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AN EXPLORATION OF NORTHEASTERN THAI WOMEN'S PERCEPTION OF PERSONAL RISK OF CONTRACTING HIV AND THEIR INTENTIONS, STRATEGIES, AND BARRIERS TO SELF-PROTECTION

by

Karen Metcalfe

A Thesis
Submitted to the Faculty of Graduate Studies and Research
through the Department of Sociology and Anthropology
in Partial Fulfillment of the Requirements for
the Degree of Master of Arts at the
University of Windsor

Windsor, Ontario, Canada

1997

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Abstract

The purpose of this study was to explore, within the context of Thai culture, how married Northeastern Thai women form their perception of personal risk and their intentions and strategies of self-protection with respect to sexual transmission of HIV. A modified version of the health belief model was used with a particular emphasis placed on cultural context. Structured face-to-face interviews and focus groups with married women from six Northeastern Thai villages were used. Overall, Thai women's perceptions of risk demonstrated the existence of an optimistic bias and were developed and maintained through the use of various judgmental heuristics. The majority of women outlined elaborate strategies regarding their intentions to protect themselves from HIV infection. Despite strong intentions, women's actions were not effective for protection. The major factor stopping intentions from becoming actions were the barriers to effective protection that exist for these women. Social psychological theories rooted in a rational risk analysis framework helped to identify the personal strategies associated with risk for Thai women, but cultural understanding was necessary when addressing how each model component played out in the lives of these women. Concepts such as judgmental heuristics, optimistic bias, and intentions were embedded in a cultural framework where Thai beliefs in Karma, making merit, Siang Duang, maintaining a cool-heart, and mai pen rai, set the foundation on which the social psychological concepts were built. Culture sets the underlying themes on which sexuality is based, therefore, knowledge of HIV and its sexual transmission, the understanding that condoms can prevent transmission, and knowing their husbands are their main source of risk are not enough to prevent HIV infection. Culture needs to not

only be a factor that is considered but to provide the foundation for which prevention efforts are based.

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CHAPTER I

INTRODUCTION

The World Health Organization estimated in July, 1996, that 21.8 million adults had been infected with HIV worldwide. Heterosexual intercourse accounted for more than 70% of adult infections (Joint United Nations Programme on HIV/AIDS, 1996). At the beginning of the AIDS epidemic in the 1980s, women, worldwide, made up only a small percentage of those infected, but today, women represent 50% of all new HIV infections (Center for Disease Control, 1995). It is estimated that by the year 2000, 13 million women will have been infected and 4 million will have died from AIDS. As early as 1992, official calculations by the World Health Organization estimated that by the year 2000, Asia would have the highest incidence for HIV infection in the world and that Thailand would lead this explosive growth (Handley, 1992). In 1991, it was estimated that 200,000 to 400,000 people in Thailand were infected with HIV. In 1992, The Ministry of Public Health updated this figure to 350,000 to 500,000 people. Based on these estimates, "it is projected that there may be 16,000-30,000 HIV infected persons developing AIDS annually [in Thailand] during 1993-1997" (Ministry of Health, 1993, p. 5). With such increases in HIV infection taking place, even though knowledge of HIV transmission is now widely understood by the Thai populace (Shah et al., 1991), the question remains as to why people continue to take personal risks that can have such fatal consequences.

Research in Thailand initially focused on the populations within the major cities and those groups that were first affected by HIV/AIDS. These included intravenous drug

users (IVDUs), sex workers, and the men who were customers of sex workers. One group that was, until recently, ignored in Thailand's AIDS research was rural, married women. This was based on the assumption that they were at low risk compared to women living in cities and single women. However, since going to prostitutes is tolerated not only for single men but also for married men in Thailand, since estimates indicate that 50% of married men have, at some time, visited a sex worker (Maticka-Tyndale et al., 1997; Prathana, 1996), and since 80% of married men who have multiple sex partners never use condoms with their wives (Havanon, Knodel, & Bennett, 1992), clearly married women are at risk for HIV infection. In addition, approximately 80% of Thailand's population live in rural villages and prostitution exists in these villages as much as it does in cities (Lyttleton, 1994). Therefore, it is important that there be a shift in AIDS research in Thailand to include married women who live in rural areas.

The purpose of this study was to explore Northeastern Thai women's perception of their own personal risk of contracting HIV, how this influences their intention to protect themselves, their strategies for self-protection, and the fit between these strategies and those that would keep them free from infection. In addition, this study addressed those concepts within Thai culture which have an influence on perception of risk, intentions, and action, in an effort to create a basis for prevention programs that are sensitive to Northeastern Thai culture. This will be a secondary data analysis, using data that were collected in structured interviews and focus groups between 1991 and 1994 in Northeast Thailand.

CHAPTER II

THEORY AND LITERATURE REVIEW

Overview

In North America it is assumed that people are at risk for HIV because of a particular lifestyle "choice." For example, Douglas and Calvez (1990) comment in their analysis of HIV risk behaviours that refusal to take safety precautions, such as using condoms, is not a result of poor understanding, but is rather a personal preference or choice. North American prevention efforts focus on increasing knowledge and accessibility to condoms in an effort to motivate people to act "responsibly," or make the choice to use condoms. While it is true that certain behaviours allow HIV to be transmitted, on a global scale "choice" may not be the most useful focus for prevention efforts, since exposure to the possibility of HIV transmission is not always the result of conscious behaviour choices. The relationships between how people perceive their risk, what behaviours in their individual lives place them at risk, and the actions that they take (intentional or not) are more complicated than a simple focus on making good choices implies. One such complication is that risk perception is a personal interpretation and often one which is, as Weinstein (1980, 1982, 1987) points out, optimistically biased. This makes it crucial to examine how people's perceptions of personal risk are formed. A second complication is the multiplicity of potential personal and social factors that may result in the actions that do not effectively minimize risk. These include the relative ranking of various preferences and risks, only one of which is HIV, the related necessity of balancing multiple choices and actions, the limitations to action posed by women's status

in sexual relationships, and the fact that prevention requires collaboration with a partner who is balancing other priorities and risks and has other status requirements. Culture introduces a third dimension. Culture sets the underlying themes on which sexuality and gender construction are based. Consequently, action will be based on the dominant cultural themes of sexuality and gender. As Bayer (1994) suggests, "Failure to understand the complex ways in which culture filters prevention messages is a recipe for failure in AIDS prevention" (p. 896).

In summary, the decisions individuals make with regards to their health behaviours are embedded within a cultural framework which is constantly influencing their perceptions, beliefs, and actions, and are linked to whether or not they view themselves to be at risk of a particular health threat (e.g., contracting HIV). It is important to consider how risk perceptions are formed, the techniques or judgmental heuristics people use to formulate their perception, and the cultural basis from which these perceptions emerge (Kahneman & Tversky, 1982). In addition, it is necessary to address the intentions people have to protect themselves, the actions that they take and how their culture and social structure influence both intention and action.

Theoretical Models

At the beginning of the AIDS epidemic theories that provided the foundation for prevention efforts were primarily knowledge based. It was expected that having accurate information regarding HIV and its transmission would consequently influence people to avoid high risk behaviours. The results of using this approach in prevention strategies was that it increased knowledge and decreased unwarranted fears, but had little influence on

assessments of risk and motivation to change personal risky behaviours. It was evident that knowledge was not enough to combat the AIDS crisis (Maticka-Tyndale, 1995). This realization led to the application of existing cognitive theories which had originally been developed to deal with other potential health problems (e.g., smoking) to AIDS prevention efforts. One such theory was the health belief model. This model has been influential in looking at the reasons why people participate in both health enhancing and inhibiting behaviours (Kirscht & Joseph, 1989; Ronis, 1992). The health belief model was the earliest to introduce the concept of risk perception and to outline the importance of personal perceptions in influencing intentions to reduce health threats. The basic premise of the health belief model is that a person's intentions to act are influenced by three beliefs: belief about the severity of the health threat, perception of personal risk or susceptibility, and the balance between the benefits and the costs of the preventive action (see Figure 1). Intentions, then, have a direct causal influence on actions. The health belief model, therefore, predicts that a person is more likely to act in a preventative way if the severity of the threat is high, they perceive themselves to be at risk, there are benefits to taking preventative action, and the costs of taking the action are low (Kirscht & Joseph, 1989; Leviton, 1989; Ronis, 1992).

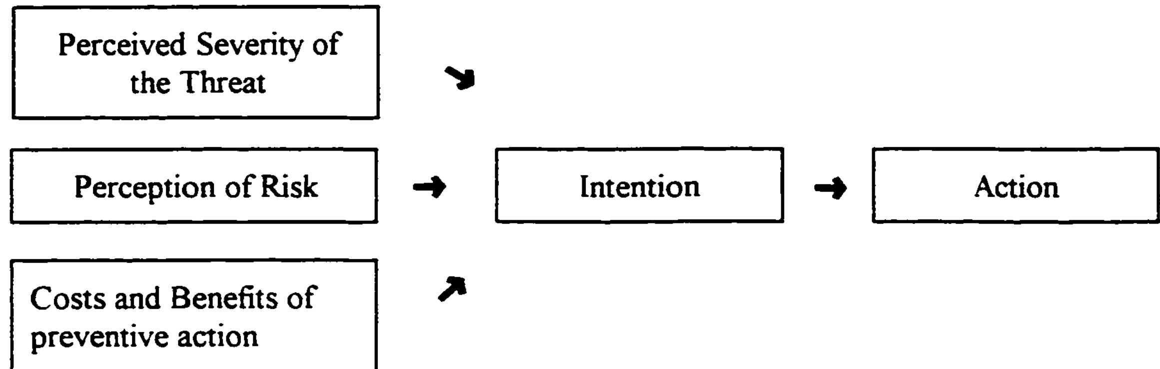

Figure 1. The Health Belief Model

The health belief model has useful features, such as bringing attention to personal vulnerability and recognizing that there are personal, social, and environmental costs to behavior change. But numerous researchers have pointed out that it is inadequate, when it stands alone, to deal with decisions about sexual behaviours and requires synthesis with other frameworks to be useful (Kirscht & Joseph, 1989; Kronenfeld & Glik, 1990; Maticka-Tyndale & Levy, 1993; Ronis, 1992; van der Velde, van der Pligt, & Hooykaas, 1994). Researchers continue to develop models for HIV prevention programs. By doing so they have brought attention to the factors which have been left out of the health belief model but that need to be addressed. These include the specific factors that contribute and lead to people's perceptions, the importance of intentions, the process by which intentions and other factors influence actions, and the influence of culture on how people act (Ronis, 1992). In addition, many researchers have pointed out that it is important to recognize that HIV infection is different from other personal health threats in that infection requires people to consider not only their own actions but also those of their partners (Guimaraes, 1996; Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1990; Rowe,

1994). The health belief model does not take these variables into account although it continues to provide the foundation for researchers interested in health behaviours by recognizing the relevance of people's perception, in that the motivation to act, first, depends on whether a person perceives her/himself to be at risk (Rosenstock, 1991; Taylor, 1991). This study acknowledges the importance of the factors outlined by the health belief model (perception of risk, severity of the threat, intentions, and the cost/benefit balance). In addition, this study adds to the health belief model by addressing how people form their perceptions of risk, the specific ways in which intentions and actions are connected, the inconsistencies between intentions and actions, the importance of culture, and the actions of sexual partners.

Key Social-Psychological Concepts

Perception of Risk

Risk perception is the subjective interpretation which people form in order to determine whether they are at risk or not at risk of a certain outcome. It is an influential factor in determining health behaviours, especially precautionary behaviour, and is viewed as an important element in education and prevention programs (Joseph et al., 1987; Prohaska, Albrecht, Levy, Sugrue, & Kim, 1990). Kok (1991) in his research on health education theories and AIDS prevention, emphasizes that despite accurate knowledge, people's perceptions can inhibit AIDS prevention, "in the case of AIDS, people know how serious AIDS is, they know that condom use is preventive, but they might not consider themselves susceptible to infection"(p.33). The tenuous relationship between knowledge, personal susceptibility, and taking protective action leads to the question: Is perception of

risk necessarily relevant in influencing health behaviours? The connection between knowledge, perception, and action may be best illustrated by examining a health issue such as smoking. It has been found that people are aware of the risks associated with smoking but are reluctant to change their behaviour. For example, 1996 statistics on teenagers and smoking show that nine out of ten teens are aware smoking is a health hazard, however, one in four teens are regular smokers (Sumi, 1996). This suggests that although people know that a health threat exists they may still place themselves at risk. What we do not know from this illustration is how many people knowingly take the risk and how many place themselves at risk because they have not personalized the risk. What research has shown, however, is that despite factual knowledge of the risks of a particular behaviour, such as smoking, people do not always perceive themselves to be at risk (Gerrard, Gibbons, & Bushman, 1996; Cochran, 1989). This suggests that although accurate knowledge is necessary in understanding how to protect oneself, knowledge does not guarantee protective action. In addition, since people do not always perceive themselves to be personally at risk, it is essential that the focus not only be at the level of final risk assessment but on the process of how risk perceptions are formed. As with most human behaviour, there is a continuous feedback cycle that allows for people to adapt their behaviours. Therefore, just as perceptions are expected to influence how people act, actions will in turn influence future perceptions, creating a continuous cycle of re-evaluation and possible behaviour change. This study proposes that identifying how married Thai women form their perceptions of risk is essential when exploring whether or not they take protective action.

Judgmental Heuristics

The ways that people make sense of the world of AIDS influences their perception of their own risk for HIV infection. Personal risk perceptions are the interpretations people make about whether they are likely to be affected by a particular threat, for example whether they are susceptible. Researchers (Gerrard et al., 1996; Goldstein, 1992; Kahneman & Tversky, 1982; Weinstein, 1982) have explained that people form their personal perceptions of risk, not from purely rational foundations, but from biased judgements, referred to as judgmental heuristics. With regards to risk perception involving HIV infection, judgmental heuristics are the various methods people use to construct their perception of personal risk from HIV infection (Kronenfeld & Glik, 1990; Maticka-Tyndale & Levy, 1993; Weinstein, 1980, 1982). Heuristics demonstrate people's preference for manipulating perceptions to justify behaviours rather than changing them. For example, instead of recognizing that having multiple sexual partners and not using condoms are activities that can potentially lead to risk for HIV infection, the tendency is to associate AIDS with groups of people, places, or relationships, distant from oneself. People know how HIV is transmitted. However they also live in societies that have identified and labeled particular groups as "at risk" or "risk groups." This facilitates the social construction of AIDS as a foreign disease, something that happens to others, and a further labeling of those who contract AIDS as "bad," while "we" are "good" (Goldstein, 1992; Waller, 1992). From here it is a small step to the conclusion that those who get AIDS deserve it (Waller, 1992). Thus, individuals take the factual information, the social labeling, and the social constructions, to form their own judgments or conclusions about

their personal risk. Researchers Burger and Burns (1988) and Weinstein (1982) point out that heuristics serve a protective function by decreasing people's levels of fear and anxiety about undesirable or frightening situations. Although peace of mind is clearly a benefit, there are also disadvantages. If people use judgmental heuristics to evaluate whether or not they are at risk and come to the conclusion that they are not, convincing these people that prevention is necessary is a difficult task. Therefore, prevention efforts need to focus on judgmental heuristics in order to reconstruct personal risk perceptions. Gerrard et al. (1996), Kahneman and Tversky (1982), and Weinstein (1982) have identified five heuristics: representativeness, availability, anchoring, denial, and delayed effect.

The first heuristic, representativeness, involves assessing your own level of risk by comparing yourself or your partner to a stereotypic model of who is at risk. For example, a common stereotype in Thailand is that prostitutes and IVDU's are those who are at risk of contracting HIV (Maticka-Tyndale et al., 1994). In addition, it is often the location of the brothel or the appearance of the prostitute that carries with it a particular stereotype about risk carriers (Maticka-Tyndale et al., 1997; Tern & Sudachan, 1996). This heuristic was used by Thai men in Havanon et al.'s (1992) study, to explain that they did not use condoms with "ugly" prostitutes since these women did not have as many partners as "pretty" prostitutes and therefore were less likely to be infected. The heuristic was again used by men to explain their reason for having sex without using a condom if a woman "looked clean, fair skinned, and dressed well" (Havanon et al., 1992, p. 24) since she then did not fit the stereotype of what someone with HIV looked like. This statement has significant implications for Northeastern Thai women who usually have darker skin

and would not fit into the "fair skinned, at risk" category. Therefore, those people who do not view themselves or their partner as fitting the "risky" stereotype see themselves as not at risk (Tern & Sudachan, 1996). Goldstein (1992), a folklorist, has explored how Newfoundlanders view AIDS as being a "mainland" disease and is characterized as "imported." Goldstein (1992) expands our understanding of the use of stereotypes as judgmental heuristics in her suggestion that "a natural inclination for cultures, is to seek scapegoats who are taken to be responsible for the community's sins. The guilty party is always the same; foreigners, those who are not integrated into the collectivity, and those that do not share beliefs" (p. 36). Representativeness is used to perpetuate the idea of people with AIDS as "bad" and the group that "we" belong to as "good," as well as the notion of "them" as being at risk, while "we" are safe. However, there are very few people who would ever want to place themselves in the "bad" or "them" category. This heuristic may prove to be particularly relevant to the lives of women where simply belonging to the category of "wife" is assumed, by virtue of association with only having one partner, to protect from HIV infection.

A second judgmental heuristic is referred to as availability. Availability addresses the notion of recall, conceptualization, and personal experience. More specifically, if a person cannot recall anyone in the same type of relationship (married, single, dating, etc.) as themselves having been infected, it is unlikely that they will perceive themselves as being at risk (Maticka-Tyndale & Levy, 1993). Jedlick and Robinson (1987) found the availability heuristic operating with young adults who did not conceptualize sex, which was considered an act of love, as allowing them to be at risk for sexually transmitted

diseases (STD's). Phrases such as, "After all, I don't have sex with just anyone, it has to be someone special, and then I trust him" (Maticka-Tyndale & Levy, 1993, p. 47), "Because I love her . . . it's kind of hard to think that [about AIDS]" (Williams et al., 1992, p. 926) and "[I] only [have sex] with a girl who cares about me and who I care about, and I trust her" (Maticka-Tyndale, 1992, p. 245) are characteristic of availability.

The third judgmental heuristic is anchoring. Although quite similar to representativeness, anchoring moves beyond stereotypes or broad categories to peers who are used as an anchoring point to which individuals compare themselves. For example, women in Thailand may compare themselves to other women in their village. They would then evaluate their risk relative to that of people they know. An important issue involving anchoring is the idea of invisibility. HIV infection is invisible since those who are infected may not know for months or years that they are infected, and they appear uninfected for a significant period of time. In addition to the absence of an obvious physical appearance with HIV infection, there is a stigma associated with the disease that encourages people who are infected not to tell others, prolonging and compounding their invisibility. This invisibility factor is extremely important in that people may think they have no or few people in their lives who have been infected, yet this may not be true.

The fourth judgmental heuristic is denial, which can operate in two ways. First, a person may deny that their own actions are risky. Second, and more relevant for Thai women, is the denial of other's actions (e.g., their husbands) as affecting their own susceptibility. For example, women in Thailand may deny that their husbands go to prostitutes, or may reason that if they do not see them go, they do not need to worry.

And finally, is the delayed effect heuristic which is linked to health risks in which the consequences can not be seen until years later. Researchers have found that when the detrimental effects of a particular health threat are not immediate (e.g., HIV) people have a diminished perception of risk and less motivation to change their behaviour. Maticka-Tyndale and Levy's (1993) research on students' perceptions of risk, found references made to the fact that with AIDS, "you don't get sick for six maybe more years . . . so by that time they'll be able to treat it" (p.47). Delayed effect, combined with a belief in the power of medicine to eventually provide a cure reduces the seriousness of the threat.

When dealing with human behaviour and social constructs such as the five judgmental heuristics outlined above, it is difficult to place each judgment into a distinct category or to establish precise boundaries between heuristics. For example, Fordham (1993) in his research on Northern Thai male culture and HIV risk assessment found that Northern Thai men felt that they did not need to use condoms at their local brothels because they knew all the clients, but they would never visit a brothel in a large city such as Bangkok. Fordham's (1993) research could be illustrating a representative bias with the Northern Thai males stereotyping brothels in Bangkok as risky and their own brothels as safe, therefore concluding that they are not at risk at home. It could also be representing anchoring since, as far as these men know, no one in their village who goes to the local brothel has been infected with HIV, therefore, it must be safe. In addition, this example could also be illustrating the denial heuristic with the men simply denying that they are at risk. Regardless of which heuristic is considered to be operating, the consequence is still a perception of nonsusceptibility. Analyzing statements by judgmental

heuristics is merely a tool used by researchers to help understand the dynamics involved in formulating personal perceptions.

Optimistic Bias

Regardless of which judgmental heuristic is operating, Weinstein (1987) suggests that they all help individuals to construct an understanding of their lives as relatively free from risk. Weinstein (1980, 1982, 1987) labels this tendency of people to be extremely optimistic about their individual chances of avoiding risk an optimistic bias. Therefore, people use judgmental heuristics to ignore or interpret facts in order to maintain a pre-established notion that they are not at risk.

Weinstein was not the first or only researcher to study optimistic bias. Heider (as cited in Hansen, Hahn, & Wolkenstein, 1990) initially proposed the idea, but referred to it as 'perceived personal immunity.' van der Velde et al. (1994) also used this label and concluded that optimism is used as a way of reducing fear. Perloff and Fetzer (1986) studied what they called the 'illusion of unique invulnerability.' They found that people typically viewed themselves as unlikely victims, did not believe misfortune could happen to them, and underestimated their chances of being at risk. Burger and Burns (1988) found that people tended to see misfortune as happening to someone else rather than to themselves. They further explained that this may be used as a protection against "anxiety provoking thoughts" (p. 269). Regardless of the name given to this concept, the focus of interest in an optimistic bias is on the effect it has on action, "an optimistic bias may lower feelings of vulnerability and hence affect risk-reduction motivation and activities" (van der Velde et al., 1994, p. 25).

Intention and Action

A second area of research has focused on intention. Researchers exploring health behaviours often use models, such as the health belief model, which focus exclusively on people's present intentions and from these presume later action. In these models it is assumed that the intention to act in a self-protecting way has a strong, direct influence on action, but rarely is this assumption tested. This is largely due to the difficulty in studying the relationship between people's intentions and actions since this would call for a longitudinal design. Gerrard et al.'s 1996 meta-analysis of the relationship between perceived susceptibility and precautionary behaviour illustrates the infrequent use of longitudinal designs with only 4 of the 32 studies they located using longitudinal compared to 28 using cross-sectional designs. Studies which have examined the relationship between intentions and actions suggest that intention does not always translate into protective action. For example, in their longitudinal study of young women in England, Holland et al. (1990, 1992) found that though the women were aware of their risks and intended to protect themselves, few did. One woman's strong intentions were highlighted in an interview, "I wouldn't [have sex] if they [men] couldn't accept that [using a condom]. It's just mindless not to be aware of the risks and be prepared to lessen them now" (Holland et al., 1992, p. 149). In a later meeting, this same woman revealed that she had recently had unprotected sex with three different men on numerous occasions. Intentions, regardless of how strong, are not necessarily good indications of action that will be taken. In addition, research dealing with issues involving sexual behaviours need to take into consideration that condom use is dependent on the cooperation of a partner.

Regardless of the potential intention-action link for an individually controlled activity, a partner's opposition to using condoms may inhibit intentions being transformed into action. Therefore, though exploring women's intentions to protect themselves is an important step in understanding women's self-protective behaviours, it cannot be assumed that intentions will automatically result in protective action.

Another way of understanding the intention-action connection can be illustrated in a comparison of three possible scenarios regarding women's intentions to use condoms. The scenario that illustrates a positive causal relationship between intention and action is one in which a woman intends to protect herself from HIV infection by using a condom and actually uses a condom with her husband. Here intention has resulted in protection from HIV. Consider, however, a second case where a woman intends to reduce her risk of infection through a means that she believes to be effective protection, but which is not. For example, she provides her husband with condoms whenever he travels believing that though he may not be celibate when he is away, he will use a condom. If her husband is not celibate but does not use the condoms, she is not safe. Although this woman formed an appropriate intention with respect to what she believed to be a risk reducing strategy, and carried through with the appropriate action, her behaviour did not have the desired outcome of reducing her risk from HIV infection. A third case illustrates the opposite result. A woman uses condoms with her husband with the intention of preventing pregnancy and no consideration of HIV infection. Here there is an absence of intention to protect against HIV but an action which, nonetheless, reduces the woman's risk. The danger of ignoring this scenario, perhaps because it does not relate to HIV prevention, or

because the intention has been assumed based on the observed action, is seen when we consider this same woman, who uses condoms with her husband for contraception. When she decides to use a different contraceptive, or none at all, she no longer uses condoms, and is now at risk from HIV infection. Without having formed an intention specifically to reduce risk, she has not considered risk in deciding on a course of action with respect to condom use. These three illustrations demonstrate the importance of considering both intentions and actions as well as illustrating the necessity of exploring the specifics of the intention-action connection and the self-defined content of each.

A final factor to be considered in the intention-action link is the place of the cost-benefit factor in the health belief model. Research suggests (Holland et al., 1990, 1992; Kok, 1991) that some women may realize that they are at risk, have the intention to protect themselves, develop prevention strategies, but come up against barriers (costs) which prevent the strategies from being turned into action. In the health belief model these barriers inhibit intentions, but research suggests that they also directly limit the action that women can take. Several researchers have identified such barriers on both the societal and interpersonal levels. These include: 1) negative attitudes towards condoms (Guinan, 1992), 2) negative connotations associated with condoms within long term relationships (Heise & Elias, 1995; Novello, 1991; Wyatt & Riederle, 1994), 3) a lack of viable options for protecting oneself (Wyatt & Riederle, 1994), 4) a power imbalance in the relationship (Guinan, 1992; Heise & Elias, 1995; Novello, 1991; Stein, 1994; Worth, 1989; Wyatt & Riederle, 1994), 5) a lack of control over sexual decision making (Novello, 1991; Worth, 1989; Wyatt & Riederle, 1994), 6) difficulty in negotiating condom use

(Guinan, 1992; Heise & Elias, 1995; Wilson, Zenda, & Lavelle, 1991), and 7) economic dependence (Wyatt & Riederle, 1994). If the barriers to self-protection are too great, personal perceptions of risk and intentions will have a diminished effect on protective actions.

Social Context - Thai Culture

Risk perceptions, intentions, barriers, and action are not only influenced by psychological or individual factors, but also by the society in which a person lives (Ford & Koetsawang, 1991). Douglas and Wildavsky (1982) stress the importance of setting the social psychological factors considered in the previous section into the context of cultural beliefs and practices. People interact, make decisions, and act within a social structure and culture; they live in societies which reinforce certain social expectations, sexual hierarchies, social constructions of gender and power, and various religious beliefs, all of which can influence their views with regards to risk, sexuality, gender construction, and marriage. Culture is the foundation on which people's beliefs, perceptions, and actions are built and therefore, plays a significant role in how people view themselves, as well as the ways in which they will act with regards to risk of HIV infection (Douglas & Wildavsky, 1982; Ford & Koetsawang, 1991; Fordham, 1993; Wingood & DiClemente, 1995). An understanding of the way in which Northeastern Thai women view their risk, the intentions they have to protect themselves, and their eventual actions will only be gained through an understanding of these women's situation within the context of Northeastern Thai culture.

Economic, Village, and Family Structure

In order to understand the "situation" that exists for the women in this study, it is necessary to provide a brief description of the environment that they live in. The Northeast is the poorest region in Thailand with most families living in rural villages. Their income is agriculturally based with rice being the main crop cultivated. Since the rice farming is not enough to live on, their income must be supplemented by finding work outside the village (Klausner, 1987; Maticka-Tyndale et al., 1997). Therefore, circular migration is a typical way of life. Men of all ages and younger women work outside the village to supplement income, but once a couple has children, it is more difficult for women to leave the village for work, leaving them somewhat dependant. Men, especially younger men, spend several months, even years, away from the village with only occasional visits to their families. This leads to couples' relationships and time together being loosely structured with the village organized along the lines of peer couples and extended families (Klausner, 1987). Understanding this lifestyle of rural living, poverty, and circular migration is imperative in order to fully appreciate the activities of Thai men and the perceptions, intentions, and actions of Northeastern Thai women.

Buddhism

Scholars who have studied Thailand stress that Buddhism is the "ideological base" (Muecke, 1994, p. 505) for Thai thinking. With 95% of Thai people being Buddists, Buddhism shapes the meanings of everyday life in Northeastern Thai villages (Limanonda, 1995; Muecke, 1994). Buddhist beliefs which may be influential in the formation of women's perceptions of risk, their intentions to protect themselves, and the actions they

take, include those about women's status in society, Karma, merit, Siang Duang, harmony, and the notion of the cool-heart. Karma is based on an underlying belief in rebirth. According to this belief, good actions earn merit while wrong actions lead to the loss of merit. The amount of merit gained will determine a person's position in their next life. The ways in which merit is acquired include Siang Duang or "taking your fate," maintaining harmony or balance in everyday life, and remaining calm or "cool-hearted" throughout life experiences. All of these work through a structure of gender inequality, also embedded in Buddhist ideology.

Buddhism affirms the status of Thai women as inferior to men (Muecke, 1994; Truong, 1990; VanEsterik, 1982; Vichit-Vadakan, 1994). Muecke (1994) suggests that this is seen in the way wives address their husbands as, "older" or "greater brother," a sign of their own lower position in the family. It has been suggested by VanEsterik (1982) that although Thai women have significant economic responsibilities within the family, they live in a system of male dominance which reinforces gender inequality. Some people may assume that because women are economically in charge of the household, men and women, in Thailand, are equal. Kirsch (1982) points out, however, that women's control of economics does not necessarily indicate high status for women, but instead indicates low status when viewed within a Buddhist framework, which devalues economic pursuits, as well as women. It is important to recognize the inferior status of women when developing an understanding of women's risk of HIV infection and possibilities for prevention. A woman's status influences the actions women do and do not take for HIV prevention which, for Thai women, does not allow for insistence of condom use by their

male partners or prohibiting husbands from going to prostitutes. If this is not understood, programs aimed at prevention may develop strategies that are not realistic for women to implement.

In a Buddhist society, not only is the status of women inferior, but being a woman means being automatically born with inferior Karma. The underlying focus of Karma is that a person's actions in the present life will have an effect on his or her position in the next. Thus, actions are directed towards bettering a person's "merit" position so as to achieve a better life in a future existence. If bad or wrong actions out balance "merit" in one's Karmic scale, then a life of poverty and hardship will follow at the time of rebirth. A woman can improve her Karma by being a responsible daughter, a reliable and supportive wife, and a nurturing mother (Carmody, 1989; Pyne, 1994; Truong, 1990). A person can change his/her Karma by purposely making merit and through living by the principles that are valued in Buddhism. These values are Siang Duang, cool-heartedness, and harmony.

The Thai belief, "Siang Duang" refers to the position of "taking your fate" or "accepting whatever happens to you." In following with this notion of accepting your fate, Thais view accepting misfortune (e.g., your own HIV infection) as more valued than preventing the misfortune from happening. Therefore, people accept their fate rather than rebelling against it, since acceptance gains merit and the merit gained will help a person's position in their next life. This relationship between Siang Duang, Karma, and AIDS was explained by Fordham (1993),

> The risk of HIV has been found to be compared with other misfortunes in life such as poverty in that both merely indicate bad karma, which may be extinguished by the time of the next rebirth...Thai people may fear losing

merit more than they fear AIDS. (p.11)

It is not only accepting your fate that is valued, but also the way in which you manage your day to day activities which allows a person to acquire merit.

> One of the most prevalent patterns of social behavior in Thai village society is that of harmonious human relationships with one's fellow villagers and a concomitant avoidance of overt acts that express anger, displeasure, criticism and the like. The "cool-heart" is that ideal; the "hot-heart" is to be avoided. (Klausner, 1987, p. 78)

This belief in a cool-heart teaches that people should avoid emotional extremes as they cause friction in the family and can bring about misfortune. Common phrases in Thailand are built into this concept of the cool-heart, such as:

> The concept of 'mai pen rai' or never mind, [which means that] when something unfortunate happens one must gracefully submit to external forces beyond one's control and a concept of 'krenchai', an extreme reluctance to impose on anyone or disturb his personal equilibrium by direct criticism, challenge, or confrontation so as to maintain social harmony. Outward expressions of anger are considered to be signs of ignorance, cruelty, and immaturity, so one has to learn how to control one's self. (Limanonda, 1995, p. 78)

Although these beliefs may be functional within many facets of Thai society, they do not allow for women to openly confront their husbands' risky behaviours or their own risk for HIV infection without going against strong Buddhist ideologies. Instead, they must find ways to deal with the threat of AIDS that fit within the "Thai way" of life.

These beliefs (Siang Duang, cool-heartedness, mai pen rai, and krenchai) work together to uphold the Buddhist value of maintaining harmony. Maintaining harmony, especially within marriage, is valued and necessary for achieving merit for the next life. In order to do this, Thai thought distinguishes males and females on the basis of natural

biological givens that predispose each sex to different roles. This hierarchy within marriage is said to serve the function of allowing each person to gain merit by having their proper place, as well as maintaining harmony (Limanonda, 1995). Separate and unequal roles for husbands and wives eliminates any competition for merit that would exist if male and female roles were not rigidly defined and differentiated. Since Thais are anxious to build up their share of merit, it is quite natural that they would strive to have merit ascribed to every act possible (Klausner, 1987). For example, to achieve merit, part of a husband's role is to take risks, work away from home, and even to have multiple sexual partners. This is complemented by the role of the wife, which is to be a good housekeeper, a good mother, be monogamous, and not question the actions of her husband (Knodel, VanLandingham, Saengtienchai, & Pramualratana, 1996). Having these separate and complementary roles, with the husband taking risks (including sexual risks) and the wife responding to the risk taking with a cool-heart and not herself taking risks, allows husbands and wives to each achieve merit without competition, in addition to maintaining harmony within marriage. Both their gender prescribed roles and the emphasis on harmony in marriage are useful in acquiring merit, but make it difficult for wives to discuss their husbands' risky behaviours, to suggest using condoms, or to protect themselves from HIV infection.

In conclusion, Buddhism provides women with an inferior position in society and prescribes subordinate roles for wives within marriage. In addition, women acquire merit by following the teachings of Buddhism. The belief in Siang Duang leads them to accept their husbands' risky behaviours as well as accepting the influence their husbands' actions

may have on their own fate (possible HIV infection). Through the notion of the 'cool-heart,' women believe that to confront issues such as using a condom and their husbands' extra-marital affairs could prove to have serious consequences for themselves and their families, not only in this life, but in the next life as well. By accepting their fate and remaining calm with regards to their husbands' risky behaviours, Thai women act in accordance with Buddhist teachings and acquire merit, in an effort to better their Karma for their next life.

Thai Men and Sexual Risk Taking

Women's sexual decision making cannot be understood in isolation from the sexual decisions of their partners (Holland et al.,1992; VanLandingham, Supraset, Sittitrai, Vaddhanaphuti, & Grandjean, 1993). In Thailand, men's sexual risk-taking behaviours pose a serious threat to women. Women are "unable to prevent men from engaging in risky behaviours, or to persuade their partners to wear condoms. They are, therefore, unable to protect themselves" (Pyne, 1994, p. 37). Research has shown that in order to be characterized as a man in Thailand and to "add flavour to life," men are expected to take risks. Based on his ethnographic research with Thai men, Fordham (1993) proposed that risk taking is a valued male characteristic. In addition, Fordham (1993) suggests that, in Thailand, everyday risks such as road accidents, theft, and fire are viewed as posing a greater and more immediate risk than HIV infection. Therefore, the cultural belief that taking risks demonstrates masculinity, the view that there are more immediate risks evident in Thai society, together with Buddhist values, all contribute to lack of concern with HIV or the acceptance of one's fate, even if this means HIV infection.

Thai beliefs regarding risk taking and Karma are reflected in attitudes toward male promiscuity. In Northern Thai villages, common phrases are "he's not afraid of AIDS he's afraid of going without sex" (Fordham, 1993, p. 5) or "a man who 'mai thiew' (does not go to prostitutes) is not a real man" (Ford & Koetsawang, 1991, p. 408). Researchers have repeatedly found that, for married men, having multiple sexual partners is tolerated and continues to be a significant component within Thailand's overall sexual culture (Ford & Koetsawang, 1991; Fordham, 1993; Havanon et al. 1992; Klausner, 1987; Knodel et al., 1996; Pyne, 1994; VanLandingham et al., 1993). The attitude of both men and women towards Thai male promiscuity can be illustrated by the frequently used phrases found in the research, such as, it is "natural," " normal," "expected," and "socially acceptable" for men to pursue sex or that promiscuity is a "basic minimum need" and "adds variety to married life" (Ford & Koetsawang, 1991; Fordham, 1993; Havanon et al., 1992; Klausner, 1987; Knodel et al., 1996; Pyne, 1994; VanLandingham et al., 1993). Although this attitude is true for men, Thai women must be sure to "always keep their sexuality in check" (Pyne, 1994, p. 25) since a Thai man expects to marry a virgin and expects his wife to be faithful (Havanon et al., 1992; Klausner, 1987; VanLandingham et al., 1993). Pyne (1994) concludes that prostitutes enable men to have a number of sexual partners while at the same time making it possible for them to marry virgins. As Havanon et al. (1994) point out, the Thai perspective suggests that going to prostitutes prevents the "corruption" of non-prostitute women. Despite the sexual freedom that men have, married men do not have total freedom to act as they choose. Although there are no sanctions imposed against married men's sexual promiscuity, the cultural norms of cool-

heartedness and Siang Duang prescribe the way in which these activities must be carried out. Extra-marital sex is not to be discussed openly since it will bring "sadness" to wives, money set aside for the family cannot be used to purchase sexual services, and wives follow the belief in Siang Duang by accepting their husbands' behaviour as long as he does not neglect family needs and responsibilities (Havanon et al., 1992; Klausner, 1987; Knodel et al., 1996). Although husbands are expected to save their wives and families from financial burdens and social embarrassment which could result from their involvement with prostitutes, what is not thought of is the possibility that their wives' health may not be safe.

Thai Women

In addition to the status of women in Thailand and the various Buddhist beliefs which have implications for women's protection, cultural beliefs surrounding sexuality also affect Thai women's perceptions and actions regarding HIV infection. As previously discussed, a double standard exists between men and women, with women expected to be virgins at marriage, while men are expected to be sexually experienced. This expectation of how women are to behave was explained by this Thai woman,

> It is common for men to sleep with women other than their wives. But as for women, if they have affairs, it is unacceptable. . . . Such behaviour of women is against Thai culture. But as for men, it is common. The only thing that women have to keep in mind is that they have to take good care of the family, make their family happy. (Knodel et al., 1996, p. 195)

Not only is this an expectation held by the couple being married, but also by the bride's family. A Thai bride must be a virgin or she could bring shame to her parents as well as suffering personal discrimination. Though some researchers are finding that restrictions

on female sexuality are beginning to relax in Thailand, the double standard still exists both in and outside marriage (Knodel et al., 1996; Lyttleton, 1994; O'Malley, 1988). Wives follow the strict guidelines of monogamy, while husbands are encouraged by peers to have more than one partner. This double standard has significant consequences for perceptions of risk for HIV if monogamy is to be relied on as the primary mode of protection. Monogamy can only protect against HIV infection if it is completely mutual and life-long. It is particularly detrimental if those who are monogamous do not recognize that the actions of their partners affect them. Women may cite their own monogamy as their form of protection without recognizing the risk to their own health that is due to their partners' actions. Women usually have little control over the actions of their partners, yet health campaigns which turn to monogamy and condom use as the primary methods of protection fail to understand the complexities of either, particularly in a social and cultural system such as that of Thailand (Holland et al., 1990, 1992; Mann, 1993; Women and AIDS, 1995; World Health Organization, 1993).

Condom Use in Thailand

Knowledge of condom use as a method of protection from HIV infection and condom availability are quite high in Thailand. In addition, condom use with prostitutes has risen sharply in recent years (Im-Em, 1996; Maticka-Tyndale et al., 1997). Although using condoms with prostitutes may offer some indirect protection for married women whose husbands go to prostitutes, it does not directly address these women's risk since few married couples report using condoms, whether for disease prevention or for contraception (Fordham, 1993; Havanon et al., 1992; Pyne, 1994). Pyne (1994) found

that female sterilization was the most frequently used method of contraception, followed by the birth control pill. The least popular method was the condom (Pyne, 1994). Researchers suggest that lack of condom use within Thai marriages may be due to the negative connotations derived from the association of condoms with prostitutes. Another possibility found from research in other countries is that the very suggestion of condom use within marriage carries with it an implication of infidelity which could threaten the security of the relationship (Knodel, Chamratrithirong, & Debavalya, 1987; Women and AIDS, 1995; World Health Organization, 1993). Therefore, application of the knowledge that condoms can protect against HIV infection is hampered by cultural norms and expectations and may not be the most viable option of protection for married women in Northeast Thailand.

Summary of Purpose

This thesis explores the process by which married women in Northeast Thailand perceive themselves to be at risk for HIV infection and how these perceptions translate into self-protection. The review of literature on the health belief model (see Figure 1), related social psychological theories, and Thai cultural systems suggests a modification to the health belief model as portrayed in Figure 2.

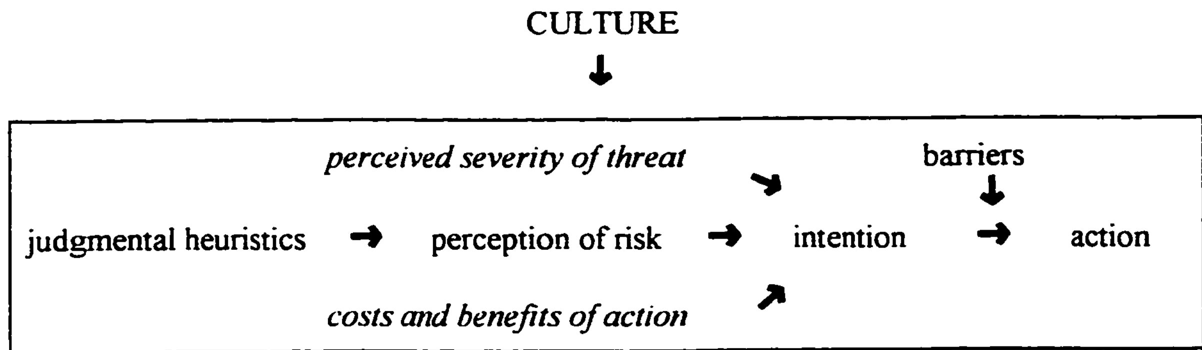

Figure 2. Modified Version of the Health Belief Model

This model proposes that women use judgmental heuristics to formulate their perception of whether or not they are at risk. These in turn, together with perceptions of severity and the costs and benefits of preventive action, influence intentions. Women develop strategies which indicate their intentions to protect themselves but these intentions are not proposed to be directly correlated to action, and particularly not to action that is effective in reducing risk. The key factors inhibiting intentions from becoming effective actions are the barriers to action that Northeastern Thai women face and the less effective strategies that they enact. These barriers and alternative actions lessen the influence of personal perceived susceptibility and intentions on protective action. All of this occurs within the context of Thai culture. Components of the modified health belief model that are not dealt with in this thesis have been italicized in Figure 2. Since there is consensus as to the "severity" of AIDS as a life-threatening illness, this component of the health belief model was not expected to be an influential element in this research. The costs and benefits of preventive action are being included in the exploration of barriers.

Each component of the proposed model will be explored within the cultural

context of these women's everyday lives. The judgmental heuristics used by these women to form their perceptions of risk are expected to fit into the categories of representativeness, availability, anchoring, denial, and delayed effect. These heuristics will be set within a cultural framework which provides the justification for their use. In addition, the intentions that women have to protect themselves are expected to be developed through strategies which are embedded within Northeastern Thai Buddhist culture and values. And finally, the barriers to self-protection that exist for these women are anticipated to include some that are shared globally with other women as well as barriers that are particular to the cultural framework in which Northeastern Thai women live.

CHAPTER III

METHODOLOGY

A secondary analysis using data obtained through structured face-to-face interviews and focus groups for the study, "Women and AIDS in Northeast Thailand" was used in this research (Kuyyakanond & Maticka-Tyndale, 1994). The original study of village women was conducted from 1991 to 1994 in Northeast Thailand. Structured face-to-face interviews were completed by 1379 women representing over 85% of the women originally approached. It is important to point out that the data used in this analysis were collected across three separate times. Phase one, conducted from October 1991 to January 1992, included 330 women, phase two began in late 1992 and ended in early 1993 and included 654 women, and phase three, conducted from late 1993 to February 1994, had 395 women. Not all structured interview questions were asked in each phase; therefore, the total number of women responding varies for each question of this analysis. Twelve focus groups were conducted with a total of 288 women (Kuyyakanond & Maticka-Tyndale, 1994). The two data collection methods provide a rich data base. The structured interview data quantify the incidence of responses to specific questions. Complementing this are the focus group transcripts, which provide in-depth insights and personal accounts of life experiences, behaviours, and perceptions regarding sexual behaviour. For details on sampling procedures used by the principal investigators refer to Appendix A.

Data Analysis

The questions used for data analysis in this thesis were chosen from 123 structured

interview questions and included all questions which pertained to a person's knowledge of AIDS, perception of risk for self and spouse, condom use, issues pertaining to prostitution, and Thai beliefs (see Appendix B). In using a structured interview that has already been written and distributed, the operational definitions of all concepts have been previously determined by the principal investigators. Given the open-ended, multiple response nature of the questions, the most appropriate data analysis was to run frequencies and to conduct multiple cross tabulations on various combinations of questions. Responses of specific subgroups of women were compared. The younger, more recently married women were compared to the older women. In addition, women who believed that they were at risk were compared to those who believed they were not and women who had used condoms were compared to women who had never used them. The focus group questions were similar to those used in the structured interviews but were more in-depth. The focus group discussions clarified responses to structured questions, provided more in-depth answers, illustrated connections and links between variables, and outlined the judgmental heuristics that women used, the intentions they had to protect themselves, and the barriers that existed.

Reliability and Validity

The reliability and validity of this study were, in large part, dependent on the measures taken by the principal investigators to maximize both.

Generalizability

The generalizability of the results for this study were influenced by the sampling procedures used by the principal investigators. The sampling procedure employed by

Kuyyakanond and Maticka-Tyndale (1994) was a stratified random sample. This strategy supports generalizability to a population (Creswell, 1994) in this case, villagers in Northeast Thailand.

Reliability

The principal investigators followed various procedures to assess reliability (see Appendix C). Additional reliability checks were conducted for this thesis. These included statistical checks on the questions used in this study and an audit trail of the decisions and rules made throughout the research process. This allowed for interpretations and conclusions to be tracked back to the source and for others to repeat the present study, therefore increasing reliability (Creswell, 1994).

Validity

The method of triangulation is receiving increased use by researchers as it "tries to pinpoint the values of a phenomenon more accurately by sighting in on it from different methodological viewpoints" (Brewer & Hunter, 1989, p. 17). Using more than one methodology addresses the convergent validity of the research. Triangulation was employed by Kuyyakanond and Maticka-Tyndale (1994) through the use of structured interviews and focus groups.

Content validity addresses the degree to which "an empirical measurement reflects a specific domain of content" (Carmines & Zeller, 1979). Therefore, the issue for this study is whether or not the models that were chosen, the questions asked, as well as the way the concepts were measured, are valid indicators of perception of risk, intentions, barriers, and actions. Carmines and Zeller (1979) state that in order to establish a content-

valid measure it is necessary to investigate the available literature. Many years of research in social psychology has strengthened the validity of the theories that I employed such as the health belief model, judgmental heuristics, and optimistic bias (Glanz, Lewis, and Rimer, 1991; Gochman, 1988; Weinstein, 1987). A question remains, however, as to whether these models, which were designed within a Western cultural context, are relevant when applied to the health behaviours of Thai women. To deal with this I have done a literature review on Thai culture, as well as remaining aware of and open to my own biases of growing up in a Western society. In addition, my advisor Eleanor Maticka-Tyndale, having done a significant amount of research in this area, provided continuous feedback and served as a constant check against false interpretations. To check for accuracy in interpretation of Thai culture, Kathryn Stam an anthropologist, formerly with the Northeast Centre: AIDS Prevention and Care, Khon Kaen Province, Thailand and currently with Syracuse University, who lived and worked in Northeast Thailand for ten years and is fluent in Isan, the local dialect, reviewed and provided advice on the sections of this study that deal with Thai culture.

Kuyyakanond and Maticka-Tyndale (1994) have used the data they collected to examine Thai women's knowledge, attitudes, and beliefs about HIV/AIDS (Elkins, Maticka-Tyndale, Kuyyakanond, Miller, & Hawell-Elkins, 1997; Maticka-Tyndale et al., 1994). It has not yet been used with a focus placed on the formation of risk perception or with an emphasis on cultural context. This research analyzed existing data in a way that has not been previously done and will be useful in designing culturally sensitive prevention programs in the future.

CHAPTER IV

RESULTS AND DISCUSSIONS

Presentation of Results

Quantitative and qualitative data are integrated throughout the presentation of the study results in order to provide a more complete understanding of how judgmental heuristics help to form perception, the perceptions of risk that Thai women have, their protective intentions, women's actions, and the barriers to effective preventive action. Data on Northeastern Thai men, collected at the same time and in the same villages as the women's data, is used to provide information that will be helpful in understanding women's situation. In addition, the total structured interview sample is divided into groups on dimensions that were considered of particular importance to compare. These include age, perception of personal risk, and condom use.

Sample Profile

The total sample available for this study included 1379 women from 30 villages in rural Northeast Thailand. The women ranged in age from 15 to 53 years, with a mean age of 31 years. All of the women were married or had been married at one time and 90% had four to six years of elementary school education (see Table 1).

Table 1

Profile of Participants by Age, Education, and Marital Status

Variable	Percent Reporting (N=1379)
Age	
15 yrs to 30 yrs	51
31 yrs to 53 yrs	49
Education	
<4 yrs elementary	4
4-6 yrs elementary	90
1-6 yrs secondary	5
post secondary	1
Marital Status	
married	96
separated/divorced	2
widowed	2

Note. From "The design, implementation, and assessment of AIDS health promotion targeted toward rural women in Northeast Thailand," by T. Kuyyakanond and E. Maticka-Tyndale, 1994, Report to International Development Research Centre., p. 23. Adapted with permission of the authors.

AIDS Knowledge

Consistent with previous findings on married women in Bangkok (Shah et al., 1991), married women in Northeast Thailand, overall, had adequate knowledge of HIV

and the ways in which it is transmitted. The majority of women were aware that people with AIDS do not always appear sick (59.7%), that there is no cure for AIDS (67%), that people who feel healthy can infect (78.6%), and that a blood test is required in order to test for HIV (65.0%). However, some misconceptions were still present. In Canada people now assume that knowledge of HIV is a given (Goldstein, 1991), and although the majority of women in this study had adequate HIV knowledge, any inaccurate knowledge can inhibit prevention and therefore misconceptions need to be addressed. Quite a few women (33%) believed that there is a cure for AIDS, 35% did not know that blood tests were used to test for infection, and 35.5 % were not sure if infection was noticeable by appearance. For prevention purposes, it is important that women be aware that there is no cure for AIDS, since people may be less careful about infection when a cure is readily available. In addition, for those women who believed that a person with HIV can be detected by sight, protection will not be effective if they wait until symptoms appear before taking any action to protect themselves. Despite these misconceptions, most women knew that HIV could be transmitted through heterosexual intercourse (87.1%) and that casual contact cannot lead to infection (85.4%) (see Table 2). The most common response regarding modes of transmission was "sexual behaviour between men and women." It is important that the majority of women recognized heterosexual transmission as leading to infection since this is the most likely mode of transmission to them. Responses which were reported less frequently included HIV transmission through sexual behaviour between two men, prenatally, or contact with infected blood.

Table 2

Women's Knowledge of HIV Infection and Transmission

Factor	N	Percent Responding Yes	Don't Know	No
can tell if infected by appearance	1364	4.8	35.5	59.7
there is a cure for AIDS	1379	33.0		67.0
if a person feels well they can infect	1366	78.6	9.3	12.1
can tell if infected by blood test	1379	65.0		35.0
Can get AIDS through...	1364	% Volunteering this Response		
casual contact		14.6		
medical procedures		9.0		
sexual behaviour between men and women		87.1		
sexual behaviour between 2 men		5.4		
contact with infected blood		22.1		
injections and cuts		67.4		
prenatal transmission		6.1		
mosquitos		1.0		

Note. From "The design, implementation, and assessment of AIDS health promotion targeted toward rural women in Northeast Thailand," by T. Kuyyakanond and E. Maticka-Tyndale, 1994, Report to International Development Research Centre., p. 65. Adapted with permission of the authors.

Perception and Source of Risk

Personal Risk

In structured interviews, the majority (60.7%) of women indicated that they believed that they were not at risk of contracting HIV (N=1220). In contrast to this finding, in focus group discussions the majority of women indicated that they felt that they were at risk. At the outset of the focus group discussions, women were reluctant to state if they were at risk or not, with many dismissing their risk altogether. As the discussions progressed, women challenged each other with regards to their personal susceptibility to HIV infection. In all 12 focus groups the majority of women came to the conclusion that they were all at risk, with only a few maintaining that they were absolutely sure that they were not. One woman explained how "housewive's" perceptions of their own risk are different today than they were in the past:

> In the past when AIDS was first known they said people who had more chance to catch it were prostitutes and others. Now even us housewives who stay home are at risk too. Before this they said it would be all right the housewives wouldn't have to worry about it. Now it is different, we are at risk too. We have the chance too.

The apparent contradiction between structured interview and focus group responses and the change in women's perceptions has three possible explanations. First, women who initially stated, in the structured interviews, that they were not at risk may have believed this. After participating in the focus group discussions and listening to their peers who had stories which paralleled their own lives, they may have realized that the factors which were responsible for other women's possible risk were present in their lives as well. These women then questioned their initial perception and discussed the possibility of their risk in

the group discussions. The second possibility is that women who responded that they were not at risk on the structured questions may actually have perceived themselves to be at risk, but until they were confronted by their peers in the focus groups, did not want to admit it. Third, the contradictions may be illustrating the conflict and confusion that is occurring in these women's lives due to the recognition of married women's possible risk of HIV infection. For example, there may be times when a woman feels that she is at risk. Perhaps these perceptions of being at risk occur when she is listening to the media or talking with her peers. There may also be occasions in the same woman's day when she believes that she is not at risk, which may involve influences such as her husband or a day working in the fields alone. The woman may be unsure of her own risk and, therefore, her perceptions will change depending on what factors are influencing her at that moment in time. The contradiction between these two research methods provides support for the strength of using more than one research technique in order to provide a more complete understanding of relationships that exist and a more realistic representation of the ambiguity in people's lives.

Reasons for Risk

The findings of this study were consistent with findings on women in Uganda, Rwanda, and Rio de Janeiro where women are faced with similar cultural situations which tolerate multiple sexual partners for married men (Guimaraes, 1996; Lindan et al., 1991; McGrath et al., 1993). Women recognized that they did not bring HIV into their marital relationships but that their risk for exposure resulted from the extra-marital activities of their husbands. Of the 39.2% of women who felt that they were at risk, the majority

(53.4%) stated that the source of their risk was their husbands, 17.0% felt they were at risk because of casual contact, and 12.9% stated that everyone was at risk. This perception of men seems to be an accurate one since 50% of married men in the men's portion of the Northeast Thai study admitted to having, at some time, purchased sexual services (Maticka-Tyndale et al., 1997).

The focus group discussions supported the structured interview findings that women believed their husbands were their source of risk. Frequently heard throughout the discussions were references made to the fact that husbands were the only way married women could contract HIV. A common reply to the question, "what is the most dangerous way for HIV to be transmitted?" was "our husbands," or when asked "why do you think you are at risk?" one woman replied, "because he goes alone." This reference to "going alone"was often used by women in the focus groups as a way of saying that when a man is without his wife he may have sex with prostitutes. Even those women who felt they were not at risk showed doubt in the fidelity of their husbands:

> **Interviewer**: Are housewives at risk?
> **W1**: not that risky for me since my husband is not that type. <u>But</u> if he happens to be in the mood [to see a prostitute] I think he will use a condom

One group of women made it very clear that they knew why housewives were at risk:

> **W2**: ...but it's among the housewives too. How could that happen?
> **W3**: Well the husbands are the carriers!
> **W2**: The husband is the carrier! He brings it home!
> **W4**: That's because he goes out to have fun
> **W2**: So this disease can be called the 'asking for it,' can't it?

Reasons for No Risk

The 60.7% of women who stated that they were not at risk, were asked what they thought kept them safe. The main reason given by women was that their husbands did not go to prostitutes (see Table 3). In addition, many women felt that they were not at risk because they only had sex with their spouse. Women have repeatedly been found to view their own position of monogamy as the main reason for their low susceptibility and therefore the primary reason for not using protection (Holland et al., 1990, 1992; Mann, 1993, Women & AIDS, 1995; World Health Organization, 1993). McGrath et al. (1993) in their research on the sexual risk behaviour of women in Uganda pointed out that there is a danger in using monogamy as a prevention strategy if the actions of partners are not taken into consideration. Rowe (1994) in his research regarding protecting women from AIDS, points out that although the most common risk factor for HIV infection is having multiple sex partners, the next is having a risky primary partner. Thai studies have found between 28% (Heise & Elias, 1995; Im-Em, 1996) and 50% (Maticka-Tyndale et al., 1997) of married men reporting they engaged in sex with prostitutes. Considering these facts and that using monogamy as the primary means of protection against HIV infection is only effective if both partners comply, it is evident that, for many of these women, monogamy is not an effective approach to protection, but still may be the one that is most relied upon when understood within a cultural context. When considering the dynamics of Thai women's everyday lives, such as wives being expected to be monogamous, not only by husbands, but by society, that remaining monogamous is an acceptance of fate and therefore acquires merit, and that wives maintain harmony by remaining monogamous,

monogamy seems to be the strategy which allows for more benefits than costs.

Table 3

Reasons Provided for Not Being at Risk

Reason for not being at risk	(N=830) Percent Volunteering Responses
husband does not go to prostitutes	63.3
only have sex with spouse	31.1
celibate	4.5
do not use drugs	2.2
good luck	2.0
husbands use condoms with prostitute	0.7

Comparisons by Perception of Risk

Comparisons were conducted, on all questions, to assess the similarities and differences between those women who perceived themselves to be at risk to those who did not. Women who perceived themselves to be susceptible to HIV infection were significantly more likely to believe their husbands were at risk, that their husbands went to prostitutes, to have ever used a condom (still only 39.1%), to recognize that prostitutes were at risk, and to feel that it is easy to use a condom and that pleasurable sex was possible when using a condom. When comparing themselves to other women, women who perceived themselves to be at risk did not consider themselves to be at greater risk, but at less risk or the same as other women in the village. Only 7.7% believed that they

were at greater risk than their peers. In addition, although the difference was statistically significant ($p \leq .05$), only 18.7% of those who perceived themselvcs to be at risk claimed that they had done anything to protect themselves, compared to 8.5% of women who did not believe they were susceptible. Clearly, regardless of perception, most women had not taken protective action. A complete summary of the comparisons on each of these questions can be found in Appendix D.

Wives' Perception of Their Husbands' Risk

In addition to responding to questions regarding their own risk, in phase three of the study women (N=395) were also asked a series of questions with respect to their perception of their husbands' risk of infection and the reasons for this risk. For perception of risk, the most common response was that husbands were at some degree of risk (45.5%), though 38% replied that husbands were not at risk, and 16.5% responded that they did not know (N=395). As already cited, research on Northeastern Thai males suggests that these women have an accurate picture of their husbands' risk. Recall that in the study by Maticka-Tyndale et al. (1997) 50% of married men had visited sex workers. Although only 13% reported that they had purchased sexual services in the past year, 47% had purchased services since marriage and 19% reported having begun purchasing services since marriage. It is important to point out that this research on Northeastern Thai males was conducted in conjunction with the study whose data are used in this analysis and therefore includes husbands of the women in this study.

For those women who felt their husbands were at risk, the two main reasons provided were: because "he travels" (26.5%) and because he has sex with other women

(24.9%) (see Table 4). The phrase "he travels" was often used by the women instead of "he goes to a prostitute." It is common for men in Northeastern Thailand to travel for work. Maticka-Tyndale et al. (1997) explain the various patterns of migratory labour for village men with the most typical pattern for older married men consisting of over-night trips, "to district centres, cattlemarkets, and other villages for purposes of trade" (p. 202). Younger married men are more likely to be away from their village for six to eight months during the "off-season of rice cultivation [when] villagers leave for employment in other regions. The most common destination is Bangkok" (p.202). Sixty-eight percent of these married men reported that they were away from the village over night at least once a year with the majority away more often. According to discussions in men's focus groups, "most people look for it [sex with prostitutes] when they are working in other places far away from their wives. It's like that. It's normal" (Maticka-Tyndale et al., 1997, p. 207). In addition, when provided with the statement "When men travel, they find women to have sex with" 47% of married men agreed. This is not only consistent with the findings in Thailand, but also with samples in other countries. Several studies of travelers support the aphorisms "out of sight out of mind" and "when away people play" (Eiser & Ford, 1995; Mewhinney, Herold, & Maticka-Tyndale, 1995).

Table 4

Reasons Provided for Husbands Risk

Reason for husband's risk	**Percent Responding** (N=245)
sex with other women	24.9
he travels	26.5
everyone is at risk	13.5
casual contact	8.2
other	22.4

Optimistic Bias

Evidence for an optimistic bias was found in the focus group discussions as well as in the structured interviews for the majority of women. Recall that in focus groups women initially stated that they were not at risk for HIV infection. It was not until they were confronted by their peers that they concluded that they were at risk. Phrases that suggest an optimistic bias, such as, "I don't think we've got it," "I never dream of getting it," and "I don't think that will happen to me" were evident in 6 out of the 12 focus groups. One woman, who was optimistically biased, showed the effect this perception can have on her protective action, "I never think I'll contract it. That's why I haven't done anything to protect myself against it."

Judgmental Heuristics

According to Gerrard et al. (1996) when a disease is extremely threatening or precautionary measures are either unavailable or perceived to be difficult to implement or

sustain, the typical reaction is to ignore or distort the threat rather than to attempt to change personal behaviour. Although condom use and monogamy appear to be simple solutions to avoiding HIV transmission, for Thai women self-protection through condom use or controlling the actions of their husbands is difficult. Cultural beliefs such as remaining cool-hearted and accepting your fate as well as the inferior status of women are influential factors in the formation of women's personal perceptions. Within a cultural framework, it is easier for these women to distort the threat of HIV than to change their husbands' or their own behaviours. When dealing with issues involved with HIV and its transmission, the methods people use to evaluate and maintain their level of risk perception are crucial to understand since these beliefs of personal non-susceptibility can inhibit preventive behaviours. The overall concept of judgmental heuristics is complemented by many of the Buddhist beliefs. For example, heuristics have been found to reduce anxiety and keep a person calm regarding their own health much like the concept of the cool-heart. In addition, judgmental heuristics are an attempt by people to manipulate perceptions to fit behaviour rather than changing their behaviour (Gerrard et al., 1996). Therefore, heuristics are used by people to Siang Duang or accept their fate. The concept of judgmental heuristics supports everyday beliefs found in Thai society and therefore are helpful in acquiring merit and in improving Karma for their next life.

Representativeness Heuristic

The representativeness heuristic, which involves determining your own level of risk by comparing yourself or your partner to stereotypes rather than to facts, was evident throughout the focus group discussions. Three stereotypes were generally used to make

comparisons. First, the women compared their villages to the cities, usually Bangkok, where risk was perceived to be greater. For example, one woman suggested that she and her husband were not at risk, "because we live in the country." This is consistent with previous research in Thailand as well as other countries where the risk is always placed in other cities (Goldstein, 1992; Havanon et al., 1992; Maticka-Tyndale & Levy, 1993; Maticka-Tyndale et al., 1997; Tern & Sudachan, 1996). Second, the women compared themselves to the type of person that they believed was most likely to become infected. Repeated references were made to the appearance of a person such as:

> Pretty women tend to have promiscuous sex. Nobody pays attention to ugly women. So they have a rare chance to catch it. But beautiful women . . .
>
> Her face was so pale. I was afraid she would carry the AIDS disease. (pale skin is considered beautiful in Thailand, therefore, pale, beautiful prostitutes would have a greater chance of becoming infected)
>
> If they do it with women in the village, that's not so bad, but the women at festivals . . .

In addition, references were made to "reasonable" women and how they could not be infected, as well as to prostitutes that "looked clean" as being safe. Third, comparisons were made to the amount their husbands went out. This illustrates the stereotype that those men who go out more are at greater risk than those who usually stay home. Women made comments such as, "they hardly go out to enjoy themselves so we aren't worried," or "he knows that AIDS is spreading so he barely goes out." Similar to this is the belief that those men who stay out all night are at greater risk than those who come home. One woman used this logic to explain why she was not afraid of being infected with HIV, "[my

husband] doesn't go for a long time so I'm not afraid."

The structured interview data also revealed the particular stereotypes that exist as to who is at risk. Men who go to prostitutes were characterized as being the most susceptible, even more so than the prostitutes themselves. No connection was made, however, between men's risk and wive's risk (see Table 6). Women, especially married women, often use stereotypes to discount their own risk since they do not usually fit into the popular images of people who contract AIDS. A comparison between North American stereotypes and the stereotypes in Thailand provide evidence of the social construction of AIDS. In Western societies, AIDS is characterized as a homosexual disease whereas in Thailand, AIDS is associated with prostitution. Only 10.2% of this sample reported homosexuals as a group who are at risk. Therefore with regards to perception of risk, in North America, heterosexuals feel safe whereas in Thailand, wives do.

Table 6

Women's Beliefs as to Who is at Risk of HIV Infection

Who is at risk	**Percent Responding** Yes (N=1339)
Men who go to prostitutes	82.6
Prostitutes	43.2
Wives	9.3
People who don't use condoms	1.8
Homosexuals	10.2

Note. Percents do not add to 100% because of multiple response possibilities

Availability Heuristic

Only limited evidence of the availability heuristic, which addresses the notion of recall, conceptualization, and personal experience, was found in focus group discussion. This study's findings were consistent with previous research (Jedlick & Robinson, 1987; Maticka-Tyndale & Levy, 1993) which found that people had difficulty conceptualizing relationships that were based on love and trust as exposing them to HIV. For example, a number of women, when asked if their husbands went to prostitutes, responded as this woman did, "It's alright [if he goes to prostitutes] because he loves his wife and children." In addition, this woman explains that she knows her husband goes to prostitutes, but, "if he loves me, he shouldn't transmit it to me."

Anchoring Heuristic

Evidence for the anchoring heuristic, which involves using peers as the anchoring point to which a person compares him/herself, was found in both the structured interviews and focus group data. Ninety-seven percent of the women responded that they did not know any one with AIDS (N=1366). When asked to compare their own level of risk with other women in the village, few women felt that they were at greater risk than their peers (3.9%), with more frequent responses being that they were not at risk (37.6%), they were at less risk (25.2%), or they were the same as other women (23.9%). Only 9.4% of the women were unsure of how they compared to others (N=1042). As previously reported, a comparison was made between women who believed that they were at risk to those who were not and how they viewed their risk in comparison to other women. The results indicated that the majority of women who perceived themselves at risk, viewed themselves

as either the same (35.6%) or at somewhat less risk (33.2%) than their peers, with only 7.7% perceiving themselves to be at greater risk. Support for this third heuristic was found in the focus groups with women stating that they were not at risk of HIV infection, since "there haven't been any AIDS victims in our village. We haven't seen what it's like to have AIDS." Not only did they believe that it was not present in their village, but reference was made to the belief that AIDS did exist in other villages, "there aren't any here [AIDS cases], but I've heard about it in other villages."

Denial

Denial can operate at two levels, a person may deny that his/her own actions are risky or he/she may deny that the actions of their partners are risky. Due to the cultural double standard that Thai wives remain monogamous with their husbands having multiple sexual partners, denial of their husbands' actions was more relevant in affecting Thai women's susceptibility. Evidence was found in focus group discussions that women often denied their risk by denying the risky actions of their husbands. For example, by saying that they did not see their husband go to prostitutes, women would presume that they were not at risk:

> If I don't see it it's o.k., but if I hear people talk about it
>
> If I don't see him go I'd tell him nicely, I'd ask him not to go there, for AIDS is too scary

In a culture that expects men to hide their multiple sexual relationships in order to not bring shame to their wives, yet tolerates extra-marital activities, denial can be particularly dangerous. In addition, it is much easier to deny that their husbands go to prostitutes if

societal beliefs reinforce that the activity be hidden. Finally, one woman tried to rationalize her perception of risk by insisting that she uses condoms with her husband and finally admitted that she used them in the past but not now:

> **Interviewer**: Does he have to use them with you?
> **W5**: Yes, as to prevent it because I'm scared
> **Interviewer**: You said it but do you use them?
> **W5**: Yes
> **Interviewer**: Have you been using them lately?
> **W5**: No, but I did ten years ago

Holland et al. (1990) in their findings on women in England emphasized the serious consequences of denying personal risk. Women need to recognize that denial in instances of sexuality, at a time when heterosexual transmission accounts for 70% of HIV infections globally (Joint United Nations Programme on HIV/AIDS, 1996), cannot only damage the relationship between husband and wife but can be fatal. Although this statement may be true for Western marriages, for Thai women, denial will not damage their marital relationship, but maintain harmony within it. In addition, denial allows the acceptance of fate, the acquisition of merit, and the maintenance of their peace of mind. Once again, for these women, the benefits of using a judgmental heuristic outweigh the costs.

Degree of Risk

No evidence of delayed effect was found but there was evidence of an additional heuristic that did not fit into the five categories previously outlined. Women perceived themselves as being at different degrees of risk:

> **W6:** I think I'm about 80% at risk
> **W7:** me? Only 10%

This may be an indication of women comparing themselves to another group and coming

to the conclusion that they are at less risk than someone else. This would signify that the representativeness heuristic was operating, but this assumption can not be made since the women did not express an actual comparison.

Although there were contradictions in reports regarding perception of risk, there was definite evidence that judgmental heuristics were operating. Judgmental heuristics have been used by Thai women to interpret their own level of risk and help women to maintain their perception that they are not at risk. These women have socially constructed their position in the AIDS crisis by using the fact that they belong to the category of "wife," live in the country rather than cities, and have a husband that does not go out every night as keeping them relatively free from risk. Prostitutes as well as the men who go to prostitutes are characterized as the kinds of people who are at risk. Thai women have constructed their own version of who is safe and who is at risk of HIV transmission and these social constructions are clearly demonstrated in their use of judgmental heuristics.

Intention to Protect Self

This study provides further support for the connection, or lack of, between women's intentions to protect themselves and their actions. A significant amount of research has focused on this relationship and the findings suggest that women have good intentions but usually do not follow through with effective action (Holland et al, 1990, 1992; Kok, 1991). Holland et al. (1992) explain this relationship between knowing what to do and actually doing it by dividing women's behaviour into two levels. First is the intellectual level which is made up of knowledge, expectations, and intentions to protect

themselves. Second is the experiential level or the level of their sexual practice (action). Effective strategies for safer sex would not seem possible without some congruence between the two levels. Being able to follow through on the intellectual level is not enough to ensure safe sex, since it is common to express powerful intentions without protective action.

The focus group data provided a detailed explanation of women's intentions to protect themselves as well as of the actions they planned to take or had taken. Many of the women had developed well thought out plans for protection. Few of these plans, however, offered any effective protection. In the focus groups it was common for women to state that as their husbands left the house for work, they would remind them, "don't forget your condoms." Although the women repeatedly mentioned that they reminded their husbands to use condoms with other women, it was also consistently reported by the women that they were not certain whether or not their husbands would act according to their advice. The following three examples illustrate how women formed an intention to protect themselves, thought that their method was an effective one, but, from a medical perspective, the final outcome would not provide protection from possible HIV infection. One woman explained how she protected herself by using condoms:

> **W8**: I used condoms to protect myself
> **Interviewer**: Did you use them for a long period of time?
> **W8**: About a month
> **Interviewer**: Why a month?
> **W8**: To protect myself, just in case

Another woman's method allowed her husband, while he was away, to go to one prostitute a day, she even provided the condoms:

W9: He said he was afraid of living without it [sex].
W10: My husband is like that too, but I have prevented the trouble. By using a condom every time. Before he goes to the cattle market, I put a condom in his pocket. I'll ask him how many days he'll be away. If he goes away for one day, I'll give him one condom. If two, I'll give him two, if three I'll give him three, if four I'll give him four. When he returns, I'll check.

Finally, these two women expressed how they intended to protect themselves and how they followed through on these intentions:

Interviewer: Has he ever come home after sleeping with a prostitute and then slept with you without a condom?
W11: He can't. I turn my back to him. Tomorrow we'll talk again. We both forget. Later we both forget about it.

W12: Well, my husband went to work abroad, or somewhere else. When he returned, he went for a checkup before going to bed with me.

The structured interview data provided information on the actions women had already taken. Although 84% indicated that married women could protect themselves, 87.1% had not done anything to protect themselves (N=1362). It is interesting to note that, of the 95 women who indicated that they <u>had</u> taken measures to protect themselves, 44.2% did <u>not</u> perceive themselves to be at risk and did not believe that their husband went to prostitutes (see Table 5). Of course these women may not perceive themselves to be at risk because they were taking protective action. For those women who had taken measures to protect themselves, the most frequently relied on method was using a condom (23.6%) with other strategies including monogamy (16.8%), asking their husbands to use condoms with prostitutes (11.6%), and expecting husbands not to go to prostitutes (10.5%). Looking at this relationship between intention and action by referring to the model proposed by this study, women have formed strong intentions and developed

elaborate strategies of self-protection, perhaps as a response to prior risky actions.

Table 5

Women Who Have Taken Measures to Protect Themselves: How They Perceive Their Own Risk of HIV Infection By Their Belief Regarding Their Husbands' Going to Prostitutes

Response to the question, "does your husband go to prostitutes?"	**Own Level Of Risk**	**Percent Responding** (N=95)
No	not at risk	44.2
No	at risk	26.3
Yes	not at risk	5.3
Yes	at risk	24.2

Condom Use

The majority of women had seen a condom (77.3%; N=1363), knew what a condom was for (94.0%; N=1346), knew where they could get condoms (94.0%; N=1378), and claimed that they were not embarrassed to ask for condoms (61.0%; N=1315). Although knowledge and availability of condoms were high, the majority of women (67.8%) indicated that they had never used one (N=1129). Past research in Thailand has also found condom use within marriage to be low. Both Pyne (1994) and Shah et al. (1991), provide two possible explanations. One is that condoms are associated with and should be used with prostitutes not wives. Second, within marriage condoms are used for contraceptive purposes and not for protection from HIV infection. Recall that Pyne (1994) found that condoms were the least popular method of contraception with

female sterilization and the birth control pill being the most favoured. In addition, Gerrard, Breda, and Gibbons (1990) point out that although women do have power over contraception decisions, condom use was the exception to this, with men controlling their use.

Most women did not dismiss the usefulness of condoms and felt that they could be used to prevent disease, but, when asked a more personal question as to when they should use them with their spouse, the majority of women (86.5%) replied "never," with very few responding that they would use condoms for birth control (9.1%) or disease prevention (3.9%) with their spouses (N=725).

In addition, it was evident in focus groups that cooperation from husbands was not something that they could count on when it came to using condoms within the marriage. One woman expressed what she believed it would take to protect women and to use condoms:

> **W13**: I want to know how women can protect ourselves and our husbands.
> I want to ask how we can get men to wear condoms?
> **W14**: you have to wear it yourself

Women felt that the wives controlled whether or not sex was a possibility and that refusing their husband sex was often used as a means of showing dissatisfaction with their spouse. Wives did not feel, however, that they had the power to insist that condoms be used within the marriage. One woman even felt that by suggesting condom use her husband might leave her:

> **Interviewer**: so you are worried (about getting a disease)
> **W15**: yes
> **Interviewer**: But you keep quiet?

W15: right, I dare not say
Interviewer: You're afraid of getting a disease but you dare not say it
W15: I dare not talk to him about it. I'm afraid he'll divorce me, I'm also afraid of getting the disease

This illustrates the multiple risks that Thai women face. They live in a culture that values the acceptance of one's fate and not imposing on others (krenchai) as well as maintaining harmony within their marriage. Considering these facts leads to the question, what is worse for a married Thai woman, to accept her fate which includes the possibility of HIV or to go against deeply embedded beliefs, upset the harmony in her marriage, and risk divorce?

One group of women suggested that their lack of condom use was due to the trust they had in their husbands

W16: for us wives, we do nothing to protect ourselves
Interviewer: that is because you trust your husbands too much
W17: you are right
W18: yes, you can say that again

Although these women were using trust as a prevention strategy, trust may offer little protection against HIV. For Thai women the idea of trust does not necessarily mean their husbands should not go to prostitutes, but instead, that their husbands should not openly discuss their extra-marital activities in a way that will bring shame to their wives (Havanon et al., 1992; Klausner, 1987). In addition, trust is not necessarily a valued characteristic in Thai marriages. When women were asked to respond to the statement " a 'good' wife trusts her husband," 56.1% disagreed. Similar research (Heise & Elias, 1995; Novello, 1991) has also found that trust can be a barrier to using condoms, but not because the people involved actually do trust their partner but because requesting condoms displays

distrust between partners and not responsibility and concern. In addition, in a Thai marriage it symbolizes a wife stepping outside of her prescribed role of not questioning her husband's actions, accepting her fate (Siang Duang), and not upsetting marital harmony (krenchai). This perhaps helps to understand earlier comments of the Thai wife about trusting her husband too much. She knows about his behaviours, but she can do nothing without violating her place in society and her future rebirth. These findings are consistent with other research in Thailand which has found that women do not necessarily trust or approve of their husbands' discreet extra-marital activities, but consider them a "fact of life" (Knodel et al., 1996).

Although some women did comment that trusting their husbands was their protection, an equal number of women explained their lack of trust, "I trust my husband sometimes, I'll be darned if I totally trust him!" and "I trust myself, but I don't trust my husband." Some women even made the comment about men in general:

> **W19**: That's the way men are. They aren't totally honest to their wives
> **W20**: Once they step out of the house they're single. That's the way they are

Research on Thai men has not addressed condom use within marriage, however, it has focused on men's condom use with prostitutes where significant changes have been found. The Joint United Nations Programme on HIV/AIDS (1996) reported that condom distribution in Thailand went from 15 million in 1990 to 88 million in 1992 and that actual use during commercial sexual activity rose from 14% to 90%. Earlier research in Thailand found that 55% of men "usually" wore condoms with prostitutes (Havanon et al., 1992). The most recent studies conducted by Im-Em (1996) and Maticka-Tyndale et al. (1997)

both found an increase in condom use with prostitutes to 90%. There were, however, specific situations in which condom use was lower and seen to be more difficult. These included sex with prostitutes at festivals which took place in the home villages, "the hurried nature of the episode [going to prostitutes in their own village], the line up of men, hiding from a wife, excessive drinking, and a sense of safety in the familiar surroundings of the village, all detracted from the likelihood that condoms would be used" (p. 208). At the cattle market, when the prostitutes were asked about condom use with clients, they said that they always used them, "however . . . in some instances men paid several hundred baht more in order <u>not</u> to use a condom" (p. 210) (25 baht = $1.00 Canadian). One group of women offered additional possibilities as to why women have not taken steps to protect themselves. They commented on how easy it is to protect themselves, yet realized that most of them do nothing. The reason is that they "are too careless . . . we are too lazy, too careless." One wonders, however, whether this statement demonstrates the conflict between cultural beliefs and the new issues that are arising in their lives due to AIDS. These women may be defining inaction as a personal failure, yet they live within a culture that does not value action and makes action by women a near impossibility, particularly for an inferior, "careless," "lazy" woman, who by her inaction obtains merit and the potential of rebirth as a man.

Thai women had numerous plans that represented their intention to protect themselves, although the chosen strategies were often indirect methods of protection that may or may not lead to minimizing their risk. For example, women intended to protect themselves by influencing their husbands to use condoms with prostitutes, to remain calm

regarding his extra-marital activities since men are more likely to listen to cool-hearted women, and to not have sex with their husbands on the nights when they thought they had been with prostitutes. A direct approach such as insisting on using condoms within their marriage was not viewed as an option available to them. Short (1984) points out that choices involving protection are not always as simple as people make them out to be, "these choices involve basic values by which people live, often values which are implicit rather than openly avowed" (p. 716). This is true in the lives of Thai women where their protective strategies are embedded in cultural practices and beliefs. Their inferior status does not allow them to insist that their husbands use condoms with their wives, and the value of maintaining harmony leads to women accepting their fate and submitting to the external forces (mai pen rai) that their husbands have control over. These beliefs directly influence the choices that women can make and are expressed through the many intentions they had developed in order to protect themselves.

Barriers to Effective Self-protection

The majority of prevention programs emphasize the acquisition of knowledge of HIV and the use of condoms as protection against HIV infection. These approaches do not take into account the barriers that women face when trying to put their knowledge into action, particularly when trying to implement a male controlled protective strategy (Holland et al., 1990). As Stein (1994) points out, although, "the HIV epidemic did not create these barriers, it has made them both more burdensome and more visible" (p. 1887). These barriers include lack of power for women, lack of viable protection options, attitudes toward condoms, negotiating condom use, and risky behaviours of partners.

Power and Lack of Viable Options

In studies which address women's barriers to protection against HIV infection, researchers have usually treated women's power and lack of options for protection as two separate issues (Heise & Elias, 1995; Wyatt & Riederle, 1994). Through an analysis of the results of this study, power and lack of options have been found to be so closely linked that it is difficult to treat them as separate units. Thai women are aware of the risky behaviours of their husbands. They make statements, among friends, that demonstrate this awareness and that illustrate that they feel they have control over their husbands. Yet these expressions of power and the arena in which the power is exercised do not provide realistic or effective protection against HIV. For example, relying on strategies such as following their husbands twenty-four hours a day or providing condoms that are to be used with prostitutes and never really knowing if they will be used (both strategies were among those proposed by women in this study) are, in the first instance, unrealistic, and in the second, ineffective. Without power in sexual decision-making, the ability to introduce condoms within marriage, or the ability to control the actions of their husbands in terms of extra-marital activities, Thai women have few, if any, options open to them. This lack of power and protective options, as well as the understanding that their husbands control their risk, was clearly demonstrated in focus groups as well as structured interview responses. These findings are consistent with studies which have focused on the position of women in Thai society. The status of Thai women has been summarized in phrases such as, "the younger are subordinate to the old and women are subordinate to men," (Limanonda, 1995, p. 69) and "men lead and women follow" (Muecke, 1994, p. 507).

Northeastern Thai women's inferior status and lack of power is exemplified through the many strategies that they use for self-protection. These strategies clearly demonstrate the lack of protective options that are realistically available to these women when understood within the cultural context.

Consistent with previous research on Thai women (Muecke, 1984, 1992; O'Malley, 1988; Pyne, 1994), this study found evidence that there are situations, within marriage, when women feel that they do possess a certain amount of power. When discussing women's options for protection, women felt that they controlled the family's finances and often suggested that they would not provide their husbands with money as a way to stop them from going to prostitutes. However, this form of power was not one that translated into an effective prevention strategy and women were aware of the other ways that men found to get money. One woman explained this process, "instead of giving money to their wives, they visit the brothel. They usually keep some of the money anyway, give half to their wife and hide half." This is consistent with studies on Thai men which have found that men who earn a living by selling rice or cattle can bring home a portion of their earnings to their wives and save some for themselves. Since the wives have no way of knowing how much their husbands have made in these sales, men can easily set aside a portion for themselves thereby acting in a way that seemed to keep their extra-marital activities from their wives (Havanon et al., 1992; Maticka-Tyndale et al., 1997).

Additional expressions of power were exchanged between women, not as an indication of the power that they felt they actually had, but as a comical response to the

realization that they did not have power to protect themselves within their own marriages. When asked what they should do to protect themselves, women, in all focus groups, responded sarcastically with statements such as, "after you have sex with him, ask him for money to make it like being with a prostitute," or "we should cut it off [the husband's penis] and get it over with."

When examining the more serious comments women made with regards to the power they had to protect themselves from HIV infection, both structured interviews and focus group responses suggested that many women felt they did not have any. Married women's protection was controlled by their husbands, which left them with only limited possibilities, such as suggesting or providing condoms for use with prostitutes. When the women were asked what they could do to protect themselves, the most common response was to tell their husbands not to go to prostitutes (72.5%), with only 14.1% stating that they would use condoms with their husband (N=444). The majority of women (63.1%) replied that they would use condoms with their husband if they thought that he was at risk. One quarter of the women (25.9%) responded that they would not have sex with their husband. Other responses included: talking about it (7.7%), throwing their husband out (6.9%) and, doing nothing (14.0%).

Similar to the findings of the face-to-face-structured interviews were the comments made in the focus group discussions, where one woman, when asked if it was hard for women to protect themselves stated, "I don't think women can do that [protect themselves]. Men will have to do it." Another woman felt that, "there is no way to protect ourselves," and others simply wanted other ways of protection rather than

condoms. Women showed a preference towards having a method of protection which was under their own control and not one that needed the cooperation of their husbands:

W21: It's very hard for women to protect ourselves
W22: a female condom would be good

Overall, women explained that they did not trust their husbands to either refrain from visiting prostitutes or to consistently use condoms, but did not feel that they had the means to protect themselves. Many women indicated that the only method of protection available was to not let their husbands ever be alone, to follow them wherever they went, "He can't go anywhere without his wife saying, 'I'm coming.' When he goes out to eat beef with his friends, I will say that I want to go too. [I will have to] go to work with him, go everywhere with him, go to the bathroom with him!" Two methods women felt that they could not use, evident in all 12 of the focus groups, were to "forbid" their husbands to go to prostitutes or to use condoms regularly with their husbands. The idea of forbidding husbands from behaving in a particular way or insisting on condoms would have consequences for Thai women in their effort to acquire merit for a better position at the time of rebirth. Women's inferior status, the accepting of their fate, the expectation that they submit to external forces (mai pen rai), that they not impose their desires on others (krenchai), and the value of maintaining a cool-heart all reinforce the difficulty women face when attempting to protect themselves from infection.

Attitude Towards Condoms

Past research has found that attitudes towards condoms can either promote or inhibit condom use (Caron, Davis, Halteman, & Stickle, 1993; Havanon et al., 1992;

Williams et al., 1992). Havanon et al. (1992) found that for Thai men the main reasons for not using condoms were negative attitudes such as feeling that condoms are not natural or that they decrease sexual pleasure. Similar results have been found in North American samples where men feel that condoms decrease sensation, are unpleasant to use, and decrease spontaneity (Williams et al., 1992). Although these researchers indicate a strong correlation between attitudes toward condoms and their use, Caron et al. (1993) found that 60% of women sampled were favourable toward condoms, but only 16% were using them. This relationship is comparable to the findings of this study where the majority of women held positive attitudes towards condoms, yet few had ever used one (32.2%).

More specifically, most women (82.3%) felt that it was both easy to get condoms and easy to use them (78.5%). The majority of women (51.4%; N=395) agreed that most people can use a condom and still get pleasure from sex, while only 15.0% disagreed. The relationship between those women who have used condoms and those who have not was explored in order to determine whether or not there were any differences in attitudes towards condoms. Women who reported that they had tried condoms were more likely to agree that sex was pleasurable when using condoms, that condoms were easy to get, and easy to use than were women who have never used condoms (see Table 7).

Table 7

Differences Between Those Women Who Have Used Condoms and Those Who Have Not With Regards to Their Attitudes Towards Condom Use

Question	Never used a condom	Used a condom	χ^2 Sig.
Response	Percent	Responding	
I agree that . . .	(N=395)	(N=395)	
sex is still pleasurable with a condom	43.2	74.8	*
condoms are easy to get	71.9	97.1	*
condoms are easy to get	77.7	95.2	*

Note. All significant chi square results are indicated with a *.
* $p < .05$.

Condom use was found to be dependent on women's perceptions of their husbands' attitudes regardless of their own attitudes. Thirty-eight percent stated that their husbands would not use a condom, 27.9% replied that their husbands said they didn't need to use one since they did not go to prostitutes, 6.5% responded that their husbands told them they were careful, and 13.4% indicated that their husband had told them it was uncomfortable to use a condom.

In focus group discussions, women were asked about their attitudes towards condoms. It was clear that women were not expressing their own views towards condoms, but the views of their husbands. References were repeatedly made to the negative feelings, on the part of their husbands, about using condoms, evidently leading to condoms not being used within the marriage. Many women expressed a desire to use

condoms but mentioned the numerous explanations that their husbands had provided as to why they should not be used, such as "it's not good," there is "no time," "it gives a different shade of feeling," "it's not natural," and "it's not like the real thing." Two women told of the many reasons they had been given to not use condoms despite the fact that they would like to use them:

W23: I tell my husband to use it, but he refuses
Interviewer: What does he say?
W23: He says it's not good!
Interviewer: How's that?
W23: He says it's not convenient
W24: He's afraid that it'll break. He says that it's not good, it's not natural
W23: Yes, I want him to use it but he has never used it

Women not only expressed the desire to use condoms, but they also maintained that for women, using them feels "normal" or the "same as usual":

W25: It's the same to me. But my husband says it isn't
W26: Like a hand wearing a boxing glove
W27: Men say it's not the same, they don't want to use condoms
W28: But women say it's the same as usual
W29: The same as usual
W28: No differences

In addition, condoms were often portrayed, within marriage, as necessary only for contraception. One woman expressed her husband's view toward using condoms for contraception as compared to protection from AIDS, "Yes, I've asked my husband. He'll use it [condoms] only if any other means of birth control hasn't been used. If it's for AIDS prevention he may not use it." These findings suggest that a woman's positive attitude towards condoms is not a factor in determining condom use, but instead, it is the attitude of her male partner that seems to be the deciding factor.

Thai Culture

The perception of risk of HIV infection, as well as the ability to act on this perception, needs to be understood within a societal and cultural framework. In Thailand, as in many countries, social systems reinforce women's vulnerability to HIV and are barriers to women's protection. In Northeastern Thailand these include women's inferior status in society and the various Buddhist beliefs such as the notion of Siang Duang, cool-heartedness, and maintaining harmony, which lead to an acceptance by women of their vulnerability to HIV infection. This section further examines the relationships that exist between perceived risk, judgmental heuristics, optimistic bias, intention, and action by recognizing Northeastern Thai women's cultural context.

Overall Perception of Men and Their Behaviour

It is important to consider the perception and actions of Thai men when examining the risk of married women since, as Holland et al. (1990) have stated, "the main thing standing between women and safe sex is the men they are with" (p.347). Rodrigues and Moreno (1992) point out that, "In the U.K. 43% of women who acquired HIV infection did so through having a partner in a high risk group, even though in many cases these were steady relationships or marriages" (p. 966). The situation in Thailand is increasingly the same (Prathana, 1996). The only official indication of the increase of HIV infection among non-prostitute women is the rise in infection among pregnant women. The sentinel surveillance system that insures regular testing of all people in particular categories reports that for pregnant women in Northeast Thailand HIV infection has risen from 0% in 1990 to 1.61% in 1994 (AIDS Newsletter, 1995).

The Thai women in this study were aware of the reckless behaviours of men. They portrayed men as needing sex, being irresponsible, dishonest, and being negatively influenced by drinking. In a manner consistent with that found by other researchers (Ford, 1996; Fordham, 1993; Havanon et al., 1992; Lyttleton, 1994), the women in all 12 focus groups made reference to how men were not, "afraid of AIDS [but] . . . afraid of not having sex." One woman explained what kind of men are interested in women and going out:

> **W30**: Upon seeing a beautiful girl, they may be tempted to go out
> **Interviewer**: What type of man likes to go out?
> **W30**: Every type I suppose

Research on Northeastern Thai men found that husbands feel that purchasing sexual services can be done in such a way that their activities are hidden from their wives. Husbands "find a time when there is a movie. They have a wife and kids but they tell them that they are going to watch a movie. This is the more modern way" (Maticka-Tyndale et al., 1997, p. 208). Despite this belief that men's activities are secret, women expressed openly the knowledge they had of men's activities, "He may seem trustworthy but when he leaves home . . . he would get some peanuts, but instead he went to a whore house!" This may indicate that it is not the fact that women are aware of men's activities that is important to both husbands and wives, but instead, the fact that men make the effort to hide their activities from their wives. This is consistent with valued cultural beliefs, illustrating men's attempts to maintain harmony within the marriage. Their extra-marital activities allow them to "be men," while hiding them allows them to save their wives from social embarrassment, and allows them to "be good husbands."

Thai men have been characterized in the literature as engaging in reckless behaviour in general, with alcohol consumption contributing to additional recklessness (Havanon et al., 1992; Lyttleton, 1994; Vanlandingham et al., 1993). Lyttleton (1994) found that men used drunkenness as an alibi for a wide variety of norm breaking activities such as reckless driving and motorcycle racing. The most current research on Thai men found focus group discussions to include comments such as, "before they were drunk they could control it. Once they were drunk, they didn't think about it. They see it [the women] and then they stop thinking. It goes with being drunk" (Maticka-Tyndale et al., 1997, p. 206). Despite these types of reckless behaviours, it was also found that most men in Northeastern Thailand did not consider themselves to be at risk for HIV infection. This seems to be a general attitude for many high risk males. Hansen et al. (1990) found that, "males showed a tendency to believe males in general were less vulnerable to AIDS even if they engaged in highly risky behaviours such as having intercourse with numerous partners and not using condoms" (p. 627). Women were aware of the drinking behaviours of men and referred to alcohol as the, "water that can change human beings behaviours." Women believed that alcohol use was a contributing factor to their increased level of risk, since it affected the risk-taking behaviours of their husbands, especially with regards to condom use. Husbands were often viewed as being responsible and careful with the well being of their wives until alcohol was involved. Alcohol, however, made the husbands "forget themselves" and "after heavy drinking nothing can stop them from a one night fling." The following dialogue illustrates how alcohol can affect condom use:

W31: But men when drunk think nothing of it [going without a condom].

> They think only of their natural sexual pleasure
> **W32**: Uncontrollable sexual urge!
> **W33**: More sexual urge than responsibility. Whiskey upon intake would change their personality and thinking process

Some women indicated that they believed their husbands used condoms, but their statements usually ended up being conditional, as suggested by this woman:

> **Interviewed**: Do you think your husband uses condoms if he goes out?
> **W34**: Yes
> **W35**: Yes
> **W34**: Except when he is drunk
> **W36**: It'd be nice if he used it when drunk

Although they were aware of the role that alcohol played, structured interview responses indicated that wives did not believe that being drunk lessened the husband's responsibility (80.0%). When asked why men don't use condoms with prostitutes, one woman replied, "They don't think of using condoms. They know, but they won't use them." Although women are aware of men's risky behaviours, the difficulty lies in the lack of control women have over the sexual activities of their partner (McGrath et al., 1993). Awareness of a partner's actions does not protect from HIV infection.

Overall the women did not approve of their husbands' going to prostitutes. It was a situation of acceptance, not approval, as the following three examples illustrate. Women believed that their husbands' behaviour was unavoidable, since "men will be men" and, unlike women, men have no control:

> **Interviewer:** Do you think going to a prostitute is normal?
> **W37:** No
> **W38:** It is not a good thing
> **W39:** You waste money
> **W38:** You waste time too
> **W40:** They want to have fun and enjoy themselves

W41: They are men

Interviewer: Can men fight against their desire?
W42: Of course not
W43: No they can't
W42: No, unlike us women
W43: We women can
W42: We are normal.

Women's acceptance often appeared in focus groups as indifference towards men's behaviour:

W44: What did you say to him [about having sex with other women]?
W45: Nothing
W44: You didn't say anything?
W45: No. He has been out since he was a boy

In addition to their perceptions of their husbands' need for sex, drinking, multiple sex partners, and lack of condom use, the structured interview data showed that the majority of women worry when their husbands are away (67.8%) and do not think that their husband will be careful (51.9%). Contradicting this is the finding that the majority of women (70.7%) stated that their husband would never go to prostitutes, with only very few wives believing that he went occasionally (10.5%), or always (1.1%), and with 17.4% unsure. In addition, more than half (56.2%) of the women believed that their husbands would always use a condom with prostitutes (28.1% disagreed and 15.7% did not know; N=1034). And although women wanted to believe that their husbands would use condoms, they clearly expressed that they had no way of knowing:

Interviewer: Do you think it's common for men to go out for the affair with prostitutes?
W46: Yes, I think it is common, but it's risky
W47: It's common alright but I disapprove of the visit
W48: We didn't often catch him red-handed. We don't like following him

> wherever he goes everyday
> **Interviewer**: So you don't have any idea when they go out?
> **W48**: You are right, I just can't tell when he goes out, which includes my doubt if he uses condoms at all

The majority of women (74.7%) had talked to their husbands about prostitutes. The structured interviews indicated that women did not agree with their husbands going to prostitutes even if the wife did not know about it (77.2%), if the prostitute did not have a disease (61.3%), or if the husband did not spend too much money (78.7%). Contrasting the findings on Northeastern Thai men where 60% agreed with the statement that "it is only natural for men to visit female prostitutes" the majority of women in this study disagreed (65.8%) (Maticka-Tyndale et al., 1997). The structured interview responses illustrated a lack of acceptance by women that going to prostitutes is normal for men. Focus group discussions elaborated on this by showing that women did not like the extra-marital activities of their husbands but there was significant cultural acceptance that "men will be men" and "men can't fight against their desires."

Roles of Husbands and Wives

Many women expressed their belief in the status of women as these women did:

> **Interviewer**: So women are at a disadvantage?
> **W49**: Yes, every house
> **W50**: Every door

And of men and women's activities they said:

> **W51**: It's one of men's problems
> **W52**: Men like to go out to see prostitutes
> **W51**: Women stay home. Women in the country stay home. That's the problem in the country

When one woman was asked why women are not promiscuous, she replied, because

"Women don't have to be." It was also clear that it is men that go after women and not the other way around, as illustrated by this conversation:

W53: You can hardly see a woman going after a man
W54: There's none
W53: It's a man who'll go after a girl

Maintaining a Cool-heart

Evidence of the benefits of a cool-heart were present throughout all 12 focus groups. Not only did women feel that remaining calm and under control was the way they should act, but they also felt that men would respond more favourably and arguments would be avoided if a cool-heart was maintained:

W55: Yes, we've got to use sweet words. We can't be rude
W56: If we show off our anger the husbands won't listen to us
W57: If we talk to them nicely they'll feel sorry for us. You know generally people like those with nice sweet words. If we show our anger they'll do the same to us

W58: Jumping on him often ends up driving him away from staying home
W59: The more you argue with him about his going out, the more frequent his going out. The best way is to avoid argument

The wives showed tolerance for their husbands' behaviours and illustrated the lack of control they have over their husbands' actions with statements such as " we cannot forbid them to go [to prostitutes]" and we have "to be calm, we can't forbid them, we don't have the right." When looking at structured interview responses regarding the qualities of a "good wife," the majority of women indicated that a "good wife" gives her husband condoms (82.3%) and encourages him to use them with prostitutes (89.4%). Despite the significant amount of focus group discussion that indicated that women should accept the activities of their husbands, even when they did not like them, only 29.1% felt that a

quality of a "good wife" was to accept what her husband does. Also, despite the majority of women who emphasized the importance of maintaining a cool-heart and avoiding arguments, only 34.2% indicated that a "good wife" does not argue. This is consistent with previous research on Thai women which has found that characteristics of a "good wife" include being a good housekeeper, remaining monogamous, being supportive, and being reliable. Acceptance and having arguments within marriage have not been found to be a component of the "good wife" definition.

Indirectness

One aspect of Thai culture that was not addressed in the literature review but was apparent in the data analysis was the importance of indirect means of interaction. This was characterized through women's responses to questions regarding prostitution as well as the strategies chosen, and the choices of preventive action. For example, common phrases throughout focus group discussions were "he goes alone" and "he travels." Both indirect phrases were used to suggest that when a man is without his wife he may have sex with prostitutes. In addition, when examining the strategies that women had developed to protect themselves, direct approaches such as "forbidding" their husbands from going to prostitutes or using condoms within marriage were not considered viable options. Indirect plans were the preferred and most acceptable courses of action and involved providing condoms for use with prostitutes, following their husband 24 hours a day, and reminding him not to forget his condoms. This notion of indirectness complements valued Buddhist beliefs such as cool-heartedness, accepting one's fate, and maintaining harmony, in that it assists women in remaining calm, maintaining harmony, and therefore, acquiring merit.

This approach is extremely different than the direct, confrontational approach that is valued in Western cultures and will have important implications for prevention programs.

Overview of Cultural Context

Northeastern Thai women portrayed separate roles for husbands and wives with men being the irresponsible party goers and women remaining responsible and at home. In addition, women were aware of the extra-marital activities of their husbands and were not convinced that their husband would be careful and use condoms when away from home. Despite their understanding of their situation, and consistent with Buddhist teachings, women maintained a cool-heart, used "sweet" words, and did not forbid their husbands to go to prostitutes. We might say that they accepted their fate regarding HIV infection as remaining in the hands of their husbands. Vichit-Vadakan (1994) summarizes this situation by pointing out that, " Buddhists would rationalize that those who are born female have lower Karma than men from the outset. It is the belief that a woman must suffer and must learn to bear her suffering bravely so that she may be born a man in the next life. Many do not seem to question this belief, treating it as a universal truth" (p. 522).

Other Factors

Age Comparisons

Age comparisons were conducted for two reasons. First, differences found in research conducted on Northeastern Thai men were expected to coincide with differences between women. Research on men indicated that the risky behaviours of older and younger men were quite diverse, with older men no longer participating in extra-marital activities. This was expected to lead to differences between younger and older women in

areas regarding their husbands' behaviours, personal risk perception, intentions, and condom use. Second, an age difference was expected, based on the relative "newness" of AIDS with the division coming between those women who have married since the late 1980s or the beginning of the HIV/AIDS epidemic (younger women) and those who were married before HIV infection was a concern (older women). For age comparisons, women between the ages of 15 to 30 years were compared, on all questions, to those women aged 31 to 53 years. Focus group discussions were not examined for age differences. The rationale for age comparisons comes from previous research on women, both in Thailand and other countries which found that women gained power as they got older as well as marital issues being different for younger women and older women (Friedman & Pines, 1992; Muecke, 1994; Todd, Friedman, & Kariuki, 1990). If these age differences were true of this sample, it would be expected that younger women and older women may differ on questions regarding perception of risk, reasons for risk, perceived power, and perceived control over husbands' behaviours. The findings of this study are consistent with previous research on Thai women which found differences between young women and middle-aged women regarding the "worries" they had concerning their husbands' activities. Muecke (1994) found that young women seemed more worried about their husbands' lying and visiting prostitutes whereas middle-aged women seemed to be more concerned with excessive drinking and arguing. This difference would be reflected in the present study in differences between younger and older women on questions such as perception of risk for both themselves and their husbands, beliefs regarding their husbands' behaviours, and methods of protection. Significant age

differences were found on these questions. Younger women were more likely to perceive themselves to be at risk than older women (45.1%; 33.2%) and to cite husbands as the reason for their risk (58%; 47.5%). Younger women relied on not having sex as an option of protection more than older women, although both groups stated that their first choice would be condoms. Younger women were also more likely to believe that their husbands would go to prostitutes (33.8%; 25.4%) and that their husbands would not use condoms (42.5%; 34.0%). When examining the findings of Maticka-Tyndale et al. (1997) on Northeastern Thai men, the difference in this study between younger and older women corresponds with the self-reported behaviours of younger and older men. Going to prostitutes was most prevalent among young men. In addition, younger men were more likely to be away for work for several months at a time compared to the overnight trips of older men. By recognizing the difference in the actual behaviours of married men, the difference in perception of risk between younger women and older women is understandable. It is also important to identify that there were no age differences in how women dealt with their risk, the heuristics they used, the intentions they had, the barriers they faced, and the action they took. It is only the difference between men's behaviours at various ages and women's perceptions of these that differentiated younger from older women.

Research on how age influences women's power suggests this is an important dimension to explore. The findings of Friedman and Pines (1992) and Todd et al. (1990) on women and power suggests that women, as they get older, gain more power within their marital relationships. This change in power is a result of a change in their

"psychological and social situation in the marriage and in society" (Friedman & Pines, 1992, p.2). If this observation held for this sample, it would be expected that older women would feel that they possessed the power to protect themselves from HIV infection more than younger women, as well as being more likely to control their husbands' behaviours. This difference in power was not found. One possible explanation is that although older women did not feel that they had greater direct control over their husbands' behaviour, the lower proportion of older men who go to prostitutes as compared to younger men, could be an indirect indication of women's power. A second explanation which has been explored by Friedman and Pines (1992) indicates that lower class women do not experience an increase in power as a result of age as middle class women do. This explanation of social class may be applicable to Northeastern Thai women who all live in rural peasant areas and are perhaps more similar to the urban lower class. The reason provided by Friedman and Pines (1992) for this finding was that, "in situations of poverty, where women have to struggle to survive economically, the shift to power does not have a chance to manifest itself" (p.2). Finally, it must be noted that this study used a cross-sectional design and therefore it is difficult to examine differences, changes, or causality, since they are more appropriately studied longitudinally. For example, Todd et al. (1990) point out that when using a cross-sectional design, it cannot be assumed that older women do not exhibit an increase in power with age simply because no difference was found. The fact that there was no difference in power may have been a result of older women starting out with less power than today's younger women and therefore an increase in power did occur. A complete summary of the comparisons on

each question by age can be found in Appendix E.

CHAPTER V

THESIS SUMMARY AND IMPLICATIONS FOR HIV PREVENTION

Overall, the modified health belief model proposed by this study helped to outline the risk behaviours of Thai women, however, the figure which was used to illustrate the proposed model has been modified based on the analysis of these data. Since the social psychological components of the model are embedded in culture, culture is not illustrated as an outside factor but instead surrounds the remainder of the model. In addition, the previous linear depiction has been modified to represent the feedback that occurs with health behaviours (see Figure 3).

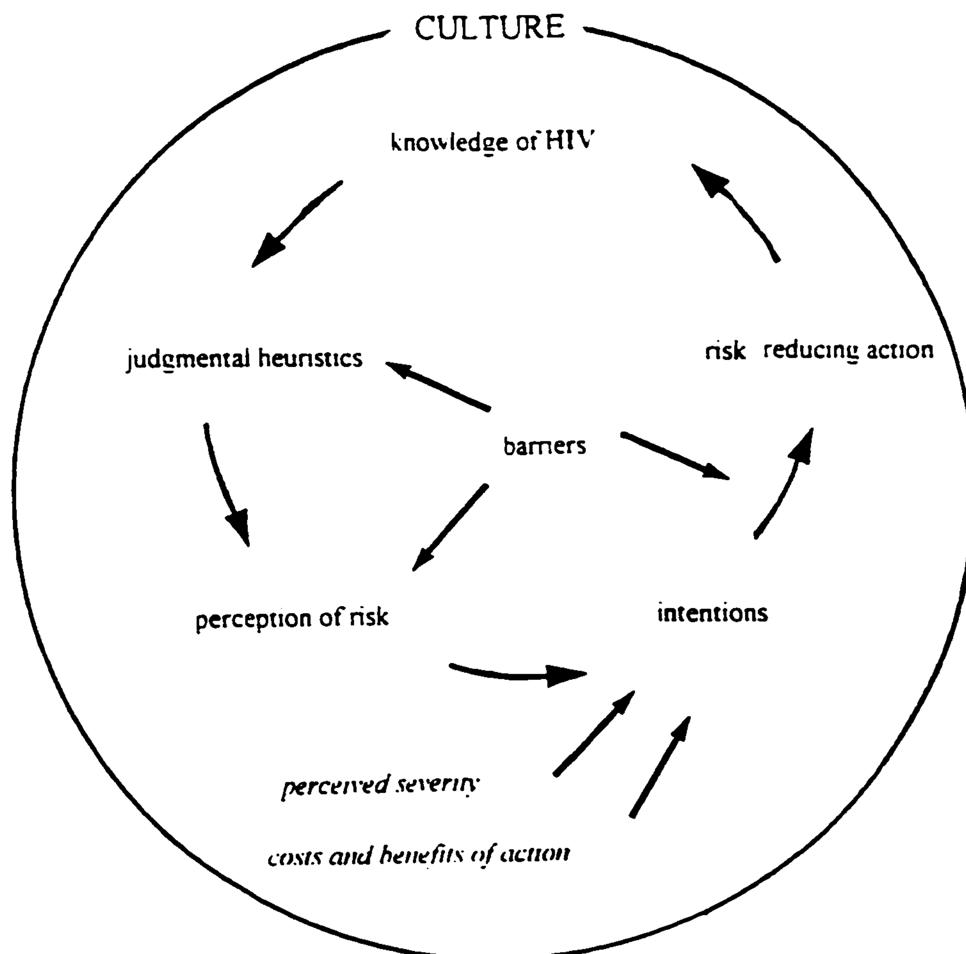

Figure 3. Final Modifed Model

Few of the women in this study had ever taken effective preventive action. In addition, the majority of women, at some point in the research, expressed that they did not perceive themselves to be at risk of HIV infection. Their personal perceptions of risk demonstrated the existence of an optimistic bias and were developed and maintained through the use of five judgmental heuristics; representativeness, availablity, anchoring, denial, and degree of risk. Women's optimistic perceptions were particularly influenced by underlying cultural beliefs and the social construction of married women as being safe from possible HIV infection. With lack of effective action in the past, as well as a lack of perceived susceptibility, it would be expected that Thai women would not develop strategies of self-protection. However, the majority of women outlined elaborate plans to protect themselves. Despite these intentions and plans, women maintained that they did not anticipate taking effective preventive action in the future. The major factor stopping these intentions from becoming effective preventive actions were the barriers that exist for these women.

The social psychological model helped to outline the risk behaviours of Thai women, but cultural understanding provided a deeper appreciation of how each component of the model fit together. Concepts such as judgmental heuristics, optimistic bias, and intentions provided the structural groundwork, but an awareness of Buddhism, marital dynamics, norms regarding gender appropriate behaviours, and the status of women in Northeastern Thailand were essential in determining the importance, relevance, and connections between the model's components. Thai beliefs in Karma, making merit, Siang Duang, maintaining a cool-heart, and mai pen rai, were found to be influential in

establishing how the modified health belief model was played out in these women's lives.

Consistent with previous research on perception of risk (Hansen et al., 1990; Perloff & Fetzer, 1986; van der Velde et al., 1994; Weinstein, 1980, 1982, 1987), Thai women used rationalizations (judgmental heuristics) to support a pre-established notion that they were not at risk. The rationale for studying people's risk perceptions is the belief that perceptions of non-susceptibility will stop people from taking preventive action and therefore have an impact on developing prevention programs. However, when looking at how this applies to Thai women, the connection between perceptions and actions cannot be assumed to be a simple or direct relationship (e.g., perceived non-susceptibility leads to no action). Although these women did not take effective preventive action, this was not due to their perceived non-susceptibility, but due to the number of barriers that inhibited such action. In addition, although Thai women did not take action that would effectively reduce possible HIV infection, they did take action nonetheless, such as suggesting their husband use condoms with prostitutes or providing the condoms while their husbands were away. The other factor to consider is that although women indicated that they did not perceive themselves to be at risk during the structured face-to-face interviews this finding was contradicted during the focus group discussions. Considering these findings, I suggest that Thai women had conflicting beliefs regarding their personal susceptibility. At times they believed they were at risk for HIV infection and at other times were optimistically biased, using judgmental heuristics to try and maintain their belief in non-susceptibility. These conflicting perceptions occurred knowing that, regardless of their perceptions, barriers inhibited them from taking protective action. Therefore, their

optimistic perceptions served a protective function that helped keep their peace of mind and allowed them to function in their day to day lives. And, whether women perceived themselves to be at risk or not did not inhibit them from wanting to take protective action, intending to act, or from following through with ineffective plans.

A cultural perspective is necessary in order to understand the specific content of each heuristic as well as which heuristics were used more than others. For example, the representativeness heuristic, which assesses a person's level of risk by comparison with a stereotypic model of who is at risk, was used more frequently than the availability heuristics. Having knowledge of Thai marriages, the fact that the availability heuristic was not popular was understandable, since monogamy is not necessarily valued within marriage as long as disgrace is not brought to the family. In addition, the stereotypes used included pale skinned, beautiful women being more susceptible than "ugly" women and men who go to prostitutes being more susceptible than homosexuals and housewives. Thai women used heuristics for the same reasons as those found in previous research, to facilitate coping, preserve their peace of mind, and remain calm regarding personal health by decreasing fear and anxiety. This study adds to previous findings by suggesting that although heuristics may be universally used and for similar reasons, the way in which Thai women rationalize their personal risk perceptions is specific to their cultural context. Cultural beliefs such as remaining cool-hearted and accepting your fate as well as the inferior status of women were influential factors in the formation of women's personal perceptions. The concept of judgmental heuristics supports everyday beliefs found in Thai society and therefore was helpful in acquiring merit and in improving Karma for their next

life. By using the judgmental heuristics, women continued to be "good" wives, maintained their cool-hearts, accepted their fate, maintained harmony, acquired merit, and improved their Karma, all of which assisted women in dealing with their personal risk of infection.

Regardless of women's perceptions, the majority of Thai women outlined elaborate plans about how they would protect themselves from HIV infection. These intentions were embedded within a Thai cultural framework and were compatible with beliefs such as maintaining a cool-heart and harmony within marriage as well as being compatible with the inferior status of Thai women. All strategies were indirect methods of protection which allowed for the women to make suggestions to their husbands regarding protection, while at the same time maintaining harmony, not imposing on their husband's activities, accepting their fate, and therefore acquiring merit. For example, many women made plans to provide their husbands with condoms when they left the house, reminding them, "don't forget your condoms," and would not have sex with them after a night of drinking. Thai women's inferior status as well as the norm against directness and confrontation regardless of status, did not allow them to ask their husbands to use condoms within their marriage and the most significant phrase used by the women in all focus groups was that women could not "forbid" their husbands from going to prostitutes. Understanding the value that Thais put on indirectness in communication and coping with problems, will be extremely important when addressing prevention program effectiveness. These intentions of self-protection were consistent with the latest findings of Knodel et al. (1996) who found that Thai women accepted their husbands' extra-marital activities as a "fact of life" and believed that their own role was to devote themselves solely to their

husband and family. Although it is difficult to know whether or not these women followed through with their intentions and plans since this would require a longitudinal design, women maintained that they had not taken effective protective action (using a condom) in the past and would not do so in the future. This does not suggest that these women would not be willing to take effective action that was more indirect and would be deemed acceptable within a Thai cultural belief system.

The major factor inhibiting intentions from becoming effective actions were the barriers imposed by women's position, the interactive nature of prevention, and Thai culture. These barriers included husbands' negative attitudes towards condoms despite the women's positive attitudes, negative connotation of condoms within marriage, lack of viable options, power imbalance, and lack of control over sexual decision making. In Western cultures significant value is placed on the concept of control. People are expected to control their futures, to take action, to overcome barriers, and to fight for what they want. This belief in personal control is not valued in a Buddhist culture, instead emphasis is placed on acceptance and harmony and is reinforced through beliefs in Siang Duang, cool-heartedness, harmony, mai pen rai, merit, and Karma. These beliefs are influential in the lives of Thai women and need to be understood in order to fully appreciate their implications for the kinds of actions women take. The women in this study were aware of the extra-marital activities of their husbands and were not convinced that their husbands would be careful and use condoms when away from home. Despite their understanding of their situation, and consistent with Buddhist teachings, women maintained a cool-heart, used "sweet" words and would not insist on using condoms

within marriage or forbid their husbands to go to prostitutes. Condom use is managed by males and is not within women's domain of control. Thai women accepted their fate regarding HIV infection as remaining in the hands of their husbands. Economic dependence which has been found to be a barrier to taking action for women in other studies was not evident in this research. Economic dependance may not have been a threatening factor for these women due to the low level of subsistence for Northeastern Thai families. In addition, with husbands working away from the village for long periods of time, women often rely on their extended families, therefore not feeling that their economic positions are solely dependant on their husbands.

Culture and AIDS Prevention Programs

This study has shown that women's perceptions of risk, their protective intentions, and the actions they take, are deeply embedded within cultural norms and expectations. Some researchers maintain that there is a conflict between culture and AIDS and that "reducing women's vulnerability will mean changing the cultural beliefs" (Heise & Elias, 1995, p. 931). This would certainly appear to be the case when examining the beliefs, realities, and actions of these women from a Western-based viewpoint. Other researchers take the view that prevention campaigns which are not culturally sensitive will not be effective (Bayer, 1994). In this view, culture is not something to be changed but programs must be formulated to fit within the contexts of cultures. Consistent with the latter view, the findings of this study suggest that prevention strategies need to be developed in such a way that they fit within Thai culture. This will require that indirect methods of prevention be available to women, that prevention allows for women to maintain harmony, and that

women will not have to openly confront their husbands or forbid them from acting in a particular way. With this cultural framework in mind, prevention programs also need to be sensitive to the position of Thai women within their marriages and within Thai society in addition to understanding the sexual dynamics and the interpersonal costs for women in sexual risk reduction. Similar to findings in Western cultures where women often fear losing the person they love (Holland et al., 1990), Thai women face the fear of losing their husbands and losing merit in addition to their fear of AIDS. Therefore, any adaptations in sexual interaction need to fit into the already existing cultural organization.

The findings of this study also demonstrate the importance of addressing the social psychological components from a Thai cultural perspective. Using a model, such as the modified health belief model, without cultural consideration can lead to ineffective programs being implemented. For instance, if prevention programs were to develop strategies which focused on the availability heuristic and delayed effect, both of which were not found to be used by Thai women, efforts would not be targeting processes that were relevant to these women's lives. In addition, if programs were to focus on decreasing stereotypes regarding homosexual transmission, northeastern Thai women would not benefit from this application since they are more likely to believe that prostitutes and men who go to prostitutes are more susceptible.

Knowing that husbands are the main source of possible risk for HIV infection for the women in this study, it is essential that prevention strategies continue to work with Thai men. This must also be done within a cultural framework with the realization that for Thai men, risk taking is expected and demonstrates masculinity. Strategies must recognize

the significance of male risk taking in Thai society and the reality of men continuing to have multiple sexual partners. Prevention programs which are culturally sensitive should focus on those Thai beliefs that would benefit HIV prevention. Although extra-marital affairs are accepted, cultural norms prescribe that these activities must be carried out in a way that does not bring shame to a man's wife and family. Similarly, a "good husband" does not impose the consequences of his actions on his wife. Therefore, prevention programs need to stress that using condoms with prostitutes would alleviate these consequences. In addition, husbands are expected to save their wives from financial burdens. Emphasis needs to be placed on the financial burdens that could result from HIV infection caused by involvement with prostitutes. Prevention programs need to make men active partners in keeping their wives safe from HIV infection by recognizing the importance of being a man as well as the importance of protecting a family

Triangulation

Using a combination of methodologies is seeing increased use, especially in the area of sex research where it is essential to not only understand what behaviours are taking place but also what the behaviours mean to the individual (Mewhinney et al., 1995; Parker, Herdt, & Carballo, 1991). Although triangulation is offering "richer" data, the concern of researchers now is how to deal with contradictory findings. Which methods are producing the right answers, which results do we believe, and how do we report them? This study provided insight into the workings of two different methodologies, that of the structured face-to-face interview and that of the open-ended focus group discussion. The apparent contradiction between the absence of an optimistic bias in the focus groups and

the clear evidence of it in the structured interviews did not lead to a dilemma of which methodology to believe but illustrated the limits of each methodology, specifically, the way in which information was obtained in the two methods. First, in structured interviews the women were expected to provide a simple yes\no response to a question regarding personal risk of contracting HIV. The focus groups, on the other hand, allowed for peer confrontation and asked the women to explain and defend their positions. The difference in how these methodologies obtained information would lead to quick, undebated responses in the structured interview while focus group responses were more complicated with the possibility of change throughout the various group discussions. Second, the focus groups allowed for the women to assess whether or not they believed themselves to be at risk through indirect means, which involved other group members facilitating in the process through a logical progression in conversation and thoughts. This method of indirect discussion would seem to be more compatible with Thai culture and may have been the more preferred technique. Focus group interactions usually began with a discussion of husband's behaviours, not necessarily characterized by a direct admittance of "he goes to prostitutes," but more indirect methods such as "he goes alone," "he goes out to have fun," or "he travels." This would allow women to indirectly discuss their husbands' risk taking (the Thai way). Also, by listening to other women make the connection between husband's risk and wife's risk, the women would transfer this possible risk to themselves.

The contradictory findings in structured interview and focus group discussions illustrated the reality of human behaviour and how people actually think. Structured

interviews get at the answers that easily come to mind, the quick responses, the undebated points, and allowed the women to answer questions without interacting with their peers. Focus group discussions, however, go deeper than structured interviews, finding the struggles that are buried, allowing people to alter their response, and the chance to confront their peers. Triangulation allows for a deeper understanding of human behaviour. And as researchers, we cannot choose which findings to believe, but instead researchers must report all of their findings and offer possibilities as to what is occurring.

Limitations

Secondary Data Analysis

Using a secondary data analysis had more benefits than drawbacks. It allowed me the opportunity to work with a large amount of data and employ two methodologies without the expense and time constraints of data collection. However the disadvantage is that it inhibited me from being able to explore the contradiction that was found between the two research methods. In addition, without the data being collected personally I was not able to experience Thai culture first-hand and could not explore some of the cultural variables that emerged.

Limited Cultural Familiarity

Born and raised in Canada, I cannot fully understand the true experience of a woman from Northeast Thailand. In addition, since the data analysis was secondary, I did not travel to Thailand and have not had the opportunity to become familiar with the people and their culture directly. Although I did an extensive literature review and corresponded with Kathryn Stam who lived and worked in Northeast Thailand, it is very

difficult to capture the true situation of these women using these indirect methods. I have relied on the observations of others in order to understand Thai culture and cannot presume that I have a total understanding of the reality of Thai women's lives.

Cross-sectional Design

An additional limitation is the drawback of using cross-sectional data. This method only allows people's perceptions of risk, intentions, plans, and actions to be measured at one point in time. This does not allow for testing causal connections or change in any of these as people's information and situations change. Although the best method for studying health behaviours and actions is to use a longitudinal design, this method is rarely employed since it involves a significant amount of time and money. Perhaps if we are going to make significant gains in health behaviour research, using longitudinal designs is going to have to be given greater consideration.

Future Research

This research outlined a model that helped to explain the risk perceptions of Northeastern Thai women. It demonstrated the importance of culturally grounded work in providing an understanding of how social psychological concepts operate. In addition, it illustrated the complexities inherent in studying human behaviour and in developing prevention strategies. The research began a process on which future research needs to continue to build.

As in previous studies, this research found that women want to be able to protect themselves in ways that do not involve the cooperation of their male partners (Guinan, 1992; Heise & Elias, 1995). The development of the new female condom has been lauded

as an important contribution to women's ability to protect themselves. Preliminary research on the acceptability and the marketability of the female condom has begun (Elias et al., 1996). A female controlled method of protection, that is acceptable to women will be a tremendous gain for women in preventing HIV infection, alleviating a significant barrier currently present in Thai women's lives. However, focusing on female methods of protection should not be viewed as a replacement to addressing protection strategies for both partners in a sexual relationship. Since heterosexual transmission accounts for 70% of HIV infections globally (Joint United Nations Programme on HIV/AIDS, 1996) prevention efforts need to continue to recognize that programs set within the cultural and societal context must be developed for both partners in a heterosexual relationship. As an example, this research has demonstrated that prevention programs which focus on personal empowerment, insisting on condom use, and confronting a partner do not fit the reality of Northeastern Thai women's lives. Future research and prevention campaigns in Thailand need to build on these findings and look to further identify and develop ways that these women can reduce their vulnerability from within their social position and cultural beliefs. Important in this quest is the recognition that concepts such as taking your fate, Karma, and acting in a way that will make merit, are not barriers to prevention, but belief systems on which prevention strategies can be built. For example, for a Thai woman, having children is an important part of Karma and taking your fate. Being a good mother is one of the most important ways a woman can acquire merit, even more important than being a good wife. Prevention programs which are dealing with women of child-bearing age, may focus on a woman's desire to safeguard her children and her family's health,

rather than trying to convince a woman to protect her own health. Thus, a woman who finds ways to keep herself and her children safe from AIDS is a woman who fulfills her most important role, she builds merit.

Most importantly, researchers must recognize that people will not change their behaviours simply because prevention programs demand it. Therefore it would be most beneficial in working with Thai women, to understand and accept their culture, rather than to judge and label their lifestyle as a dangerous one. Guimaraes (1996), in her work on Brazilian women in stable relationships, points out that:

> Intervention programs would do well in examining the concrete lives of those most affected by the [AIDS] epidemic with eyes that are not sociocentric or, should I venture to say, socially vulnerable? In the case of the lower class population, this would allow for a closer understanding of their daily problems of subsistence, not to be denied, but could also uncover the specific values and practices which women and men hold to be positive to their social and sexual relationships, and that ensure a minimum of status and dignity in a highly unequal and unjust society, despite the ultimate cost of an HIV infection. (p. 6)

Guimaraes' comments summarize the goal of this thesis, to begin the work of examining risks, perceptions, vulnerability, and prevention strategies of Northeastern Thai women, from the perspective of their "concrete" lives. It is hoped that this thesis will provide a foundation for future research and prevention programs for Northeastern Thai women.

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Appendix A

Sampling Procedure Used by the Principal Investigators

Thirty participating villages were randomly selected from a total of 1,892 villages in Khon Kaen Province. A demographic survey was conducted by village health workers in every household in each of the 30 villages. From this, a stratified random sample of both married women and men was established for structured interviews and focus groups. Face-to-face structured interviews were administered by public health nurses trained for this project as face-to-face structured surveys to avoid literacy problems. Most questions were asked in an open-ended manner in order to minimize response compliance and guessing. The women were encouraged to provide more than one response, with all answers recorded. Focus groups were stratified by gender and age (one group was under 30 years of age the other was over 30 years of age) to establish homogeneous groups in which participants were more likely to have shared life stages and experiences. A research team member met with each selected person to explain the purpose and procedures of the research and to obtain consent to participate. Confidentiality was ensured by survey interviewers and focus group facilitators not knowing the names of any of the participants. Each participant was given the date, time, and place of the survey, and focus groups. To minimize the influence of the Thai norm of compliance with all requests, no attempts were made to locate those who did not arrive at their designated time with their absence taken as lack of consent.

Appendix B

Structured Interview Questions Administered by the Principal Investigators

Instructions:

All questionnaires are administered in an open-ended fashion, i.e. participants are not given the response categories, but rather, interviewers record the answers in the appropriate categories. If the appropriate coding is unclear from the participants initial response, the interviewer requests clarification. This request may include providing some information from the potential categories (i.e. if a television program is named in response to a question the interviewer may ask if this is a play, game show, etc.)

The response categories for each question were established as a result of pilot interviewing where the questions were asked and responses written down. Categories were then established that reflected the responses given. It is recommended that similar piloting work be done to establish the appropriate categories for regions other than rural northeastern Thailand

Note: Some questions may appear to be missing since all questions were not used in this study.

1. Age ___________

2. Occupation

	in wet season	in dry season
farmer	___	___
merchant	___	___
govt official	___	___
housewife	___	___
sews	___	___
work for hire	___	___
other	___	___
no answer	___	___

3. Education
   0 ___ no education
   1 ___ less than po 4
   2 ___ po 4 to po 6
   3 ___ mo 1 to mo 3
   4 ___ mo 4 to mo 6
   5 ___ some post secondary
   6 ___ bachelors
   8 ___ other
   9 ___ no answer

4. Marital Status
   0 ___ single
   1 ___ married
   2 ___ widowed
   3 ___ separated
   4 ___ divorced
   8 ___ other
   9 ___ no answer

5. Have you heard of AIDS?
   0 ___ no ... skip to question 36
   1 ___ not sure
   2 ___ yes

6. Can you tell by looking at someone if they have AIDS?
   0 ___ no
   1 ___ not sure
   2 ___ yes

7. Can an infected person who looks and feels well infect other people so they might get AIDS?
   0 ___ no
   1 ___ not sure
   2 ___ yes

8. Do you personally know anyone who has or who had AIDS?
   0 ___ no
   1 ___ not sure
   2 ___ yes

9. What do you think cures AIDS? Anything else?
   ___ drugs, medicines
   ___ doctors
   ___ traditional, village medicines or practices
   ___ self care (keep self clean, eat well, keep home clean)
   ___ there is a cure, but I don't know it
   ___ don't know

10. How do you think that people get infected with AIDS? Any other way?
   ___ saliva mentioned
   ___ casual contact - clothes, food, eating, utensils, sitting near others
   ___ toilets
   ___ medical procedures
   ___ cutting or injecting (nonmedical)
   ___ drugs mentioned, no mention of injection
   ___ mosquitoes
   ___ unprotected sex with a prostitute
   ___ wives of men who have sex with prostitutes
   ___ other heterosexual contact
   ___ blood
   ___ mother to child transmission
   ___ men having sex with other men
   ___ other

11. What about yourself, how much do you think you are at risk of getting AIDS?

___ (not at all) skip to question 13) ___ (a little) ___ (somewhat) ___ (a lot) ___ (definitely)

_____ uncertain

12. Why do you think you are at risk? Any other reasons?
   ___ I have sex with others
   ___ my husband places me at risk
   ___ everyone is at risk
   ___ it is a matter of fate/bad luck
   ___ general health
   ___ mentions casual contacts which place her at risk
   ___ mentions contact with blood that places her at risk
   ___ mentions medical procedures which place her at risk
   ___ mentions injection drug use
   ___ other

GO ON TO QUESTION 14

13. Why do you think you are not at risk? Any other reasons?
    ___ has sex only with husband
    ___ both husband and wife monogamous
    ___ husband never goes to prostitutes
    ___ uses condoms at all times
    ___ husband uses condoms with prostitutes
    ___ never uses drugs
    ___ husband never uses drugs
    ___ never gets sick/is very healthy
    ___ is too old or too young
    ___ celibate
    ___ doesn't live with husband
    ___ has good fate/luck
    ___ never receives blood transfusions
    ___ always stays in the village
    ___ other

14. What about your husband, how much do you think he is at risk of getting AIDS?

___ (not at all) skip to question 16)   ___ (a little)   ___ (somewhat)   ___ (a lot)   ___ (definitely)

_____ uncertain

15. Why do you think your husband is at risk? Any other reasons?
    ___ he has sex with other women
    ___ he has sex with prostitutes
    ___ he travels
    ___ he has sex with otther men
    ___ everyone is at risk
    ___ mentions casual contact that puts husband at risk
    ___ mentions blood contact that puts husband at risk
    ___ mentions injections that put husband at risk
    ___ other

16. Compared to other women in this village like yourself, would you say you were more or less at risk of getting AIDS than they were?

___ (definitely less)   ___ (somewhat less)   ___ (about the same)   ___ (somewhat more)   ___ (definitely more)

___ uncertain

17. Some married men go to prostitutes. Some go a great deal, some onl
occasionally, and some very rarely. On this card, please point to the plac
that you think is most like your husband.

___ never ___ doesn't, might ___ < 1/year ___ every few months ___ often ___ daily

___ uncertain

18. Do you think a married woman who suspects her husband might catch AIDS car
do anything to protect herself from becoming infected?
0 ___ no ... skip to question 20
1 ___ not sure ... skip to question 20
2 ___ yes

19. What can one do? Anything else?
___ tell husband never to go to prostitutes
___ don't let husband have sex with others
___ tell husband to use condoms with prostitutes/others
___ use condoms with husband
___ mention medical procedures (examine for AIDS, see doctor, excludinc
test for AIDS)
___ AIDS testing
___ mention avoiding casual contact (eating with others, going to the
city, using others' things)
___ mention toilets
___ other

20. If you thought your husband carried AIDS, what would you do to protect
yourself?
___ talk to him
___ use condoms with him
___ throw him out of the house
___ not have sex with him
___ nothing
___ other

21. Have you done anything to protect yourself from getting infected?
0 ___ no ... go to question 23
1 ___ not sure ... go to question 23
2 ___ yes

22. What have you done? Anything else?
- ___ monogamous
- ___ have discussed with husband why he shouldn't go to prostitutes
- ___ don't let husband go to prostitutes
- ___ husband uses condoms with prostitutes
- ___ use condoms
- ___ don't use drugs
- ___ got a blood test
- ___ self care (keep clean, clean house, eat well, keep healthy)
- ___ no casual contact (clothes, eating together, sitting together)
- ___ sterlized, or mention other birth control method
- ___ other

GO TO QUESTION 24

23. Could you tell me why you haven't done anything? Any other reason?
- ___ not at risk, doesn't think she is at risk
- ___ husband doesn't go to prostitutes
- ___ husband uses condoms with prostitues
- ___ don't want to change
- ___ husband doesn't want to change
- ___ no one in the village is infected
- ___ other

30. What type of person is likely to get AIDS? Anyone else?
- ___ homosexuals
- ___ prostitutes, waitresses, call girls, bar girls
- ___ people who have sex with more than one partner/more than wife or husba
- ___ men who go to prostitutes
- ___ wives of men who go to prostitutes
- ___ single people
- ___ men
- ___ people who use drugs
- ___ people who are injected with unclean needles
- ___ people who are injected
- ___ people who travel a great deal
- ___ people who don't use condoms
- ___ babies of infected mothers
- ___ other

31. From this list, who is most at risk? (code 1)
Who is next most at risk? (code 2) And next? (code 3)
And next? (code 4)
- ___ homosexuals
- ___ prostitutes
- ___ waitresses
- ___ men who go to prostitutes
- ___ wives of men who go to prostitutes
- ___ single people
- ___ people who use drugs
- ___ men who travel a great deal
- ___ people who are injected
- ___ babies of infected mothers

32. How does a person know for sure if he or she has AIDS?
    0 ___ doesn't know ...skip to question 35
    1 ___ takes a test
    2 ___ go to a doctor
    3 ___ other

33. What kind of test tells you if you have AIDS?
    ___ blood
    ___ urine
    ___ stool
    ___ gynecological exam
    ___ skin and body exam
    ___ not sure

36. Have you ever seen one of these? (show condom)
    0 ___ no
    1 ___ not sure
    2 ___ yes

37. Do you know what a condom is for?
    0 ___ no ... skip to question 39
    1 ___ not sure
    2 ___ yes

38. When do you think someone should use a condom?
    ___ when having sex with husband
    ___ when hving sex with someone other than wife
    ___ when having sex with prostitute
    ___ to protect against disease
    ___ to prevent pregnancy
    ___ if recently had baby
    ___ to cover penis
    ___ never
    ___ don't know

40. Would you be embarrassed to go somewhere and ask for condoms?
    0 ___ no
    1 ___ yes
    2 ___ it would depend on the place
    3 ___ doesn't need condoms
    4 ___ doesn't know

41. Do you ever talk about using condoms with anyone?
    0 ___ no
    1 ___ yes

42. Have you ever talked to your husband about using condoms?
    0 ___ no ... skip to question 45
    1 ___ yes

43. When was the last time you talked to your husband about condoms?
    0. ___ never
    1. ___ within past week
    2. ___ within past two weeks
    3. ___ within past month
    4. ___ within past two months
    5. ___ more distant than past two months
    6. ___ makes specific reference to around time of village program

44. What was his reponse?
    ___ said he didn't visit prostitutes
    ___ says he is careful
    ___ says he uses condoms
    ___ says they's uncomfortable, doesn't like them
    ___ other

46. Have you talked to your husband about AIDS?
    0 ___ no
    1 ___ yes

48. Have you talked to your husband about prostitutes?
    0 ___ no
    1 ___ yes

50. Who else have you talked to about AIDS or condoms? Anyone else?
    ___ women friends
    ___ men and women in the village
    ___ relatives
    ___ village headman
    ___ son
    ___ daughter
    ___ doctor, health worker, clinic staff
    ___ other

51. How often have you used condoms?
    0 ___ never ... skip to question 55
    1 ___ once
    2 ___ many times
    3 ___ all the time
    4 ___ in the past, but not recently

52. Are you using condoms now?
    0 ___ no
    1 ___ yes

53. The last time you used a condom, why did you use it?
    ___ contraception
    ___ prevent disease
    ___ menstruating, afraid have wound
    ___ thought husband went to prostitues or might have a disease
    ___ partner wanted to
    ___ other

54. Why do you not use condoms?
    ___ use other birth control or sterilized (she or husband)
    ___ husband doesn't go to prostitues, husband is faithful
    ___ no opportunity to get infected
    ___ husband refused
    ___ wants to have children
    ___ other

Please say whether you agree or disagree with the following statements I will rea to you. (A card is shown with the five choices of answer wirtten on it: 1. strong agree, 2. agree, 3. disagree, 4. strongly disagree, 5. don't know)

QUESTIONS ON MEN AND PROSTITUTION:

It is all right for men to have sex with prostitutes as long as they are quiet abou it.

If a man is very drunk he is not responsible for his actions.

If my husband went to a prostitute he would be careful not to get a disease.

My husband often goes out drinking with his friends and they drink until they ge drunk.

A wife can tell if her husband has been to a prostitute.

If my husband went to a prostitute he would only go to a disease free prostitute.

It is only natural for men to visit female prostitutes.

It is all right for men to have sex with prostitutes as long as they don't bring hom a disease.

If my husband went to a prostitute he would always use a condom.

It is all right for men to have sex with prostitutes as long as they don't spend t
much money.

WHAT A WIFE, GOOD WIFE, ETC. CAN/SHOULD DO
(NORMS AND POSSIBILITIES)

It is important for a wife to talk to her husband about AIDS.

A wife should give condoms to her husband when he leaves the village.

A wife should talk to her husband about men going to prostitutes.

A wife should talk to her husband about her fears about AIDS and other diseases.

A wife should encourage her husband to use condoms away from home.

A good wife never talks about prostitution with her husband.

I worry when my husband is away from the village that he might see a prostitute.

A good wife trusts her husband without question.

A good wife accepts what her husband does, no matter what that is.

It is not good for a wife to argue with her husband.

It is not good for a wife to question her husband about what he does.

So long as my husband comes home, I don't question what he does.

CONDOM ATTITUDES

Using a condom with prostitutes reduces the risk of getting a disease.

Condoms are easy to use.

Using a condom reduces pleasure.

It hurts to have sex with a condom.

Most people can use a condom and still get pleasure from sex.

It is easy to get condoms.

Condoms are expensive.

AIDS PERCEPTIONS

AIDS is a serious problem for my village.

My village should set a plan for how to deal with AIDS.

AIDS is a serious problem for in Thailand.

Appendix C

Reliability of Survey Responses and Focus Group Discussions Conducted by the Principal Investigators

Reliability of structured interview answers were assessed by checking for contradictions in response patterns. Less than 1% of responses in comparisons across 8 pairs of questions were contradictory (e.g., responding that condoms were used but also answering that condoms had never been seen). For focus group data, the transcripts were translated under the supervision of a consultant from the Modern Language Department at Khon Kaen University who is fluent in English, Thai, and Isan (the local dialect). The reliability of the translations from Isan and Thai to English was then confirmed by selecting a random set of passages consisting of 300 lines of transcript and determining the agreement between two independent translations. A difference in interpretation of the translation was present in 2% of the lines (6/300 lines) examined (Kuyyakanond & Maticka-Tyndale, 1994).

Appendix D

Summary of Differences Between Women According to Their Perceived Level of Risk

Question	Percentage who perceive themselves as...		Significant Relationships
Responses	not at risk	at risk	χ^2 p≤ .05
Perception and Source of Risk			
Compared to women in this village I am:			*
(N)	(547)	(374)	
at no risk	55.0	17.6	
somewhat less at risk	19.6	35.6	
at the same risk	17.7	33.2	
more at risk	1.7	7.7	
don't know	6.0	5.9	
Husband's level of risk:			*
(N)	(171)	(160)	
not at risk	80.1	4.4	
at risk	12.3	88.8	
don't know	7.6	6.8	
†Reasons for husbands risk:			
(N)	(34)	(153)	
sex with other women	32.4	26.8	
'he travels'	8.8	34.6	*
everyone is at risk	8.8	19.6	
casual contact	5.9	10.5	
How often does your husband go to prostitutes?:			*
(N)	(543)	(372)	
never	90.8	47.6	
occasionally	3.0	22.5	
always	0.9	1.6	
don't know	5.3	28.3	
Judgmental Heuristics			
†Who is at risk?:			
(N)	(714)	(472)	

homosexuals	9.7	12.3	
prostitutes	39.7	50.6	
men who go to prostitutes	82.7	83.7	*
wives	9.8	9.5	
people who don't use condoms	2.2	1.7	

<u>Intention to Protect Self</u>

Have you done anything to protect yourself?:			*
(N)	(738)	(476)	
yes	8.5	18.7	
no	91.5	81.3	
Have you ever used a condom:			*
(N)	(593)	(407)	
yes	28.2	39.1	
no	71.8	60.9	
†What have you done to protect yourself?:			
(N)	(64)	(92)	
I always use condoms	18.8	23.9	
I am monogamous	23.4	17.4	
tell husband to use condoms with prostitutes	6.3	12.6	
tell husband no prostitutes	12.5	9.8	
†What can you do to protect yourself?:			
(N)	(188)	(182)	
tell husband no prostitutes	72.3	73.1	
use condoms with my husband	5.0	7.6	
†What would you do to protect yourself if you thought your husband was infected?:			
(N)	(155)	(148)	
use condoms	60.6	69.6	
no sex	25.8	25.7	
talk about it	7.7	6.1	
(N)	(169)	(160)	
do nothing	15.4	13.8	
†Reasons provided for not protecting self:			
(N)	(675)	(387)	
I am monogamous	61.0	46.4	*
I am not at risk	42.8	12.7	*

†When should someone use a condom?:

(N)	(724)	(468)	
with someone other than wife	14.3	16.4	
to prevent pregnancy	49.8	47.1	
to prevent disease	65.3	67.9	

When should you use condoms with your spouse?:

(N)	(364)	(265)	
never	88.1	83.0	
for birth control	9.7	10.6	
to prevent disease	2.2	6.4	

<u>Power</u>

Can married women protect themselves?:

(N)	(729)	(475)	
yes	83.1	85.5	
no	8.8	6.1	
don't know	8.1	8.4	

<u>Attitude Towards Condoms</u>

You can still get pleasure from sex if you use a condom: ✱

(N)	(171)	(160)	
agree	43.8	64.4	
don't know	42.7	23.7	
disagree	13.5	11.9	

It is easy to get condoms:

(N)	(171)	(160)	
agree	76.6	88.7	
don't know	15.2	6.9	
disagree	8.2	4.4	

It is easy to use condoms: ✱

(N)	(171)	(160)	
agree	74.2	85.6	
don't know	21.7	10.0	
disagree	4.1	4.4	

†Husbands response regarding why he does not use condoms:

(N)	(289)	(256)	
does not go to prostitutes	30.8	23.8	
(N)	(294)	(255)	
I'm careful	2.7	9.0	*
(N)	(329)	(275)	
I won't use condoms	38.3	39.3	
condoms are uncomfortable	12.2	16.0	

Thai Culture

You worry when your husband is away:			
(N)	(171)	(160)	
agree	64.4	71.3	
don't know	2.8	4.3	
disagree	32.8	24.4	
Your husband will be careful:			
(N)	(171)	(160)	
agree	43.3	40.7	
don't know	5.2	7.4	
disagree	51.5	51.9	
Your husband will always use a condom with prostitutes:			
(N)	(171)	(160)	
agree	54.4	60.7	
don't know	14.0	13.7	
disagree	31.6	25.6	
†Agree that a good wife...:			
(N)	(171)	(160)	
trusts her husband	48.5	33.7	*
gives her husband condoms	79.5	87.5	
never talks about prostitutes with husband	29.2	27.5	
doesn't argue with husband	39.2	30.6	
†You have talked to your husband about:			
(N)	(167)	(163)	
prostitutes	64.7	81.9	*
(N)	(693)	(454)	
using condoms	40.5	55.1	*
(N)	(595)	(407)	
AIDS	28.4	38.1	*

Men going to prostitutes is natural:		
(N)	(171)	(160)
agree	32.2	29.4
don't know	3.5	2.5
disagree	64.3	68.1
Being drunk lessens husband's responsibility:		
(N)	(171)	(160)
agree	17.5	18.1
don't know	3.0	1.9
disagree	79.5	80.0
†Agree that going to a prostitute is o.k. if:		
(N)	(171)	(160)
wife doesn't know about it	15.2	18.2
prostitute is disease free	36.3	36.9
they are not too expensive	18.1	16.2

Note. All significant chi square results are indicated with a ∗. All results which had less than 5 responses in a cell have been excluded. The questions which have percentages that will not add to 100% are indicated with a †. These questions were open-ended and therefore the percent is given only for those who answered the question.

Appendix E

Summary of Age Differences Between Women

Question:		Age Group		Significant Relationships
Responses		15-30	31-53	
		%	%	χ^2 $p \leq .05$
Perception and Source of Risk				
Own level of risk:				*
	(N)	(623)	(597)	
not at risk		54.9	66.8	
at risk		45.1	33.2	
†Reasons for risk:				
	(N)	(357)	(280)	
everyone is at risk		10.9	15.5	
husband		58.0	47.5	*
casual contact		15.4	18.9	
†Reasons for no risk:				
	(N)	(382)	(448)	
he doesn't go to prostitutes		66.2	60.7	
only have sex with spouse		30.6	31.5	
celibate		4.5	4.2	
do not use drugs		2.6	1.8	
good luck		1.0	2.9	
husband uses condoms with prostitutes		0.3	1.1	
Husband's level of Risk:				
	(N)	(197)	(198)	
not at risk		33.5	42.5	
at risk		48.2	42.9	
don't know		18.3	14.6	
†Reasons for husbands risk:				
	(N)	(131)	(114)	
sex with other women		20.6	29.8	
'he travels'		29.8	22.8	
everyone is at risk		12.2	14.9	

casual contact		8.4	7.9	
How often does your husband go to prostitutes?:				*
	(N)	(535)	(499)	
never		66.2	75.6	
occasionally		12.7	9.8	
always		1.1	1.0	
don't know		20.0	14.6	
Judgmental Heuristics				
†Who is at risk?:				
	(N)	(688)	(651)	
homosexuals		11.2	9.1	
prostitutes		46.8	39.5	
men who go to prostitutes		82.6	82.7	
wives		8.6	10.1	
people who don't use condoms		1.5	2.1	
Intention to Protect Self				
Have you done anything to protect yourself ?:				
	(N)	(692)	(670)	
yes		12.6	13.3	
no		87.4	86.7	
Have you ever used a condom?:				
	(N)	(577)	(552)	
yes		34.0	30.0	
no		66.0	70.0	
†What have you done to protect yourself?:				
	(N)	(95)	(96)	
I always use condoms		20.0	27.1	
I am monogamous		15.8	17.7	
tell husband to use condoms with prostitutes		12.4	10.9	
tell husband no prostitutes		8.4	12.5	
†What can you do to protect yourself?:				
	(N)	(228)	(216)	
tell husband no prostitutes		71.5	73.6	

use condoms with my husband		7.2	4.6	
†What would you do to protect yourself if you thought your husband was infected?:				
	(N)	(182)	(181)	
use condoms		59.9	66.3	
no sex		31.3	20.4	*
talk about it		10.4	5.0	*
do nothing		16.8	11.2	
throw him out		4.4	9.4	
†Reasons provided for not protecting self:				
	(N)	(606)	(579)	
I am monogamous		52.7	56.4	
I am not at risk		28.5	33.2	
†When should someone use a condom?:				
	(N)	(678)	(632)	
with someone other than wife		17.7	13.8	
to prevent pregnancy		47.3	48.5	
to prevent disease		69.2	64.7	
When should you use a condom with your spouse?:				
	(N)	(357)	(368)	
never		88.0	84.9	
for birth control		9.0	9.4	
to prevent disease		3.0	5.7	
Power				
Can married women protect themselves?:				
	(N)	(684)	(667)	
yes		83.5	84.6	
no		8.9	7.5	
don't know		7.6	8.0	
Attitude Towards Condoms				
You can still get pleasure from sex if you use a condom:				
	(N)	(197)	(198)	
agree		51.8	51.0	
don't know		32.5	34.9	
disagree		15.7	14.1	

	(N)			
It is easy to get condoms:				
	(N)	(197)	(198)	
agree		83.8	80.8	
don't know		9.6	12.1	
disagree		6.6	7.1	
It is easy to use condoms:				
	(N)	(197)	(198)	
agree		79.2	77.8	
don't know		15.2	18.2	
disagree		5.6	4.0	
†Husbands response regarding why he does not use condoms:				
	(N)	(316)	(296)	
does not go to prostitutes		25.9	30.1	
	(N)	(317)	(299)	
careful		5.4	7.7	
	(N)	(343)	(338)	
I won't use condoms		42.5	34.0	*
condoms are uncomfortable		12.8	13.9	

Thai Culture

	(N)			
You worry when your husband is away:				
	(N)	(197)	(198)	
agree		70.1	65.7	
don't know		4.0	3.0	
disagree		25.9	31.3	
Your husband will be careful:				
	(N)	(197)	(198)	
agree		43.7	36.4	
don't know		8.1	8.1	
disagree		48.2	55.5	
Your husband will always use condoms with prostitutes:				
	(N)	(197)	(198)	
agree		46.8	55.5	
don't know		16.8	14.6	
disagree		26.4	29.9	
†Agree that a good wife...:				
	(N)	(197)	(198)	

trusts her husband		38.3	46.0	
gives her husband condoms		80.2	84.3	
never talks about prostitutes with husband		23.9	32.8	
doesn't argue with husband		32.0	36.4	
†You have talked to your husband about:				
	(N)	(196)	(195)	
prostitutes		76.5	70.2	
	(N)	(668)	(625)	
using condoms		46.6	45.4	
	(N)	(586)	(550)	
AIDS		32.1	34.4	
Men going to prostitutes is natural:				
	(N)	(197)	(198)	
agree		28.4	34.3	
don't know		3.1	2.6	
disagree		68.5	63.1	
Being drunk lessens husband's responsibility:				
	(N)	(197)	(198)	
agree		15.2	20.2	
don't know		3.6	1.0	
disagree		81.2	78.8	
†Agree that going to a prostitute is o.k. if:				
	(N)	(197)	(198)	
wife doesn't know about it		17.3	16.2	
prostitute is disease free		36.5	35.9	
they are not too expensive		12.6	22.7	*

Note. All significant chi square results are indicated with a *. All results which had less than 5 responses in a cell have been excluded. The questions which have percentages that will not add to 100% are indicated with a †. These questions were open-ended and therefore the percentage is given only for those who answered the question.

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