RESEARCH COMMUNICATION

Health Promotion for Middle-aged Isan Women, Thailand: A Participatory Approach

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Abstract

It is increasingly clear that non-communicable diseases (NCDs), including cancer, diabetes, hypertension and atherosclerosis, are important not only for the developed but also the developing world. Prevention efforts depend on community-based interventions and for these to be successful a participatory approach is necessary. The present paper describes experiences with middle-aged females living in a village in Isan, the Northeastern area of Thailand, focusing on the steps necessary to develop trust between researcher and subjects, the actual conditions of the women involved and their problems. From this base a number of interventions are planned taking into account the wishes of the villagers themselves, including a project to facilitate participation in physical exercise, a prime measure for prevention of cancer and other NCDs.

Key Words: Health promotion - middle-aged women - Isan, Thailand - exercise

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Introduction

Non-communicable diseases are increasing in Thailand. According to the 1998 National Health Survey, the top five leading causes of death among Thai women aged 45-59 were, in descending order, cancer, circulatory system failure, diabetes, accidents, and infections (e.g., AIDS, tuberculosis). Similarly men in the same age group suffer from cancer, accidents, circulatory failure, infection and gastro-intestinal problems. However, the incidences of the diseases differ between the sexes. Women aged between 50 and 59 are 3, 2.8, 2.5, and 2 times more likely than men to have cardiovascular diseases, diabetes, arthritis, and hypertension, respectively (Chuprapawon, 1997). Almost all of these non-communicable diseases are being increasingly recognized as major causes of morbidity and mortality globally, including developing countries in Southeast Asia (WHO, 2002).

With prevention of non-communicable diseases, the focus should be on common preventable risk factors related to lifestyle, such as unhealthy diet and physical inactivity. The most feasible approach for developing countries is promotion of health during the entire life course and should be applied in an integrated manner (WHO, 2002). The non-communicable diseases, however, are related to multiple factors, particularly in the lifestyle context, which varies with the place and gender. Therefore, it is important to have a specific health promotion approach or policy, especially for women in the Northeast region of Thailand.

The Thai Ministry of Public Health has developed and implemented a public health policy with the introduction of health promotion programs nationwide. Although particular health promotion programs, such as family planning or immunization services, have been successful, others such as for traffic accident prevention, smoking cessation or campaigns against liver cancer not been proved effective or sustainable (Lyttleton, 1996). In general, health promotion programs are only effective when health practitioners have to follow policy decisions or when it is financed by both government and non-government organizations (Wibulpolprasert, 2000). Some programs are also short term in practice because responsible health personnel have to turn their attention to new policies (Tassaniyom et al, 2004). In terms of health promotion for middle-aged women, the focused has been on reproductive health, such as menopausal clinic and cervical screening programs, which have been established both in the government and private health sectors (Boonmongkol, 1999). This, however, is not totally consistent with the local women's way of life and/or their perception of health (Whittaker, 2000; Boonmongkol, 2001; Chirawatkul, 2002).

Worldwide, women are taught to take care of their families, in addition to their mothering role and giving birth (Charmian, 1985; Giddens, 1993; Halroyd, 2001). In accepting this role, women place family needs before themselves (Kar et al, 1999; Choudhry, 2002). This is also applicable to women living in "Isan", the Northeastern part of Thailand. Middle-aged Isan women are expected to limit

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their space to the household, generating and managing the family's financial affairs and taking care of their family members (Attig et al., 1992;; Jongudomkarn and West, 2004). They are responsible for the well-being of both younger and older family members, as well as their husbands (Rungreangkulkij et al, 2002). This double role consumes almost all of their time. Participatory action research is a methodology aiming to help people to investigate reality, in order to improve their lives (Lindsey et al., 1999). Applying participatory action research with middle-aged Isan women could empower them to create changes both individually and collectively towards the maintaining of their health (Gillies, 1998; Li et al., 2001; Ismael, 2002). The present study was concerned with practical necessities in this regard.

Materials and Methods

Study site

The study was conducted in Ban Noi (pseudonym). The village, 120 years old, is located 17 kilometres from Khon Kaen city. In 2001, there were 450 households with 2,880 inhabitants, including 247 women aged between 45 and 59; the age group of middle-aged Isan women which were the focus of this particular study. This village has a good infrastructure, with electricity, concrete roads, running water, public telephones and a local food market. Most of the villagers aged 45 and older have been educated up to grade 4. Young men, aged between 18-35 years old, work mostly with subcontract groups for construction companies in Khon Kaen city. The sources of work for young women are the garment, shoes, and furniture factories which surround the village. Due to the impact of national economic crisis since 1997, their wages have been unreliable (Tanchareonsathien et al., 2002). A number of the middle-aged women of the village work at home as housewives and look after grandchildren. Some of the supplementary family income comes from selling food, joining housewive's groups to produce and sell items such as sausages, engaging in subcontract work (e.g., fixing fishnets), raising silkworms and weaving silk cloth at home. Men in the same age group and healthy elders go out everyday to look after farm animals and their rice fields. Sticky rice is planted once a year, mostly for household consumption. There is a health centre, 4 kilometres from the village, as well as clinics run by nurses, traditional healers and street vendors selling traditional (e.g., herbs, balms) or modern medicine (e.g., pharmaceutical products).

Research methodology

Participatory action research was conducted with villagers and particularly a core group of 16 middle- aged Isan women during the period from June 2001 to April 2004. The study methods used are summarized in Table 1. One of the authors (Wiporn Senarak) played the major role in collecting, recording and analysing the data in the first phase and the members of the core group of villagers were involved themselves in validating and verifying both collected data and findings through a process of dialogue and reflection. In addition, formal presentations to the villagers were conducted to confirm the findings using triangulation. Through the participatory action research, the members of the core group gradually increased their role in collecting and analysing data with encouragement and coaching from the researcher. Information for representative individuals is used here to illustrate themes pertinent to women's experience in relation to health promotion.

Results

In order to allow a good understanding of village life and middle-aged Isan women's way of thought, the first author lived for about one year within the village. In this

Table 1. Study Methods used in the Participatory Action Research

Phase 1. Situational analysis (June 2001 to July 2002)

1. Participant and non participant observation (e.g. meetings, weddings, merit makings, community cultural events and daily life of villagers)
2. Focus group discussions with middle aged Isan women aged 48-59 years
3. A health survey with 80 middle aged women
4. In depth interviews with 64 key informants and 25 middle-aged women
5. Life histories with 9 women aged 48-59 years and 4 elders aged 80-90 years

Phase 2. Establishing a culturally appropriate health program (September 2002-April 2004)

Collaborative activities with two core groups comprised of 16 women in total, aged 47-59 years:
. Health consciousness raising
Visits to other villages to gain knowledge about possible activities
. Identifying and prioritising women and community needs
. Introducing health promotion programs ,Ä e.g. making and selling environmentally friendly cleaning products, establishing the Community Income Savings Fund, campaigning for and planting organic rice and vegetables, and establishing a middle-aged women aerobic exercise group

Phase 3. Evaluation (May 2004)

1. In-depth interviews with middle-aged women, their families and community leaders

way rapport could be established, with progressive decrease in the power gap between researcher as an outsider scholar and the villagers. The middle-aged Isan women played active roles in describing, explaining and demonstrating, while the researcher played mostly a passive role. Methods such as observing, listening, clarifying, taking pictures and recording were used, followed by dialectic and critical reflection. The interactions made the village women recognize the importance of their own knowledge and skills that they had previously "taken for granted". Through the process of participatory action research, the core group initiated health promotion activities, including exercise.

Results of the initial survey are listed in Table 2. The study found several barriers inhibiting middle-aged Isan women to engage in physical activities. This included misconception as to women's roles, inaccessibility, shame and negative experiences related to physical exercise. Many women perceived that physical exercise is necessary only for those with obesity, diabetes or hypertension. Women with no chronic illness were not interested in any physical exercise. Some women had no time to attend physical activities while others had physical problems, such as knee and other joint pain that inhibited them from performing aged inappropriate physical activities. In addition, women felt that some kinds of physical exercise particularly aerobic exercises were not appropriate to middle-aged women in terms of gender expectations in Isan culture. One study participant, a 50 year old woman with diabetes, said "I dared not to go out for jogging or exercises because I didn't like to hear the gossip that I am old and almost in the coffin but still act like young people; so it is not good for me to go out to dance and jump as we often saw in a national campaign show on television". This finding supports the study of Berg, Cromwell and Arnett (2002) regarding barriers inhibiting participation in physical activities.

Based on this perception, only a few middle aged Isan women with diabetes participated in a walking group set up for early in the morning. There was no other physical exercise group in the village even though there was a national campaign for establishing such groups in every village. After participating and empowering through the present study, the core group had developed the physical exercise group appropriate for their ages and ways of life, which consisted of five important components:

1) Establishing the core group responsible for performing physical exercises.

2) Raising the awareness of middle-aged Isan women using a group discussion regarding physical exercises, particularly amongst friends and neighbours.

3) Facilitating the accessibility for middle-aged Isan women to perform physical exercises by establishing group exercises appropriate for them in terms of exercise types, place, time and length to enhance their participation.

4) Motivating sustainable exercises by making the exercises enjoyable for the group. These physical exercises were performed using traditional or country music.

5) Having devoted and skilled leaders to lead the exercise group.

Table 2. Results of the Survey

Parameter	Category	Number	%age
Perceived Health			
Health status	Good	25	31.3
	Fair	37	46.3
	Poor	18	22.5
Health problems			
Back and shoulder ache		40	50.0
Knee and joint pain		32	40.0
Gastritis		12	15.0
Diabetes		12	15.0
Hypertension		4	5.0
Obesity	Yes	29	36.3
	No	51	63.8
Health Practice			
Utilization of health services			
Private nurses practice		57	71.3
Self treatments		34	42.5
Traditional healers		33	41.3
Hospitals		24	30.0
Health center		12	15.0
Pap smear check up	Ever	37	46.3
	Never	43	53.8
Breast self examination (BSE)			
	Ever	32	40.0
	Never	48	60.0
Physical exercises	None	74	92.5
	Regular	6	7.5

Discussion

From our experience, applying participatory action research with middle-aged Isan women could empower them to create changes both individually and collectively towards maintaining of their health. The implementation of health promotion activities was begun with activities related to income generation, as the middle aged Isan women perceived that financial problems impacted their psychological health. The success of applying participatory action research for health promotion with middle-aged Isan women was based on the recognition of the socio-cultural context of these women and of appropriate empowering activities. Health personnel should recognize these issues while working on health development programs, particularly with middle-aged women in a similar context. They should set aside their biomedical model of health and open their mind to accept the health perspective of local people to ensure commitment and participation to work with participatory action research. Although, it requires patience and time, it contributes to a great reward. As the Thai proverb goes, "To get the sweet mango, one needs to wait until it is ripe".

From the present survey it is clear that diabetes and other obesity-related diseases are a problem in the female population of Isan. From the latest cancer registry data, breast and cervical cancer are both important in this region (Sriplung et al., 2005), as elsewhere in Thailand, and rates for screening are relatively low. Clearly this is an area

requiring further emphasis in future now that the initial phase of the participatory research is completed. Another project is to identfy people at risk of undiagnosed type II diabetes.

The history of participatory research in Asia is relatively short but one recent study in Thailand showed that participation with farmers could create a real sustainable model to promote their health and prevent occupational health hazards (Buranatrevedh and Sweatsriskul, 2005). In South Africa, by engaging community stakeholders, it was possible to develop a research framework that incorporated the community's concerns and priorities, and stressed the intersecting roles of poverty, violence, and other cultural forces in shaping community members' health and wellbeing (Mosavel et al., 2005). Community members helped to refocus research from cervical cancer to 'cervical health,' a concept acknowledging the impact on women's bodies and lives of HIV-AIDS and STDs, sexual violence, poverty, and multiple social problems. A cardiovascular disease prevention program for women was similarly designed to build on the strengths of the Alaska Native culture as a way to support and encourage positive lifestyle behaviors with the focus on healthy eating, active living, stress management, and tobacco cessation (Stefanich et al 2005). In Taiwan community health development (CHD), has been initiated, a new approach to national community health care with a shifting from 'traditional' research to 'participatory' research (Huang and Wang, 2005). The way forward now is to utilize all pathways and interested individuals to bring across the message. One example of an innovative approach is use of trained licensed cosmetologists as effective for promoting health messages to their customers (Linnan et al., 2005). The future of cancer prevention research must be at the community level if the interventions and transfer of information envisaged in the Practical Prevention Program (Tajima and Moore, 2003) are to become a reality. The present participatory research project shows how goals can begin to be achieved in practice.

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