CHAPTER 2

LITERATURE REVIEW

The purpose of this chapter is to provide an overview of current knowledge relevant to the focus of the study. Impact of socioeconomic changes and health care reform on Thai women is presented. Current knowledge about the meaning of "midlife" for women and women's health experiences in midlife is reviewed.

Impact of Socioeconomic Changes and Health Care Reform on Thai Women

Socioeconomic Changes of Thailand

Thailand is situated in the heart of Southeast Asia, bordering the Democratic People's Republic of Laos in the north and northeast, the union of Myanmar to the north and west, the Andaman Sea in the west, Cambodia and the Gulf of Thailand in the east, and Malaysia in the south. Thailand is divided into four regions: the North, the Central Plain, the Northeast, and the South (Kraipornsak, 2001).

In 2002, the population of Thailand was 62.8 million, with nearly two-thirds of the population living in rural areas (National Statistic Office, 2003). However, as Thailand continues to industrialize, its urban population is growing. Thailand's population is relatively homogeneous: more than 95 percent are Buddhists and

Theravada Buddhism is the official religion of Thailand. Thai, the national and official language, is spoken by more than 85 percent of the population, who share a common culture, whereas local dialects are spoken in different parts of Thailand (PolitInfo.com United States, 2003).

Participation in waged labor is generally high in the higher age group. For instance, in 2004, about three percent of the labor forces were aged 15-19 years. Fifty percent of labor forces were in the age group 20-39 years, and approximately 40 percent were in the age group 40-59 years (National Statistic Office, 2003). Approximately 56 percent of Thailand's labor force is employed in agriculture; however, the importance of agriculture has been declining, as is evidenced by decreases in the agricultural sector from 66.8 percent in 1990 to 56.2 percent in 2000 (National Statistic Office, 2003).

Working in the government sector has been traditionally perceived as providing greater job security, benefits, and enforcement of workplace regulations. Well-educated workforces, including women, are more concentrated in the government sector. For instance, a survey of graduates in the academic year of 2000 found that 17,991 with graduate degrees participated in the government sector and 7,758 persons worked in private enterprise (National Statistic Office, 2003).

In the national Thai development plan, the focus for the next 20 years will be on the alleviation of poverty and upgrading the quality of life for the Thai people, so that sustainable development and well-being for all can be achieved. This strategic national plan for the period 2002 -2006, or the Ninth Economic and Social Development Plan, is based on sufficiency economic theory, with emphasis on the balanced development of human, social, economic, and environmental resources. A priority goal is pursuit of good governance at all levels of Thai society in order to achieve real, sustainable,

people-centered development and the strengthening of Thailand's international competitive position (National Economic and Social Development Board, 2003).

Public reform and development has been an important component of the development plan in order to modernize and improve the efficiency of the civil service system and to improve the quality and ethical values of civil servants. In 2003, the Strategic Plan for Thai Public Sector Development B.E. 2546- B.E.2550 was revised and approved by the Cabinet. The five-year plan aims to improve the quality of public services, to right-size government bureaucracy, to increase competencies of public sector employees and to ensure responsiveness to democratic governance. The major strategies include: re-engineering work processes; restructuring the framework and administration of public organizations; reforming financial and budgetary systems; reviewing the human resource management and compensation systems; changing management paradigms; culture and values; modernizing the public sector through e-government system development; and enlisting public participation in the work of the government system (United Nation, 2005).

The Thai economy is export-dependent, with exports accounting for 60 percent of the GDP (PolitInfo.com United States, 2003). The economic policy is a dual track system, which combines domestic stimulus with Thailand's traditional promotion of open markets and foreign investment (Paribatra, 2003). Tourism has also been important to economic development. The number of international tourist arrivals increased from 6.9 million in 1995 to 9.7 million in 2003, and contributed an estimated 289,600 million Baht to the national income (Tourism Authority of Thailand, 2004). Tourism is the main income in big cities in Thailand such as Chiang Mai.

Chiang Mai, which celebrated its 700th anniversary as a city in 1996, is the sixth largest province by population in Thailand (National Statistic Office, 2003), and the biggest city in the North (Worldfacts, 2004). Chiang Mai is one of Thailand's prime tourist attractions for its natural beauty and unique indigenous cultural identity. It was founded by King Mengrai the Great as the capital of the Lanna Thai kingdom by merging the various city-states in the region in 1296. Chiang Mai's culture and architecture were influenced by the Burmese, the Haripoonshai kingdom, and the Ayutthaya kingdom (Nationmaster, 2004).

Chiang Mai is now the economic, communication, cultural and tourism center of Northern Thailand. The strategic plan for integrated development for Chiang Mai during 2004-2007 has enhanced the progression of development in various sectors, such as the center of human resources and development, international tourism, international corporate banking and finance, communications, transportation, and telecommunications. Chiang Mai's gross provincial product (at market price) from the agriculture sector has slightly decreased, but revenue from service and industrial sectors has increased. In 2000, the gross provincial product stood at 81,423 million Baht ($US 2,035 million), with an average income of 55,846 Baht ($US 1,396) per person per year. The service sector has become the largest revenue source for Chiang Mai, at approximately 28 percent of provincial income; the industrial sector ranks second at 19 percent, and agriculture is third at 11 percent (Chiang Mai Province Office, 2004). The continued growth of the service sector reflects the transformation of Chiang Mai from a traditional agricultural society to an industrial capitalist society. However, the transformation to urbanization is concentrated in the Chiang Mai metropolitan area.

Outside the modern Chiang Mai metropolitan area society is still rural, without adequate development of public transportation and good sanitation.

The population in Chiang Mai was about 1.6 million in 2002 (National Statistic Office, 2003). Eighty percent of the people in Chiang Mai are locals by birth and speak a dialect, '*Kham muang'* [คำเมือง] that is a variant of the official Thai language. The remaining 20 percent is made up of Thai nationals and foreigners who have moved to Chiang Mai to work, study, or retire, as well as members of minority groups known as hill tribes, with distinct linguistic and cultural identities (Chiang Mai Province Office, 2007).

Women aged 35 - 44 years were the largest population group by age and sex. Midlife women, aged 40-59 years, are one-quarter of the total female population in the province (Unescap, 2001). The proportion of midlife women in Chiang Mai who work as government officers declines by age. For instance in 2002, the government officers were comprised of 10,126 midlife women compared with 10,912 women in adult age group. There are more professional women in the province than men; however, about two thirds of women are concentrated in education and health and social work, whereas only one third of professional men work in those careers (National Statistic Office, 2003).

Health Care Reform of Thailand

The health care system in Thailand has been transformed from Thai traditional medicine to western modernized medicine since 1828 (Wibulpolprasert, 2005). At

present, it is dual system in which Thai traditional medicine is progressively promoted as local wisdom. Although life expectancy of the Thai population has increased, Thai people are experiencing preventable diseases. Heart disease and death from accident, as well as mental and behavioral disorders, are increasing (Office of the National Economic and Social Development Board, 2004; Wibulpolprasert, 2005). Government expenditure increases every year. For instance, in 2003, the public health budget soared to 107,806 million Baht from 90,504 Baht in 2002 (Office of the National Economic and Social Development Board, 2004).

The situation entails health care reform program. Key measures of the program are health promotion and disease prevention, promotion of health insurance, development of quality of health care, and promotion of traditional Thai and alternative medicine. The seven development strategies have been formulated and used, which include: development of a management system for health; development of health security and service quality; development of basic factors for good health and health promotion; development of people's health behaviors and potential as well as strength of civil groups for health; development of health knowledge and technology; management of human resources for health; and development of the country's competitiveness in health(Wibulpolprasert, 2005). To ensure the quality of services, all public health facilities have been accredited through the Hospital Accreditation and ISO quality assessment agencies (Office of the National Economic and Social Development Board, 2004; Wibulpolprasert, 2005). The health care reform, combined with the public reform in the National Plan, has driven employees in such areas to gain more tasks, revenues and responsibilities, as well as to attain and to develop operational skills and specialized expertise. Promotion of public programs occurs throughout the

country. Moreover, the increase in the country's competitiveness in economic and health matters at the international level has provided individuals better access to and use of health information from various resources.

Concern about improving midlife women's welfare and quality of life has become a compelling issue for health care providers, policy makers, and the pharmaceutical industry in Thailand. Since 1990, statistics have indicated a progressive and steady trend in the marketing of hormonal replacement therapy, from 21 million Baht in 1992 to 172 million Baht in 1998 (Dusitsin, 2003).

Concern also exists about the potential economic burden imposed by midlife women on the existing health care system in Thailand. With the successful family planning program in Thailand, the population growth rate declined significantly from about 1.5 percent in 1990 to 0.97 percent in 2000 (National Statistic Office, 2003). The average life expectancy of Thai women has steadily increased, for instance, from 68.9 years in 1986 to 74.9 years in 2002. It is expected to be 76.5 years in 2020 (National Statistic Office, 2003), thus leading to a significant increase in the elderly population in future years. In 2005, women aged 40 - 59 years old will be 24 % of the women population compared with women in other life stages, or more than 7 million persons (National Statistic Office, 2003).

To date, the major public health programs and activities have been operated for women to gain better knowledge and attitudes towards menopause (Wibulpolprasert, 2002). Although Thai women have celebrated a longer life expectancy, they also have higher rates of illness and health care service use than do men (Fuller et al., 1993; Sermsri et al., 2005; Sobieszczyk et al., 2003). Moreover, an analysis of the differences

in causes of death in women and men reveals that women have higher proportion of circulatory system and cancer than do men (Wibulpolprasert, 2005).

The Influences of Socioeconomic Changes on Thai Women

Socioeconomic development has greatly improved Thai women's access to social program infrastructure, particularly education. When compared to males, female students have approximately equal participation rates in education. More female than male students attended higher education (National Statistic Office, 2003). However, while male students are more likely to study subjects for which there is higher market demand, such as engineering, mathematics, and sciences, females prefer the traditional female services occupations such as nursing and teaching, which are mostly concentrated in government sectors and had fewer opportunities for access to employment with high income (Phananiramai, 1997). Traditional attitudes toward gender and occupation tend to be deeply rooted, so that the long term opportunities and benefits for women are narrow.

In the civil service, especially for professional positions, the written rules and regulations for personnel management have no provisions that discriminate against women. Recruitment into the civil service through competitive examinations is open to all who meet the position requirements, which are mainly educational qualifications. Promotion in professional positions is typically judged by standard qualifications set by the Civil Service Commission and the appointing authorities of the department (Office of The Civil Service Commission, 2007). However, complimentary between the sexes also exists in that a greater percentage of women

posses professional jobs than do men (National Statistic Office, 2003) while men have far dominant in terms of administrative position (Springer & Gable, 1981) and the proportion of women engaged in service and administrative occupations declined slightly as their age increased (National Statistic Office, 2003).

Employment as professionals may provide financial security and social resources for women. They can make their own living, have more self-reliance, have professional autonomy in working; however, they may face growing demands for productivity during the transformation brought by the deregulation, downsizing, and restructuring occurring during the reform of the civil system. Moreover, the double burden of working both inside and outside the home is pronounced in Thailand. Thai women have been socialized to assume virtually full responsibility for the household, the care of their parents, affiliated ill family members, and family finances, although they also have outside employment (Muecke, 2001; Suriyasarn, 1993).

Women's roles and duties, as portrayed in the Thai context, may directly or indirectly influence the health status of Thai women, their health perceptions, and their health care practices. Establishing an empirical basis for documenting the health meaning and health care practices of midlife professional women is an increasingly important issue. The well-being of women will affect their later years of life, their families, and the organizations they engage in, particularly in the next decades when the labor force participation rate among more educated women continues to advance.

The effect of urbanization and the success of tourism in Chiang Mai are directly and indirectly contributing to the sociocultural and economic changes experienced by women. The successful growth of the tourism industry makes Chiang

Mai a multicultural city. To cater to Western tourists requires exposure to and familiarity with western culture and health behaviors. Changes in eating behaviors are noticeable, as evidenced by the wide acceptance of convenience food. The social and health behaviors of people have also changed to more modern activities. Midlife women in Chiang Mai preferred to seek help from public and private western medicine (Tonmulkayakul, Chanprasit, Tiansawad, & Fongkaew, 2000).

Prior to the recent transformation to an increasingly urban, industrial and capitalist society, the family or household was the site of economic production. All family members worked together. The work that women did, such as cooking, childbearing and child rearing, was as important as the work men did. Under the traditional quasi-matrilineal social system in the rural regions of Thailand (Suriyasarn, 1993), elderly mothers were likely to receive as much support and care as elderly fathers (Ofstedal, Reidy, & Knodel, 2003). Older women were respected and held in high status. Older women's high status could be seen in the meaning and use of kinship terms in daily life. In general, Thai culture uses title in kin terms to indicate seniority, rank, and status. The term 'par' or aunt is used widely as a term of respect for a woman who is older than either one's father or mother. Sometimes midlife women are called '*mai yai*' in the northeast or '*aui*' in the north regions, which means grandma (Chirawatkul et al., 2002). It was common practice for married daughters and their husbands to live with the wife's parents. Household decision-making was in the hands of the wife and her mother, whereas the extra-household matters were the responsibility of the father and son-in-law. The traditional inheritance system did not favor sons over daughters. The major assets went to the child who lived with the parents after marriage. The youngest daughter usually inherited the land on which the

family home was situated because of the expectation for her to take care of her parents in their old age (Choowattanapakorn, 1999; Phananiramai, 1997; Suriyasarn, 1993). Within this authority system, decisions and activities established not a superior-subordinate hierarchical arrangement, but a family organization based on complementary roles and responsibilities (Yoddumnern-Attig, 1992).

In an industrial capitalist society, wealth and higher education, rather than seniority are valued. The importance of work is recognized through payment (Im, 2000). Aging does not enhance women's status. To gain respect and authority, midlife women need to remain economically active and be better educated. For example, one study found that midlife women in northeast Thailand perceived that their social status did not change with age, but their health changes affected their economic capacity because of their difficulty in performing hard physical work (Chirawatkul et al., 2002). These findings were consistent with the findings of a study conducted in the United States in which women worried about their declining energy to perform paid work (Adler et al., 2000). Therefore, midlife women may view old age more negatively than did women in previous generations.

In addition, some symptoms that accompany aging or menopause may now have a different meaning from the perspectives of employed women, given changes in the perception of aging women's social status. Many midlife women consume foods and use various products to maintain youth and to relieve physical symptoms associated with midlife and aging (Arpanantikul, 2002; Chirawatkul et al., 2002). Some women in Bangkok use beauty products and undergo cosmetic procedures to improve their self-image and to please others, despite the high cost of cosmetic surgery (Arpanantikul, 2002). Well-educated women in urban areas of northeast

Thailand appear to be increasingly fearful of menopause, because it is associated with negative feelings about older age. Women use hormonal replacement therapy (HRT) as a health promotion activity to maintain youth and a healthy body, and to prevent thinning bones (Chirawatkul et al., 2002).

Moreover, popular media including television, magazines, newspapers, and advertisements also shape women's attitudes and practices during midlife. Menopausal women are often presented as irritable, unattractive, depressed, and hard to live with. Moreover, the cultural ideologies and social expectations of older woman may lead them to accept that they should not be sexually active. For instance, one study from northeast Thailand found that midlife women regarded themselves as old and reported a decline in sexual desire and less enjoyment in sexual activities (Chirawatkul et al., 2002). A study in Bangkok found that midlife women regarded themselves as being vulnerable to osteoporosis from health information posted by the doctor, friends, and mass media such as television, radio, or magazines. Women have been warned to be careful when they walk or move and to take more calcium through diet or supplements (Arpanantikul, 2002). These changes in personal behavior are increasingly important to understand in relation to health meanings and practices from women's perspectives, in order to develop appropriately responsive health care for these women, especially those who are exposed to the progressive import of health products from modernized countries.

Through the strategy to make Thailand the center for health service in Asia by the year 2010 (Bangkokbank, 2004), the trends in health food and health business have been progressively introduced to Thailand. Since 1990, statistics have indicated a progressive and steady trend in the marketing of the health and herbal product trade.

For instance, total market value of herbs in 2002 was about 40,000 million Baht. The spa business has been increasing by 20-25 percent annually and it is expected to have market value about 7,300 million Baht in 2004, of which women are becoming the significant consumers (Bangkokbank, 2004). A study found that wealthy midlife women in an urban area of northeast Thailand used rejuvenating potions and western style sauna, and performed aerobic exercise (Chirawatkul et al., 2002). The economic status of women as professionals can provide them opportunities to use both modernized and alternative health for their well-being; however, the advertisements of the health care business may increasingly influence women 's life style, especially this particular group of professional women who can easily gain access to the media and modernization.

Impact of Health Care Reform on Thai Women

In Thailand, women's health has been a focus in policy since Health Development Plan, the five-year plan, has been developed in 1961. However, the earlier plans had focused on maternal and child health, family planning, communicable disease control, and curative improvement and expansion. Until the eighth plan (1997-2001) the focus had emphasized on human capacity in health, particularly appropriate health behaviors and recognized midlife women's health (Wibulpolprasert, 2002). Health care system in Thailand has been transformed from Thai traditional medicine to western modernized medicine since 1828. At present, it is dual system, which Thai traditional medicine is progressively promoted as a local wisdom (Wibulpolprasert, 2002), however, health services for midlife women in Thailand are based mainly on a biomedical model, and most physicians suggest that women use

HRT (Parisunyakul et al., 2000), a biomedical solution. In addition, numerous studies of midlife women in Thailand have focused on the biological aspects of menopausal symptoms (Chaikittisilpa et al., 1997; Suwatana, Meekhangvan, Tamrongterakul, Tanapat, Asavarait, & Boonjitrpimon, 1991), reflecting biomedical assumptions about midlife. This focus reflects male-dominated assumptions that promote the view that menopause is an estrogen deficiency disease and that women in this age are defective and imperfect, resulting in increased pressure to prescribe steroid sex hormones to prevent disease. As such, women who perceive their age as a decline in health may develop fear about health changes, their vulnerability to illness, and their needs for intervention to fulfill their responsibilities (Lippert, 1997).

Health services from this perspective encourage women to perceive midlife as a period of high risk for developing irritability and diseases that increase dependence on health services for a therapeutic approach (Tonmulkayakul et al., 2000). This view is different from the traditional belief of Thai women regarding menopause, and it merits further exploration.

According to the strategic plan for good health and health promotion, the Thai government had declared 2002-2004 as the Health Promotion throughout Thailand Years. The Ministry of Public Health had launched several projects such as health events on February 17, 2002 and November 23, 2003 to encourage people to participate in exercise and to extend the practising of healthy behaviours to become a Thai lifestyle at the regional level in all 12 regions nationwide. Campaigns focused on exercise for health, on health food consumption, on non-smoking, and on health promotion for particular age groups were also implemented. Health promotion

activities for females of menopausal age were carried out at 4,146 clinics (Wibulpolprasert, 2005).

Professional Thai women may exhibit less than the recommended health promoting behaviors. A study found that nearly a quarter of teachers in Chiang Mai had health problems from allergy, hypertension, and gastric ulcer (Tumsap, 2001). Although their health promoting behaviours were found to be good, except for their sexual behaviour, the study did not analyze the difference in health behaviours between male and female teachers. Women working in both education and nursing in northern Thailand had ineffective exercise behaviours although they had regular exercise and did not have barriers to exercise (Dasa, 2001; Sriaka, 2000). Several studies in Thailand found that midlife female teachers in urban areas had good self-care behaviours regarding the postmenopausal age (Munin, 1998), and they could tolerate with menopausal symptoms during their perimenopausal period (Kamsan, 2001).

However, current research in Thailand has focused on female teachers' engagement in health activities associated with menopausal symptoms and health activities. There is no published research focused on the midlife period among other public sector professional women. Recently, a study of retired professional women from the government sector in Chiang Mai found that most of them had illnesses and physical degeneration. They expressed that, during their working lives, they had put all their physical, mental, and psychological abilities and time into their work, which left them less time to take care of themselves (Nateetanasombat, Fongkaew, Sripichyakan, & Sethabouppha, 2004). The study reflected the need to explore the meaning of health and health care practices of professional women in the public

sector during their midlife years within such a changing society as Chiang Mai, in the transformation of a new national management system by government bureaucratic reform, and in the progressive and steady trend of health businesses in Thailand.

Midlife Women Health: Women's Experience

Meaning of Midlife

There are many markers of midlife for women from various perspectives including chronological age, hormonal changes, physical changes, and role changes (Arpanantikul, 2002; Banister, 1999; Brooks-Gunn & Kirsh, 1984; Lippert, 1997). The chronological age associated with midlife varies across studies. For instance, midlife years may be started as early as 30 years (Kenney, 2000), or as late as 50 years (Li, Wilawan, Samsioe, Lidfeldt, Agardh, & Nerbrand, 2002), although most studies have used 40-59 years as the boundary of midlife (Calvaresi & Bryan, 2003; Grazer et al., 2002; Marks, Bumpass, & Jun, 2001; Tonmulkayakul et al., 2000). In western culture, some women perceived midlife as an age range between 35 to 55 years, whereas others identified the age range as 40 to 60 years old (Woods & Mitchell, 1997). Some Thai women defined themselves as midlife when they entered their 40th year (Arpanantikul, 2002). Although there is no clear line between midlife and elderly age, retirement at 60 years is well accepted as a marker of the transition from midlife to later life (Pavalko & Gong, 2003).

Hormonal change, which manifested by menopause has perhaps been the most frequently used marker of midlife, and is often considered interchangeable with the

concept of midlife for women. The biomedical model, which has been criticized as reflecting male-dominated assumptions, identifies menopause as a decline in reproductive function that increases vulnerability to psychic breakdown and as a disease of deficiency (Punyahotra & Street, 1998; Shin, 2002).

From women's perspective, menopause has been seen as a natural phenomenon, which may bring with it positive or negative life consequences. For instance, women in Burma perceived menopause as 'miyet soh' or the signal of the end of the reproductive cycle, and believed that the cessation of menstruation can cause madness and serious problems if left untreated (Skidmore, 2002). Korean women perceived menopause as the changes of body, the time of being alone, and the beginning of thinking of death (Shin, 2002). In contrast, Irish women had more positive perception of menopause; they perceived menopause as a relief from childbearing (Carolan, 2000).

In Thailand, some Thai women looked forward to menopause, while others were ambivalent towards it (Arpanantikul, 2002). Women who desired menopause believed that at the time of menopause, bad blood would no longer be retained in the body; women who did not wish to reach menopause believed that bad blood helped to maintain their youth and health (Chirawatkul et al., 2002). Traditionally, with the belief in the four major elements as the essential ingredients of body, Thai women have perceived menopause as a period of '*leod cha pai-lom cha ma*'[เลือดจะไป ลมจะมา] or 'the blood will go-the wind will come'. The end of menstruation signals not pathology but entry into a new, more spiritual phase of life (Punyahotra & Street, 1998). The women's perspective is different from that of the health services of Thailand, as rendered at present.

Physical changes associated with menopause and aging are related to decrease physical functioning and presence of illness or chronic diseases. Physical functioning limitation, which serve as an indicator of the aging process began between the ages of 40 and 55 years (Pope et al., 2001). Some women in Thailand considered themselves in midlife years when they experienced declined physical functioning and minor symptoms of aging (Arpanantikul, 2002).

Role changes during midlife have also been used as markers to define midlife, focusing on events such as a child leaving home, taking on the status of grandma and mother in law (Brooks-Gunn & Kirsh, 1984; Chirawatkul et al., 2002; Marks et al., 2001; Howell, 2003). According to Erikson's theory of psychosocial development (as cited in Whitbourne, 2001) midlife is the period of generativity versus self-absorption or stagnation. The significant task is to perpetuate culture and transmit values of the culture through the family and working to establish a stable environment. Strength comes through care of others and production for society. Those who are successful during this phase will feel that they contribute to society by being active in their home and community. Therefore, some women may associate midlife with maturity, wisdom, a symbol of achievement and freedom, and a sense of satisfaction at having successfully raised their families to adulthood (Adler et al., 2000; Carlson, 1999; Jamjan & Jerayingmongkol, 2002; Woods & Mitchell, 1997). In contrast, others may associate midlife with incapacity, confusion, and a sense of loss and uncertainty (Adler et al., 2000; Arpanantikul, 2002; Banister, 1999; Shin, 2002; Tonmulkayakul et al., 2000). Some women considered themselves as sandwich generation caregivers as they provide care to both elders and children (Carstan, 2004).

Health Status and Health Risk of Midlife Women

Midlife years for women present many challenges and opportunities. Women may experience a sense of fulfillment, and a relief from childbearing and child rearing, as well as stresses and suffering, in addition to menstrual changes, hot flushes, neuromuscular and joint pain, osteoporosis, insomnia, sleep disturbance, forgetfulness, fatigue, sexual response changes, and the development of central fat deposits (Berg, 1999; Guthrie et al., 2003; Li et al., 2002; Mitchell & Woods, 1996; Punyahotra, Dennerstein, & Lehert, 1997; Sennott-Miller, 1995). Higher rates of morbidity for midlife women have been observed routinely in health surveys. More women in midlife and older ages report trouble doing their activities due to chronic health problems than do men of the same age (Verbrugge, 1983). A study conducted in the United States found that nearly 50% of American midlife women have health conditions requiring ongoing medical treatment (Wyn & Solis, 2001). Being in the older age group, 45-65 years, raised the risk for cardiovascular disease mortality by 15 percent, and professional women had higher cardiovascular disease mortality than other employed women (Muntaner, Sorlie, O' Campo, Johnson, & Backlund, 2001).

In Thailand, the majority causes of death of midlife women were liver cancer, cerebrovascular diseases, and diabetes (Wibulpolprasert, 2005). Moreover, Thai women at midlife are at the greater risk of overweight and obesity comparing with men and adult Thai in other aged group (Aekplakorn et at., 2004). A study in Chiang Mai found that the prevalence of hypertension in women increased sharply after 40 years of age and the prevalence of pulmonary abnormalities and cardiomegaly increased with age and were common after the age of 44 years (Bhuripunyo et al.,

2000). In addition, cervical cancer and breast cancers are fatal diseases that affect Thai women and the trend is rising each year with the highest rate of cervical cancer was recorded in Chiang Mai (Wibulpolprasert, 2005).

Several studies have shown that physical and psychological symptoms are not universal for every woman; and, symptoms are associated with other factors such as personality (Kenney & Bhattacharjee, 2000; Klohnen, Vandewater, & Young, 1996), smoking (Whiteman, Staropoli, Benedict, Borgeest, & Flaws, 2003), chronic illness (Mitchell & Woods, 1996), sociocultural conditions such as education, social status and income (Ho, Chan, Yip, Chan, & Sham, 2003; Sennott-Miller, 1995) and hormone use (Kuh, Hardy, Rodgers, & Wadsworth, 2002; Richards, Kuh, Hardy, & Wadsworth, 1999).

In addition to physical concerns, midlife women may experience several negative personal life events, such as the illness and death of parents or spouse, children leaving home, and a change of residence (Glazer et al., 2002; Nolan, 1986), which may be perceived by women as distress-causing situations. Evidence from various populations has shown that midlife women have a high prevalence of psychological stress (Anantigo, 1998; Glazer et al., 2002; Ho et al., 1999; Muecke, 1994).

However, the sources of stress in this age group depend on the social context in each country. For instance, Korean immigrant women in the United States experienced psychological symptoms associated with family income, work satisfaction, and self-reported health status (Im & Meleis, 2001). Latin American women revealed a high incidence of depression. However, when social factors were examined, researchers found that these women were less educated than men, their salaried

employment decreased rapidly with age, and they did not have social security coverage (Sennott-Miller, 1995).

Another health risk concern among midlife women in Thailand is the widespread transmission of HIV/AIDS since the late 1980's among injection drug users and sex workers, to the male sex trade clients, and subsequently to their wives, partners, and children (Aver.org, 2004). A study found that a specific cultural feature regarding the extramarital sex of Thai men includes a conception of male gender that places much emphasis on sex drive and impulsiveness, a lack of emphasis on companionship within marriage, a view of commercial sex activity as a normal form of male entertainment, little stigma for regular commercial sex visitation, widespread acceptance by men and tolerance by some women of occasional commercial sex visitation by married men, and a high value on harmonious social relations within a peer group context (Vanlandingham, Knodel, Saengtienchai, & Pramualratana, 1998).

Health Meanings and Practices: Midlife Women's Perspective

Health has been a central concept in nursing that has been examined mainly from a theoretical perspective in Western culture rather than with respect to the complexity and diversity of women's lives (Smith, 1981; Lamchang, Chontawan, Suklerttrakul, & Kunaviktikul, 2003). Moreover, within empirical studies in women during midlife years, there is no consensus regarding meaning of health and health care among women. While numerous studies have concerned a particular meaning of health, such as 'menopause', the knowledge of holistic health from women's perspectives is relatively new. There are few studies concerning the health meanings

and health care of midlife women from their own experiences and perspectives. Recognizing the diversity of women's lives, and understanding the meaning of health and health care from women's viewpoints under their particular circumstances will help determine the direction of nursing practice and guide the types of interactions that take place between nurses and women.

Hwu, Coates, and Boore (2001) examined the growth rate of articles related to the concept of health within nursing research journals and the empirical indicators of health based on quantitative methods between 1988 and 1998. They concluded that health has been defined using multidimensional measures, but that no researcher has considered the spiritual dimension of health. Some researchers used well-being interchangeably with health. Moreover, the articles reviewed reflect broad theoretical literature rather than personal experiences.

In an influential work in nursing, Smith (1981) proposed that health is a relative term. People are judged healthy when measured against some standard or ideal of health. The conclusion of who is healthy will differ depending on the standard, that is, the model of health used. Smith proposed four models of health to define and understand the meaning of health: clinical, role performance, adaptive, and eudaemonistic. The clinical model that is based on a modern medical perspective emphasizes health as an absence of disease, symptoms, and pain. In this model, persons with signs and symptoms of disease are not considered healthy, regardless of how productive or creative they may be. The role performance model emphasizes health as an ability to perform socially defined roles and tasks. Sickness is an incapacity that prevents people from fulfilling roles. The adaptive model views health as an ability of persons to interact with the environment. Disease is a failure in

adaptation. The eudaemonistic model defines health as exuberant well-being and self-actualization. The availability of opportunities for growth in education, in vocation, and in emotional maturity are important issues for health professionals within this model. Laffrey (1986) developed a health conception scale based on Smith's four health models that has been tested for validity with educated adults and nursing students in the United States.

It is evident that the meaning of health depends on the women's perceptions. Across the different cultures, there are both similarities and differences in the way midlife women define health. Kenney (1992) extended the work of Smith (1981), Laffrey (1986), and Woods and colleagues (1988) by examining differences in the meaning of health accepted by women and men. The majority of participants were well-educated and Caucasian, with ages ranging from 18-73 years, who lived in the American Midwest. Midlife women indicated stronger agreement regarding social involvement and harmony than did men. Both women and men ranked self-concept, fitness, and role performance in the top three categories that defined health. Although the study used a theoretical base to study health concepts, the results showed that the meaning of health from women's perception is somewhat different from men's.

Rosenbaum (1991) used an ethnographic approach to learn about meanings and experiences of health among older Greek Canadian widows aged 50-81 years. Three major meanings of health were identified: well-being, ability to perform daily role activities with the ability to accomplish the culturally expected behaviors, and avoidance of pain and illness. Women's health beliefs and practices focused on health promoting activities within a cultural context, including a balance of hot and cold diet, exercise, clear air, rubs and compresses with herbs, and a variety of folk

remedies. This study focused on the meaning of health for widows only, which does not address health more generally for midlife women. This study revealed that women may relate to traditional beliefs and experiences that influence their health activities and meanings of health.

Banister (1999) used an ethnographic approach to learn about Australian women's responses to the changes in their bodies during midlife. Participants were women aged 40-53 years, with varying educational attainments, who identified themselves as experiencing physiological changes associated with midlife. Four themes were identified: sensing incongruent, having more questions, sensing loss and longing, and caring for self. Women were uncomfortable with themselves regarding the personal standards of youth and fertility. They sought medical advice to make sense of changes but they did not get adequate responses and empathy for their concerns from their doctors, especially when their doctors found that women were disease-free. Women's awareness was exacerbated by a loss of youthful appearance, youthful energy, and fertility. Women in midlife came to realize that, as women, they had a responsibility to themselves to engage in self-care activities. They needed to be more autonomous and take better care of themselves. Study results provided an alternative to the illness-oriented medical models that rely on a stereotypical image of midlife women as vulnerable to depression, anxiety, loss of sexual interest, and lack of confidence. Although the study focused on the women's perceptions of their changing bodies as well as their meaning of health, the findings also highlighted women's expectations and practices for their health and well-being at midlife.

There are few studies concerning the meaning of health for Thai women, particularly during midlife. Jamjan and Jerayingmongkol (2002) used focus group

interviews to study the self-images of people in their fifties. Women in the study defined health as an equilibrium of basic needs. Good health was described as a delightful mood, balance of excretion, sleep and rest; or being free of disease and personal illness. Deteriorations in health due to aging included blurred vision, hearing loss, menopause, and osteoporosis. The participants accepted that aging was a naturally occurring phenomenon but they did not want to be called 'old'. Women complained of health problems that they believed were related to the demands of looking after their husbands. Women experienced emotional changes such as increased sensitivity of feelings and need for family support. A limitation of the study was that participants were women in late midlife who attended an aging club in a health center in Bangkok and who had access to health services not available in many parts of the country, including Chiang Mai. Nevertheless, the study revealed the cultural expectation of Thai women to look after family members more than themselves.

Tonmukayakul and colleagues (2000) used qualitative methods to study folk and popular health care practices of midlife women. Participants were 55 women aged between 40-59 years old who lived in Chiang Mai. Findings indicated that the meaning of health was multidimensional. Midlife was a period of experiencing various changes and of high risk for becoming irritable and developing disease. Midlife was a confusing age because of uncertainty concerning the appropriateness of their actions. Management of physical changes depended on the severity of the symptoms. Women relied on modern health care services, but also sought care from traditional practitioners when modern medicine could not solve their concerns. Therefore, to promote the health of midlife women working as professionals in

Chiang Mai, a greater understanding of women's perceptions of health and their health activities is needed.

Chirawatkul and colleagues (2002) used qualitative methods to understand health perceptions and practices among Thai women during the menopausal period. The participants were 142 women aged 45-59 years old who were living in northeast Thailand. Four themes were identified: midlife status, menopausal experiences, medicalization and folk practice, and sexuality. Women considered themselves at midlife when adult children marry and have children. Menopause was regarded as a sign of being old and becoming unhealthy. Health changes during this time affected their economic capacity in terms of their being able to perform hard work. Women perceived that the subject of menopause is not a common topic in general conversation and that the experience of menopause is individual. Women considered symptoms of dizziness, irritability, and tiredness as instability of air and blood in the body due to aging. Educated women in urban areas were afraid of menopause and anticipated negative health consequences, as portrayed by mass media advertisements. They used both modern and traditional medicine to pursue their well-being. The study revealed women's menopausal experiences and practices during the societal transformation of northeast Thailand. However, professional women in government sectors may have different experiences and difference meanings of health, as well as alternative health practices. It is important to include women from these circumstances in studies of midlife women's health.

Arpanantikul (2002) used a combination of Heideggerian hermeneutic phenomenology and a feminist approach to investigate the midlife experiences of thirty-two women living in Bangkok, Thailand. Women hoped to have good physical

and mental health, and not suffer from illness. Although their meaning of health was not described, their health activities included searching for appropriate treatments, consuming health food, using beauty products and procedures, and accumulating merit for the next life. Women believed that money could buy happiness as they prepared for getting old and for their funeral when they died. They reported stressful life events from unfaithful husbands, financial crises, and multiple role demands. The study was done with women of various employment statuses in Bangkok who had more chances for alternative treatments and procedures for their needs.

In summary, from the literature reviewed, midlife professional women in Chiang Mai are facing significant changes in their socioeconomic status, health risks, physical symptoms, and various sources of stress. According to population demographics and the socioeconomic development, midlife professional women will increase in numbers and will be a significant portion of clients requiring health services. Few studies have provided women an opportunity to reflect on their perspectives on the meanings of health and their activities to pursue their health. The most common health image of midlife across studies from several countries emphasized the aging process and health activities women performed regarding menopausal symptoms and physical changes. By focusing on the biomedical aspects of midlife, specifically the physical symptoms of aging and menopausal symptoms, women as well as their health care providers may become dependent on therapeutic medical approaches that do not consider women's full life experiences. Therefore, there is a need for a research which provides a better understanding of women's health in Thailand and provides information to inform the development of appropriate health promotion strategies that are responsive to women's life experiences.