khon', March 26, 1999.

Ramaswamy, U. 1996. Women And Development. In Shah, A.M. et al. (eds). *Social Structure And Change: Women In Indian Society.* New Delhi: Sage Publications India Ltd.

Ratner, P.A. 1998. Modeling Act Of Aggression And Dominances As Wife Abuse And Exploring Their Adverse Health Effects. *Journal Of Marriage And The Family.* 60 (2) : 453 - 465.

Repetti, R.L, Methews, K.A. and Waldron, I. 1989. Employment And Women's Health : Effects Of Paid Employment On Women's Mental And Physical Health. *American Psychologist.* 44 (11) : 1394-1401.

Research And Development Institute (RDI), 1996. *Summary Report Of Baseline Survey Of Environmental Concerns Of The Residents* Of *Khon Kaen Municipality.* Khon Kaen : RDI & COWI-CBI Joint Venture.

Reutter, L., Neufeld, A. And Harrison, M.J. 1995. Using Critical Feminist Principles To Analyze Programs For Low-Income Urban Women. *Public Health Nursing.* 12 (6) : 424-431.

Richter, K. and Havanon, N.1995. *Women's Economic Contribution To Households In Thailand : Implication For National Development and Social Welfare.* Bangkok : The Gender press.

Ride, T.J. 2000. Nursing Policy-Strategic Approaches: An International Perspective. In Hennessey, D. & Spurgeon, P. (eds). *Health Policy And Nursing.: Influence, Development And Impact.* London: Mac Millan Press Ltd.

Richter, K. et al. 1997. *Migration And The Rural Family-Sources Of Support And Strain In A Mobile Society.* Bangkok : Institute For Population And Social Research Mahidol University.

Riessman, C.K. 1993. *Narrative Analysis.* London: SAGE Publications.

Robert, S.A. 1998. Community-Level Socioeconomic Status Effects On Adult Health. *J. Of Health And Social Behavior.* 39(1):18-37.

Roberts, L. And Leonard, K.E. 1998. An Empirical Typology Of Drinking Partnerships And Their Relationship To Marital Functioning And Drinking Consequences. *J. Of Marriage And The Family.* 60 (2) : 515 - 526.

Robertson, E.A. & Mc Ardle, K. (eds.)1996. *Postgraduate Research. A Guide For Students.* Aberdeen: RGU.

Robinson, J. 1999. The World Bank And The World Health Organization: International Sources Of Ideas For Health Policy. In *Interdisciplinary Perspectives On Health, Policy & Practice.* Edinburgh: Churchill Livingstone.

Rogers, P. 1989. *A Window On Isaan -Thailand's Northeast.* Bangkok: Duang Kamol.

Rokeach, M. 1980. Some Unresolved Issues in Theories Of Beliefs, Attitudes, and Values. In Howe, H. & Page, M. (eds.) *Nebraska Symposium On Motivation*, Vol.27 Lincoln: University Of Nebraska Press (pp. 261-304).

Ronnau, J.P. and Marlow, C.R.1993. Family Preservation, Poverty, And The Value Of Diversity. *Families In Society: The Journal* Of *Contemporary Human Services*. 74 (9) : 538-544.

Rosenwakes, Z. et al. 1987. *Gynecology- Principle And Practice*. New York: Macmillion Publishing Company.

Ross, C.E. And Mirowsky, J. 1995. Does Employment Affect Health?. *Journal Of Health And Social Behavior*. 36 (3): 230-243.

Roth, S.H. 1988. NSAID And Gastropath: A Rheumatologist's Review. *J. Of Rheumatology*. 15: 912-919.

Royal Institute (Thai). 1999. *Thai Royal Dictionary of Current Thai-Foreign Languages*. Bangkok: Thai Watana Press.

Rubin, H.J. And Rubin, I.S. 1995.*Qualitative Interviewing -The Art Of Hearing Data*. London: SAGE Publications.

Sacrobanack, S. et al. 1997. *Is It The Thai Social Way To Be Women Seller?* Bangkok: Roongsaeng Print.

Salazar, M. et al. 1991. Occupational Health Nursing. In Cookfair, J.M.(ed.) *Nursing Process And Practice In The Community*. St. Louis: Mosby Year Book.

Sandmairer, M. 1992. *The Invisible Alcoholics : Women And Alcohol*. 2nd ed. Florida : Human Services Institute.

Sarkis, J.M. & Skoner, M.M. 1987. An Analysis Of The Concept Of Holism In Nursing Literature. *Holistic Nurs Pract*. 2(1): 61-69.

Scannell-Desch, E.A. 1996. The Lived Experience Of Women Military Nurse In Vietnam During The Vietnam War. *IMAGE: Journal Of Nursing Scholarship*. 28(2):119-124.

Schabracq, M.J., Winnubst, J.A.M. And Cooper, C.L. 1996. *Handbook Of Work And Health Psychology*. Chichester : John Wiley & Sons.

Schatzman, L. and Strauss, A.L. 1973. *Field Research: Strategies For A National Sociology*. Englewood Cliffs: Prentice-Hall, Inc.

Seaman, B. 1995. Women's Health Research Blossoms. *Science*. 269(11) : 765 - 770.

Sear, R. et al. 1957. *Pattern Of Child Rearing*. Evanston: Row Peterson

Semyam, A. 1998. Sexual Abuse In Workplace. In Walaisathian, P. et al (eds.) *Women Studies*. Bangkok: Thammasart University, Pp 112-141.

Sethuraman, S.V. 1976. The Urban Informal Sector: Concept, Measurement And Policy. *International Labour Review*. 114(1): 69-81.

Sharps, P.W. 1997. Reproductive, Gynecologic, And Urinary Tract Conditions And Disorders. In K.M. Allen And J.M. Phillips. *Women's Health-Aceoss The Lifespan.* Philadelphia: Lippincott.

Siamwala, A. 1998. Thai Economics In Crisis. *Thai Case Study.* 14(2): 3-14 (In Thai).

Silbergeld, E.K. 2000. The Environment And Women's Health: An Overview. In Goldman, M.B. & Hatch, M.C. *Women And Health.* San Diego: Academic Press

Silverman, D. 1993. *Interpreting Qualitative Data.* London : SAGE Publications.

Simons, R.L. et al. 1998. Socialization In The Family Of Original And Male Dating Violence: A Prospective Study. *Journal Of Marriage And The Family.* 60(2): 467-478.

Simpson, J.A. 1988. *The Concise Oxford Dictionary Of Proverbs.* Oxford: Oxford University.

Sindhu, S. 1992. *Role clarity And Health Perceptions : Thai Women With Valvular Heart Disease.* Unpublished Doctor Of Nursing Science Dissertation Of The University Of California, USA.

Sirisampun, N. 1994. *Invisible Labour Force: Women Working In Informal Sector.* Bangkok: Freedick Aebarg Foundation.

Sirisambhand, N. 1995. *Hidden Produces In Bangkok Metropolis: Women In The Urban Informal Sectors.* Bangkok: Friedrich Ebert Stiftung.

Sittitrai, W. et al. 1992. *Thai Sexual Behaviour And Risk Of HIV Infection.* Bangkok : Thai Red Cross Society And Institute Of Population Studies. Chulalongkorn University.

Skovron, M.L. 1992. Epidemiology Of Low Back Pain. *Baillieres-Clin-Rhumatol.* 6(3): 559-573.

Smith, G.D. et al, 1998. Adverse Socioeconomic Conditions In Childhood And Cause Specific Adult Mortality: Perspective Observational Study. *BJM.* 316 (7145): 1631-1635.

Smith, J.K. & Heshusius, L. 1986. Closing Down The Conversation. The End Of The Quantitative-Qualitative Debate Among Educational Inquires. *Educational Researcher.* 15(1): 4-12.

Smyth, K. and Yarandi, H.N. 1996. Factor Analysis Of The Ways Of Coping Questionnaire For African American Women. *Nursing Research.* 45(1) : 25-29.

Sodsuchat, B. 1993. Health Beliefs In *Isaan* Culture. *Isaan Studies.* 5(1): 24-36 (In Thai).

Sohm-in, A. 1994. *World Visions Of Isaan People.* Mahasarakham: University Of Srinakarintaravirot. (In Thai).

Soonthorndhada, A. 1992. Community Role Behaviour, Expectations And Adaptations: Past To Present. In *Changing Roles And Statuses Of Women In Thailand: A Documentary Assessment.* Nakhonphathom: Mahidol University.

Sorensen, G. and Verbrugge, L.M. 1987. Women, Work, And Health. *Ann. Rev. Public Health.* 8 : 235-251.

Spindel, C.R. 1987. The Social Invisibility Of Women's Work In Brazillian Agriculture. In Deere, C.D. & Leon, M. (eds). *Rural Women And State Policy.* London: West View Press.

Sriluecha, P. et al. 1993. *The Amphetamines Abuse Among The Heavy Truck Drivers.* Khon Kaen: KKU. (In Thai).

Srithumma, S et al. 1994. *The Project For Developing The Health Care Services For The People Living Low-Income Areas, Khon Kaen Municipality.* Khon Kaen: KK. Provincial Health Office.

Steers, R. M. and Porter, L. W. 1987. *Motivation And Work Behaviour.* New York: Mc Graw-Hill Book Company.

Stellman, J.M. & Lucas, A. 2000. Women's Occupational Health: International Perspectives. In Goldman, M.B. & M.C.(eds.) *Women And Health.* San Diego: Academic Press.

Stiller, L. et al. 1998. Using Injury Data To Identify Industry Reason Priorities. In Feyer, A.M., William, A. (ed.). *Occupational Injury: Risk, Prevention & Intervention.* London: Taylor & Francis.

Strauss, A. And Corbin. J. 1990. *Basics Of Qualitative Research.* London : SAGE Publications.

Streubert, H.J. And Carpenter, D.R. 1995.*Qualitative Research In Nursing.* Philadelphia: J.B. Lippincott Company.

Suntornchai, T. 1995. *Esaan Women And Managing Of Natural Resources Of Water.* Khon Kaen: RDI. KKU.(In Thai)

Suntornchai, T., 1996. Migration Of Esarn Women : Impacts On Families And Communities. *R D I Symposium I.* Khon Kaen : R D I. Khon Kaen University (In Thai).

Supanchaiyamat, W. et al. 1993. *Evaluation Of Dangerous Working Conditions In The Quarry And Grindstone Mill In Khon Kaen Province.* Khon Kaen: Provincial Health Governer (In Thai).

Sutherland, V. J. And Cooper, C. L. 1993. *Understanding Stress: A Psychological Perspective For Health Performance, Psychology And Health Series 5.* London: Chapman & Hall.

Swanson, J.M. And Chenitz, W.C. 1982. Why Qualitative Research In Nursing ? *Nursing Outlook.* 30 : 241 - 245.

Swanson, N.G. & Becker, A.B. 1997. Women's Health In The Workplace. In Allen, K.M. & Phillips, J.M. (eds.) *Women's Health Across The Lifespan.* Philadelphia: Lippincott.

Szalai, A. 1972. *The Use Of Time: Daily Activities Of Urban And Suburban Populations In Twelve Communities.* Mouton: The Hague.

Tantiwiramanond, D. And Pandey, S.R. 1996. New Opportunities Or New Inequalities: Development Issues And Women's Lives In Thailand. *Proceedings Of The 6th International Conference On Thai Studies.* Women, Gender Relations And Development In Thai Society. Chiangmai, 14-17 October 1996. Pp 79-110.

Tashakkori, A. & Teddlie, C. 1998. *Mixed Methodology: Combining Qualitative And Quantitative Approaches.* London: SAGE Publications.

Tausig, M. And Fenwick, R. 1999. Recession And Well-Being. *J. Of Health And Social Behaviour.* 40(1): 1-16.

Thailand Health Profile, 1998. http://www.eng.moph.go.th/hst/profile97-98/CHAPTER32.php.

Thammawat, J. 1992. *Women And Rural Development.* Khon Kaen: KKU (In Thai).

Thammawat, J. 1998. *Isaan* Women And Their Earning Money Ways. In *Isaan Women: Alternative Potential And Developmental Strategies.* Khon Kaen: RDI (In Thai).

Thanachusil, W. et al. 1984. *Work Situations Of Women And Children In Construction Work.* Bangkok: Ministry Of Interior (In Thai).

Thaver, I.H. et al. 1998. Private Practitioners In Slums Of Karach: What Quality Of Care Do They Offer? *Soc.Sci.Med.* 46(11):1441-1449.

The Committee Of Non-Communicable Disease Control. 1995. *The Situation Of Non-Communicable Diseases In Thailand 1995: Trends, Issues, And Strategies For Improvement.* Bangkok: Ministry Of Public Health (In Thai).

The Medical Sciences Centre. 1991. *Report Of Identification Of Medicines In Ya -Chud For The Treatment Of Musculoskeletal Pain.* Bangkok: The Ministry Of Public Health (In Thai).

The National Statistical Office. 1993. *Report Of The 1993 Household Socioeconomics Survey.* Bangkok: Office Of The Prime minister.

The Pharmacy Department, 1990. *Srinakharind Hospital's Drug Use Guideline.* Khon Kaen: Khon Kaen University (In Thai).

The Provincial Health Office, 2000. *Lessons Plan For The Health Care Reform In Khon Kaen.* Bangkok: The Provincial Health Care Office (In Thai).

The WHOQOL Group. 1998. The World Health Organization Quality Of Life Assessment: Development And General Psychometric Properties. *Soc.Sci.Med.* 40(12):1569-1585.

Thiralaph, P. 1990. The Recurrent Psychoses. *Clinical Psychology Journal.* 20(1): 12-24 (In Thai).

Thoits, P.A. 1986. Multiple Identities : Examining Gender And Marital Status Differences In Distress. *American Sociological Review.* 51 (April) : 259-272.

Thomson, H. et al. 1995. *Health And Social Care: Advanced GNVQ.* 2nd ed. London: Hodder & Stoughton.

Thompson, S. 1990. *Gender Issues In Thailand Development* Bangkok: Gender And Development Research Institute.

Thompson, T.L. 2000. The Nature And Language Of Illness Explanations. In Whaley, B.B. (ed.) *Explaining Illness: Research, Theory and Strategies.* London: Lawrence Erlbaum Associates, Publishers. Pp. 3-39.

Thongbor, S. 1996. *A Study Of The Mental Health Status And Coping Devices Of The Heads Of Families In Slum Areas In Khon Kaen Municipality.* Khon Kaen : Khon Kaen University. (In Thai)

Tillich, P. 1961. The Meaning Of Health. *Perspectives In Biology And Medicine*, 5: 92-100.

Tong-uthai, P. 1990. *Conditions And Perspects For Women's Employment In Thailand. Reported To The International Labour Organisation, Regional Office For Asia And The Pacific.* Bangkok: August.

Travell, J.G. 1976. Myofacial Trigger Points: Clinical View In J.J. Bonica And D. Albe-Fessard (eds). *Advances In Pain Research And Therapy Vol.1.* New York: Raven Press: 919-926.

Tulapunt, P.S. 1998. Women And Informal Economic Sectors. In *Isaan Women: Alternative Choices, Potential And Strategies For Development.* Khon Kaen: RDI. (In Thai).

Usanawarong, S. et al. 1997. *The Study Of Problems Of Drug And Substance Addict In Khon Kaen.* Khon Kaen: KKU. (In Thai).

Van Dalen, D.B. and Meyer, W.J. 1966. *Understanding Educational Research : An Introduction.* New York : Mc Graw-Hill Book Company.

Van Manen, J.1983. *Qualitative Methodology.* London : SAGE Publication.

Vessey, J.A. & Richardson, B.L. 1993. A Holistic Approach To Symptom Assessment and Intervention. *Holistic Nurs Pract.* 7(2): 13-21.

Walcott, H.F. 1994. *Transforming Qualitative Data.* London : SAGE Publication.

Waldron, I. And Jacobs, J.A.1989. Effects Of Multiple Roles On Women's Health-Evidence From A National Longitudinal Study. *Women & Health.* 15(1): 3-19.

Waldron, I. et al. 1998a. Interacting Effect Of Multiple Role On Women's Health. *Journal Of Health And Social Behaviour.* 39 (September): 216-236.

Waldron, I. et al. 1998b. Effects Of Labour Force Participation On Women's Health: New Evidence From A Longitudinal Study. *Journal Of Occupational Medicine.* 30 (12):977-983.

Walster, E., Walster, W. & Bersheid, E. 1978. *Equity: Theory And Research.* Boston: Allyn And Bacon.

Watts, T.E. And Siziya, S. 1997. Education, Occupation And Health Status Of People Of Age Five Years Or More Living In A High Density Urban Area In Zimbabwe. *Cent. Afr. J. Med.* 43(9): 260-264.

Weiss, G.L. & Lynne, E.L. 1996. *The Sociology Of Health, Healing And Illness.* New Jersey: Prentice Hall.

Wenger, A.F.Z., 1993. Cultural Meaning Of Symptoms. *Holistic Nurs Pract.* 7(2): 22-35.

Whittaker, A.M. 1994. *Isaan Women: Ethnicity, Gender, And Health In N.E. Thailand.* Doctoral Thesis Of University Of Queensland Australia: 108.

Williams, B.L. 1994. Reflections On Family Poverty. *Families In Society : The Journal Of Contemporary Human Services.* 75 (1) : 47-50.

Williams, K. & Umberson, D. 2000. Women, Stress and Health. In Goldman, M.B. & Hatch, M.C. *Women And Health.* San Diego: Academic Press. Pp 553-562.

Wimpenny, P. 2000. *An Examination Of Nursing Models From The Practitioner's Perspective.* A Thesis Presented For The Degree Of pH At The University Of Aberdeen, Aberdeen, Scotland, UK.

Wohlfarth, T. And Brink, W.V.D. 1998. Social Class And Substance Use Disorders : The Value Of Social Class As Distinct From Socioeconomic Status. *Soc. Sci. Med.* 47(1): 51 - 58.

Wongpohm, C. 1998. *Isaan Women Status. In Isaan Women: Alternative, Potential And Developmental Strategies.* Khon Kaen: RDI, KKU (In Thai).

Woody, B. 1992. *Black Women. In The Workplace : Impacts Of Structural Change In The Economy.* New York : Greenwood Press.

Worasiriamorn, Y. et al. 1990. *Women's Role In Self-Help Organisation.* Khon Kaen: RDI, KKU (In Thai).

World Health Organization (WHO). 1988. *Urbanization and Its Implication For Child Health : Potential For Action.* Geneva : World Health Organization.

World Health Organization (WHO). 1996. *World Health Report.* Geneva: World Health Organization.

World Health Organization (WHO). 1996. *Integration Of Health Care Delivery: Report Of A WHO Study Group.* Geneva: World Health Organization.

Worrall, A. et al 1997. Counting the Cost Of Social Disadvantage In Primary Care: Retrospective Analysis Of Patient Data. *BJM.* 314 (7073): 38-42.

Wright, S. G. 1990. *Building And Using A Model Of Nursing.* 2nd ed. London: Edward Arnold.

Yin, R.K. 1989. *Case Study Research: Design & Methods.* Newbury Park: SAGE.

Yin, R.K. 1994. *Case Study Research: Design & Methods.* London: SAGE.

Yoddumnern-Attig, B. 1992. Thai Family Structure And Organization Changing Role And Duties In Historical Perspective. In *Changing Roles And Statuses Of Women In Thailand : A Documentaty Assessment.* Nakon Pathom : Institute For Population And Social Research, Mahidol University.

Yoddumnern-Attig, B. 1993. Analyzing And Combining Qualitative And Quantitative Data. In *Qualitative Methods For Population and Health Research.* Nakhonphathom: Mahidol University.

Yongkittikul, C. And Chayutsahakit, N. 1989.The Study On Adaptation To Environment: Case Study Of Thai Families, Bangkok. Bangkok: Chulalongkorn University (In Thai).

Young, K. 1978. Modes Of Appropriation And The Sexual Division Of Labour: A Case Study From Oaxaca, Mexico. In Kuhn, A & Wolpe, A.M. (eds). *Feminsm And Materialism.* London: Routledge And Kegan Paul.

Yzaguirre, R. 1992. *State Of Hispanic America 1992 :An Overview.* Washington D.C.: National Council Of La Raza.

Zambrana, R.E. 1982. *Work, Family And Health : Latina Women In Transition.* New York : Hispanic Research Center.

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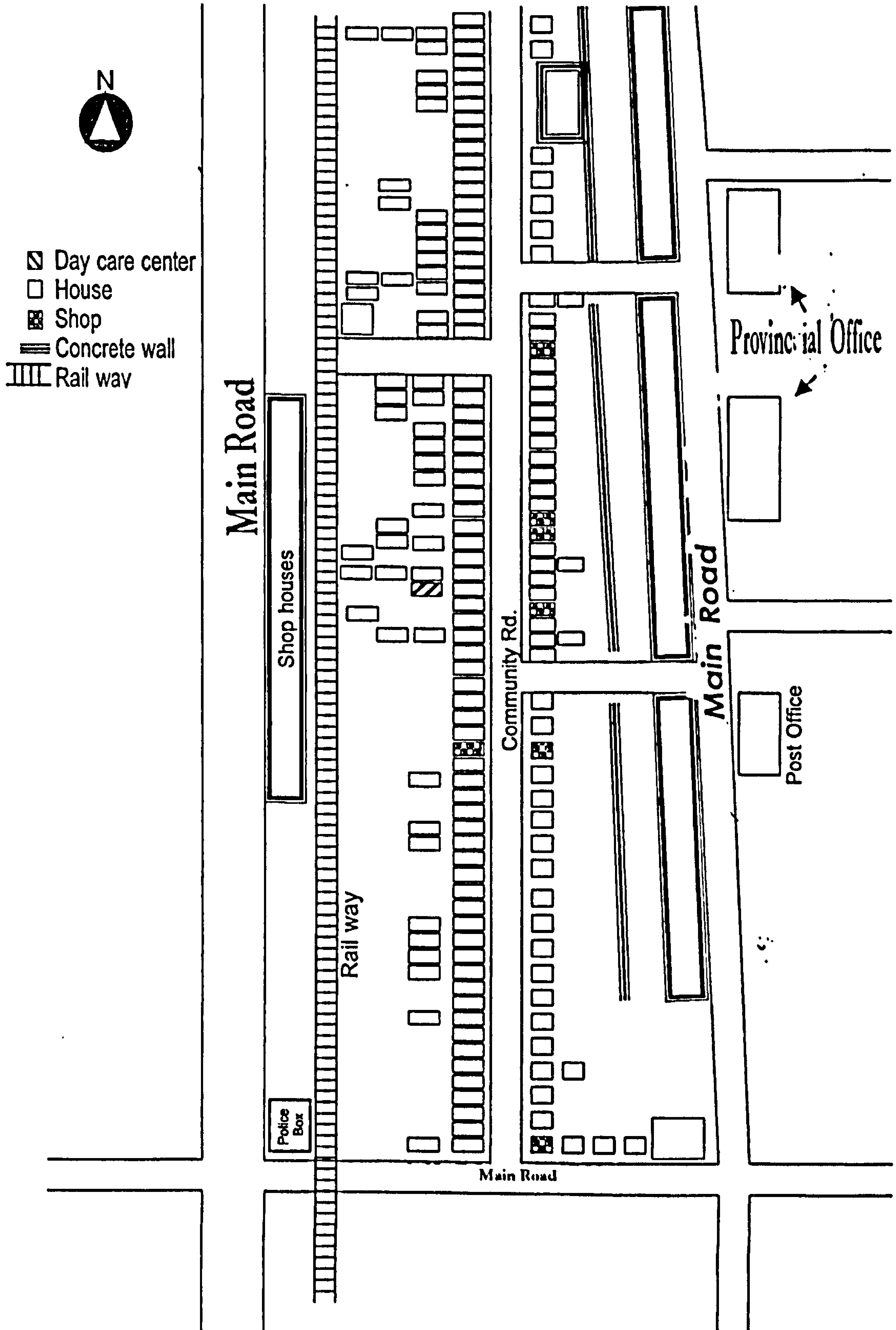
Appendix 1

North-Eastern Thailand

Figure A-1

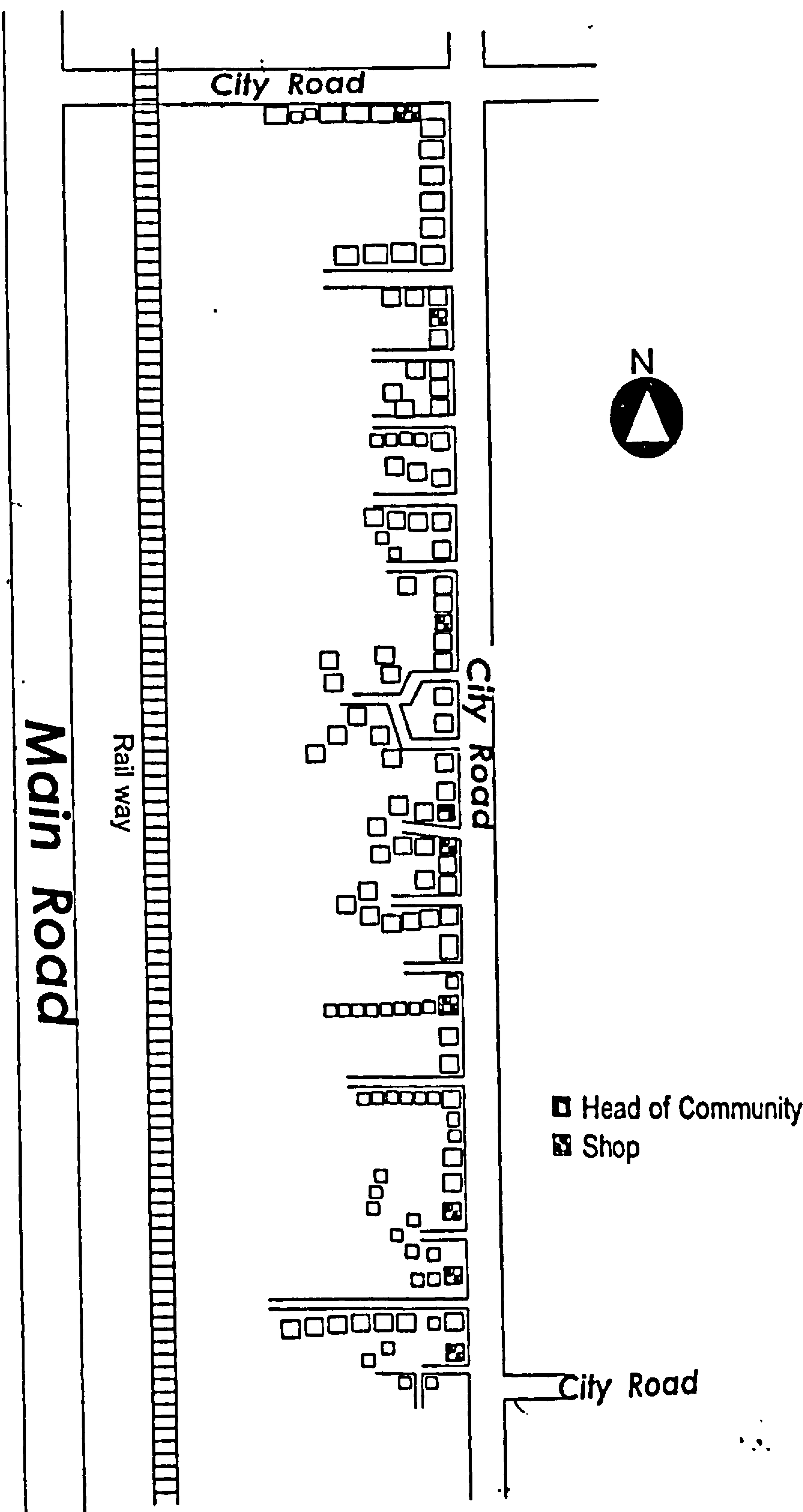
Appendix 2-1

The Guardian Community



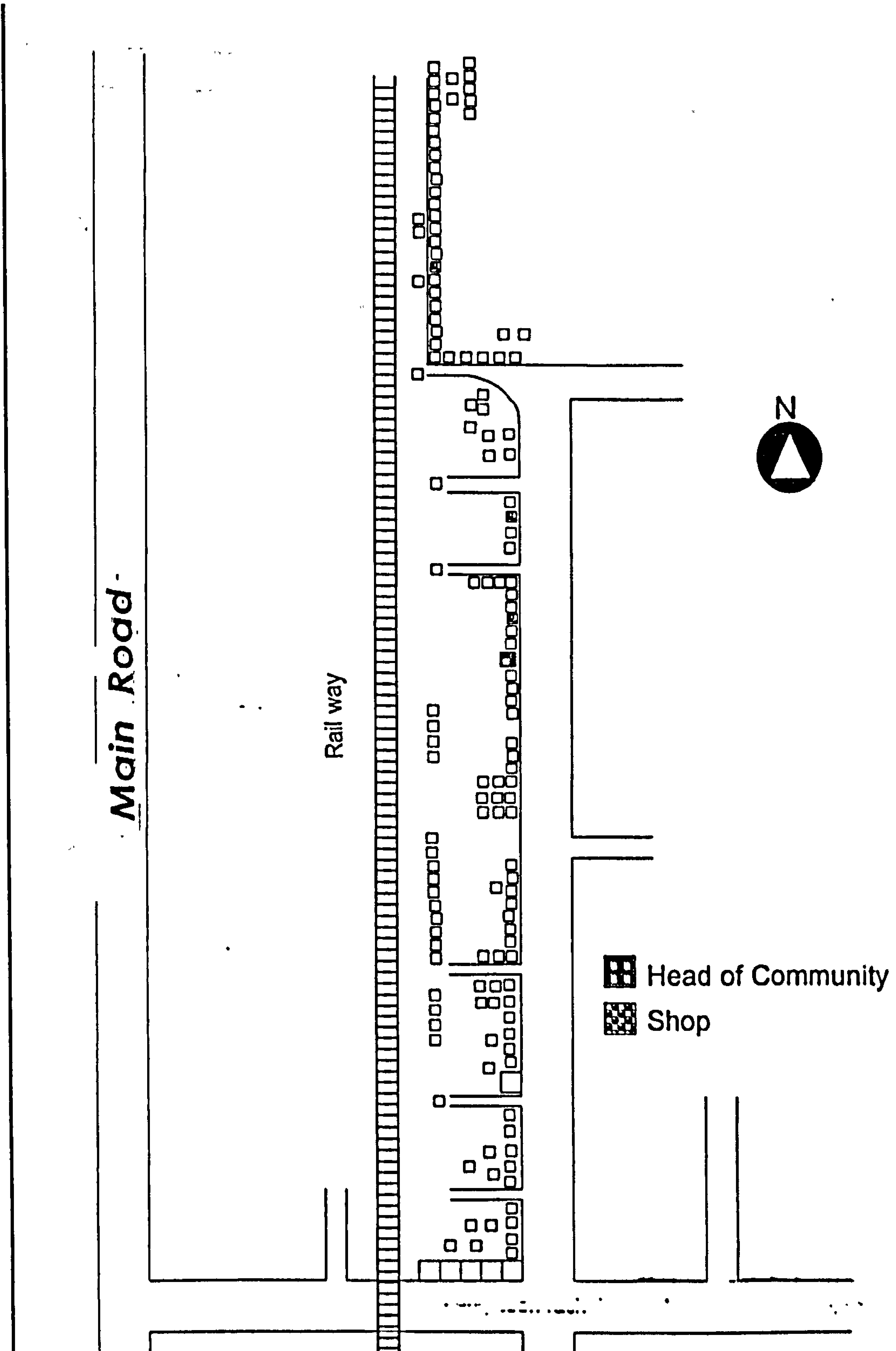
Appendix 2-2

The Rental Community



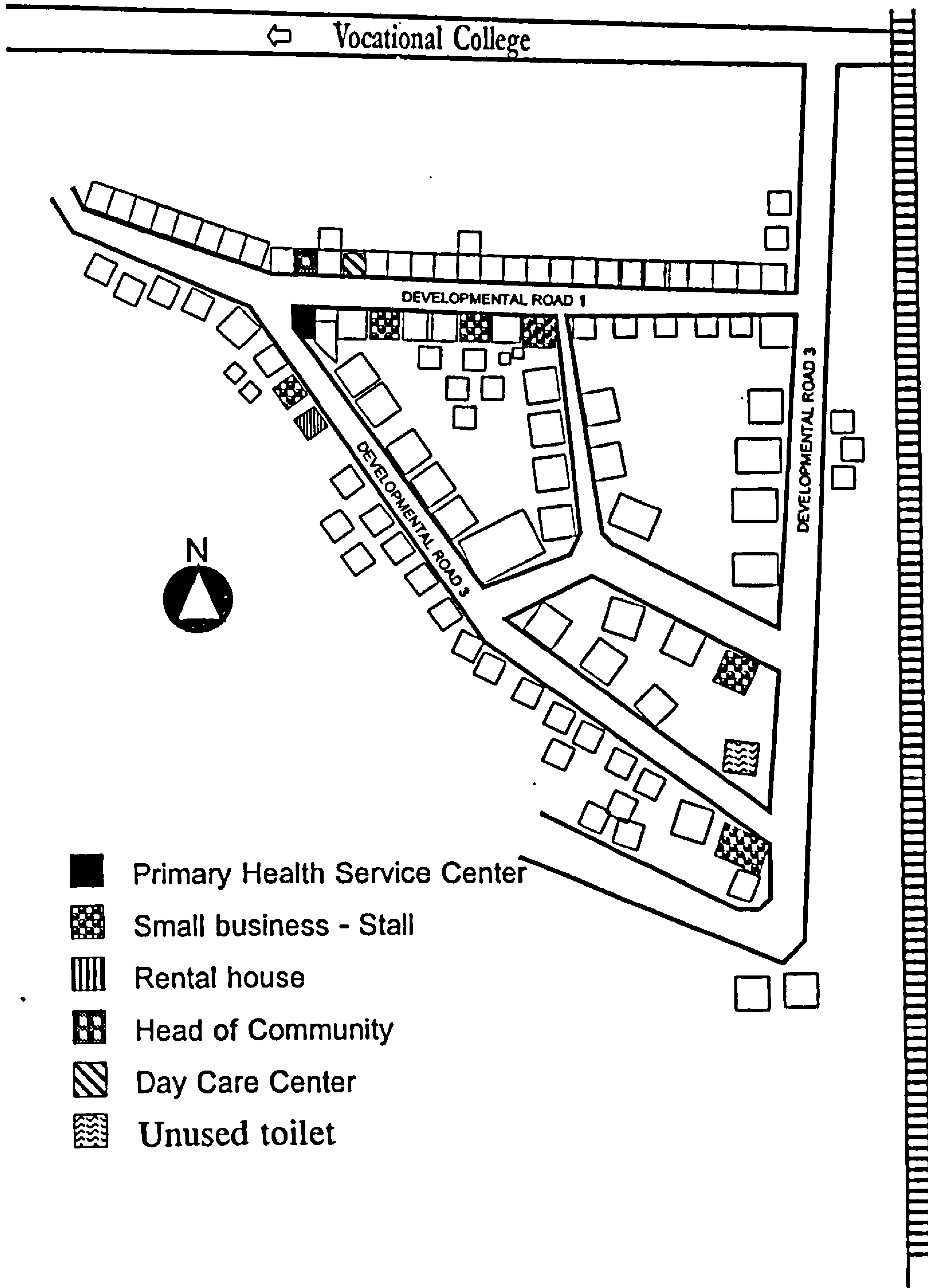
Appendix 2-3

The Stranger Community



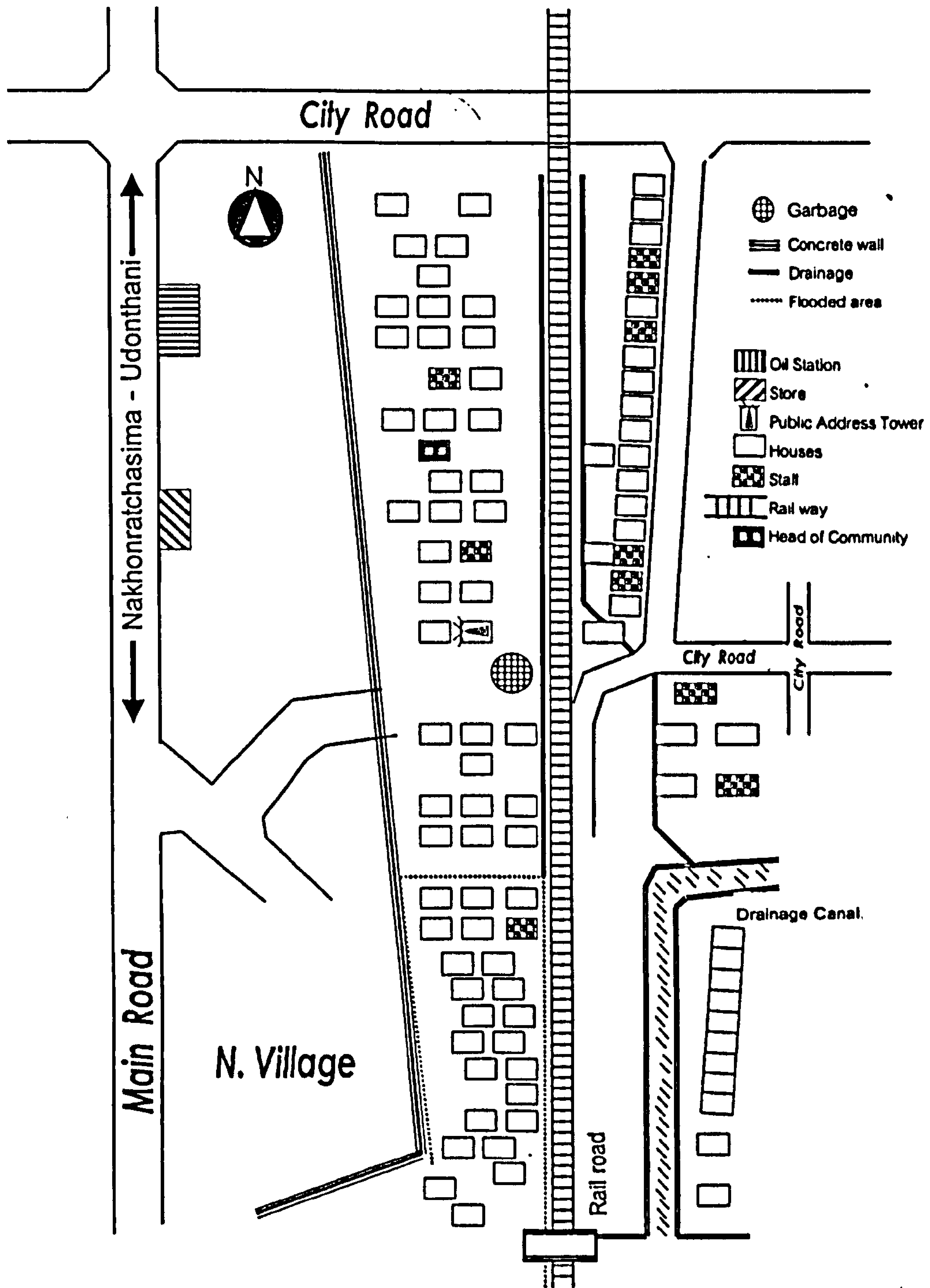
Appendix 2-4

The Temple Community



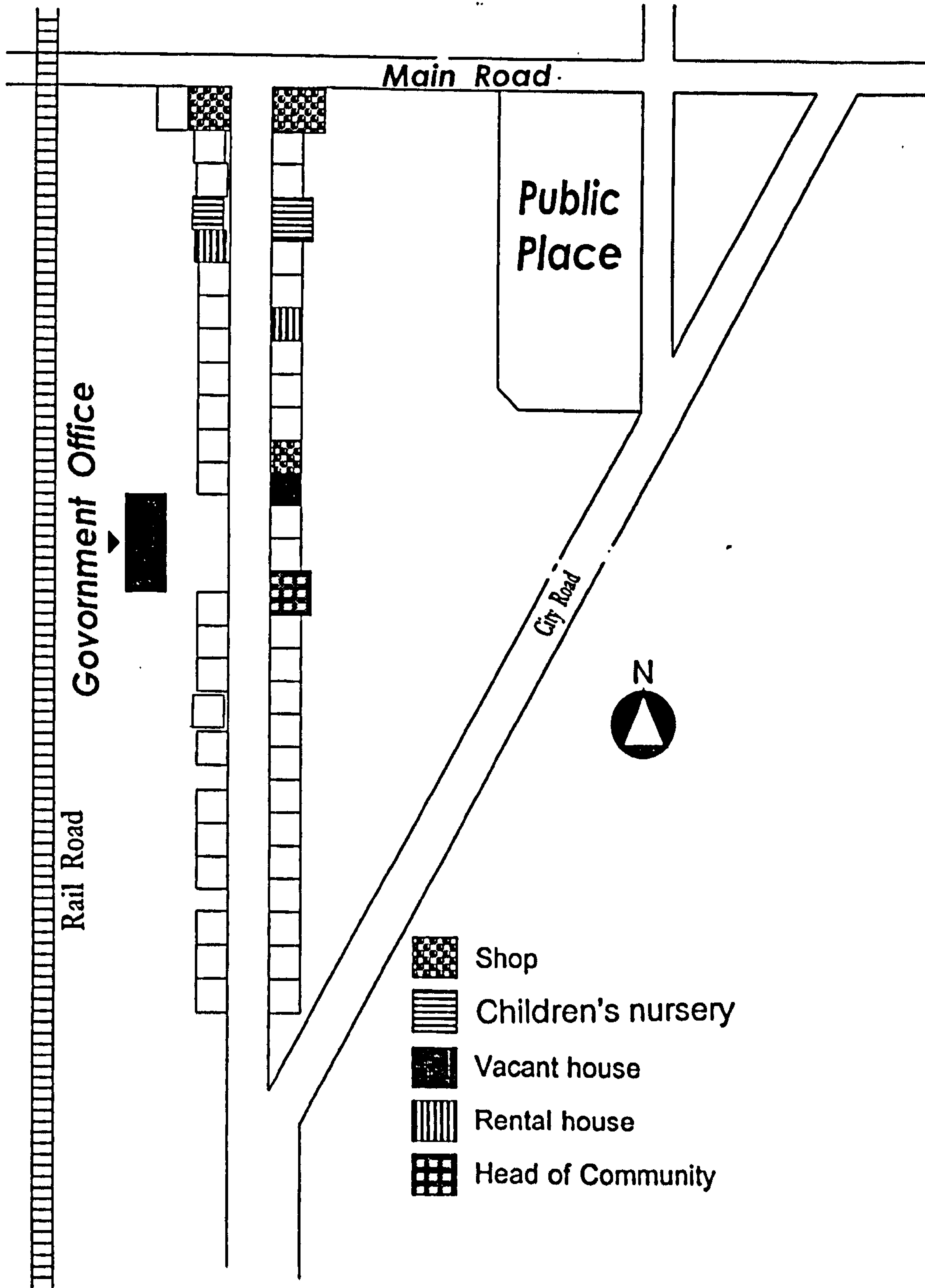
Appendix 2-5

The Railway Community



Appendix 2-6

The Joss Community



Appendix 3

Supplementary Tables

Table 4.1.2 The classification of households (n = 209)

Type	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Unrelated individual family	2	2.8	3	10.3	5	15.2	1	3.2	1	3.3	0	0	12	5.7
Nuclear family	44	61.1	20	69.0	10	30.3	22	71.0	16	53.3	8	57.1	120	57.4
Stem family	12	16.7	1	3.4	6	18.2	1	3.2	9	30.0	0	0	29	13.9
Joint family	8	11.1	3	10.3	7	21.2	5	16.1	4	13.3	1	7.1	28	13.4
Stem-joint family	3	4.2	0	0.0	5	15.2	2	6.5	0	0.0	5	35.7	15	7.2
No response	3	4.2	2	6.9	0	0.0	0	0.0	0	0.0	0	0.0	5	2.3
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.3 Women's marital status

Status	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Single	1	1.4	0	0.0	0	0.0	0	0.0	2	6.7	2	14.3	5	2.4
Divorced	4	5.6	3	10.3	2	6.1	2	6.5	0	0.0	0	0.0	11	5.3
Married/living with partner	61	84.7	22	75.9	27	81.8	25	80.6	25	83.3	10	71.4	170	81.3
Widow	5	6.9	3	10.3	3	9.1	4	12.9	3	10.0	2	14.3	20	9.6
Separated	1	1.4	1	3.4	1	3.0	0	0.0	0	0.0	0	0.0	3	1.4
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.4 Women's highest educational level acheived

Education	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Primary school	46	63.9	22	75.9	27	81.8	23	74.2	23	76.7	10	71.4	151	72.2
Middle school	14	19.4	3	10.3	3	9.1	3	9.7	5	16.7	2	14.3	30	14.4
High school	3	4.2	0	0.0	0	0.0	3	9.7	0	0.0	0	0.0	6	2.9
Industrial/Vocational school	2	2.8	1	3.4	1	3.0	0	0	2	6.7	2	14.3	8	3.8
University	0	0.0	1	3.4	0	0.0	0	0.0	0	0.0	0	0.0	1	0.5
No formal education	7	9.7	2	6.9	2	6.1	2	6.5	0	0.0	0	0.0	13	6.2
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.5 Women's principle occupation

Occupation	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Government Service	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	7.1	1	0.5
Temporary governmental service	0	0.0	0	0.0	0	0.0	3	100	0	0.0	0	0.0	3	1.4
Private business employee	2	2.8	0	0.0	3	9.1	4	12.9	1	3.3	1	7.1	11	5.3
Self-employed small business (Stationary)	20	27.8	9	31.0	6	18.2	6	19.4	12	40.0	6	42.9	59	28.2
Hair dressing	0	0.0	1	3.4	0	0.0	0	0.0	0	0.0	0	0.0	1	0.5
Self-employed small business (Mobile)	5	6.9	3	10.3	2	6.1	1	3.2	7	23.3	0	0.0	18	8.6
Housewife	12	16.7	8	27.6	4	12.1	3	9.7	2	6.7	0	0.0	29	13.9
Garbage scavenger	8	11.1	0	0.0	5	15.2	0	0.0	0	0.0	0	0.0	13	6.2
Gardening	0	0.0	0	0.0	0	0.0	1	100	0	0.0	0	0.0	1	0.5
Labourer	13	18.0	4	13.8	5	15.2	4	12.9	3	10	0	0.0	29	13.9
Dress maker	12	16.7	4	13.8	8	24.2	9	29.0	5	16.7	6	42.9	44	21.1
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.6 Women's principle income / month (*Baht*)

Income	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
< 1,500	24	33.3	12	41.4	11	33.3	8	25.8	2	6.7	0	0.0	57	27.3
1,500 – 3,000	24	33.3	7	24.1	10	30.3	8	25.8	11	36.7	1	7.1	61	29.2
3,000 – 5,000	10	13.9	6	20.7	9	27.3	9	29.0	9	30.0	4	28.6	47	22.5
5,000 – 10,000	12	16.7	1	3.4	0	0.0	4	12.9	5	16.7	7	50.0	29	13.9
> 10,000	2	2.8	3	10.3	3	9.1	2	6.5	3	10.0	2	14.3	15	7.2
Total	72	100.0	29	100.0	33	100.0	31	100.0	30	100.0	14	100.0	209	100.0

Table 4.1.7 Income and expenditure balancing

Budget Balancing	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Imbalanced	44	61.1	14	48.3	18	54.5	21	67.7	16	53.3	1	7.1	114	54.5
Balanced	25	34.7	15	51.7	14	42.4	10	32.3	14	46.7	11	78.6	89	42.6
No debt	3	4.2	0	0.0	1	3.0	0	0.0	0	0.0	2	14.3	6	2.9
Total	72	100.0	29	100.0	33	100.0	31	100.0	30	100.0	14	100.0	209	100.0

Table 4.1.8 The primary bread winner in the family

The primary bread winner	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Respondent	42	58.3	17	58.6	10	30.3	11	35.5	14	46.7	9	64.3	103	49.3
Respondent's husband	21	29.2	10	34.5	14	42.4	18	58.1	12	40.0	3	21.4	78	37.3
Respondent's daughter	2	2.8	0	0.0	3	9.1	2	6.5	0	0.0	1	7.1	8	3.8
Respondent's daughter's husband	0	0.0	0	0.0	1	3	0	0.0	0	0.0	0	0.0	1	0.5
Respondent's son	2	2.8	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	1.0
Respondent's son's wife	5	6.9	2	6.9	5	15.2	0	0.0	4	13.3	1	7.1	17	8.1
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.9 Women's age at becoming a wage earner

Age (years)	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
≤ 10	7	9.7	1	3.4	2	6.1	3	9.7	9	30.0	2	14.3	24	11.5
11	0	0.0	0	0.0	2	6.1	2	6.5	1	3.3	1	7.1	6	2.9
12	7	9.7	1	3.4	3	9.1	3	9.7	2	6.7	3	21.4	19	9.1
13	6	8.3	3	10.3	5	15.2	8	25.8	4	13.3	3	21.4	29	13.9
14	11	15.3	2	6.9	5	15.2	2	6.5	2	6.7	2	14.3	24	11.5
15	14	19.4	11	37.9	2	6.1	4	12.9	6	20.0	1	7.1	38	18.2
16	4	5.6	2	6.9	2	6.1	2	6.5	2	6.7	1	7.1	13	6.2
17	3	4.2	2	6.9	2	6.1	5	16.1	1	3.3	0	0.0	13	6.2
≥ 18	20	27.8	7	24.1	10	30.3	2	6.5	3	10	1	7.1	43	20.6
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.10 Age of women when first married

Age (years)	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
11-13	2	2.8	1	3.5	0	0.0	1	3.2	0	0.0	0	0	4	1.9
14	5	6.9	0	0	1	3.0	0	0	1	3.3	0	0	7	3.3
15	7	9.7	1	3.4	2	6.1	0	0.0	0	0.0	1	7.1	11	5.3
16	5	6.9	1	3.4	7	21.2	3	9.7	2	6.7	1	7.1	19	9.1
17	13	18.1	4	13.8	7	21.2	6	19.4	7	23.3	2	14.3	39	18.7
18	9	12.5	6	20.7	3	9.1	4	12.9	5	16.7	0	0	27	12.9
19	5	6.9	1	3.4	5	15.2	4	12.9	5	16.7	0	0	20	9.6
20	7	9.7	3	10.3	1	3.0	2	6.5	4	13.3	4	28.6	21	10.0
21-25	15	20.8	11	37.9	6	18.2	10	32.3	2	6.7	4	28.6	48	23.0
26-32	3	42	1	3.5	1	3.0	1	3.2	2	6.7	1	7.1	9	4.3
No response	1	1.4	0	0.0	0	0.0	0	0.0	2	6.7	1	7.1	4	1.9
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.11 Number of times married

Times married	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1	43	59.7	22	75.9	24	72.7	19	61.3	18	60.6	9	64.3	135	64.6
2	23	31.9	6	20.7	7	21.2	11	35.5	8	26.7	3	21.4	58	27.8
3	4	5.6	1	3.4	2	6.1	1	3.2	2	6.7	0	0	10	4.8
No response	2	2.8	0	0.0	0	0.0	0	0.0	2	6.7	2	14.3	6	2.9
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.12 Total number of women's children (both living and dead)

Number of Children	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1	8	11.1	5	17.2	5	15.2	6	19.4	6	20.0	3	21.4	33	15.8
2	20	27.8	7	24.1	9	27.3	10	32.3	11	36.7	4	28.6	61	29.2
3	11	15.3	9	31.0	4	12.1	5	16.1	1	3.3	2	14.3	32	15.3
4	13	18.1	4	13.8	4	12.1	2	6.5	2	6.7	1	7.1	26	12.4
5	5	6.9	0	0.0	2	6.1	2	6.5	5	16.7	0	0.0	14	6.7
6	5	6.9	1	3.4	1	3.0	1	3.2	1	3.3	0	0.0	9	4.3
≥ 7	2	2.8	1	3.5	3	9.1	1	3.2	1	3.3	2	14.3	10	4.8
No response	8	11.1	2	6.9	5	15.2	4	12.9	3	10.0	2	14.3	24	11.5
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.13 Ages of children

Age (years)	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
< one	3	5.0	3	11.1	2	8.7	1	3.7	1	3.0	3	27.3	13	7.2
1 - 5	13	21.7	9	33.3	5	21.7	8	29.6	9	27.3	2	18.2	46	25.4
6 – 8	14	23.3	4	14.8	8	34.8	6	22.2	7	21.2	2	18.2	41	22.7
8 – 15	30	50.0	11	40.7	8	34.8	12	44.4	16	48.5	4	36.4	81	44.8
Total	**60**	**100.0**	**27**	**100.0**	**23**	**100.0**	**27**	**100.0**	**33**	**100.0**	**11**	**100.0**	**181**	**100.0**

Table 4.1.16 Current work time

Work Time	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Day time	38	54.2	18	62.1	22	66.7	25	80.6	22	73.3	9	64.3	134	64.6
Night time	8	11.1	2	6.9	5	15.2	1	3.2	1	3.3	2	14.3	19	9.1
Day and Night time	7	9.7	2	6.9	1	3.0	0	0.0	4	13.3	2	14.3	16	7.7
Variable	19	26.4	7	24.1	5	15.2	5	16.1	3	10	1	7.1	40	19.1
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.17 Hours of women's sleep

Hours	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
< 3	2	2.8	1	3.4	0	0.0	0	0.0	2	6.7	0	0.0	5	2.4
3-5	5	6.9	3	10.3	3	9.1	1	3.2	2	6.7	2	14.3	16	7.7
6-8	40	55.6	18	62.1	23	69.7	22	71.0	23	76.7	11	78.6	137	65.6
>8	23	31.9	7	24.1	6	18.2	8	25.8	2	6.7	1	7.1	47	22.5
Not sure	2	2.8	0	0.0	1	3.0	0	0.0	1	3.3	0	0.0	4	1.9
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.18 Women's vacation days earned per month

Vacation days earned	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1	10	13.9	11	37.9	5	15.2	2	6.5	6	20.0	6	42.9	40	19.1
2	4	5.6	1	3.4	0	0.0	0	0.0	0	0.0	0	0.0	5	2.4
3	4	5.6	0	0.0	4	12.1	1	3.2	1	3.3	0	0.0	10	4.8
4	1	1.4	0	0.0	1	3.0	0	0.0	2	6.7	1	7.1	5	2.4
5	5	6.9	3	10.3	5	15.2	13	41.9	6	20.0	3	21.4	35	16.7
>5	40	55.6	12	41.4	15	45.5	15	48.4	12	40	4	28.6	98	46.9
Uncertainty	8	11.1	2	6.9	3	9.1	0	0.0	3	10.0	0	0.0	16	7.7
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.19 Payment for holidays

Paid	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Same as work day	6	8.3	3	10.3	11	33.3	9	29.0	5	16.7	4	28.6	38	18.2
Less than work day	1	1.4	0	0.0	3	9.1	2	6.5	2	6.7	3	21.4	11	5.3
Not paid	59	81.9	24	82.8	19	57.6	19	61.3	23	76.7	7	50.0	151	72.2
No answer	6	8.3	2	6.9	0	0.0	1	3.2	0	0.0	0	0	9	4.3
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.20 Activities women do for recreation

Activities	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Have no recreation	5	1.4	1	0.8	3	2.1	1	.7	0	0.0	0	0.0	10	1.0
Talk with family members	67	18.5	23	18.5	29	20	27	18.5	27	19.0	12	30	185	18.7
Talk with neighbours	57	15.7	23	18.5	21	14.5	19	13.0	25	17.6	11	22.4	156	15.8
Drinking	32	8.8	7	5.6	9	6.2	12	8.2	14	9.9	3	7.5	77	7.8
Exercise	20	5.5	8	6.5	9	6.2	5	3.4	9	6.3	1	2.0	52	5.3
Sport	0	0.0	1	0.8	0	0.0	0	0.0	1	0.7	0	0.0	2	0.2
Gambling	24	6.6	2	1.6	5	3.5	8	5.5	7	4.9	1	2.0	47	4.8
T.V.	57	15.7	22	17.7	23	15.9	27	18.5	27	19.0	14	28.6	170	17.2
Movies	7	1.9	2	1.6	4	2.8	3	2.1	5	3.5	2	4.1	23	2.3
Radio	43	11.9	16	12.9	20	13.8	15	10.3	2	1.4	3	7.5	118	11.9
Shopping	26	7.2	10	8.1	8	5.5	12	8.2	15	10.6	2	4.1	73	7.4
Go to a public park	7	1.9	0	0.0	4	2.8	7	4.8	5	3.5	0	0.0	23	2.3
Go to see traditional concert	17	4.7	9	7.3	10	6.9	10	6.8	5	3.5	0	0.0	51	5.2
Total	**362**	**100.0**	**124**	**100.0**	**145**	**100.0**	**146**	**100.0**	**142**	**100.0**	**49**	**100.0**	**987**	**100.0**

Table 4.1.21 Women's health compared to last year

Women's health	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Same as last year	20	27.8	10	34.5	7	21.2	6	19.4	10	33.3	3	21.4	56	26.8
Worse than last year	25	34.7	5	17.2	8	24.2	8	25.8	6	20.0	6	42.9	58	27.8
Much worse than last years	10	13.9	7	24.1	6	18.2	4	12.9	6	20.0	4	28.6	37	17.7
Better than last year	7	9.7	4	13.8	11	33.3	13	41.9	4	13.3	1	7.1	40	19.1
Much better than last year	10	13.9	3	10.3	1	3.0	0	0.0	3	10.0	0	0.0	17	8.1
Uncertain	0	0.0	0	0.0	0	0.0	0	0.0	1	3.3	0	0.0	1	0.5
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.22 Women's frequency of getting sick compared to last year

Frequency	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
More sick	38	52.8	11	37.9	12	36.4	13	41.9	16	53.3	8	57.1	98	46.9
Uncertain	15	20.8	7	24.1	12	36.4	7	22.6	9	30.0	5	35.7	55	25.4
Less sick	19	26.4	11	37.9	9	27.3	11	35.5	5	16.7	1	7.1	56	26.8
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.23 Acute illness in last two weeks

Answers	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	17	23.6	8	27.6	17	51.5	10	32.3	6	20.0	6	42.9	64	30.6
No	51	70.8	21	72.4	16	48.5	20	64.5	22	73.3	7	50.0	137	65.6
Uncertain	4	5.6	0	0.0	0	0.0	1	3.2	2	6.7	1	7.1	8	3.8
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.24 Symptom of illness

Symptoms	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Muscle pain	4	5.6	2	6.9	10	30.3	7	22.6	3	10.0	4	28.6	30	14.4
Allergy	0	0.0	0	0.0	0	0.0	1	3.2	1	3.3	0	0.0	2	1.0
Kidney disorder	2	2.8	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	1.0
Uncertain	66	91.7	27	93.1	23	69.7	23	74.2	26	86.7	10	71.4	175	83.7
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.25 History of allergies

History of allergies	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Have a chronic cold	9	19.6	3	23.1	3	16.7	5	18.5	4	17.4	3	23.1	27	19.3
Were diagnosed with allergies	5	10.9	3	23.1	4	22.2	6	22.2	4	17.4	5	38.5	27	19.3
Were attacked with skin allergies	24	52.2	4	30.8	9	50.0	13	48.1	10	43.5	4	30.8	64	45.7
Were attacked with face or mouth edema	8	17.4	3	23.1	2	11.1	3	11.1	5	21.7	1	7.7	22	15.7
Total	**46**	**100.0**	**13**	**100.0**	**18**	**100.0**	**27**	**100.0**	**23**	**100.0**	**13**	**100.0**	**140**	**100.0**

Table 4.1.27 Initial treatments for ill family members

Treatments	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Did nothing	53	73.6	17	58.6	25	75.8	21	67.7	24	80.0	10	71.4	150	71.8
Bought over-the-counter drugs	5	6.9	1	3.4	2	6.1	5	16.1	4	13.3	2	14.3	19	9.1
Went to the local government service	3	4.2	6	20.7	5	15.2	1	3.2	1	3.3	2	14.3	18	8.6
Went to the government hospital	9	12.5	4	13.8	1	3.0	4	12.9	0	0.0	0	0.0	18	8.6
Went to a private clinic	1	1.4	0	0.0	0	0.0	0	0.0	1	3.3	0	0.0	2	1.0
No response	1	1.4	1	3.4	0	0.0	0	0.0	0	0.0	0	0.0	2	1.0
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.28 Treatment for long term illness of family members

Treatments	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Bought over-the-counter drugs	6	8.3	2	6.9	4	12.1	1	3.2	0	0.0	0	0.0	13	6.2
Went to the local government service	2	2.8	2	6.9	2	6.1	1	3.2	3	10.0	1	7.1	11	5.3
Went to the government hospital	58	80.6	20	69.0	23	69.7	23	74.2	23	76.7	9	64.3	156	74.6
Went to a private clinic	6	8.3	4	13.8	4	12.1	4	12.9	3	10.0	3	21.4	24	11.5
Went to a private hospital	0	0.0	1	3.4	0	0.0	2	6.5	1	3.3	0	0.0	4	1.9
No response	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	7.1	1	0.5
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.29 Frequency of taking pain killers

Frequency of taking pain killers	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Everyday	9	12.5	3	10.3	2	6.1	0	0	1	3.3	3	21.4	18	8.6
When doing hard work	11	15.3	1	3.4	8	24.7	7	22.6	5	16.7	5	35.7	37	17.7
Taking it when prescribed	52	72.2	25	86.2	23	69.7	24	77.4	24	80.0	6	42.9	154	73.7
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.30 Frequency of taking stimulants

Taking stimulant tablets	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Everyday	1	1.4	1	3.4	0	0.0	0	0.0	0	0.0	0	0.0	2	1.0
When doing hard work	11	15.3	1	3.4	2	6.1	2	6.5	2	6.7	1	7.1	19	9.1
Infrequently	6	8.3	0	0.0	4	12.1	2	6.5	2	6.7	1	7.1	15	7.2
Never take it	54	75.0	26	89.7	27	81.8	27	87.1	26	86.7	10	71.4	170	81.3
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.31 Frequency of taking stimulant drink

Frequency	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Everyday	6	8.3	0	0.0	3	9.1	0	0.0	4	13.3	1	7.1	14	6.7
Every 2-3 days	8	11.1	0	0.0	2	6.1	1	3.2	2	6.7	1	7.1	14	6.7
Once a week	2	2.8	1	3.4	0	0.0	0	0.0	1	3.3	0	0.0	4	1.9
Infrequently	13	18.1	8	27.6	5	15.2	6	19.4	5	16.7	3	21.4	40	19.1
Never drink	43	59.7	20	69.0	23	69.7	24	77.4	18	60.0	9	64.3	137	65.6
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.32 Smoking habits

Smoking habits	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Never smoke	50	69.4	24	82.8	24	72.7	24	77.4	25	83.3	14	100	161	77.0
Ordinarily smoke	13	18.1	2	6.9	4	12.1	3	9.7	3	10.0	0	0.0	25	12.0
Some days	5	6.9	2	6.9	2	6.1	2	6.5	0	0.0	0	0.0	11	5.3
Used to, now quit	4	5.6	0	0.0	3	9.1	2	6.5	0	0.0	0	0.0	9	4.3
No answer	0	0.0	1	3.4	0	0.0	0	0.0	2	6.7	0	0.0	3	1.4
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.1.33 Drinking habits

Drinking habits	Guardian		Rental		Stranger		Temple		Railway		Joss		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Daily	9	12.5	2	6.9	4	12.1	0	0.0	4	13.3	1	7.1	20	9.6
Often	24	33.3	2	6.9	5	15.2	10	32.3	5	16.7	4	28.6	50	23.9
Used to, now quit	5	6.9	0	0.0	6	18.2	2	6.5	0	0.0	0	0.0	13	6.2
Never	34	47.2	25	86.2	18	54.5	18	58.1	21	70.0	9	64.3	125	59.8
No answer	0	0.0	0	0.0	0	0.0	1	3.2	0	0.0	0	0.0	1	0.5
Total	**72**	**100.0**	**29**	**100.0**	**33**	**100.0**	**31**	**100.0**	**30**	**100.0**	**14**	**100.0**	**209**	**100.0**

Table 4.2.1 Number of symptoms the women had in the previous year

History	Used to		Never		Not sure	
Oedema at any part of body	15	7.2	192	91.9	2	1.0
Stones/granules present in urine	2	1.0	202	96.7	5	2.4
Hematuria	4	1.9	203	97.1	2	1.0

Table 4.2.2 History of pain in extremities

Have pain in legs/arms	No	%
Used to	48	23.0
One time	8	3.8
Intermittent	100	47.8
Not sure	53	25.30
Total	**209**	**100**

Table 4.2.3 The frequency of pain in legs/arms.

Times/month	Number	%
1	30	14.4
2	22	10.5
3	21	10.0
4	10	4.8
5	11	5.3
6	1	0.5
8	3	1.4
9	17	8.1
No response	94	45.0
Total	**209**	**100.0**

Table 4.2.4 Duration of pain in legs/arms

Duration	No.	%
< 1.5 month	140	67.0
> 1.5 month	69	33.0
Total	**209**	**100.0**

Table 4.2.5 History of pain in back

Have pain in back	No.	%
Used to	57	27.3
Intermittent	8	3.8
One time	66	31.6
Not sure	53	25.4
No response	25	12.0
Total	**209**	**100.0**

Table 4.2.6 The frequency of pain in back

Times/month	Number	%
1	29	13.9
2	24	11.5
3	17	8.1
4	7	3.3
5	6	2.9
6	1	0.5
7	2	1.0
8	2	1.0
9	20	9.6
No response	101	48.3
Total	**209**	**100.0**

Table 4.2.7 Duration of pain in back

Duration	No.	%
< 1.5 month	134	64.1
> 1.5 month	75	35.9
Total	**209**	**100.0**

Table 4.2.8 History of a vaginal tract infection

Have of having abnormal vaginal discharge	No.	%
Used to have	25	12.0
Never	154	73.7
Not sure	1	9.5
No response	29	13.9
Total	**209**	**100.0**

Table 4.2.9 Experienced vaginal bleeding (other than regular menstruation)

	No.	%
Used to have	8	3.8
Never	173	82.8
No response	28	13.4
Total	**209**	**100.0**

Table 4.2.10 Experienced vaginal bleeding following successive incidents of sexual intercourse of more than three times

	No.	%
Used to	5	2.4
Never	175	83.7
Not sure	1	0.5
No response	28	13.4
Total	**209**	**100.0**

Table 4.2.11 Incidence of pap smear

	No.	%
Used to	89	42.6
Never	103	49.3
No response	17	8.1
Total	**209**	**100.0**

Table 4.2.12 Last time women had a pap smear

	No.	%
≤ 1 year	2	1.0
≥ 1-2 year	7	3.3
Could not remember	200	95.7
Total	**209**	**100.0**

Table 4.2.13 Findings of the pap smear

	No.	%
Abnormal	5	2.4
Normal	84	40.19
No response	120	57.41
Total	**209**	**100.0**

Table 4.2.14 History of diagnosis and medication for chronic disease

History of	Yes		Never		Not sure	
	NO.	%	NO.	%	NO.	%
• Taking medication for hypertension	13	6.2	192	91.9	4	1.91
• Diagnosed for hypertension	13	6.2	192	91.9	4	1.91
• Taking medication for diabetes mellitus	6	2.9	200	95.7	3	1.4
• Diabetes for diabetes mellitus	5	2.4	203	97.1	1	0.5
• Taking medication for reducing triglycerides	1	0.5	206	98.6	2	1.0
• Diagnosed as having elevated triglycerides	2	1.0	205	98.1	2	1.0
• Taking medication for bronchodilation	3	1.4	204	97.6	2	1.0
• Diagnosed for asthma	3	1.4	203	97.1	3	1.43
• Taking medication for tuberculosis	-	-	207	99.0	2	1.0
• Diagnosed for tuberculosis	1	0.5	206	98.6	2	1.0
• Taking medication for convulsion	-	-	208	99.5	1	0.5
• Diagnosed for convulsion	-	-	208	99.1	1	0.5
• Taking medication for pain relief continuously for than 3 months	21	10.0	182	87.1	6	2.87
• Diagnosed for anemia	15	7.2	192	91.9	2	0.96

Table 4.2.15 History of symptoms and diagnosis for chronic airflow obstruction

History	Yes		Never		No response	
	NO.	%	NO.	%	NO.	%
- History of cough and phlegm :						
• Often coughing.	46	22.0	161	77.0	2	1.0
• Coughing for more than four times a day/several days a week.	31	14.8	60	28.7	118	56.5
• Coughing with phlegm.	40	19.1	47	22.5	122	58.4
• Coughing when getting up in morning/changing position.	37	17.7	164	78.5	8	3.8
• Coughing continuously for more than 3 months.	17	8.1	58	27.8	134	64.1
• Duration for having coughed and had phlegm :						
1 year	12	5.7				
2 years	10	4.8				
3 years	4	1.9				
≥ 4 years	10	4.8				
No response	173	82.8				
- Symptoms of feeling exhausted :						
• Feeling exhausted when taking a bath and getting dressed.	32	15.3	169	80.9	8	3.8
• Feeling exhausted when walking normally.	46	22.0	160	76.6	3	1.4
• Feeling exhausted during walking upstairs or uphill.	66	31.6	142	67.9	1	0.5
- Symptoms of gasping for air						
• Sudden chest congestion or gasping for air without hard work.	42	20.1	167	79.9	-	-
• Have chest pain or coughing after doing hard work/exercise.	44	21.1	163	78.0	2	1.0
• Getting up in the night with the signs of congestion or gasping for air.	19	9.1	189	90.4	1	0.5
• Getting chest congestion coughing or grasping for air if cleaning house/making bed.	15	7.2	73	34.9	121	57.9
• Getting chest congestion, coughing or gasping for air if catching cold.	27	12.9	53	25.4	129	61.7

Table 4.2.15 History of symptoms and diagnosis for chronic airflow obstruction (continued)

History	Yes		Never		No response	
	NO.	%	NO.	%	NO.	%
• Getting chest congestion, coughing or grasping for air if confronted with smoke or strong smells.	29	13.9	53	25.4	127	60.8
• Getting chest congestion/grasping for air before a change in the weather.	24	11.5	58	27.8	127	60.8
• Getting chest congestion if emotions change.	23	11.0	58	27.8	128	61.2
• Age when first experienced congestion/grasping for air :						
22 years	1	0.5				
25 years	1	0.5				
23 years	1	0.5				
Not sure	5	2.4				
no response	201	96.2				
• Presently experiencing congestion/grasping for air for more than two times.	24	11.5	19	9.1	166	79.4

Table 4.2.16 History of Allergies.

History	Yes		Never		No response	
	NO.	%	NO.	%	NO.	%
- History of Allergies						
• Have a chronic cold	27	12.9	178	85.2	4	1.9
• Were diagnosed with allergies	27	12.9	177	84.7	5	2.4
• Had skin allergies	64	30.6	144	68.9	1	0.5
• Had face or mouth edema	22	10.5	182	87.1	5	2.4

Table 4.2.17 History of cardiovascular disease

History of	Yes		Never		Not response	
	NO.	%	NO.	%	NO.	%
- History of cardiovascular diseases						
• Have had chest pain	63	30.1	139	66.5	7	3.3
• Have had chest pain if walking briskly/uphill	41	19.6	60	28.7	108	51.7
• Have had chest pain if walking normally	23	11.0	76	36.0	110	52.6
- The chest pain disappears when stop doing the activities in	50	23.9	7	3.3	152	72.7
≤ 10 minutes	17	34.0	-	-	-	-
> 10 minutes	33	66.0	-	-	-	-
- Specifying the location of chest pain (angina pain)						
area four	12	5.7	12	5.7	185	88.5
area six	17	8.1	11	5.3	181	86.6
area seven	-	-	14	6.7	195	93.3
- Having experience with chest pain for more than ½ hour	11	5.3	17	22.5	151	72.2

Appendix 4

Guidelines for Focus Group Interviews
(For Phase 1)

The aim of conducting focus group discussions before the quantitative survey was to formulate the questionnaire in order to obtain valid data by wording questions in language easily understood by the target group. I conducted 12 group discussions (two groups per a community) in April-May 1997. The following are the characteristics of the groups that the researcher has set.

1. All participants lived in the same low-income community more than six months.
2. There were two groups in each community:
   -men group
   -women group
3. Each session was composed of 7-10 informants.

A. Introduction

1. Introduce one self
2. Reason for session:
   To learn about people's lives and health in the community.
3. Ask for help:
   Your information is very valuable. Please feel free to express your experiences and ideas. There are no right or wrong answers. If there arguments, please feel free to discuss. We will learn many things from our discussion.
4. Assure anonymity.
5. Ask for permission to tape record.
6. Confirm participant's name.
7. Tell the process of discussion.

B. Content

Question guideline:

1. The ways of people living in the community
   -Please describes the daily activities on a typical day of people here.
   -Please describes the housing, environment and mobility in the community.
   -Does your community has informal rules? Who oversees these rules?
   -Who does the people in the community respect? Why?
   -What makes you feel good about living here?
   -What makes you feel bad about living here?
   -Do you feel safe living here? Why?
2. Migration experiences
   -How often do people turn over?
   -Where do people come from?
   -What is their reason for migration?
   -Please specify the details about preference for living in Khon Kaen municipality and any problems experienced in resetting in the new community.
3. Living arrangement, life style and the relationship with each person living here.
   -What is the family relationship of the people in your household?
   And please describe other community households.
   -What do people here do for jobs?
   -Do people have an imbalance in income-living cost problems?
   How do they solve these problems?
   -Regarding social activities in the community please specify kinds of social activities, their objectives and amount of people joining the activities.
4. Children in low-income communities
   -Please tells the formal education conditions of children in your community.
   -Regarding children health, please specify their health problems and how their parents solve these Problems?
   -Who does take care of children when their parents go to work?
   -Has your community a play ground?

-Please describe children's dietary patterns, in each of four age categories: infant, toddler, pre-school and primary school.

5. Household workload and occupations
   -Regarding household work, please describe the function of male and female members at home.
   -How old is people when they start to find a job?
   -On the whole, how satisfied is you with household work and the work you do?
   -Please describes the differences between male and female role in community activities.
   -How often does people change their jobs? Why?
   -Do you think that people here feel stressed? Why? How do they escape from their worries?
   -What do people, male and female, do for recreation?
6. Social behaviours
   -Do people here have brawls? How often? How violent are they?
   -Are there people committing petty larceny here? How? Who are they?
   -Are there instances of rape in this community? Do police make any arrest?
   -Do you hear about drug addiction here? What kinds of addition? Do the sellers live in the Community?
   -Are there a lot of alcoholics in community? Do they trouble others?
   -Do you hear about amphetamine use? Why do they use?
   -Are there prostitutes in the community? Why do they become prostitutes? Please give an example case.
7. Health care
   -What do people here do when they are not well?
      -In case of a minor illness.
      -In case of a serious illness.
   -What is the health problems of men and women here? What are the causes?
   -In your opinion, what do people do for good health?
   -Have people here the following:
      -Private / government health insurance?
      -Government funded health coverage?
      -employer provided coverage?
   -Are there traditional medicine practitioners or spiritualists faith healers in this community? Do people like to consult them? Why?
   -How often does people use sleep medication?
   -Do people like to drink vitamin-nutrient drinks? Why? How often?
   -What kinds of work cause health problems? Male? Female ? How do they solve these problems?

C. Closing

1. Thank all participants for sharing information.
2. Is there anything that you want to tell me or to discuss? What?
3. Thank you again.

Appendix 5

Guidelines for Focus Group Discussion
(For Phase 2)

The aim of conducting focus group discussion in the study of phase 2 was made after the in-depth interviewing from the informants in order to check the information and ask for some more information for the incomplete information part. Two conducts have been grouped, one is a group of women aged between 16-27 years old, and the other is a group of men aged between 16-27 years old.

The groups contain 8 and 10 persons respectively. The process was carried out in August of 1998.

A. Introduction

B. Contents

Question guidelines:

1. Personal Life and Family:

The father in your opinion, probe:
-What should the characteristics of the father be?
-What roles should he have in the family?
-How is the father in the real life?
-If the father is alcoholic, what will his characteristic be?
-How does this condition affect the family?
-Please indicates your impression for the father both in positive and negative way.

The mother in your opinion, probe:
-What should the characteristics of the mother be?
-What roles should she have in the family?
-How is the mother in the real life?
-If the mother is alcoholic, what will his characteristic be?
-How does this condition affect the family?
-Please indicates your impression for the mother both in positive and negative way.

As you normally see, when do people start to drink alcohol? When do they start to drink everyday? Why do they drink?

Normally at what age do people start to gamble? What kinds of gambling do they do? How much do they get from winning and losing each time? How often do they gamble?

Are the people in the present time and people in the past different in terms of raising the children? Why is that so? How does it affect the behaviours of the children in the present time?

Did you read the news about sexual abused, which says that an eleven-year-old girl has been raped by her great grandfather and uncle for 3-4 years and get AIDS infection? How do you feel about it? Is there any kind of child abused in the community? How is it?

As for kinship, do you always visit one another and help one another? How? Why is that?

2. **Work**

-Why is some people working to earn a living? Why don't some people go out to work to earn a living? At what age did you start to work and earn money? How is your work experience?
-What kinds of housework have you ever done? Since you were young what housework have you been taught to do? Who is supposed to do this housework? What is the housework which men won't do at all? Why is that so?

-The meaning of work
-What is work?
-What is the maximum workload you can bear according to your experience?
-If you work as hard as the maximum workload, how will it affect your body and mind?
-Why don't men in this community always go to work? What is your opinion?

3. **Health**

-What is health?
-What is well-being? What should people do in order to be well-being? Please give some examples of those who are well-being in the community. Why is the well-being?
-What is illness? Why do people have illness? Please give some examples of those who have illness in the community. Why do they have illness?
-What can work affect our health?
-How does work affects the health?
-Positive way
-Negative way
-What is risk behaviour in terms of health there are in the community?
-When we have strain, how do we release the strain?

4. **What is our dream,** which we think we can make it come true?
What do you dream about in the next 10 years?

C. **Closing**

Appendix 6

Interview Guide for Quantitative Survey

Nursing Perspectives on Women, Health and Work in the Socio-Cultural Context of Poor Communities in Northeast Thailand

1. **Sampling:** Households are selected at random. If a selected household is habitually absent, interview the household to the immediate right of the household initially selected.
2. **Definitions**

2.1 **A household**

a. **Unrelated individuals** in the household: not composed of immediate family. However, it may be composed of relatives living together.

b. **Nuclear household:** composed of husband, and/or wife, more than 2 unmarried children, and/or unmarried relatives who are the same age as children living together.

c. **Stem household:** composed of husband, and/wife, married child, and/or married grandchild, unmarried children (grandchildren), and other unmarried relatives who are the same age as children / grandchildren living together.

d. **Joint household:** Composed of husband, and/or wife, same age relative, and other unmarried relative living together.

e. **Stem-Joint household:** Composed of husband and/or wife, more than two-married children/grandchildren living together. These married children may be composed of their husband/wife and married children or unmarried relative, and other relatives living together.

2.2 **Employment**

-Only women over the age of 13 who work at least one hour a week and receive payment in cash or in barter.

-Include women who are usually gainfully employed (or self-employed) but who are temporarily not working due to conditions such as the weather, seasonal fluctuations or time off (requested or directed).

-Also include household workers who work as a part of a family team on tasks sub-contracted to the head of household, but who do not receive a salary/wage directly.

2.3 **Work**

-A job for which they receive compensation directly from an employer.

-Self-employed in a small business (such as hawking, food vending scavenging, garbage seller, etc. or doing an agricultural job such as planting, tending, harvesting).

-Work as a member of a household team, but receiving no direct compensation.

2.4 **Occupation**

-Ask what is their principal occupation and if they have additional employment. If there are two occupations, which require an equal amount of time, the principal occupation is deemed to be the one for which they receive the higher compensation.

2.5 **Unemployed**

-Not presently working. Differentiate between those who never work, and those who usually work but are presently not doing so.

2.6 **Work time**

-Find out how many hours they usually work each week. If more than one occupation, use total number of hour work. It temporarily not employed, use the number of hours they would usually be working if employed.

2.7 **Educational level achieved**

-The educational system in Thailand is made up of *Primary school* (P1-6), *Middle school* (M1-3), and *High school* (M4-6). After finishing middle school, pupils may enter *Industrial/Vocational School*, are the schools for training students to work. University is a school for advance dissemination of knowledge, which gives a degree after the students completes the required course of study (4 to 6 years).

2.8 **No formal education**

-Mean people did not have a formal education. They may be literate or not.

2.9 **Head of household**

-The person who has the main responsibility for the household, or the person who is referred by the members of household as the head of household. The head of household can be either male or female.

2.10 Women

-Only female over the age of 13 who work individually or as a part of family team on tasks subcontracted to the head of household.

3. The Physical Examination Guides

3.1 The Physical Examination of Body Dysfunction

a. **Finger Count:** let the woman count the number of fingers five feet away with one eye closed. If she can answer the right answer for 5 times continuously check "right".

b. **Hearing Ability:** formal speaking at one foot distant. Let the woman speak after the tester, and have a conversation with the tester. If there are abnormalities please specify.

c. **The Cleft Lip and Cleft Palate Examination:** Let the woman open her mouth and look for the abnormality of a cleft lip and cleft palate. If she had the cleft lip and cleft palate repaired, check "normal".

d. **Test of arms, legs and body movements:** Explain the following six activities for the woman to do.

-Raise hands and arms over the head.
-Bend her elbows, until her fingers touch her lips.
-Make a first, with thumb across the knuckles, while holding the tester's finger tightly.
-Put buttons (1.5 cms) through a hole two consecutive times.
-Squat down and let one palm touch the floor, then stand up.
-Walk straight-ahead ten steps and come back to the starting point.

Joint and back pain: An interpretation of chronic joint and back pain when the respondent gave a history of pain in the joints, extremities and back for a duration of at least 15 months, or at least 6 weeks of pain in 3 months.

Impaired body movement: There are three levels of impaired body movement. There are ability, ability but abnormal movement and disability. Ability was recorded when the respondent could do routine movements as usual, with no pain or abnormal movement when they did routine activities. Ability but abnormal movement, was recorded when they could do routine as needed, but they have abnormal movement such as accurate placement of objects, rigidity, spasticity, tremor, slowness, etc. when they do routine activities. Disability was significantly improved body movement, such as that they could not do routine activities.

e. **The Physical Examination of Liver Cirrhosis:** Only women over the age of 15 are to be examined while lying down for the following systems:

-*Ascites*: look for the signs of fluid thrill, shifting dullness.
-*Pitting Edema*: look for these signs at the skin, the toes, or tip of the feet by presenting at these parts a while, then observe for the trace of pressing.
-*Jaundice*: look for abnormalities by examining the conjunctiva and other skin areas.
-*Spinder Nervi*: look for the clutching of the capillary arteries on the skin of the chest or back. These clutching would disappear if pressed, then they would return to spider net-like appearance after rebound.
-*Palmar Erythema*: look for any abnormal reddish colour of the palmars.

Criteria for diagnosis Liver Cirrhosis, by points gained from signs and symptoms in physical examination

-4 points for *Ascites*
-2 points for *Pitting Oedema*
-1 point for *Jaundice*
-1 point for *Spider Nervi* or *Palmar Erythema*
-1 point for having the record of edema recurrence which lasts for a long period

Then add up all the points, and dingoes the *Liver Cirrhosis* as follows:

-less than 4 points means the patient is unlikely to have *Liver Cirrhosis*
-more than or equal to 4 points: possible *Liver Cirrhosis*
-more than or equal to 7 points: likely or possible *Liver Cirrhosis*
-more than or equal to 9 points: highly likely *Liver Cirrhosis*

f. **Breast Examination:** Only women over the age of 30 are to be examined.

-**Inspection:** Have the woman assume a position of arms over head and hands pressed against hips. The examiner will inspect for abnormalities of shape, pitted skin, discharge, etc.

-**Palpation:**

(1) The palpation at the breasts are done by three directions, these are circular, vertical strip and wedge (see the figures). If mass is found, please record the shape, the size and the location and advise her to consult a physician.

(2) The palpation at axial, supraclavicular and infraclavicular areas. If mass is found, please record the shape, the size and the location and advise her to consult a physician.

g. **Weight and Height Records**

Weight: Place a weighting scale on a hard smooth floor. Test the weightless scale at the "zero" position. Have the woman takes her shoes off and stand at the middle of the weighting scale. Read the indicated weight from the scale after the scale pointer stop moving.

Height: Record by letting the woman stand on the hard smooth floor with shoes off and back to the wall. Her back, thighs and heels must be close to measuring stand against the wall. Her head must be erect. Pull down the measuring board until the board touches her head and read the scale.

Malnutrition: Adult malnutrition was established by calculations using the following formula:

Body Mass Index (BMI) = (Body Weight in Kgs/ Height in Metres) X 10000

Normal was interpreted with a BMI in the range of 20-25, lower than normal when the BMI was lower than 20, better than normal with a BMI in the range of 25.1-30 and obesity when the BMI was more than 30.

h. **Blood Pressure Measure** (by portable battery powered blood pressure measurer)

-Test only women over the age of 15. The woman must be in the condition of rest at least the hour before measuring. And must not ingest any hypertensive substances such as caffeine, alcohol, tea, cigarettes, etc. Check cuff and tubing for air leaks and kinks. Palpate brachial pulse. Place cuff snugly around extremity above brachial pulse. Place arm at the level of her heart in a straight position. Switch on the pump to inflate air into the cuff, until at the optimum pressure is released. Then release the air valve, obtain reading from digital display panel: - Systemic pressure and Diastolic pressure and record the measurement. Check cuff for full deflation. Recheck three times by the same process, then average the three measurement to obtain the mean blood pressure and record.

4. **Mental Status**

Read each statement on the questionnaire and ask the woman's opinion on each statement. Specify as "I strongly agree", "I agree", "I partly agree", and "I don't think so". The following definitions are defined for these statements:

-"I strongly agree": means you very much agreed with the statement/ or these events usually happen to you.

-"I agree": means you agreed with the statement/ or these events happen to you sometimes.

-"I partly agree": means you agreed with the statement a little bit/ or these events rarely happen to you.

-"I don't think so": means you don't agree with the statement/ or these events never happen to you.

Appendix 7-1

Questionnaire- Form 1
General Information on Household and Women

Nursing Perspectives on Women, Health and Work in the Socio-Cultural Context of Poor Communities in Northeast Thailand

Community Code.......
Household Code.........
Member Code...........

Name of head of household...
Name of Interviewee (If different from head of household)...
The relationship to the head of household...

I. Information of Social, Population, Economics and Environment of household
1. ( ) age under 15 years a. ( ) ......females b. ( ) ...... males
2. ( ) age 16-60 years a. ( ).......females b. ( )........males
3. ( ) age > 60 years a. ( ).......females b. ( )........males

2. What is the relationship to the head of household? (all members)
1. ( ) father 2. ( ) mother 3. ( ) child 4. ( ) child's wife
5. ( ) child's husband 6. ( ) husband 7 ( ) wife 8. ( ) grandchild
9. ( ) grandchild's spouse 10. ( ) other relative.........(specify)

3. How would the household specified?
1. ( ) unrelated individual family
2. ( ) nuclear family
3. ( ) stem family
4. ( ) joint family
5. ( ) stem-joint family

4. What is the head of household's religion ?
1. ( ) Buddhist
2. ( ) Christian
3. ( ) Muslim
4. ( ) Others.........................

5. Family member's education

Number	Relative to head	Age	Sex	Education

6. Marital status
( ) 1. single
( ) 2. divorced
( ) 3. married/living with consort
( ) 4. separated

7. Age..........years.
8. Highest educational level achieved
( ) 1. Primary school
( ) 2. Middle school
( ) 3. High school
( ) 4. Industrial/ Vocational school
( ) 5. University ( ) 6. No formal education

9. What is your principle occupation? ....
10. How much is your principle income / month? ....*Baht* / month
11. What is your additional occupation? ....
12. How much is the income / month from additional occupation? .... *Baht* / month
13. How long have you been in this community? ....
14. Where were you born? ....
    a. Where was your mother born? ....
    b. Where was your father born? ....
15. Does your family have the following things?

Things	Number (s)
a. Vehicle	
1. bicycle	
2. motorcycle	
3. manual three wheeled vehicle	
4. others (specify)......................................	
b. Appliances	
1. radio	
2. TV	
3. others (specify)......................................	

16. Last year, what was the cost for the following bills for your household?

Fee for	*Baht* / month
1. house renting / land renting	
2. water supply	
3. electricity	
4. food	
5. clothing	
6. medical care	
7. cigarettes	
8. whiskey	
9. stimulant / tonic drinks	
10. tablets of painkillers	
11. household usage chemicals	
12. support of relative or parents	
13. transportation	
14. school expenses	
15. others (specify)..	

17. Do the income and expenditure balance?
    1. ( ) Yes   2. ( ) No, how do you solve this problem? ....
18. Compared with the income-expenditures of last year, what is your opinion?
    1. ( ) Same
    2. ( ) It was better than last year
    3. ( ) It was worse than last year
    4. ( ) I am not sure
19. House observation by interviewer regarding to house appearance, roof, walls and floors....................
20. Do you have a toilet? ....
21. If yes, what kind of toilet do you have? ....
22. If no, how do you solve this problem? ....
23. Does the house have uncovered drainage ditches? (observation)...
24. What is your source of water for using in household ?
    1. ( ) Piped water
    2. ( ) Underground water
    3. ( ) Rain water
    4. ( ) Others...
25. Do you have electricity? ....
26. If no, what do you have for lighting? ....

27. What is your greatest environmental problem? ....
28. Last year, was there any patient in your family?
    1. ( ) Yes, ...patient(s)
    2. ( ) No.
29. By your experience, what treatment did your family member initially receive?
    1. ( ) Didn't do anything.
    2. ( ) Bought over the counter drugs.
    3. ( ) Went to the local government service.
    4. ( ) Went to the government hospital
    5. ( ) Went to the private clinic
    6. ( ) Went to the private hospital
    7. ( ) Traditional hospital
    8. ( ) Spiritual counsellor
    9. ( ) Others......................................
30. If the illness/disease is still active, what treatment are your family members receiving?
    1. ( ) Didn't do anything.
    2. ( ) Bought over the counter drugs.
    3. ( ) Went to the local government service.
    4. ( ) Went to the government hospital
    5. ( ) Went to the private clinic
    6. ( ) Went to the private hospital
    7. ( ) Traditional hospital
    8. ( ) Spiritual counsellor
    9. ( ) Others......................................
31. Do you and your family members have these health cards?
    1. Government health insurance 1.1 ( ) Yes, 1.2 ( ) No
    2. Private health insurance 2.1 ( ) Yes, 2.2 ( ) No
    3. Employer provided coverage 3.1 ( ) Yes, 3.2 ( ) No
    4. Old age government funded health coverage 4.1 ( ) Yes, 4.2 ( ) No
32. In the last 3 years, has any of your family died?
    1. ( ) Yes,.........people (s), the cause (s) was..
    2. ( ) No.
33. Please specify which activities is whose function?

Activities	Whose	
	Male	Female
1. Daily food/ meal providing	1. ( )	2. ( )
2. Making beds	1. ( )	2. ( )
3. Dish washing	1. ( )	2. ( )
4. House cleaning	1. ( )	2. ( )
5. Garbage management	1. ( )	2. ( )
6. (Hand) clothes washing	1. ( )	2. ( )
7. Carry water	1. ( )	2. ( )
8. Child rearing	1. ( )	2. ( )
9. Others (specify)...	1. ( )	2. ( )

34. In the last three months, did your community have these problems?

1. A brawl (husband & wife / neighbour)	1. ( ) Every day	2. ( ) Sometime	3. ( ) No.
2. Larceny	1. ( ) Every day	2. ( ) Sometime	3. ( ) No.
3. Gambling	1. ( ) Every day	2. ( ) Sometime	3. ( ) No.
4. Alcoholics & drunkards	1. ( ) Every day	2. ( ) Sometime	3. ( ) No.
5. Psychiatric	1. ( ) Every day	2. ( ) Sometime	3. ( ) No.
6. Others (specify).........................	1. ( ) Every day	2. ( ) Sometime	3. ( ) No.

35. In the last 2 years, did your community have these epidemics?

1. Diarrhoea	1. ( ) Yes	2. ( ) No
2. Haemorrhagic diseases	1. ( ) Yes	2. ( ) No
3. Influenza	1. ( ) Yes	2. ( ) No

36. Age when first married.................................years
37. Number of times married ...time (s)
38. Duration of cohabitation with current spouse ....month / year.

Social Relations

1. What is your activity in community affair?

1. Head of community	1. () Yes	2. () No
2. Community committee	1. () Yes	2. () No
3. Health volunteer	1. () Yes	2. () No
4. Money keeping group	1. () Yes	2. () No
5. Ageing activity	1. () Yes	2. () No
6. Gardening for increased income group	1. () Yes	2. () No
7. Christian study group	1. () Yes	2. () No
8. Others (specify)...	1. () Yes	2. () No

2. What is your preference of community activities?

1. Traditional fair	1. () Yes	2. () No
2. Community infrastructure development	1. () Yes	2. () No
3. Community meeting	1. () Yes	2. () No
4. Others	1. () Yes	2. () No

4. Why didn't you join with the activities of question number 3? ....
5. Do you have any relative to support you in Khon Kaen? ....
6. Do you have any neighbour to support you when you need? ....
7. Do you have any friend to support you when you are in need? ....

Family Life Style

1. Do you live with your spouse? ....
2. About the decision making in family, please specify the following activities.

Activities	Your decision making (1)	Your spouse decision making (2)	Co-operation (3)	Uncertain (4)
1. Daily food / meal providing / selecting				
2. Your work / job				
3. Buying sweets for your children				
4. Minor furniture/ appliances/ tools				
5. Major furniture/ appliances/ tools				
6. Your vacation				
7. Finding/ choosing children school				
8. Children vacation/ school break				
9. Choosing jobs for children				
10. Migration				
11. Source of medication for family members				
12. Loaning money				
13. Borrowing money				
14. Financial support for relatives of you/ your husband				
15. Community activity joining				
16. Others (specify).......................................				

3. Who is the primary breadwinner in your family? ....

Occupation and Recreation

1. What are the sources of your family total income? ....
2. The total family income is...........................*Baht*/ month
3. How many times have you moved? ....
4. What is your previous job (s)? ....
5. At what age did you become a wage earner? ....
6. What was the job? ....
7. For your current job, what is the duration?

1. ( ) day time	(a) start from.......................	to......................................
2. ( ) night time	(b) start from.......................	to......................................
3. ( ) day & night time	(c) start from.......................	to......................................
4. ( ) others (specify)...............	(d) start from.......................	to......................................

8. How many hours do you sleep?
1. ( ) < 3 hours / day 2. ( ) 3-5 hours / day
3. ( ) 5-8 hours / day 4. ( ) > 8 hours / day
9. How long is you worked at your current jobs? ....months / years
10. How do you go to work? ....
11. Last month, did you have earned vacation? ....
12 Total holidays................................days / year
13. If you don't work on national holiday, are you paid?
14. If you don't work when you get sick, are you paid?
15. What do you do for recreation? ....

Care

1. Last year, did you miss work because of illness?
2. Compared to last year, how do you think of your health?
   1. ( ) Same as last year
   2. ( ) Worse than last year
   3. ( ) Much worse than last year
   4. ( ) Better than last year
   5. ( ) Much better than last year
3. Do you think that you get sick more than easily than last year? ....
4. In your opinion, what diseases were caused by workload? ....
5. Acute illness:
   5.1 In the last 2 weeks, have you felt sick?
   1. ( ) Yes 2. ( ) No (skip to question number 6)
   5.2 If yes, what is the illness.....................(specify the most important symptom or problem)
   5.3 What treatment did you receive for this problem for each stage?
   5.3.1 What initial treatment did you receive for this problem?
   1. ( ) Didn't do any thing.
   2. ( ) Herbal medicine
   3. ( ) Traditional doctor
   4. ( ) Health volunteer
   5. ( ) Buy drug yourself
   6. ( ) Local government service
   7. ( ) Government hospital
   8. ( ) Private clinic
   9. ( ) Private hospital
   10. ( ) Others........................

5.3.2 What intermediate treatment did you receive?
1. ( ) Didn't do any thing.
2. ( ) Herbal medicine
3. ( ) Traditional doctor
4. ( ) Health volunteer
5. ( ) Buy drug yourself
6. ( ) Local government service
7. ( ) Government hospital
8. ( ) Private clinic
9. ( ) Private hospital
10. ( ) Others.......................

5.3.3 If the illness / disease is still active, what treatment are you receiving?
1. ( ) Didn't do any thing.
2. ( ) Herbal medicine
3. ( ) Traditional doctor
4. ( ) Health volunteer
5. ( ) Buy drug yourself
6. ( ) Local government service
7. ( ) Government hospital
8. ( ) Private clinic
9. ( ) Private hospital
10. ( ) Others.......................

6. Absence due to an accident

6.1 In the last 2 weeks, did you have any accident? ....

6.2 What was the cause of this accident?

Accidents	Time		
	1	2	3
1. Fell down			
2. Knife / other sharp things cut			
3. Burn			
4. Insect bite			
5. Vehicle accident			
6. Near downing incident			
7. Electric shock			
8. From workplace equipment			
9. Others (specify..			
10. No accident			

6.3 Where did the accident happen? ....

Risk Factors

1. Do you smoke?
1. ( ) Yes, ordinarily
2. ( ) Yes, someday. (skip to question number 6)
3. ( ) Yes, used to, now quit (skip to question number 2)
4. ( ) No, never (skip to question number 6)

2. If quit, how long? ....

The causes of quitting are? ....

3. When did you begin to smoke? ....years.

The cause of trying cigarette (only one reason)
1. ( ) Want to test
2. ( ) Social reason
3. ( ) Friends
4. ( ) Stress / Pressure
5. ( ) Others (specify)...

4. The average number of cigarettes per day.../ day

5. Did you smoke during pregnancy? (Ask mothers who have children or were pregnant).................

6. Do you drink an alcohol?
   1. ( ) Yes, daily (skip to no 9)
   2. ( ) Yes, often (skip to no 9)
   3. ( ) Yes, used to, now quit.
   4. ( ) No, never (skip to no 13)

7. If quit, how long? ....
8. The cause of quitting is? ....
9. At what age did you begin to drink alcohol..............................year
10. The causes of trying drinking alcohol
    1. ( ) Want to test
    2. ( ) Social reason
    3. ( ) Friends
    4. ( ) Stress / Pressure
    5. ( ) Others (specify)...

11. The periodicity of drinking alcohol?
    1. ( ) Everyday
    2. ( ) 3-4 times / week
    3. ( ) 1-2 times / week
    4. ( ) 1-2 times / month
    5. ( ) Less frequently than monthly
    6. ( ) Never drink

12. Did you drink during pregnancy? (Ask mothers who have children or were pregnant)................
13. Do you drink a stimulant drink?
    1. ( ) Yes, everyday
    2. ( ) Yes, drink every 2-3 day
    3. ( ) Yes, once a week
    4. ( ) Yes, infrequently
    5. ( ) Never drink (Skip to question number 15)

14. Did you drink this during pregnancy? (Ask mothers who have children or were pregnant)..........
15. How often do you take painkillers?
    1. ( ) Everyday
    2. ( ) When I do hard work.
    3. ( ) I don't take it unless prescribed.

16. Did you take painkillers during pregnancy? (Ask mother who have children or were pregnancy)....
17. Do you take a stimulant tablet?
    1. ( ) Yes, everyday
    2. ( ) Yes, I do hard work.
    3. ( ) Infrequently
    4. ( ) Never take it

18. Did you take a stimulant tablet during pregnancy? (Ask mother who have children or were pregnancy)..

Appendix 7-2

Questionnaire- Form 2
Women's Health Histories, Physical Examination and Mental Status

Nursing Perspectives on Women, Health and Work in the Socio-Cultural Context of Poor Communities in Northeast Thailand

Community Code........
Household Code.........
Member Code............

1. History taking

Last year, did you have these symptoms?
1. Oedema at any part of your body
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure

Do not include oedema during

2. There are stones / granules contaminating your urine
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure
3. Hematuria
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure

If "yes" in number 2/3, suggest that she see a doctor for treatment to rule out problems

4. Did you have any pain in legs or arms?
 1. ( ) Used to 3. ( ) Intermittent
 2. ( ) Yes, one time 4. ( ) Not sure
5. Have you have any dull pain in parts of your body of unknown origins?
 1. ( ) Used to 3. ( ) Intermittent
 2. ( ) Yes, one time 4. ( ) Not sure
6. How often do you have these pains, and when was the last time you had them? ....

Questions 7 through 9 are for respondents over 30 year of age

7. Have you ever had a vaginal tract infection or vaginal discharges?
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure
8. In the past year, have you experienced vaginal bleeding (other than regular menstruation)?
 1. ( ) Used to 3. ( ) Intermittent
 2. ( ) Yes, one time 4. ( ) Not sure
9. In the past year, have you experienced vaginal bleeding following three successive incidents of sexual intercourse?
 1. ( ) Used to 3. ( ) Intermittent
 2. ( ) Yes, one time 4. ( ) Not sure

II. History of diagnosis and medication for chronic disease or illness

1. Are you presently taking medication for hypertension?
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure
 Have you ever been diagnosed for hypertension?
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure
2. Are you presently taking medication for diabetes mellitus?
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure
 Have you ever been diagnosed for diabetes mellitus?
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure
3. Are you presently taking medication to reduce triglycerides ?
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure
 Have you ever been diagnosed as having elevated triglycerides ?
 1. ( ) Used to 2. ( ) Never 3. ( ) Not sure

4. Are you presently taking medication for bronchodilation ?
   1. ( ) Used to   2. ( ) Never   3. ( ) Not sure
   Have you ever been diagnosed for bronchodilation ?
   1. ( ) Used to   2. ( ) Never   3. ( ) Not sure
5. Are you presently taking medication for tuberculosis?
   1. ( ) Used to   2. ( ) Never   3. ( ) Not sure
   Have you ever been diagnosed for tuberculosis ?
   1. ( ) Used to   2. ( ) Never   3. ( ) Not sure
6. Are you presently taking medication for convulsion?
   1. ( ) Used to   2. ( ) Never   3. ( ) Not sure
   Have you ever been diagnosed for convulsion?
   1. ( ) Used to   2. ( ) Never   3. ( ) Not sure
7. Have you ever taking medication for pain relief continuously for more than 3 months?
   1. ( ) Used to   2. ( ) Never   3. ( ) Not sure
8. Have you ever been diagnosed for anaemia?
   1. ( ) Used to   2. ( ) Never   3. ( ) Not sure

III. History of symptoms and diagnosis for chronic airflow obstruction

History of cough and phlegm

1. Did you cough often?
   1. ( ) Yes   2. ( ) No (Skip to question number 5)
2. Did you cough more than 4 times a day or several day a week?
   1. ( ) Yes   2. ( ) No
3. Did you have phlegm when you coughed?
   1. ( ) Yes   2. ( ) No   3. ( ) Sometime
4. Did you cough if you got up in morning or change position?
   1. ( ) Yes   2. ( ) No

If "yes" in question number 1,2,3 or 4 please ask question number 5 and 6
If "no" in question number 1,2,3 or 4 please ask question number 7

5. Have you coughed continuously more than 3 month?
   1. ( ) Yes   2. ( ) No
6. How long have you coughed and ad phlegm.....................year (s)

Symptoms of feeling exhausted

7. Did you feel exhausted if you take a bath and get dressed?
   1. ( ) Yes   2. ( ) No
8. Did you feel exhausted if you walk normally?
   1. ( ) Yes   2. ( ) No
9. Did you feel exhausted if you walk upstairs or uphill ?
   1. ( ) Yes   2. ( ) No

Symptoms of gasping for air

10. Have you ever had sudden chest congestion or gasping for air without hard work?
    1. ( ) Yes   2. ( ) No
11. Did you have chest congestion or cough after doing hard work or exercises ?
    1. ( ) Yes   2. ( ) No
12. Did you get up in the night with the signs of congestion or gasping for air?
    1. ( ) Yes   2. ( ) No

If "no" in question number 10-12, please skip to question number 22

13. Did you have chest congestion, cough, or gasping for air if you clean up your house or make bed?
    1. ( ) Yes   2. ( ) No

14. Did you have chest congestion, cough, or gasping for air if you caught cold?
    1. ( ) Yes   2. ( ) No
15. Did you have chest congestion, cough, or gasping for air if you are confronted with smoke or strong smell?
    1. ( ) Yes   2. ( ) No
16. Did you have congestion, or gasping for air before a change in the weather, i.e. before rain, or a cold front?
    1. ( ) Yes   2. ( ) No
17. Did you have congestion, if your emotion change, such as angry to happy?
    1. ( ) Yes   2. ( ) No

If "no" in every question, please skip to question number 22

18. When were you first (attacked) with congestion or gasping for air....................years old.
    0. ( ) I am not sure.
19. How often are you attacked with congestion or gasping for air...........................times.
    0. ( ) I am not sure.
20. Presently, have you been attacked with congestion or gasping for air?
    1. ( ) Yes   2. ( ) No
21. When did this problem disappear (congestion)? ....years old.
    0. ( ) I am not sure.

History of allergies

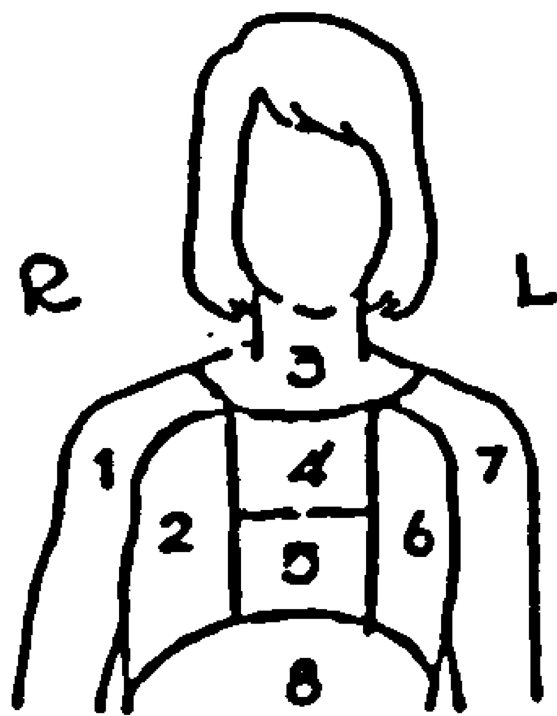
22. Have you had the problem of chronic cold? (Chronic sneezing, chronic, rhinorrhea, chronic nose congestion)
    1. ( ) Yes   2. ( ) No (skip to question number 24)
23. If you have had this problem, when did this problem occur?
    1. ( ) Never occurred   4 ( ) Rainy season
    2. ( ) All year   5 ( ) Summer
    3. ( ) Winter
24. Have you ever been diagnoses for allergy?
    1. ( ) Yes   2. ( ) No
25. Have you ever been attacked with skin allergy?
    1. ( ) Yes   2. ( ) No
26. Have you ever been attacked with face or mouth oedema?
    1. ( ) Yes   2. ( ) No

IV. History of cardiovascular diseases

27. Have you had chest pain or chest congestion?
    1. ( ) Yes   2. ( ) No
28. Have you had chest pain or chest congestion if you walk briskly or walk uphill?
    1. ( ) Yes   2. ( ) No
29. Have you have chest pain or chest congestion if you walk normally?
    1. ( ) Yes   2. ( ) No

30. What did you do if you had chest pain or chest congestion?
    1. ( ) Stop doing activities / or take a pill.
    2. ( ) Go on with the activity
    00. ( ) Skip this question
31. Did this problem disappear if you stopped doing the activity?
    1. ( ) Yes, in..................minute
    2. ( ) No.
    00. ( ) Skip this question

32. Please specify the location of chest pain.



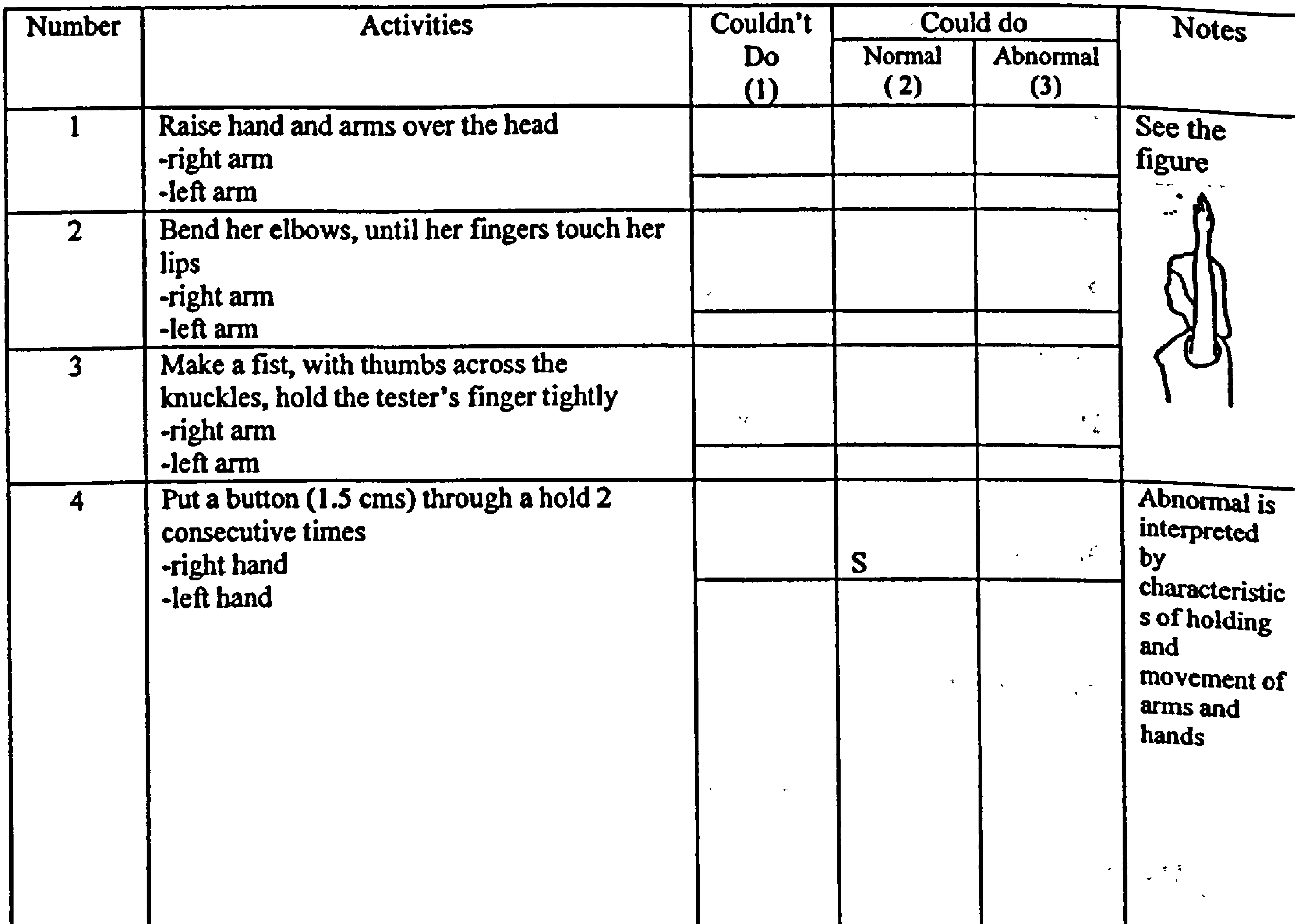
( ) Point 1	1. ( ) Pain	2. ( ) No Pain
( ) Point 2	1. ( ) Pain	2. ( ) No Pain
( ) Point 3	1. ( ) Pain	2. ( ) No Pain
( ) Point 4	1. ( ) Pain	2. ( ) No Pain
( ) Point 5	1. ( ) Pain	2. ( ) No Pain
( ) Point 6	1. ( ) Pain	2. ( ) No Pain
( ) Point 7	1. ( ) Pain	2. ( ) No Pain
( ) Point 8	1. ( ) Pain	2. ( ) No Pain

33. Did you have other points (other than the location of number 32)?
1. ( ) Yes, at..
2. ( ) No.

34. Have you ever experienced pain in the chest more than ½ hour?
1. ( ) Yes
2. ( ) No.

The Physical Examination

1. Finger count (Let the women count the number of finger five feet away with one eye closed. If she can answer the right answers for 5 times, check "right")
   Right eye ( ) right ( ) wrong
   Left eye ( ) right ( ) wrong
2. Hearing ability for normal speaking at 1 foot discount
   ( ) Yes ( ) No
3. Speaking ability
   ( ) Noticeable difficulties
   ( ) No noticeable difficulties
4. Cleft lip ( ) Yes ( ) No
   Cleft palate ( ) Yes ( ) No
4. The test of arms, legs and body movements



Number	Activities	Couldn't Do (1)	Could do: Normal (2)	Could do: Abnormal (3)	Notes
1	Raise hand and arms over the head -right arm -left arm				See the figure
2	Bend her elbows, until her fingers touch her lips -right arm -left arm				
3	Make a fist, with thumbs across the knuckles, hold the tester's finger tightly -right arm -left arm				
4	Put a button (1.5 cms) through a hold 2 consecutive times -right hand -left hand		S		Abnormal is interpreted by characteristics of holding and movement of arms and hands

Number	Activities	Couldn't Do (1)	Could do		Notes
			Normal (2)	Abnormal (3)	
5	Squat down and let her palm touch the floor, then stand up -right leg -left leg				Interpret by the movement of legs. If she could squat down and straighten up without using her hands, if was interpreted as normal. But if there is any wrong movement of arms, it was interpreted as abnormal.
6	Walk straight ahead 10 steps and comes back at straight point -right leg -left leg				Interpretation was by the characteristics of walking, eg. Walk too slowly, walk on their toes, bowlegs, haltingly, not walk unassisted. These were abnormal.

5. Can you do daily life activities yourself?
   1. ( ) Yes 2. ( ) No 3. ( ) Not sure
6. Cirrhosis of the liver (for women aged more than 15 years)

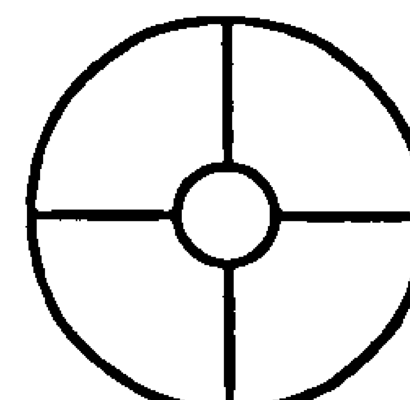
Ascites	1. ( ) Yes	2. ( ) No
Pitting oedema	1. ( ) Yes	2. ( ) No
Jaundice	1. ( ) Yes	2. ( ) No
Spider nevi	1. ( ) Yes	2. ( ) No
Palmar erythema	1. ( ) Yes	2. ( ) No

7. Breast examination
   <u>Inspection</u>

	Normal (1)	Abnormal (2)
1. Arms over head		
2. Hands pressed against hips		

<u>Palpation</u>

1. At breast
   1. ( ) Normal 2. ( ) Abnormal was.............................



2. At axillaes, superclavicular and infraclavicular areas
1. ( ) Normal 2 ( ) Abnormal were.................................

9. Evidence of anaemia
At conjunctivas, 1. ( ) Normal 2 ( ) Pale
At nail colour 1. ( ) Normal 2 ( ) Pale

10. Weight..................................kgs.
Height..................................cms.

11. Blood pressure
Systolic pressure..................mmHg.
Diastolic pressure................. mmHg.

12. Other problems (specify)..

II. Mental Status (The following questions refer only to the two week period prior).

Number	Statements	I strongly agree	I agreed	I partly agreed	I don't think so
1	I have been feeling very good				
2	I am an optimist				
3	I feel under pressure all the time				
4	I always worry about the future				
5	I feel that something bad will happen to me and my family				
6	I am always afraid of something unreasonable				
7	I think that I have had the happiest of lives				
8	I am always comfortable with what I am doing				
9	I have a happy family				
10	I am always moody with everyday events				
11	I feel so anxious that I can't do anything				
12	I feel unhappy				
13	I think that I always get the bad things in life				
14	It is very difficulty for me to sleep				
15	I didn't get much sleep				
16	I get up at night and can't go back to sleep				
17	I think that my daily life activities are interesting				
18	I am enthusiastic about everything in my life				
19	I feel happy				
20	I am full of vitality and am prompt to face any problems				
21	I think that I have very good health				
22	I am proud of my achievements				
23	I feel useful to others				
24	I want to cry and feel sad				
25	I am a pessimist				
26	I feel lonely and cheerful				

Number	Statements	I strongly agree	I agreed	I partly agreed	I don't think so
27	I feel that I couldn't confront and solve any problems				
28	I am in low spirits and bored with everything				
29	I feel tired and unreasonably weak				
30	I want to cry				
31	I want to die				
32	I feel hopeless				

Appendix 8-1

Interview Guide for Qualitative Study
(Women)

Code #............. # Of Interview..............
Date................

A. Biographic and Socio-Economics Information:

1. Your age:...
2. Marital Status:...................................
3. Educational level.................................
4. Number of children in year household:...
5. Number of people in your household:..............., please specify...............
6. What is your position in the household...
7. Your occupation...
8. Your spouse's occupation...
9. Family income / month:..
10. Economic resources:...
11. How long have you been living in the community?...............................
    Probe: migration experiences...
12. What health services are available within this community?.......................
    Probe: Community drug store;
    Are there any public clinics?
    What kind of traditional health, spiritual healer is available?
13. What are the health problems for people living in the community?
    Probe: Reasons............(e.g. Environments, workload, etc.).....................
14. Do you have any participating activity in the community?.........................
    How? / What?...

B. The Experiences of Women with a Workload:

1. What does work mean to you?, How do you work?
   Probe: -Perception of workload
   -What is different between daytime work and nighttime work? How does it effect the people?
   -Are there differences between workplace? How does it effect people?
   -How does the workload effect people? long time work, hard work, etc..........................
   -Do you want to change your current job? ....Why?...............................
   satisfaction with job..
   -How do these factors (work time, rest time, recreation time) effect on your life?
2. How do you cope / manage with workload?
   Probe: -Living arrangement
   -Child caring
   -Seeking helps from whom?

C. The Effect of Workload on Their Health Status

Probe:

1. Feeling and attitudes toward workload's affect or people / on life.
2. Health Status:
   -Perception of health and wellness
   -In your perception, when we give the best possible health status 10 scores and the worst possible health status 1 score. What score of your possible health status do you obtain?................Why?...............
   -How do you treat these symptoms?..

3. Health-Seeking Behaviours:
   -What symptoms do you often attack this year? How?
   -How do you manage with them? Why?
   -How do the following factors: cost, symptom, causes of disease: influence on your decision-making to see a doctor? Where?
   -Do you buy over-the counter drugs?
   Probe: where?, symptoms, causes, reasons, cost.
   -What medicine do you know that your friends or people who work advise you to often take? Why?
4. Please tell me about feeling and satisfaction with job / health / family / friend / financial status, others.
5. Please tell me about feeling about life and life situations at present.
6. Is these anything about your experiences of work and health that you would like to share that I neglected to ask?...

Appendix 8-2

Interview Guide for Key Informant

Code #....................... # Of Interview......................
Date...........................

1. Sex......................
2. How long have you been living in the community?
3. What is your position in the community?
4. How long have you had this position?
5. Could you please describe the administrative structure of this community?
   Probe: management; health; education; community development; foundation.
6. How does the community get information about women's health?
7. What health services are available within this community?
   Probe: community drug stores; traditional healer, public clinics.
8. What are the health problems for people living in this community?
   Probe: reasons...
9. What are the common health problems for women living in this community? Why?
10. What do you think about the government health services in Khon Kaen for women?
    Probe: reasons- do people living in the community have access to these services.
11. Do you have any suggestions for future women health care politics or programmes that the Government should implement?
12. Is there anything else you would like to tell me?..

Appendix 9

Letter of Information- Interviews

You are invited to participate in a study of 'nursing perspectives on women. health and work in the socio-cultural context of poor communities in Northeast Thailand'. I am conducting this study as my dissertation work at The Robert Gordon University, Scotland UK.

If you decide to participate in the interview section of this study you will be asked to answer several questions concerning your work experiences and the effects on your health being. You will be asked to participate in a 1 to 2 hour interview. The interviews will be schedule at a time that is convenient to you and will take place in your house. No one except the investigator will be present at and listen to interview. The interviews will be auto-tape recorded and kept in a secure cabinet before transcribing. The cassette tape containing interview data will be erased after its use for the purposes of this study. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Your name will not be on the transcriptions, instead, a code number will be assigned. Information obtained from the interviews will be reported together as a group.

Your participation in this study is voluntary. There is no cost and no compensation to you for participating in this study. If you decide to participate, you are free to discontinue the participation at any time. You are free to refuse to answer any questions you do not want to discuss or stop the interviews at any time.

If you have any questions, please let me know. If you have any additional questions later please feel free to contact me at the following address:

Darunee Jingudomkarn
Faculty of Nursing
Khon Kaen University
Khon Kaen, Thailand
40002

Human Subject Approval Document

Appendix 10

FACULTY OF MEDICINE
KHON KAEN UNIVERSITY

Our ref: K. K. U. 0507.12.1 /01-02-1998 January 7, 1998

This is to certify that the Ethics Committee of the Faculty of Medicine of Khon Kaen University has thoroughly studied the research project protocol from Ms. Darunee Jongudomkarn entitled **"Analysis of the Affect of Women's Workload on their Health Status : A Study in Low-Income (Slum) Communities, Khon Kaen Municipality, Northeast, Thailand."** and has unanimously approved the project to be conducted at the Faculty of Medicine of Khon Kaen University, Khon Kaen, Thailand.

Pyatat Tatsanavivat

Pyatat Tatsanavivat, M.D.
Chairman, Ethics Committee
Faculty of Medicine
Khon Kaen University

123 Mitraparp Highway, Khon Kaen 40002, Thailand. ✆ (043) 242342-46 The Dean's ext. 3239 Foreign Relations Office ext. 3491
The Dean's Office (043) 237-909 Fax: 66-43-243064 Telex: 55303 UNIKHON TH. Email: "Sukanya @kku1. kku.ac.th"

Appendix 11

Example of Field Note (Fn) and First Coding

line	Fn 13-06-98	Coding
	June 13, 98 (Saturday)	
1	(6:00 AM): There is a lot of smoke around two houses whose owners are	-Women and
2	grilling chicken to sell. The houses are Mrs. Wang's and Mrs. Pui's which	employment
3	are at the beginning of the lane. Mrs. Gai says that this is her morning	economic crisis
4	routine. Now they can't sell their goods well, so around 3-4 AM. There	
5	will be only two groups who go out. One group consists of the	
6	treadeswomen who cook food to sell; for example, Mrs. Jai, Mrs. Wang,	
7	Grandmother Duan. They will go out to buy ingredients to cook. The other	
8	group comprises the driven of food carry in tricycles who go to the market	
9	to be hired. The tradeswomen will walk to the market and go back by these	
10	tricycles. The tricycle drivers will go back home about 8 AM. The Kao	
11	Lam (glutinous rice cooked in bamboo joints), jujube, and packed fruit	
12	sellers will go out about 6 AM in order to buy the stuff and pack in a sack to	
13	sell. We can see the tradesman and tradeswomen who will go to *Or Chira*	
14	market walk past the railway which is in the east of the community. Those	
15	who ride motorcycle will use the community entrance in the west. More	
16	than 10 people who are in the movement are aged between 30 to 70 years	
17	old, no children or teenagers. Mrs. Gai says that the children have not	
18	wakes up yet, they are still sleeping. The youngsters are used to getting up	
19	late. They, the elder people, wake up in the morning and get used to it. At 3	
20	AM, Mr. Li already wakes up to clean the community's lane because he	
21	doesn't know what to do, even though he is a painter, not a tradesman.	
22		
23		
24	(7:00 AM) Two or three groups of the tradeswomen who sell roasted	
25	chicken at the bus station gradually follow one another, out of the	
26	community each group consisting of 2-3 women. They carry some stuff;	
27	some carry trays, some carry baskets, which contain plastic sacks, paper and	
28	rubber banks. Everybody goes to get chickens from Mrs. Wang's or Mrs.	
29	Pui's houses. There are about ten persons. Each one has a belt-like waist	
30	bag hanging around the waist. When they get the chickens as much as they	
31	want, they walk across the railway heading for the bus station. There are	
32	two women riding a motorcycle out of the gate. Those who sell *Kao Lam*	
33	and fruits at the bus station to walk out also.	
34		
35	Mrs. Duan complains that now she feels that her health is not good, she as a	-Women working and
36	hypersensitivity. Because she has been selling things at the bus station for	health: allergy
37	20 years, and has been breathing the smoke. She also complaints about the	
38	bad environment, such as her neighbour (Mrs. Od with 12 children). People	
39	think that the children are strong because angels help take care of them.	
40	Every morning the mother will give each child 1-2 *Baht*.(£ .02-£ .03), and	
41	they will take care of themselves all day long. "Look!, it's noon time but	
42	they haven't cooked rice yet. All her..."	
43		

line	Fn 21-06-98	Coding
	At the Community 1:00 PM.	
1	It's been raining all the afternoon. Pieces of paper, plastic sack and different	- The Community and
2	kinds of garbage are floating rowdily all over the place. The housewives	environment
3	have to sweep and remove the garbage out of their houses. Petrol flows	
4	along the stream and float over the water surface. The petrol's scarf-skin is	
5	flowing from the drain in front of the community, where there are some	
6	*Siang King* (used machine and spare-part shops), car repair shop and gas	
7	stations all along the high-way road and pay with the rain. They stumble	
8	down on the dirty water floating on the floor, so their bodies are dirty	
9		

because of the petrol's scarfskin. Their bodies smell as bad as the water, which smells terrible all the time.

In the north area, the water has been flooding for about one hour, and then it begins to flow down to the drain next to the community. After that the water flows to the south area and floods again around the houses. There has already been a big waterway with a lot of water all year long in that area. So the water still floods and the houses-whose floors haven't been raised up in order to be higher than the water surface when there is a flood-are all flooded. A lot of garbage road in front of the Community's entrances. The petrol is mixed with the filthy water flowing along with the stream, so it smells so bad all around the place. When the children see the rain falling, they are glad because the weather is cooler. The children come running out when the rain stops, the water begins to dry. The life of the people here is be back to the normal. Parents make their children wash the bodies, change the clothes and dry the hair. Some people go to buy medicine at Mrs. Yen's store, which is next to the community but does not belong to the community. The medicine sold over there is mixed medicine, each set costs 5 *Baht* (£ .08). Most of the medicine is *Yaa Chud* (mixed medicine) to relieve muscle pain, etc. Besides, there is aspirin and pain relievers being sold separately too. The people, who go to buy this medicine, when being asked, say that they are labourers who use their strength to carry heavy load, tricycle drivers. Workers who sit fill sausages' filling for a long time, workers who sit and peel eggshells in order to make *Palo* (Chinese soup with cinnamon; eggs and pork or duck), and workers who walk a lot. The mixed medicine stated above is from a drug store in the *Or Chira* market. They will pack the mixed medicine, and there will be a label explaining the medicine quality. A set of mixed medicine will contain 3-6 pills, the price will be different depending on the amount of the pills. Each pack of the medicine is to be taken one. A person at the drug store says that a mixed medicine pack will contain pain reliever, anti-inflammation and steroid, in almost every pack. However, here are some people going to get medicines from the health volunteer when they are mildly sick as having a headache or having a fever. They don't need to buy mixed medicine to take. And if the symptom is more serious, the people will choose to go to Khon Kaen Hospital in case they have a health insurance card and have enough time because they will have to wait for a long time. Or they will go to a clinic near the community in case they don't have a health insurance card and have enough money to pay, which is more than 200 Baht (£ 3) a visit.................

-Health Seeking Behaviour: Self-medication; *Yaa Chud*

Fn 16-07-98
At 05:00 AM

I go to *Or Chira* market, and it's incredible because the market is so lively today. So many people come here to shop. But most the merchandises are wholesales. There are many people from different districts, these people are called "country side people". They come to sell and to buy ere, some of them finish buying and are preparing to.....

-Ways of Women's Life

Fn 20-07-98 (Monday)

Today merchants from different areas come to the community to have the *Huai Om Sin* (The Saving Bank Lottery). The people are very interested in the lottery, almost all the people buy it for 20-50 *Baht* (£ .31 - £ .78) each.

-Postpartum: Traditional Health Behaviours

I go to visit Mrs. Jek at home, she does not *Yoo Fai* (remain by a fire after parturition) but drinks hot water. She doesn't take preserved or fermented food, *Cha Om* (a kind of vegetable), and oily food. She takes *Yaa Satri Singhay*, *Yaa Satri Pen Park* and *Yaa More Sorn* (feminine traditional liquid medicine) in order to drive away the lochia and refresh her body. Today Mrs. Jek has breast engorgement so Mrs. Gai, the mother, uses a milk pump

8 to pump milk out. The son is not crying, he drinks milk well. But now Mrs.
9 Jek still get hurt from the operation wound.

Fn 21-07-98

1 At Mrs. Wangtai house, Mrs. Aom is still very sick. Mrs. Wangtai goes to
2 invite the priest from *Wat PNT* (Forestry Temple) to come to heal Mrs.
3 Aom. Because she believes that Mrs. Aom is haunted by *Phii Pob* (spirits
4 that may be sent to devour the entrails of other people). The people say that
5 there are five *Phii Pob* haunting back and forth within Mrs. Aom body.
6 When there are nine *Phii Pob,* Mrs.Aom will die. The reason why she is
7 haunted by *Phii Pob* is because when she went to get a healing in *Nakhon*
8 *Sawan* Province. Which is the province that Mrs. Aom lives with her
9 husband, she went to see '*Ong Thep*' (a residence that heal people by
10 magical art) and then she set a *Khan Haa* (a basin filled with some cones of
11 flowers, incenses and candles to show a promise to be a retinue). She came
12 back to Khon Kaen without telling anything and she didn't bring the *Khan*
13 *Haa* with her, so the ghosts over there are angry at her and make her very
14 sick. Mrs. Aom symptoms are of a terminal stage AIDS patient with lots of
15 rashes all over her body and a big one on the back. She talks incoherently,
16 not according to the situation every now and then. Sometimes she smokes
17 two cigarettes at the same time, even though she had never smoked in the
18 past. She always says, "Don't hurt me, I am afraid of you". Sometimes she
19 jumps out off the house to the flood areas or jumps to the walkway. During
20 this time Mrs. Aom can't eat anything at all, she is very thin. She just drinks
21 holy water which the priest............

-Health and Belief

Appendix 12

Example of In-depth Interviews and Coding (Id)

Mrs. Wang (Id 24-06-98)
June 24, 98: 10.57 AM
At Mrs. Wang's House

line		Coding
1	**Situation:** Mrs. Wang was sitting and being interviewed on her bamboo bed,	
2	which is on the ground, under the first floor of her house. Mrs. Wang was	
3	wearing old-rose T-shirt without sleeve, with white flowers and *Pa Toong*	
4	(sarong). About 80-90 centimetres from the interviews point to the left, there	
5	was girl named Kai, about 15 years old, shorthaired, tall, dark and thin. Kai	
6	was wearing short pants and yellow cloth with white stripes. She was eating	
7	fresh guava, watermelon, pineapple and was listening to the interviews	
8	quietly. Two to five metres from the interview point there were five children	
9	from 3-5 years old playing with water from the drain loudly. The atmosphere	
10	of the conversation at the beginning was just simple. Around the end, the	
11	interviewee talked more about personal stories by and by until the end of the	
12	interviews.	
	Could you please tell me about your personal life story from your childhood?	
13	When I was young my name was Tam and it has been changed to Wang.	
14	According to the nickname. Now I m's 40 years old, going on 41. My ighed	
15	education is *Pratom 4* (Grade 4), my mother told me that I was born in	
16	Vientien. I got two brother and sister with the same father and mother. But	
17	there are another four younger ones with the same mother. I'm the first child	
18	of the family; my mother is from *Nakhon Ratchasima*.Province.	
	At what age did you start working?	
19	I was first working at 8, 9 or 10 years old. I was doing housework in *Nong*	-Ways of women's
20	*Pai Lom* with the people I had known before. They saw me and convinced me	life
21	to work with. My wage was 50 *Baht* (£ .78) a month. Before I left they	
22	increased my wage to be 100 *Baht* (£ 1.56). At that time I didn't keep my	
23	wage. My mother came to take it every month.	-Sacrifice to the Family
	Compare to others, is it hard to be the first child of the family?	
24	I think so, it is so hard that I never know what teenage is. I finished with	-Ways of Women's
25	grade 4 and have been working from then on. My mom didn't really force me	Life
26	to work. I saw her working and I just couldn't stay still. I never know how it	
27	is to be high educated and it's gonna be in the future. I didn't think about my	
28	future, I only thought that I had to go selling to earn money for our living.	
29	When I grew up and got pregnant I still went selling, went selling until I gave	
30	birth. It was strange, when I was about to give birth I got a pre-notion. I	
31	wanted to quit selling. I counted the days until I have birth. When I got a	
32	baby, I have given a breast-feeding for about two months some children of	
33	mine might be 4-5 months, depends. And I never *Yoo Fai* (remain by a fire	
34	after parturition), just by a hot water bottle. I took *Yaa More Sorn, Yaa Satri*	
35	*Sing* and *Yaa Dong* (traditional preserved medicine with alcohol). The old	
36	didn't me *Yoo Fai*. I have ever seen others do that, it seems to be a good	
37	recovering. Seems like we can strong and healthy after doing that. I saw	
38	others, without any piece of............	

How about your health condition?

39	I used to be allergic to some medicine. First, I got a sore throat ad I thought I	-Health Seeking
40	got cold. I bought *Yaa Chud* (mixed medicine) but I got allergic, I got a rotten	Behaviour: Self
41	wound. The doctor said I was allergic to penicillin. I had never known what	Medication-*Yaa*
42	kind of medicine I was allergic to. At that time I ad a fever and a sore throat,	*Chud*
43	my husband bought aspirin and a sore throat reliever. The seller at the drug	
44	store gave us mixed medicine, with penicillin. After I took the medicine, I got	
45	a rash, a high fever, a numb face and a feeling of thick lips. When it subsided	
46	my lips began to have a wound, and then I know I was allergic to the	
47	medicine. I went to see doctor, he told me to drink lots of water. I took more	
48	than 10 days to recover. At that time I could not roast chicken, I had to quit	
49	because of the wound. I could not touch the smoke from...........	
50		

Appendix 13

Example of Card Used for Data Collection and Analysis

(Nuntaboot, 1994)

Place :	**Date and Time :**	**Code :**
Event :		
Persons Concerned :		
Summarised Topic or Categories :		

Example of a Completed Card after Data Collection

Place : the desolate house near to Mrs. Aom's house	**Date and Time :** July, 1, 98 02:04-03:05 PM	**Code :** Id 01-07-98

Event : Mrs. Aom has just left the card party in a neighbourhood and finished drinking beer.

Persons Concerned : We two talk without anybody else

Summarised Topic or Categories :.

-Gambling in community
-Drinking in community
-Ways of women's life
-Women and employment (AIDS)
-Coping with the economic disadvantage
-Traditional health belief and health seeking behaviours

Appendix 14

GLOSSARY LISTS

The following glossary lists Thai and Lao term used in this text. Terms are lists in English alphabetical order. Some terms in the text-have been transcribed following conventional usage rather than the transcription system outlined in the front of the thesis, for example, '*Isaan*' and '*Plaa*' (pronounced with a long vowel).

Phonetic Transcription	Thai Script	English Gloss
Aei	อ้าย	Older brother
Anichang	อนิจจัง	Transitory, fickle, not changeless or certain
Ajarn	อาจารย์	Term of respect for teachers
Aii	อี	Word prefixed to name of younger female relatives indicating affection
Ariyasat	อริยสัจ	Four Noble Truths leading to nirvana
Baap	บาป	Sin
Baat	บาด	Cut, incision
Baht	บาท	Unit of currency, 60 *baht* = 1 pound
Buat	บวช	To ordain
Bubpakarii	บุพการี	People to whom one owes a debt of gratitude: parents, teachers, Buddha
Bubpesanniwas	บุพเพสันนิวาส	State of having been each others spouses in previous incarnation
Bun	บุญ	Buddhist merit
Bun baang fai	บุญบั้งไฟ	The rocket ceremony held in the sixth month associated with ensuring and predicting the coming of the rains and the fertility of the land
Bun khun	บุญคุณ	People to whom one has a special obligation, such as one's parents
Bun phawet	บุญพระเวส	Merit-making ceremony celebrating the story of *Vessadorn*, a name of the Lord Buddha in a previous incarnation
Buri	บุหรี่	Cigarette, tobacco
Fai	ไฟ	fire

Phonetic Transcription	Thai Script	English Gloss
Hed	เฮ็ด	To do, to make
Heet sibsong, kong sibsee	ฮีต สิบสอง คอง สิบสี่	Twelve annual festivals of *Isaan* observed one per month, and the fourteen traditional laws governing behaviour
Kai ping	ไก่ปิ้ง	Grilled chicken, this is a hawker food, which can be found at nearly every street of big city. Chicken is grilled on charcoal stove. Most Thai like to take the grilled chicken with steamed glutinous rice and chili sauce.
Lod chong	ลอดช่อง	Green string: this cooled desert, is a favourite among the Thai especially on a warm day. The green strings are made of a dough of crushed green beans mixed with tapioca flour, then boiled. The cooked strings are added with a mixture of coconut juice, water and syrup. Cracked ice is added when served.
Jangwat	จังหวัด	Province
Jau baaw	จ้าวบ่าว	Groom
Jau saaw	จ้าวสาว	Bride
Jeb	เจ็บ	Sharp pain
Jon	จน	Poor
Kam	กรรม	Karma, misfortune
Karuna	กรุณา	Buddhist concept of compassion mercy
Kathin	กฐิน	Saffron robe given to Buddhist monks after Lent, name of this tradition with accompanying practices.
Katanya kata weti khun	กตัญญู กตเวทีคุณ	Gratitude, debt of gratitude
Khaaw niew	ข้าวเหนียว	Glutinous rice, the staple of central and northern *Isaan*
Khaaw saan	ข้าวสาร	Uncooked husked or milled rice
Khai	ไข้	Fever, also general term for illness
Khan haa	ขันธ์ห้า	Offering consisting of a set of five pairs of candles and five pairs of flowers

Phonetic Transcription	Thai Script	English Gloss
Khaan	คาน	Shoulder-carry pole made of hardwood
Khanom	ขนม	Sweets
Khanom jean namya	ขนมจีนน้ำยา	Thai noodles with fish curry sauce. The sauce is composed boiled and finely-crushed fish, herb and spices. The rice noodles are round like spaghetti, but instead of long strand, the rice noodles are rolled into pieces. The fish curry sauce is poured over the noodles when served.
Khii	ขี้	Excrement, prefix for unpleasant body wastes
Khon	คน	Person, people, mankind/to stir, mix together
Khong dorng	ของดอง	Pickled foods
Khwam dan sung	ความดันสูง	Hypertension
Kwan	ขวัญ	Soul, souls associated with parts of body, morale
Lai phii	ไล่ผี	To chase the spirits
Lao	เหล้า	Alcohol, whiskey
Len bok	เล่นโบก	It is an *Isaan* ancient gambling.
Luang phor	หลวงพ่อ	Term of respect used for monks, 'reverend father'
Maag	หมาก	Areca nut, betel palm, betel chew
Mia	เมีย	Wife
Mia noi	เมียน้อย	Minor wife
Naam mon	น้ำมนต์	Holy water
Nang	นาง	Miss, Mrs., word used before or in place of name of women or girl, affectionate pronoun used in place of name of little girl
Nii	หนี้	Debt. Credit, loan
Ngoen	เงิน	Money, silver
Nuai	เหนื่อย	To feel tired, be fatigued
Pii pob	ผีปอบ	Traditional Thai and Lao vampire and accompanying vampire spirit that feeds on entrails of its victim causing death

Phonetic Transcription	Thai Script	English Gloss
Od	อด	To restrain oneself, endure without-complaint, try something difficult
Paa	ป้า	Aunt, older sister (or wife of older brother) of father or mother
Panan	พนัน	Gambling
Plaraa. plaadaeg	ปลาร้า ปลาแดก	Preserved, fermented fish in salty sauce, a staple food of northeast Thailand
Plasom	ปลาส้ม	Pickled fish
Phaa	ฝ้า	Dull, over cast, also: having bad complexion
Phig khu	ภิกษุ	Buddhist monk
Phra	พระ	Term used for monks, reverend
Polamaisod –rot khen	รถเข็นผลไม้สด	A fresh fruit hawker-the fruits inside his/her pushcarts, which can be clearly seen, mostly include pineapple, papaya, water melon, mango, guava, rose apple, and preserved fruits. The fruits are always sold by the piece, and not by weight.
Rai	ไร่	Unit of area equal to 1,600 square metres.
Samlor	สามล้อ	Three-wheeled vehicle
Sai krok	ไส้กรอก	Thai sausages: there are beef and pork sausages, other ingredients in the sausages include glutinous rice, minced ginger, pepper and salt. Sausages are grilled only and served with some vegetables.
Sai sin	สายสิญจน์	Holy cotton thread
Saw	ซาว	To grab, or twenty
Songkraan	สงกรานต์	Thai New Year
Talaad	ตลาด	Market
Tamyae	ตำแย	Traditional mid-wife
Tham	ธรรม	Goodness, righteousness, honesty, justice, merit
Thaukae	เถ้าแก่	Elders, also used to refer to money lenders and people with authority and control over one