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BEING A COMMERCIAL SEX WORKER IN THAILAND: EXPERIENCES AND HEALTH CARE SEEKING BEHAVIORS

by

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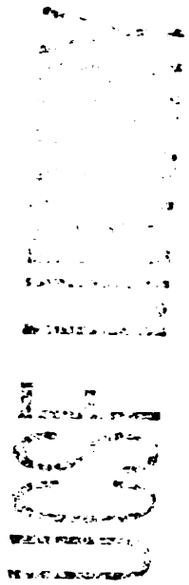

To
My Beloved Father
Who
Always believed in me

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I consider this dissertation to be a part of my life's journey. Along the way, I have received a lot of support, guidance, and mentorship from many significant people whom I would like to thank. To those whom I name here and to those whom I may have forgotten, I appreciate everything you have shared with me.

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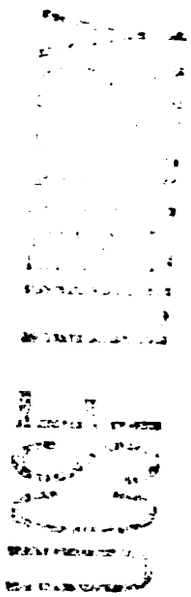
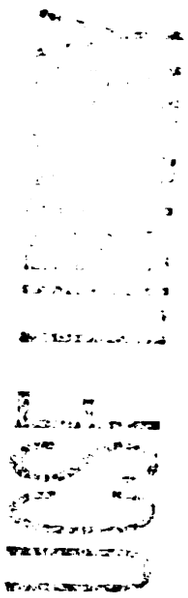


I would like to thank my parents for their unconditional love and support, especially, my father, who nurtured me with his love, caring, spirit and wisdom and always believed in me. I also thank my sisters and brothers who took over my role in caring for my parents and for helping me in numerous ways during the past six years.

Most of all, I would like to thank each of my participants, "Thai Female Commercial Sex Workers," who gave me their trust, shared their life stories and expanded my understanding of the lives of Thai women. I hope that my dissertation provides truths about their lives, contributes to making their voices heard, and ultimately improves the health services available to them.



ABSTRACT

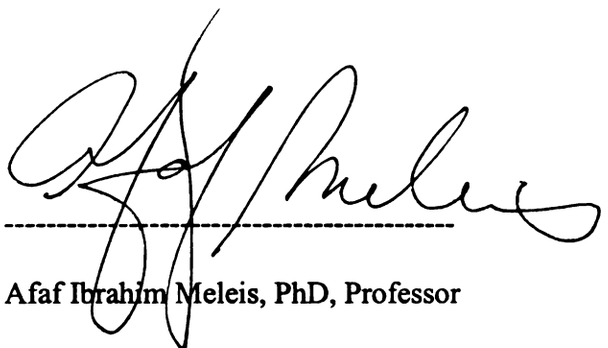
BEING A COMMERCIAL SEX WORKER IN THAILAND: EXPERIENCES AND HEALTH CARE SEEKING BEHAVIORS

Ameporn Ratinthorn

Research related to health of vulnerable groups is identified as a priority for nursing care. Commercial sex worker (CSW) is one vulnerable group with major risks. The purposes of this study were to describe: (a) the work experiences and meaning of health by CSW in Thailand; (b) the strategies they use to maintain their health and respond to their illnesses; and (c) the determinants of their health and health seeking behaviors. A triangulation of quantitative and qualitative methods was used. One hundred CSW were recruited from both clinic and community based settings in Bangkok, Thailand. The data were obtained through questionnaires (i.e., demographics, perceived health status, general health (GHQ-28), physical health problems, importance of health, and perceived work condition questionnaires), and participant observation in clinical and community based settings. Thirty-five participants were selected for in-depth interviews. Descriptive, simultaneous regression and logistic regression methods were used to analyze the quantitative data. Grounded theory method was used to analyze the qualitative data.

Participants described their work as stigmatized, secret, isolated, uncertain, risky, and violent. To them, being healthy meant being able to work and earn a living, and health was thought of in terms of sexual health. Work conditions varied according to the types of establishments (e.g., massage parlor, a-go-go bar, teahouse, and streetwalker). Work condition variables such as higher numbers of customers per night, lower numbers of customers per month and having choices in work, were significantly related to lower

perceived health status ($p < .05$). The greater the balance between perceived stress and satisfaction in work, a lack of violence at work, and higher educational levels were associated with a better mental health status ($p < .01$). Finally, the more years in sex work, violence in the work place and providing financial support for family were significantly related to higher total number of symptoms ($p < .01$). The major health care seeking strategies used by participants were self-medication, ignoring health concerns, and seeking professional health care. A model explaining the relations between these factors of the health care seeking in sex work was developed. According to the model, health care seeking strategies were influenced by women's perceptions of sex work, perceptions of health, conditions of sex work, and their experiences in living with sex work.



Afaf Ibrahim Meleis, PhD, Professor

Committee Chair

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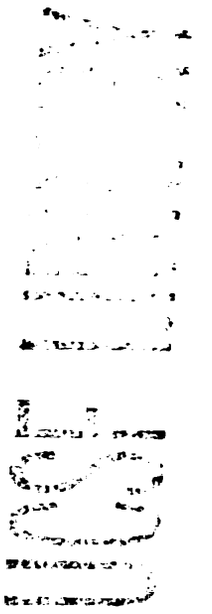
CHAPTER 1

INTRODUCTION

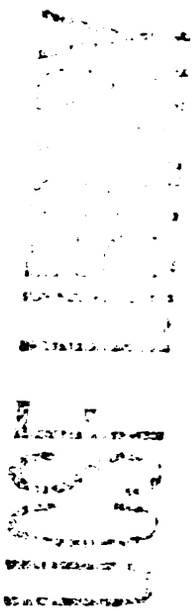
Commercial sex work has always been perceived as a social problem that should be invisible or controlled by law enforcement. Policies regarding commercial sex work have been ambiguous in Thailand (Bishop & Robinson, 1998; Ford & Koetsawang, 1999). While governments have tried to suppress the number of sex workers, some have also included the sex industry as the part of the national development plans (Bell, 1997; Phongpaichit, 1982; Sanghera, 1998; Sittirak, 1996). Sex workers have been used as a commodity to attract tourists from all over the world. However, sex work has never been recognized as making a major contribution to any national economy. It is rarely viewed as a work (Bishop & Robinson, 1998). Most societies pay attention to how prostitution affects the image of the country but show little concern for how it affects women who are working as sex workers. Sex workers are considered as lacking moral judgment. They are generally stigmatized and marginalized.



Commercial sex work in Thailand has been the focus of many social science research studies (Phongpaichit, 1982; Pongsapich, 1997; Sanghera, 1998; Sittirak, 1996). Mainly, the studies on commercial sex work have tried to explain what makes women become commercial sex workers and to seek strategies to prevent women from entering this profession. After the onset of the anti-sex trade movement, many social scholars started to view the problems of prostitution as cultural, social, political and economic (Sittirak, 1996). Sex work began to be viewed as a product of social gender inequity (Bell, 1997; Pongsapich, 1997; Sanghera, 1998).

Attention to health of commercial sex workers (CSW) was historically absent from women's health care provision, and received attention from public health only after the epidemic of sexually transmitted diseases in the late 1980's (Van Esterik, 1992). In the past, female commercial sex workers were viewed as a bridge in the transmission of sexually transmitted disease to the general population (Barnard, 1993). In order to prevent the spread of sexually transmitted diseases, the first venereal clinic for commercial sex workers in Thailand was established based upon the Contagious Diseases Prevention policy (Boonchalaksi & Guest, 1994). More recently, during the AIDS era, it was reported that the major mode of the transmission of AIDS in Thailand was through commercial sex workers, not through intravenous drug use as was the case in developed countries (Van Esterik, 1992). However, the focus of much of the HIV prevention research was on how commercial sex workers could provide preventive interventions for their male clients, rather than on how they could protect themselves from health risk (Beyrer et al., 1995; Maticka-Tyndale et al., 1997; Nelson et al., 1996; Rojanapithayakorn & Goedken, 1995). Health education for commercial sex workers has mainly focused on STD and HIV/AIDS prevention (Jessen, Luck, & Taylor, 1994; Sawanpanyalert, Ungchusak, Thanprasertsuk, & Akarasewi, 1994; van Griensven, Limanonda, Chongwatana, Tirasawat, & Coutinho, 1995; Wawer, Podhista, Kanungsukkasem, Pramualratana, & McNamara, 1996). A few researchers in the field of HIV prevention have started to look at the conditions of sex work that relate to health prevention, such as, the impact of the owner of establishment on the consistency of condom use. Nonetheless, none of these studies have looked at the total health of these women and none have incorporated the women's perspective (Evans & Lambert, 1997).

The health of commercial sex workers in Thailand has rarely been explored, although, there are some research findings reported about sexual health practices (i.e., contraceptive use or abortion) (Tophothai, 1997), perception of health (Tritrakan, 1997) and health protective strategies, such as self-medication and cleaning after sexual intercourse (Rawungpan & Pornsiriphong, 1996; Tophothai, 1997). There is still a lack of information regarding how women perceive their health, what their health practices are, why women use particular strategies, how they get health information, where information comes from, the role of health care providers in affecting outcomes, the types of health care services that are provided to sex workers, and work conditions influencing their health and health practices.

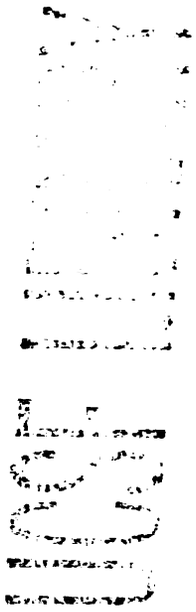


Because working as commercial sex worker violates the norms of "good women," the health needs of CSW are often unrecognized and considered unimportant. Because of the illegal status and stigma of sex work, commercial sex workers tend to be "invisible" in the health care system. Health problems associated with sex work, such as sexually transmitted diseases and violence, are commonly assumed to be "risks of the trade." (Barnard, 1993; Farley & Barkan, 1998; Vanwesenbeeck, de Graaf, van Zessen, Straver, & Visser, 1995). They have prevented the health care system from viewing these problems through the lens of occupational health. Consequently, health care providers tend not to look at such daily work conditions or illnesses other than sexually transmitted diseases, such as repetitive stress injuries and other musculoskeletal problems, and work-related stress that may be health concerns to sex workers (Alexander, 1998). In additions, the issue of violence in sex work in Thailand has always been neglected by the social system. As an approach to better understanding the health of commercial sex workers, prostitution or commercial sex work should be considered as a form of work (Alexander, 1998). In addition, we have to

understand that sex work is governed by various types of social relations (Kempodoo & Doezema, 1998; Truong, 1990). It is also a form of violence against women (Farley, Baral, Kiremire, & Sezgin, 1998).

Significance of the Study

The health of vulnerable groups has been clearly identified as a priority for nursing (Meleis, 1992, Hall, Stevens, & Meleis, 1994). Knowledge development in nursing has emphasized the importance of uncovering the experiences and needs of marginalized populations (Meleis, 1998). In the last decade, increasing numbers of nurse researchers have uncovered and analyzed the health care needs, the experiences of health and illness, and the responses to health care of vulnerable or marginalized populations. However, little knowledge is available about the potential impact of nursing upon such a specific marginalized population as commercial sex workers. The health of commercial sex workers needs to be considered as a women's health issue (Misner, Parker, & McElmurry, 1995).



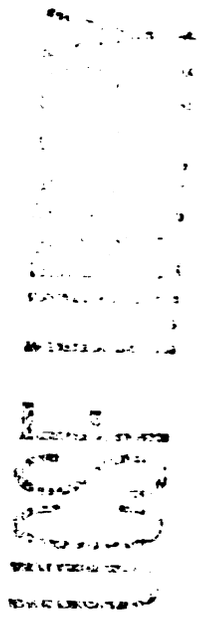
To date, there has been little investigation of the daily life context of sex workers and health practices. Thus, the present study was formulated in order to gain a better understanding of women's perceptions of their life situation, including work conditions, their health, and health seeking strategies. This research provides an understanding of health from the perspective of commercial sex workers. It provides an explanation of their health practices and of the patterns of sharing information among sex workers. It gives us insight about the lived experiences of sex workers. It tells us about the conditions in sex work and whether they have any significant impact on health and health practices. The study thus, provides information that guides strategies for improving the health of this vulnerable population.

Purpose of the Study

The aims of the study were: (a) describe work experiences and meaning of health by female commercial sex workers in Thailand; (b) uncover the strategies that the women use to maintain their health and respond to their illnesses; and (c) describe determinants of their health and health seeking behaviors. The major research questions to be answered were: how do commercial sex workers tend to define personal health and work conditions, and what strategies do female commercial sex workers use to seek health care in Thailand?

Organization of the Chapters

This dissertation is organized into seven chapters. Chapter 2 includes the conceptual framework for the study and a review of the literature related to commercial sex work. The research questions are presented at the end of Chapter 2. In Chapter 3, research methodology, including research design and settings, recruitment of the participants, instrument and methods used to collect and analyze the data are described. Chapters 4 and 5 present the findings of the study. Chapter 4 explores sex work conditions, the meaning of work, and the experiences living with sex work. Chapter 5 describes health and health care seeking experiences among commercial sex workers. In Chapter 6, the findings are integrated and discussed. Finally, in Chapter 7, the findings and discussion are summarized; the limitations of the study are discussed; and implications for future research, clinical practice and health policies are presented.



CHAPTER 2

THEORETICAL BACKGROUND AND LITERATURE REVIEW

In this chapter, I will provide a critical review of the literature about commercial sex work in general, and more specifically, in Thailand. The different models used to explicate the relationship between women's work and their health and the models used for describing and predicting health care seeking behaviors will be discussed. The review will also include how commercial sex work may place women at health risk and/ or decrease access to health care. To understand patterns of health care seeking behaviors in female commercial sex workers (CSW) in Thailand, this research was framed within a feminist perspective, utilizing the role integration model of women's work and health, and the social behavior models. Each of the models is discussed in the chapter. The conceptual framework of the study is presented in this chapter, as well

A Feminist Perspective

This study was developed using a feminist perspective. The feminist perspective values the experiences of all women and the diversity of women's lives. The situations of women and the analysis of women and their lived experiences are the foci of all feminists (Flax, 1990). Feminists emphasize that the position of women in society, particularly marginalized women, impacts the roles they occupy, the resources at their command, their interactions with the environment, the behaviors they manifest, and the responses of individuals or institutions to such behaviors (Thomas, 1994).

Although feminist frameworks are very diverse, they all focus on the oppression of women in society and aim to create change that improves the lives of women (Mitsunaga, 1994). Feminist theories suggest approaches to understanding and reconstituting the self,

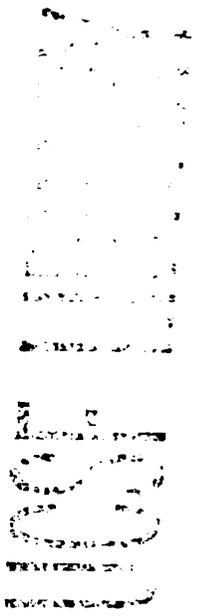
gender, knowledge, social relations, and culture without resorting to linear, teleological, hierarchical, or binary ways of thinking and being (Flax, 1990). Three basic principles of all feminisms are: 1) valuing and validating women's experiences, ideas, and needs; 2) recognizing the existence of ideological, structural, and interpersonal conditions that oppress women; and 3) eliminating women's oppression through criticisms and political action (Hall & Stevens, 1991).

While feminist approaches have not generally been used to guide nursing research in the past, they provide a lens for shaping research questions about meaning and lived experience. One principle of feminist research is to contribute to women's liberation by producing knowledge that can be used by women themselves (Acker, Barry, & Esseveld, 1983). Feminist research is not only conducted to describe and interpret phenomena of women's lives but also to raise consciousness about women's issues (Hall & Stevens 1991). Distinguishing features of feminist research include: a) interest in particular groups of women done for the purpose of finding answers for women, providing explanations that women want about phenomena that affect their lives and avoiding the exploitation of women; b) investigation into human diversity, rather than homogeneity; c) consciousness about the value of research by explicitly scrutinizing study processes, including the researcher's history, assumptions, motives, interests, and interpretation; d) emphasis on the equality of relationships between researchers and participants; e) use of multiple research method; and f) creating social change that benefits women (Bunting & Champbell, 1994; Hall & Stevens, 1991).

Feminist approaches have been use to capture the realities of women's lives from the standpoint of the women who live them (Kasper, 1994). A qualitative feminist approach is

an appropriate methodology for this research topic because it focuses on uncovering the social relations that deny the lived realities of oppressed groups, in this case, commercial sex workers. Listening to women talk about health from their own point of view and situating these accounts in the context of their everyday lives provides a better understanding of women's health related strategies (Evan & Lambert, 1997). Stories from the lives of marginalized commercial sex workers helps generate knowledge that can be used for them, rather than only for the dominant groups who manage the lives of these women (Harding, 1993).

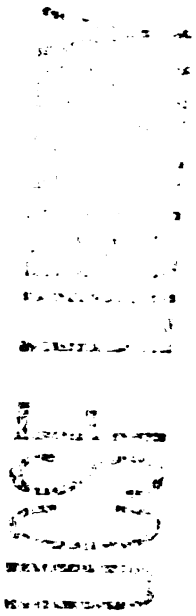
In this study, a feminist framework was used as a guide for reviewing the literature on CSWs and selecting appropriate theoretical and methodological approaches. The feminist perspective guided me to look at the health and health behavior of women in the context of their daily-lived experiences. Throughout the process of the study, the value of the research, the researcher's history, assumptions, motives, personal values, interests, relationships between researcher and participant, and interpretation were explicitly scrutinized.



Feminist and Women's Work

Messias and colleagues (1997) examined the ways in which the definition of work as paid employment has affected women's health research, knowledge and understanding about the relationship between women's work and health; and the impact of social policies on health. They proposed that in relation to health, women's work needs to be considered in terms of the multiplicity of its contexts, properties and dimensions. This means that women's work has to be understood within multiple social, cultural, emotional, structural, and environmental contexts.

Properties of women's work should be considered in terms of activity and energy, space, time, resources, results, values, and meanings. The properties of work *activities* and *energy* refer to type, intensity, and duration of work as well as the distribution of expenditure of energy and overload. The properties of *space* refer to the geographic location in which work occurs. *Time* includes time spent in working, planning, preparing oneself for work, and in getting to and from work. *Resources* include information, materials, transportation and social support. *Results* from work can be in the form of direct compensation or rewards for work such as money, self-fulfillment, personal independence, autonomy, and daily survival needs. *Values* of work may include personal, social or monetary value, or stigma (Messias et al., 1997). The *meanings* of work are influenced by social values and the degree to which the work is valued.



Thanh-Dam Truong (1990) challenged us to look at the many assumptions underlining the definition of prostitution. She pointed out that the definition of prostitution is an expression of the cultural hegemony of men over women. She proposed that prostitution should be seen as sexual services under exchange relations. She suggested that we should examine how the nature of such service and the relations surrounding them are transformed. Prostitution must be understood as a set of social relations that involve not only the provider of sexual services, but also the receivers or buyers of the services, and the regulator. We need to recognize that prostitution is work, and that it is governed by various types of social relations.

In the next section, the literature related to commercial sex work will be reviewed.

Review of the Literature

Commercial Sex Work

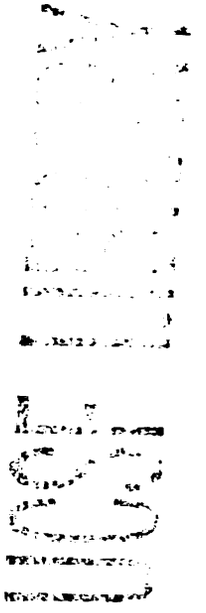
The words "*commercial sex work*" and "*prostitution*" have been used interchangeably in the literature, although the implicit meanings attached to each of them have not been examined. Recently, a group of feminist researchers has pointed out that there is a need to reconsider the definition of these two words in terms of the rights of the women who are in this group (Alexander, 1998; Kempodoo & Doezema, 1998; Truong, 1990). Clarifying the concept of commercial sex work is an important step in the research about women who work as commercial sex workers. In the following section, the concept of commercial sex work will be clarified. First, the definition of prostitution will be discussed. After which I will differentiate between commercial sex work and prostitution. In addition, I will analyze the social, cultural, historical, legislative contexts of the concepts, identify the properties of commercial sex work; and examine the health consequences of commercial sex work.

Definition of Prostitution

Prostitution is defined as the practice of habitual or intermittent sexual union, more or less promiscuous, for mercenary inducement (Truong, 1990). In Thailand, "prostitute" was defined as "women who gave sexual service promiscuously for money" (Hantrakul, 1983). Presently, prostitution is defined as "the acceptance of sexual intercourse or the acceptance of any other act, or the commission of any other act in order to gratify the sexual desire of another person in a promiscuous manner in return for earning or any other benefit" (Ministry of Labor and Social Welfare, Thailand, 1996). These definitions of prostitution are characterized by three elements- payment, promiscuity, and emotional indifference.

Differentiation of Commercial Sex Work and Prostitution

The concept of commercial sex work emerged in the 1970s during the prostitutes' rights movement in the United States and Western Europe (Kempodoo & Doezema, 1998). Than-Dam Truong (1990) presented one of the first extensive theoretical elaborations of this concept. Based on the ideas that work is the way in which basic needs are met, and human life is produced and reproduced, she argued that activities involving sexual components of the body and sexual energy should be considered important to the fulfillment of basic human needs. Thus, sex work should be viewed as similar to other forms of labor performed by humans in order to sustain itself. Kempadoo and Doezema (1998) proposed that the term sex work suggests we view the prostitution not as an identity, or as social or psychological characteristic of women, but as an income-generating activity or form of labor for women. This definition allows us to see sex work as employment. However, some feminists have commented that using the word commercial sex work comes from a capitalist perspective and gives the sense of exploitation of women (Shrage, 1994). Some of them continue to use the term 'prostitution' in discussions about issues of ethics and morality.



When using the keywords "prostitution" and "sex work" to search for articles from Medline, it was found that they were used interchangeably. Prostitution and commercial sex work were analyzed and discussed in the literature as they related to other concepts such as the concept of sexually transmitted disease, the control of sexually transmitted disease, and the concept of strengthening community action (Day & Ward, 1997; Dawne, 1997; Thomas & Tucker, 1996). For example, Day and Ward (1997) reviewed medical, historical and social literature to describe and assess measures meant to control sexually transmitted diseases among sex workers and their partners. The authors concluded that a broad social

definition of prostitution that goes beyond discussion of sexual activity is important for effective disease control. Understanding the relationship between social disadvantage and sexual activity will broaden the provision of occupational health services to sex workers. In this article, the authors also related prostitution to the concepts of vulnerability, oppression, discrimination, criminalization, and inaccessibility to health care service. Although, the authors did not explicitly state that the term prostitution should be replaced by the term commercial sex work, they suggested that prostitution needed to be redefined more broadly.

There are significant differences in the literature in the meanings attached to the terms, *'prostitution and commercial sex work'* and how these terms generate different approaches to research and health care practice. In Thailand, there are several different terms used for female commercial sex workers. Each term conveys a different connotation and represents a particular type of sex worker. The term for "prostitute" in the Thai language is "sopheni." This term has a very specific negative meaning and mostly refers to brothel workers and streetwalkers. The term for a female commercial sex worker in the Thai language is "phuying borikan." This term has a more neutral meaning and refers to sex workers who work in bars, massage parlors, and cocktail lounges.

When comparing how the terms "prostitution" and "commercial sex work" have been used, it seems that the term prostitution is used in the sense of "being," while the term commercial sex work is used in the sense of "doing." Generally, when we think about "being," we focus only on the subject, not on the context or the environment. The word "prostitution" already implies a negative meaning that cannot be changed. On the other hand, commercial sex work, having the sense of doing, allows us to consider context and work environment. Using this term allows us to view commercial sex workers as women

who might have health problems that result from a risky work environment. Making distinctions between prostitution and commercial sex work is important in exploring potential problems, outcomes of health care seeking behaviors, and research models.

In general, when women are labeled as prostitutes, the potential problems are less disclosure of status, increased risk of being jailed, increased chance of normalizing pathology and receiving negative treatment, increased risk of violence, and less voice (Alexander, 1998). For example, health problems associated with prostitution, such as STDs and violence are assumed to be common problems for prostitutes. It might be assumed that prostitutes bear the responsibility for the spread of STDs and HIV/AIDS in the general population (Beyrer et al., 1995; Maticka-Tyndale et al., 1997; Nelson et al., 1996; Rojanapithayakorn & Goedken, 1995). Police might ignore cases of violence in prostitutes and assume that it is just something prostitutes should expect. Health care providers might view prostitution in isolation, excluding these women from the usual aspects of human life and work. The stigma and illegal status of prostitution have prevented the health care system from viewing it through the lens of occupational health and safety (Alexander, 1998). Health care providers may delay diagnosing and treating their illnesses, be less vigilant in deciding on an appropriate diagnosis or in asking the correct questions, and have little concern about preventive health issues for these women. Likewise, health care providers often fail to look at daily work conditions and illnesses such as repetitive stress injuries and other musculoskeletal problems, bladder infections, and the work-related stresses that may be of primary concern to sex workers (Alexander, 1998). The women might delay seeking care or inappropriately use self-medication because they experience stress when accessing health care (Abellanosa & Nichter, 1996; Kilmarx et al., 1997).

Using the term "commercial sex work" allows us to recognize sex work as an occupation (Alexander, 1998). The health of commercial sex workers is then viewed within the context of occupational hazards. When health care providers consider sex work as a work, they tend to gather more appropriate information, make correct diagnoses, and provide proper treatments. They are more likely to link the conditions of sex work to the repetitive health problems of women in other occupations. For example, knee pain may be related to working in a crouched position in a strip club, or recurrent bladder infections might be associated with the use of diaphragms. The concept of commercial sex work encourages us to consider many other work-related health problems such as psychological and contagious diseases like tuberculosis and bronchitis. We are more aware of their problems in accessing health care for such reasons as lack of health insurance (Alexander, 1998). These attitudes might help sex workers feel safer in their work, seek more attention from the health care system and feel comfortable in accessing care.

Therefore, in this study I have adopted the view that commercial sex work is one type of the work that women do. In the next section, the antecedents of this concept will be examined in terms of the historical, social, political, and legislative contexts of commercial sex work, with a focus on the Thai context.

History of Prostitution in Thailand

The practice of commercial sex work in Thailand can be traced to the 15th century (Wawer, Podhista, Kanungsukkasem, Pramualratana, & McNamara, 1996). During that period, marriage often meant that a woman was transferred from her father's custody to the custody of her husband (Hantrakul, 1983). Women went directly from being confined in the father's home to husbands, and always under a male's domination. They could neither

choose nor divorce their husbands, although men could both choose and divorce their wives. Women were expected to be subservient at all times. Wives and daughters could be sold or given away as presents or in payment of debt. Sex workers were seen as being lower in status than slaves.

In the late 19th century, Thailand commercialized the rice trade. This brought an influx of immigrants from China, mostly men. To fill the sexual needs of these immigrants males, selling sex was introduced on a large scale for the first time.

The number of commercial sex workers is believed to have greatly increased since 1960 because of the presence of the United States military in Thailand during the Vietnam War and later because of international sex tourism (Cincone, 1988). Although commercial sex work has been a factor in the economy of the country, no attention has been paid to issues of exploitation of these women.

Buddhism and Thai Cultural Values

Most Thais accept reincarnation and believe that the degree of suffering a person experiences is determined by the person's karma. According to the law of karma, good actions earn merit and bad actions earn demerits. Both alter one's karma with implications for the extent of suffering to be experienced in one's current and next life (Muecke, 1992). Sex workers are perceived as having lowered karma. However, if the woman sells sex with the intention of helping others such as her parents and family, the merit accumulated by doing so may counterbalance the demerits of working as a sex worker. In addition, she could also add to her merit by making donations to monks or temples or by sponsoring religious activities (Muecke, 1992, Wawer & etal., 1996). Women who engage in commercial sex

work hope that earning merit will alter their bad karma and result in less suffering later in the present or next life

Additionally, while there are normative rules against commercial sex at the societal level, women may be forgiven because they are viewed as lacking sufficient choice and because they are fulfilling valued obligations. The study of Thai attitudes toward female sex workers by Peracca and colleagues (1998) revealed that both Thai men and women saw these women as victims of societal circumstances. The participants also conveyed that these women deserved forgiveness and understanding due to their desire to help their families. They also believed that many women enter this work because of impoverished family situations.

In Thai culture women are also subordinated and submissive to men and fill decorative roles. It is widely accepted as normal for Thai men to visit sex workers (Dumronggittigule, Arthamet, Taywaditep, Mandel, & Chaikunar, 1993) and to have multiple partners if they are not satisfied with the sexual relationship with their wives. Moreover, some wives think that visiting a sex worker is better for their husbands than having a minor wife. Therefore, it is hard to change the norm of visiting prostitutes in the Thai culture.

Prostitution and Law

Historically, legislation regarding prostitution provided no benefit to women working in a commercial sex. In 1908, the Communicable Diseases Act was passed because of the spread of sexually transmitted diseases through commercial sex. It required all brothels to apply for a certificate of operation. Sex workers were also required to undergo tests to

ensure they were free of venereal diseases. Brothels were required to place a red or green lantern at their entrances indicating the health of the women.

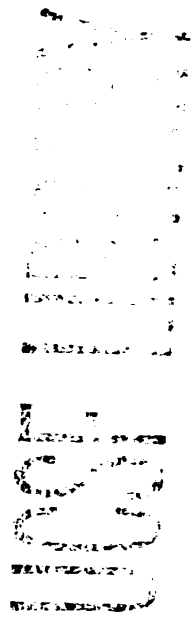
The first Anti-Prostitution Act was passed in 1960. The law banned prostitution by both women and men. Penalties covered procurers and brothel owners, as well as the prostitutes. Rather than being jailed, prostitutes could be sent for rehabilitation and vocational training for a period of up to a year.

In an attempt to inhibit the problem of prostitution, the Banharn Silpa-archa Government enacted a law that more harshly punished clients, procurers, operators and parents who brought under-age girls into the sex trade. The 1996 Act stipulated longer prison terms for those who have sex with prostitutes under 18 up to one to two years and/or a fine of 20,000-60,000 baht ($ 500-1,500). A jail term of 2-20 years and/or a fine of 40,000-400,000 baht was imposed on those having sex with prostitutes under 15. Procurers and operators who brought those under 18 into prostitution faced a 5-15 year jail sentence and/or a fine of 200,000-400,000 baht ($ 5,000-10,000). Parents or patrons who conspire with others to bring minors into prostitution faced similar penalties. The law also established an Occupation Protection and Development Committee to map out prevention policies, protective mechanisms and measures to equip former prostitutes with the skills to enter other occupations and improve their lives (Ministry of Labor and Social Welfare, 1996). However, the Prostitution Prevention and Suppression Act failed to address the crux of the problem and should be entirely abolished. In addition, because prostitution is illegal, it promotes corruption among local police, and oppression by procurers and brothel and establishment owners. Because prostitution is not accepted as an occupation, sex workers cannot be protected under the Labor Protection Act like other workers (Vanaspong, 1996).

Reasons for Entering Commercial Sex Work

According to the literature, the major reasons for entering sex work are poverty and coercion.

Poverty. One of the meanings of commercial sex work is clearly related to economic advantage. Poverty is accepted as the main reason that many young women enter the sex industry. Thailand is a newly industrialized society. This has created a wide disparity in income between cities dwellers and those in rural areas (Berer & Ray, 1993). This change has had a devastating impact on the social, environmental, and cultural spheres of people's lives (Shih, 1994). It has led to the inability of rural communities to survive on agricultural income alone, the accumulation of rural debt, and the physical and cultural disintegration of families and communities. As a result, young men and women have migrated to urban centers and foreign lands to seek better paying jobs, including jobs in the sex-service industry (Berer & Ray, 1993). Women are expected to take care of their families, especially in poor family. This situation has brought many young women to the cities to work in sex industry to support their families (Shih, 1994).

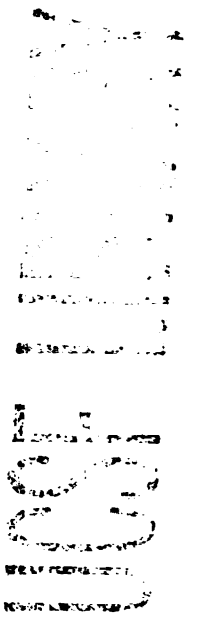


However, it is not only economic pressure that has pushed many young girls into sex work. Many parents have pushed them by insisting they be dutiful daughters and help support their families by working in a commercial sex establishment (Hantrakul, 1983).

Coercion. Other reasons for entering sex work include being cheated or sold into prostitution, inability to find jobs in the provinces, running away from broken families or relationships, or the attractions of an upwardly mobile lifestyle in Bangkok (Wawer et al., 1996). In making the decision to enter commercial work, two-thirds of commercial sex workers working in brothels in Northern and Southern Thailand said that it was their own

decision, while one-fourth said they were influenced by family members, friends, and neighbors. Among commercial sex workers working in other establishments, 40% joined the occupation willingly and the same percentage were influenced by others, including former commercial sex workers (Mahapol, 1995).

Differing reasons for entering sex work might lead to differing working conditions impact on women's well being, and their health practices. The differences in person, social, and work conditions can affect how women enter sex work. This consequently impacts their willingness and ability to engage in healthy and protective behaviors. The study conducted by Sedyaningsih-Mamahit (1999) indicated that sex workers who were forced into sex work by situations such as no money, insufficient education, no other job opportunities, and being the sole breadwinner, tend to have more responsibilities for their health. In contrast, women who enter sex work because of conflicts in their life such as anger with parents or lovers, tend to be reckless and engage in negative health behaviors such as using drugs and alcohol, and unprotected sex. The study also suggested that STD/HIV programs for commercial sex workers need to be planned based on understanding of sex workers as persons and as well as understanding the nature and conditions of their work (Sedyaningsih-Mamahit, 1999)

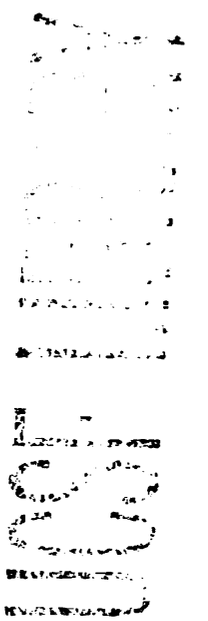


Properties of Commercial Sex Work

From the dictionary, commercial is defined as:"1. a. Of or relating to commerce. b. Engaged in commerce. c. Involved in work that is intended for the mass market. 2. Of, relating to, or being goods, often unrefined, produced and distributed in large quantities for use by industry. 3. Having profit as a chief aim" (The American Heritage Dictionary, 1993 p 280).

The properties of commercial sex work are defined as: being in public, selling sex as a commodity, interacting and negotiating with unknown persons, pleasing others and control of self-expression, and types and conditions of sex work. Each of these properties is defined in the following sections.

Being in public. The first property of commercial sex work is being in the public sphere. Commercial sex work requires the women to be in a place where customers can have access. Being in public can occur in various ways such as walking or standing on the street in specific areas, sitting in a waiting room that can be seen from the outside, or wearing clothing that is sexually provocative. In a study conducted by Soponkanaporn, (1996), most sex workers initially felt reluctant dress in the way that the establishment required because it is considered as inappropriate in the Thai culture. They also reported that such dress increased vulnerability to invasion and sexual harassment by their clients. However, most women follow the regulations of their establishments since they have no choice.



Selling sex as a commodity. Commercial sex work involves the sale of sexual services; sex is treated as a *commodity* (de Zalduondo, 1991). In commercial transactions, the social identity and personal characteristics of the buyer are usually unimportant relative to his ability and willingness to pay for the service (de Zalduondo, 1991). The practice of exchanging sex for material goods or protection may vary with social context. The transaction is either implicitly or explicitly time-limited, involves an agreed upon unit price, and is explicitly divorced from commitments for future exchange.

Interaction and negotiation with unknown persons. Interaction and negotiation are properties of sex work. Interaction and negotiation between sex workers and their clients are considered crucially important in condom use (Browne & Minichiello, 1995;

Vanwesenbeech et al., 1994) as is support by the owner of the establishment (Visrutaratna, Linda, Sirhorachai, & Mandel, 1995). Vanwesenbeech and colleagues identified four interaction scenarios: standard; romantic; friendship; and fighting scenarios. A standard interaction means that both sex workers and customers are aware that money is exchanged for sex, time, intimacy, and specific sexual techniques. In a romantic situation, both sex workers and their clients may present themselves with a need for friendship and intimacy. A friendship scenario occurs when the participants have become familiar with each other (Peracca, Knodel, & Saengtienchai, 1998). In such cases, clients may come to a specific sex worker. Lastly, the fighting scenario occurs when there is neither familiarity nor mutual trust. These clients feel negative about sex work and are vindictive toward sex workers. They are more likely to be recalcitrant protectors (Vanwesenbeech et al., 1994).

Pleasing others and control of self-expression. Pleasing customers and control of self-expression are also properties of commercial sex work. When women enter into this type of work, the first lesson they learn and practice is to please their customers and control their self-expression (Soponkanaporn, 1996). In order to please customers, women are expected to be immodest. Women may have to sit and drink with their clients, provide nice conversation, allow body contact, and perform sexual intercourse as required by the customer. Women have to control their emotions and learn to express them in passive ways.

Types and Conditions of Sex Work

Because prostitution has been illegal in Thailand since 1960, commercial sex work is often disguised as other forms of entertainment. In Thailand, commercial sex work establishments include those that provide only sexual services, predominately brothels, and those that provide a wider variety of services including sexual contact, such as massage

parlors, bars, and karaoke clubs. In direct service establishments, male clients are more likely to be from lower socio-economic classes, such as laborers and agricultural workers. Direct commercial sex workers are younger and usually start at a younger age than do indirect commercial sex workers. They are also more often HIV positive and less likely to use condoms (van Griensven et al., 1998). Eighty-nine percent of direct commercial sex workers move from their village of origin right into to engaging in commercial sex work in an urban area. The education level of commercial sex workers is low; 87% complete less than seven grades of school and 25% cannot read or write (Limanonda, 1993).

Environmental and behavioral changes, a sedentary lifestyle, and the stress of work conditions for these women are associated with a high prevalence of disease (Ghannem & Hadj Fredj, 1997). The poor conditions in brothels critically affect workers' physical and psychological development and place them at greater risk of contracting diseases, such as malnutrition, tuberculosis and other conditions that are not necessarily associated with commercial sex work. The movement of the women outside the brothel is strictly controlled. Women taking excursions without permission are heavily fined and permission to leave is rarely granted by brothel managers. Outside activities for health care or shopping are supervised. In one study conducted by Wawer and colleagues (1996), it was found that 50% of the informants made weekly visits to the health clinic to be checked for sexually transmitted diseases, while 43% went about once or twice a month. Some women have to work 10-12 hours a night and can refuse clients only with the consent of the manager.

Being in debt to the employer is associated with risk of HIV infection. One explanation for this is that debt makes women work longer, have more customers, or accept unprotected intercourse when more money is offered. In contrast, in the evaluation of an

HIV prevention program among commercial sex workers, it was found that support from the manager was the only variable related to positive changes in condom use (van Griensven et al., 1998). Conditions of work are important factors that can affect the commercial sex worker's health practices.

Health Consequences of Commercial Sex Work

Clarifying the properties of commercial sex work allows us to see the linkages between the characteristics of commercial sex work and the health of commercial sex workers. The health consequences of commercial sex work include being marginalized and invisible in the health care system, being at-risk for sexually transmitted diseases, victimization, and violence, and developing autonomy.

Being marginalized and invisible in health care system. Stigmatized persons are avoided, rejected, and seen as a source of contamination. In the institutional worldview, their self-identities are excluded, rephrased, distorted and/or devalued (Stoller, 1997). Most women who engage in commercial sex work are subject to the risks of stigmatization, incarceration, violence, exposure to drugs and sexually transmitted diseases, and limited long-term economic benefits (Misner et al., 1995). Society's response to this identity is most typically exclusion and marginalization, both of which reinforce stigma and isolation. Since commercial sex workers experience outright rejection from Thai society and discrimination on the part of their customers, the mental health of commercial sex workers is also often compromised. As a consequence, many seek consolation in drugs and alcohol. However, the mental health of sex workers has never been seriously assessed nor given a high priority in research.

Access to health care. Within the health care system, people of marginal status are likely to face difficulties in gaining access to services and often receive lower quality care. Social prejudice and legal sanctions cause some sex workers to avoid appropriate and accessible specialist services for sexually transmitted diseases. Generally, the criminalization of prostitution combined with widespread prejudice creates difficulties for disease prevention and treatments because many sex workers remain invisible and inaccessible to health care. In addition, sex workers are traditionally seen as a source of disease, and they are often the focus of sexually transmitted disease control measures.

In Thailand, the clinics that provide health care service to commercial sex workers are mainly operated under the Ministry of Public Health. The purpose of these clinics is to provide pelvic examinations for STD checkups and blood tests for syphilis and HIV infection. However, preventing disease is not always the first priority of sex workers. Some feel that they do not have the power to protect themselves from disease. There is no literature about how sex workers feel about their access to health care, and whether they perceived it as being different from other women.

Self-treatment. Because of their limited access to health care and their ongoing need to maintain their health in order to continue working, some commercial sex workers treat themselves. Abellanosa and Nichter (1996) found that unregistered commercial sex workers are five times more likely to use prophylactic antibiotics than registered commercial sex workers, and they are seven times less likely to use condoms with 80% or more of their customers. Self-treatment with low dose prophylactic antibiotics provides no protection against STDs, impedes STD screening and leads to antibiotic resistance (Abellanosa & Nichter, 1996). In Thailand, antibiotics are often not prescribed by trained practitioners but

are obtained directly from a pharmacy, friends, or other sources in the community. In a study conducted by Kilmarx and colleagues (1997) it was found that more than half of the subjects reported having taken medications by mouth and injection that were not obtained from an official government STD clinic.

In addition to self-treatment, there are a range of preventive strategies that women used to avoid contacting an STD during and after sexual intercourse (Donovan, 2000). Besides using condom, the preventive strategies that have been reported were inspection of prospective partners' genitals, washing partners' genitals before coitus, practicing non-penetrative sex, washing the external genitalia and vaginal douche after sexual intercourse (Donovan, 2000). In a study of the sexual health practices of Thai female commercial sex workers, Tophothai (1997) revealed that most participants cleaned themselves with soap, antiseptic solution, feminine hygiene solution, and toothpaste after sexual intercourse. Half of the participants also observed for symptoms such as vaginal discharge everyday. However, both practicing improper protective strategies and using prophylactics may offer them an illusion of security in the high-risk work environment and delay seeking appropriate care. To date, insufficient data are available to determine relative efficacy of these strategies and how women construct and engage in these behaviors. Thus, how conditions of work influence the way commercial sex workers seek care, especially self-medication is a crucial issue that needs to be examined.

Being at-risk for sexually transmitted disease, victimization, and violence. Commercial sex work is characterized by many forms of risk such as infection with HIV and STDs, physical and sexual violence, and social exclusion. Lack of assertiveness and ego strength prevents CSWs from setting safe limits safety with their sexual partners.

Victimization may lead to increased use of alcohol and drugs that may result in riskier behaviors. In the relationship between victimization, violence and HIV infection, Allers (1993) proposed that exposure to HIV may take the form of self-destructive behaviors; this results from low self-esteem and feelings of hopelessness and helplessness.

One study conducted by Vanwesenbeeck and colleagues (1995) indicated that the more severe the victimization among women, the more they report complaints, problems, and emotion-directed coping responses such as dissociation and denial. This study also suggested that having several experiences with violence on the job was most strongly related to higher HIV risk. Risk takers who had been more severely victimized in childhood and as adults reported the most psychosomatic complaints and dissociative symptoms, the lowest job satisfaction, and the highest financial need and job stress. Victimization of CSWs, such as working under force from third parties and sexual violence by customers, may have an effect on condom use. A history of victimization is not only related to general well being and to coping processes but to protective behaviors. It is also related to the meaning of prostitution. Victimized women may attach more negative meanings to prostitution and feel less encouraged to comply with consistent use of condoms.

One of the few published psychological studies about CSWs found that among female sex workers in Puerto Rico, rates of depression and chronic intravenous drug and alcohol use appeared to be higher than in women who were not involved in sex work (Algria et al., 1994). The study on violence and posttraumatic stress disorder in 130 commercial sex workers in San Francisco conducted by Farley and Barkan (1998) also indicated that there was a significant relationship between posttraumatic stress disorder, being raped in sex work ($t = 2.77$, $p = .03$) and chronic physical health problems ($t = 2.11$, $p = .04$). Moreover, results

from a study by Boyle and colleagues (1997) on psychological distress among female commercial sex workers in Queensland, Australia, revealed that psychological distress levels have statistically significant association with fewer health-protective behaviors including using condom for sex practices, being checked for STDs less often than every three months, and having HIV testing. Currently, there is still limited data on the violence and mental health status of commercial sex workers in Thailand.

Developing autonomy. Although most commercial sex workers enter this occupation for economic reasons, we cannot assume that all commercial sex workers view themselves as victims (Van Esterisk, 1992). According to the literature on sex work, it was argued that despite its uncertainties and risk, sex work also gives women some independence from patriarchal restrictions and the responsibility and oppression of their conventional roles in situations of poverty (Campbell, 2000). Some women may well have the capability to separate their sex-work from their self-identity and to develop autonomy. After becoming commercial sex workers, some girls are able to change themselves from innocent and obedient young girls into sophisticated and assertive women (Hantrakul, 1983). Hantrakul explained that commercial sex workers who were submissive and worked under the control of brothels were more likely to wait until they were allowed to go for health care services, while independent CSWs always took good care of themselves by holding a health card and visiting the clinic as often as they wanted.

In commercial sex work, risk taking or practicing unsafe sex appeared to be strongly correlated with financial need, as well as to job satisfaction and job stress. The highest levels of health risk are found among dissatisfied workers and the lowest levels among satisfied

workers (Vanwesenbeeck et al., 1995). Therefore, we cannot assume that the meanings of being a commercial sex worker are the same for every one of them.

For the purpose of examining the patterns of health care seeking in CSWs, understanding the existing theoretical models of women's work and health care seeking is vital for this study. In the next section, the theories that have been used in the area of women's work and health, and health care seeking will be critically reviewed and analyzed from the feminist perspective.

Theoretical Models of Women's Work and Health

Role theories have provided a crucial theoretical framework for many studies on women's work and health. Role overload, role enhancement and role integration models are the three role theories that are mostly used in studies of women's work and health (Adelmann, Antonucci, Crohan, & Coleman, 1990; Aston & Lavery, 1993; Barnett, Davidson, & Marshall, 1991; Barnett & Marshall, 1992; Barnett, Marshall, & Singer, 1992b; Bird & Fremont, 1991; Douglas, Meleis, & Paul, 1997; Houston, Cates, & Kelly, 1992; Martikainen, 1995; Meleis, Messias, & Arruda, 1996b; Meleis & Stevens, 1992; Messias, Hall, & Meleis, 1996; Rivera, Torres, & Carre, 1997). In this section, a review of the role overload, role enhancement and role integration models will be presented with an attempt to explain the relationship between women's work and health.

Role Overload Model

According to the role overload model, having to balance the demands and obligations of multiple social roles will have detrimental effects on health. It is assumed that stress and exhaustion result from unsuccessful attempts to juggle competing domestic and employment role demands on personal time and energy. The result of overload is higher levels of stress

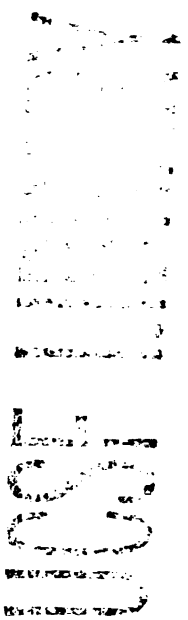
for women (Hall, 1989). This model emphasizes work as paid employment and reflects the belief that the workplace is a primary stressor and contributor to poor health. As a result of exposure to physical hazards, work stress, or overload, employment may increase women's risk of physical and mental health problems. The research studies based on this model were conducted to test the relationship between job-overload, role conflict, and underutilization and psychological strain, reported physical problems and mortality rates (Houston et al., 1992; Rivera et al., 1997; Spitze, Logan, Joseph, & Lee, 1994; Weatherall, Joshi, & Macran, 1994).

The assumptions of the overload model disregard the fact that women are primarily employed in female dominated occupations when they enter the workforce. They fail to take into account women's biology or women's health. The model also assumes that women's traditonal workplaces, such as the home, hospitals, and schools, are safe work environments, relatively free from health hazards (Zones and Karpilow, 1993). In addition, while men typically work at only one job, the majority of women have multiple work responsibilities, including primary responsibility for child care and household maintainence in addition to various forms of market work, wage employment, and community support (Messias etal 1997). As a result, women's work experiences differ from men's in terms of structures, rewards, and pressures. Hall (1989) points out that the relationship between work, stress and health status is not likely to be comparable between women and men.

Role Enhancement Model

The role enhancement model proposes that health benefits are derived from participation in several social roles, such as marriage, parenthood and employment. Based on role enhancement, paid employment has been shown to be associated with better health

(Aston & Lavery, 1993; Barley, Popay, & Plewis, 1992; Hibbard & Pope, 1992). The research studies based on this model were mostly conducted to test the hypotheses that the more social roles women occupy, the better their health. The researchers using this model tended to consider employment as a more socially valued activity for women (Rodin, 1991). Increasing opportunities for social support, self-esteem, and social identity was viewed as a benefit of existing in multiple roles (Aston & Lavery, 1993; Hibbard & Pope, 1992; Houston et al., 1992).

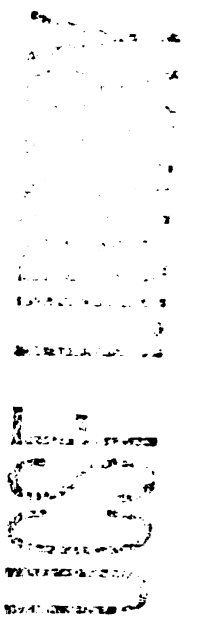


Although it was found that employed women have better health than unemployed women (Bartley et al., 1992), the relationship of women's work and health is quite complex and such generalized conclusions need to be carefully contextualized (Messias et al., 1997). It is evident that employment does not affect all women in the same ways; in fact many variables, such as age, parental status, marital status, job characteristics, and socio-cultural context can influence women's health outcomes. For example, in a study conducted by Rivera, Torres, and Carre (1995), it was found that age, ethnicity, income, and language proficiency were significant variables in predicting the health status of Latino women.

Researchers commonly categorized women's work into two categories: paid and nonpaid , or employed and unemployed. As a result, it is difficult to differentiate between social causation effects (i.e., how the quantity and quality of roles influence health) and social selection effects (i.e., how health influences role involvements) (Verbrugge, 1986). It is evident that health problems force people to reduce work involvement and devise special schedules. On the other hand, people with tight time constraints and pressures, high income burdens, and high family dependency might experience more health problems. Dissatisfied and inactive people may be vulnerable to illness and more likely to take curative actions for

their health problems. Thus, instead of treating these variables as dichotomies, some researchers have tried to capture women's life contexts by adding employment conditions such as full-time and part-time work, and by adding domestic conditions such as the number of children in the family and the need to care for children under 3 years old and older persons over 75 years (Elliott & Huppert, 1991).

The relationship between women's work and health is complex and multidimensional. Different relationships between women's work and health may exist between different types of work and different aspects of health. It was found that the relationship between women's work roles and health is not as simple as role overload or role enhancement models would predict. Moreover, the results of the research based on these role theories are contradictory. Therefore, another group of researchers proposed a new theory, the role integration model.



Role Integration Model

The role integration model differs from the role overload and role enhancement models in that is does not predict the direction of the effect of work on health but considers that health effects depend on the balance between rewards and concerns (Barnett et al., 1991; Barnett & Marshall, 1992; Barnett, Marshall, Raudenbush, & Brennan, 1993; Barnett, Marshall, & Sayer, 1992a; Barnett et al., 1992b). This is called role quality or the balance between role satisfaction and role stress (Meleis, Douglas, Eribes, Shih, & Messias, 1996a; Meleis et al., 1996b; Meleis & Stevens, 1992). The model states that a positive balance between role satisfaction and role stress tends to increase the sense of well being, while a negative balance between role satisfaction and role stress tends to decrease well-being.

There are a series of qualitative studies based on the role integration model, conducted to explore the daily life experiences of women in various occupations and socioeconomic and cultural contexts in different countries (Bernal & Meleis, 1995; Douglas et al., 1997; Hall, Stevens, & Meleis, 1992; Meleis et al., 1996a; Meleis et al., 1996b; Meleis & Stevens, 1992; Messias et al., 1996; Stevens, Hall, & Meleis, 1992; Stevens & Meleis, 1991). In these studies, women were asked about stress and satisfaction in their roles as spouse, mother, and employed worker, as well as their coping strategies. A wide range of feelings described by these women included being loved and cared for, being valued, being devalued, feeling powerless, feeling empowered, being worried, feeling disconnected, feeling resignation, being overloaded, being recognized, being supported, being anxious, sharing, participating and interacting with others. Traditional female roles may be stressful for some women, depending on the value that societies attribute to their maternal or spousal roles (Meleis et al., 1996a). The strategies that these women used included taking time out, having emotional reactions, juggling priorities, utilizing family resources, and talking to others. It was also revealed that some women consciously decide to accept subordination in living with their companions because these conditions were balanced by the support they received in caring for their children.

Another group of quantitative researchers using the Role Integration Model (Barnett et al., 1991; Barnett & Marshall, 1992; Barnett et al., 1993; Barnett et al., 1992a; Barnett et al., 1992b) suggested that instead of using only role status and role characteristics, adding role factors such as role quality, role involvement, and role change allows us to enhance the explanation of how roles are related to health outcomes. Role quality was identified as the balance between job-reward factors and job-concerns factors. Job-reward factors were

conceptualized as decision-making authority, challenge, helping others, recognition, supervisor support, and satisfaction with salary. Job-concern factors were conceptualized as overload, poor supervision, lack of advancement, discrimination, and exposure to hazard. Role quality was found to be a better predictor of well-being and stress outcomes than role occupancy which was measured by number of roles (Bullers, 1994). Both cross-sectional and longitudinal research were utilized to support the expansion model of multiple role involvements, which implied that women's involvement in multiple roles is health-enhancing (Barnett et al., 1991; Barnett & Marshall, 1992; Barnett et al., 1993; Barnett et al., 1992a; Barnett et al., 1992b). The results from the studies also indicated that there were both positive and negative spill-over effects across different roles. In a longitudinal study assessing changes in job experiences, it was found that changes in job-role quality were also related to psychological distress (Barnett et al., 1992b). When compared to the role overload and role enhancement models, the conceptualization of role integration appears to reflect the complexity and diversity of women's work more than do the others.

Theories on Health Care Seeking

Selecting a theory to explain health care seeking depends on how we define the term *'health care seeking behavior'*. From literature on health behavior, *"health seeking"* refers to the behavior of individuals who desire a higher level of wellness whereas *"care seeking"* refers to behaviors that involve the services of other persons, either a lay person, health professional, or healer in health related issues for preventive reasons or as a response to illness (Gochman, 1997). Thus, *"health care seeking"* may be defined as behavior performed to protect, promote, and maintain health and/ or in response to symptoms/ illness. The theoretical models that are used to study health care seeking behaviors should explain

preventive health behaviors such as actions undertaken by individuals that tend to prevent disease or disability and/ or detect disease at an asymptomatic stage; illness behaviors such as activities undertaken by an individual to obtain a diagnosis and to discover suitable treatment in the presence of symptoms; and sick role behaviors such as activities undertaken after diagnosis in order to restore good health or to prevent the further progress of the disease (Glanz, Lewis, Rimer, 1997; Gochman, 1997).

For more than four decades, health care seeking behaviors have received attention by health researchers, including nurse researchers. Many theoretical models have been used in an attempt to answer such questions as: What factors will increase the use of prenatal services in low-income women? How can we improve patients' compliance with prescribed medication regimens? What will be the best education program to increase the use of cervical cancer screening in women over 35? Most of these questions have not been completely answered. Marginalized populations such as gay men and lesbians, female commercial sex workers, and people with low incomes and limited education have especially been seen as at-risk populations who need health education programs to modify their health behaviors. Recently, feminist researchers, including nursing feminists, have started to question how much knowledge gained from social behavioral theories can explain the characteristics of these diverse groups and how such knowledge can be used for planning health education programs.

In the following section, three major theories about health care seeking behavior, the Health Belief Model, the Self-Regulation Model, and Triandis's Model will be reviewed.

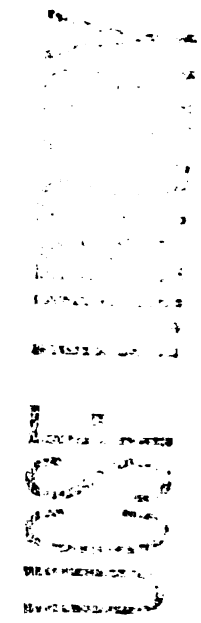
Health Belief Model

The Health Belief Model (HBM), developed by Rosenstock (1974), was originally influenced by Lewin's motivational theory. From the idea that motivation is required for perception and action, Rosenstock outlined three basic principles of health motivations: (a) Preventive or therapeutic behavior addressing a given health problem in individuals is determined by the extent to which they see the problem as having both serious consequences and a high probability of occurring in their case, and the extent to which they believe that some course of action open to them will be effective in reducing that threat; (b) Readiness to act is defined in terms of the individual's views about susceptibility and seriousness rather than the professional's view of reality; and (c) Health-related motives may not always give rise to health-related behavior and, conversely, health-related behavior may not always be determined by health-related motives (McKinley, 1972).

The Health Belief Model proposed that a person's response to a threatening illness depends on five factors: (a) perceived susceptibility, feelings of personal vulnerability to a condition; (b) perceived severity, feelings concerning the seriousness of contracting an illness or disease; (c) perceived benefits, beliefs regarding the effectiveness of the health care action to reduce the threat; (d) perceived barriers, potential negative consequences of a particular action; and (e) cues to action. The level of perceived susceptibility and seriousness may provide the energy to act, while the perception of benefits and fewer barriers provides a preferred path of action. The level of susceptibility can range from denying that there is any possibility of contracting a disease to expressing complete vulnerability. The degree of seriousness may be determined by the level of emotional arousal created by the thought of a disease as well as by the difficulties that individuals believe a given health condition will

cause them. The perceived seriousness of a condition may include broader and more complex implications as the effects of the disease on job, family life, and social relations.

The direction of a person's behavior will depend on the perception of the availability and benefits of alternatives. In perceived barriers, individuals may believe that a given action will be effective in reducing the threat of disease but at the same time they may see the action as unpleasant, painful, inconvenient or intrusive. Such negative aspects of health actions can arouse conflicting motives of avoidance. However, the combination of these four factors might not reach the level of overt action unless some trigger event or cue to action sets the process into action. Cues to action may be internal (e.g., perception of bodily states) or external (e.g., knowledge, the impact of media, interpersonal interactions). The focus of the HBM is the current subjective state of the individual, not past history or experience.



Becker (1974), another HBM theorist, conceptualized health motivation for general health and perceived control over health outcomes as health beliefs. Becker also discussed the application of the HBM in illness and sick role behaviors (Becker, 1974). The HBM assumes that persons who exhibit the appropriate combination of motive and belief will accept and undertake recommended behaviors designed to define the state of their health in the presence of symptoms and to restore health after diagnosis of actual illness (Becker, 1974). In illness behavior, symptoms have dual roles as clues regarding the presence of conditions (cue to action), and as disruptive threats to functioning in themselves. Perception of symptoms is closely linked to perceived susceptibility and seriousness, with the individual's action judgment including perception of benefits. Finally, it is assumed that diverse demographics such as age, sex, ethnic group, socioeconomic status, and level of

education, as well as the sociopsychological, and structural variables in any given instance, might affect the individual's perception and thus indirectly influence health-related behavior.

The Health Belief Model has been widely used in many studies to attempt to explain preventive behavior, response to symptoms, and compliance with recommended or prescribed medical regimens. A review of the literature using the Health Belief Model from 1994-1998 found that the HBM was mostly used in the studies of mammography and breast self examination for early detection of breast cancer, and in studies about the use of condoms or safer-sex behaviors in protecting against sexually transmitted disease and AIDS. Most of the studies were conducted in cross-sectional, correlational research designs and predominantly in Caucasian groups. The basic interventions in these studies were mainly focused on changing personal knowledge about susceptibility and seriousness of the disease by providing education programs to target populations.

Although the HBM has been widely used in research studies, it has contributed only limited understanding about the diversity and complexity of individuals' health/illness behaviors. Thomas (1995) said that the HBM was developed based upon theory and research from a traditional paradigm inspired by patriarchal values. For example, it attempted to develop generalizable and universal knowledge. A complex phenomena was simply explained as a linear relationship among variables in the HBM. Most of the research studies guided by the HBM attempted to predict and explain factors that would determine the individual's willingness to initiate and sustain healthy practices. In addition, survey instruments based on the HBM were developed mainly from Western assumptions about health and illness behaviors, and were assumed to be a culturally neutral and appropriate for every culture. The investigators did not attempt to capture the variation in beliefs that arise

within culturally diverse groups (Facione, 1993b). Although many researchers attempted to conduct their studies among diverse cultural groups (Erwin, Spatz, Stotts, Hollenberg, & Deloney, 1996; Ford et al., 1996a; Fulton, Rakowski, & Jones, 1995), the studies utilizing the HBM often failed to capture sociocultural factors such as religious beliefs, traditional beliefs, and work roles that might be important in shaping health care seeking behaviors because of the lack of a culturally sensitive instrument.

The focus of the Health Belief model is on individual perceptions and the act-of-decision process rather than on interactions between person and environment. The HBM omits social, political, personal and environmental contexts from the theory. It does not emphasize important factors that can affect patients' decision making such as general health beliefs, personal roles, affect, and the individual's previous experiences. Because the HBM was developed from a Western perspective, individuals are assumed to be independent in their decision making. In contrast, people from Eastern countries tend to rely on social norms and their families. For example, a woman might not seek care from a professional care provider, although she perceives that she is at risk of having sexually transmitted disease that might cause serious consequence, and despite the availability of a low cost clinic. Rather she chooses to take a home remedy that is more acceptable among her group of women. Furthermore, the findings from research in women's work and health reveal that women's access to health services is limited by their family and home responsibilities (Young, 1996). Inadequate consideration of social, environment, and political determinants of health in everyday life results in both distorted impressions of clients' health behaviors and in a restricted range of possible nursing interventions.

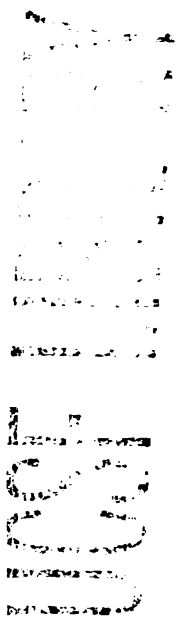
The conceptualization of the HBM variables does not accommodate the diversity of beliefs about health and illness behaviors that are present in marginalized populations. Moreover, the HBM tends to view many aspects of diversity as deviance rather than variance. Studies based on the HBM were conducted to compare the factors among different groups. They suggest how to manipulate rather than how to understand the context of daily life experiences (Fulton et al., 1995). Then, at the practice level, this model focuses on interventions designed to modify the patients' distorted perceptions of benefits and barriers. For example, education programs based on the HBM are planned to increase the patients' knowledge about their disease to the same level as that of the majority group. The model places the burden of action exclusively on patients who have distorted or negative perceptions of specified diseases or who fail to follow recommended health practices. (Butterfield, 1990).

In summary, the HBM may be viewed as a simple and comprehensive model in examining the internal dynamics of health decision making, but it does not allow us to understand the complexity and diversity of the lived experiences of human beings as they make health care decisions.

Self-Regulation Model

The Self-Regulation Model (SRM) views persons as active problem solvers in addressing threats to their health (Leventhal, Nerenz, & Steele, 1984). Personal behavior depends on people's cognitive representations of their current state, the goal state, plans for changing the current state, and techniques for appraising progress. The SRM suggests that individuals react both cognitively and emotionally to health threats in three stages; (a) illness representation, (b) the action plan or coping, and (c) appraisal (Leventhal et al., 1984). The

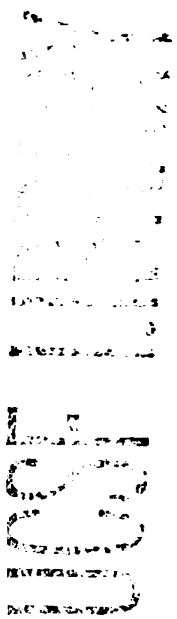
self-regulation model provides a framework that links the experience of disease with the constructive process involved in both *episodic memories*, which are autobiographical memories of each individual's past experiences, and *semantic memories*, which reflect personal, general, abstract, or conceptual knowledge about concepts. The construction of the mental representation of the health threat, the generation of a coping plan, and the activation of criteria for appraising outcomes reflect the constant interaction of these stimuli with the individual memory system. For example, compliance is determined by patients' perceptions of symptoms and episodic memories of illness timelines, rather than by their semantic beliefs that the disease is asymptomatic and chronic.



According to the SRM, the illness representation, the person's perception and understanding of the illness and its treatment have five attributes: *identity*, the label applied to an illness; *cause*, the origin of illness; *consequence*, the future effect on the individual; *timeline*, the expected duration of an illness; and *controllability*, whether or not the illness has a cure (Lau, Bernard, & Hartman, 1989). Symptoms are key factors in the cognitive representation of health threats. Sources of information for illness representations may come from (a) general knowledge of illness and disease; (b) a social communication (mass media) or information obtained from direct contact with other people; and (c) personal illness experience (Leventhal et al., 1984). Illness representations guide the selection and execution of coping procedures such as trying to relax, taking over-the-counter medications, or seeking medical care in the coping stage. These representations are subsequently evaluated with respect to their impact on symptoms in the appraisal stage. The action plan or coping stage occurs when the individual formulates and begins a plan of action. Appraisal is explained as criteria and rules that the person uses to evaluate outcomes. How individuals decide whether

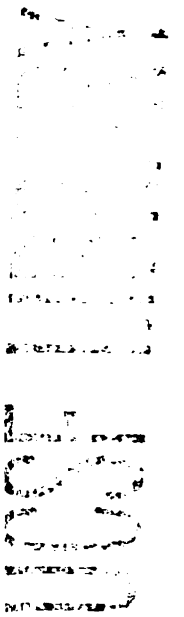
their coping has accomplished the desired effect is not explicitly discussed, but it is more likely to be based on further monitoring of symptoms. After appraisal, the illness representation may be revised and a new coping strategy may be applied (Gorbach, Hoa, Eng, & Tsui, 1997).

The SRM specifically includes an emotional component, recognizing that emotional responses to threats may be different from cognitive responses (Rimer, 1990). Emotional responses may be provoked during any of these stages and additional coping plans and appraisals may be generated to control them (Leventhal & Cameron, 1987). Emotional responses are often partially independent from and parallel to cognitive responses (Leventhal & Cameron, 1987).



To date, the SRM has been used largely in research studies on illness behavior and adherence to medical treatment. There are some studies specifically designed to test the usefulness of this model in understanding and changing health behaviors. For example, Cameron and colleagues (1995) tested the relationship between representations of serious health threat perceptions of inability to cope with the threat, and decision-making in seeking care in an elderly group. The SRM was also used as a basis for an educational program and health interventions to increase preventive health behaviors and change illness behaviors. The purpose of health education is to understand how individuals view given preventive health behaviors as effective, convenient, beneficial, and important coping strategies. In preventive health studies, the concepts of self-efficacy and outcome expectation and the predictor variables derived from the HBM were used with self-regulation to explain and predict particular preventive health behaviors. Since the development of the SRM is ongoing, some other additional variables such as life stress and optimism have been added to

the model. For example, Cameron and colleagues studied how the presence of ongoing life stress increases the attribution of symptoms to illness and the use of health care. They found that life stress did not significantly affect symptoms that were easily recognized as indicators of illness, but had significant effects on attributions and decisions to seek care for ambiguous symptoms. When persons have a concurrent long-term life stressor, they are more likely to seek health care (Cameron, Leventhal, & Leventhal, 1995). However, the use of the SRM is still limited to research samples. The studies based on the SRM were mostly conducted in white, highly educated populations in the United State by the same group of the researchers who developed this model.



Like the HBM, the SRM is limited in its understanding of the complexity of the health care seeking process, even though it has potential to capture the diversity of human cognitive processes. Leventhal and his colleagues mentioned that cultural differences in beliefs about symptom and/ or illness attributes can lead to different representations and coping strategies across various cultures; they also emphasize that the investigator needs to direct questions to the specific health problem and situations under study (Leventhal & Cameron, 1987). However, the diversity addressed by the SRM is only at the level of the personal cognitive process related to illness representation. The individual focus of the SRM allows only for identifying the relationship between perceptions and beliefs about symptoms and behaviors by individuals but does not allow us to look at the context of everyday life in decision-making. The SRM trivializes the effects of social context in the health care seeking process. Factors at the level of the health system, community, and culture are always left out of studies guided by this model. In addition, it was assumed that individuals have equal access to health services. For marginalized populations such as commercial sex worker, both

being outside the dominant system and economic constraints can affect their access to health care resources (Hall, 1999). The study of health care seeking for sexually transmitted infections in Kenya conducted by Moss and colleagues (1999), indicated that the cost of therapy had a significant impact on treatment completion rates. Some people did not have sufficient money to pay for complete treatment. Besides the economic constraints, sexually transmitted infections are stigmatized in many cultures (Campbell, 2000; Moss et al., 1999). The results of the studies on health care seeking for STD in rural Kenya (Moss et al., 1999) and Morocco (Campbell, 2000) revealed that the stigma of having an STD was a significant factor in delaying women from seeking proper treatment. In these studies, women reported fear that other people would find out that they had an STD and that they are working outside acceptable social norms as commercial sex workers. As the result, women reported not seeking treatment unless they could not tolerate the symptoms.

The basic assumption that people make decisions regarding their health are structured in a hierarchical process from illness representations, coping to appraisals process (Leventhal & Diefenbach, 1991; Leventhal, Easterling, Coons, Luchterhand, & Love, 1986). This assumption does not reflect the uniqueness of human experiences. In Western cultures, individuals commonly make decisions independently, undertaking behavior based on previous illness and on information from their social environment. However, some cultures believe that decision-making should not be seen only as an individual process but as a social process. For them, the path between an individual's cognitive processes and their behavior is directly affected by cultural, social, and political context (Thomas, 1995). Some religious such as Confucian and some social norms devalue autonomous decision-making (Gorbach, Hoa, Eng, & Tsui, 1997). Some cultures place a high value on following social norms and

little value on autonomous decision making. Thus, the process of social modeling is critical to understanding how individuals interpret and manage their symptoms or health problems (Campbell, 2000; Moss et al., 1999). If being normal and being a part of the group is a valued social characteristic within a culture, then the women of that culture will want to present themselves as being as normal as possible. As the result, some women such as commercial sex workers might not look for or be able to access information about their health problems.

In conclusion, the SRM is considered as a useful model because it includes a comprehensive array of the cognitive, emotional, and behavioral aspects of situations. It also emphasizes a total system of interacting cognitive, emotional, and behavioral variables rather than looking at these single factors in isolation. For this present study, the SRM provides a framework for qualitative questions on how people experience and interpret their symptoms and how health problems influence women's decision making in seeking health care. However, the SRM has its limitations in understanding the complex picture of health care seeking because it does not consider any variables (i.e., social variables) beyond cognitive and emotional processes. In the next section, I will present Triandis's model, which allows us to view behavior and intention to do the behavior in a sociocultural context.

Triandis'Model

According to the Triandis' model (Traiandis, 1980), the probability of an act is determined by behavioral intention, habit, physical arousal and facilitating conditions. Behavioral intention is an instruction that people give to themselves to behave in certain ways. Behavioral intention is determined by social factors (reference group's subjective culture and interpersonal agreements), affect toward behavior and the value of the perceived

consequences of the behavior. Physical arousal is a situation that is relevant to the individual's values, which can increase the probability of the act. For instance, some people may consider having symptoms as physical arousal to seek health care. Facilitating conditions are objective factors "out there" in the environment that makes an act easy to do. Affect refers to the emotional response associated with a particular act. The perceived consequence of the behavior reflects the expectations of reinforcement as well as the values of the perceived consequences (short-term memory). The value of the consequence is the affect attached to a consequence. Triandis emphasizes that being able to distinguish the difference between beliefs that concern "here and now" or *affect* and beliefs that concern the future *perceived consequences* is important in explaining and predicting behavior (Triandis, 1980).

Triandis (1980) acknowledges cultural diversity as a contributor to differences in behavior. He proposed that social factors, which reflect the individual's internalization, are directly connected with the perceptions of norms, roles and values that individuals use to judge the appropriateness of social behavior. Norms are self-instructions to do what is perceived to be correct and appropriate by members of the cultural group in certain situations. Roles are concerned with behaviors that are considered correct or appropriate for a person holding a particular position in a group or social system. Values refer to concepts that are widely used, and have three functions: a) to select perception; b) to influence the interpretation of outcomes of responses; and c) to provide nonspecific guidelines of the selection of goals. Subjective culture, a human group's characteristic way of viewing the world, is shaped by historical and ecological factors. Cultural variations have the broadest consequences and are the most likely to have psychological consequences. The belief held

about the consequences of the particular behavior and the values (positive and negative) associated with those consequences can determine one's attitude towards behaviors, and more importantly, the behavior itself.

Mostly, researchers directed by this model have tried to place model variables and scales within the cultural context of the specific study population by using open-ended questions to develop the instruments in their pilot studies. However, some of the research studies fell short by narrowly defining some of their variables. For example, Lauver (1994) conducted a study to examine the influence of psychosocial variables, facilitators, optimism, race, and interaction between psychosocial variables and facilitators on care seeking behavior with breast cancer symptoms. In this study, the norms were based on questions about whether participants discussed seeking care for their symptoms with a significant other, and about how much others thought they should seek care right away. This operational definition failed to capture the influence of norms on intention to seek care for breast cancer symptoms since norms or social influence may come both from significant others and from the media or other factors. Moreover, health behaviors influenced by significant others can result in actions such as using home remedies or doing nothing, rather than in seeking professional care.

All previous studies guided by this model were conducted using quantitative methods. Typically, they used multiple regression analyses to examine the predictive power of the model. Predictions refer to explanation of shared variance in regression analysis (Triandis, 1980). The model expresses only linear relationships between their variables. In reality, the decision making process is very complex. Sometimes decision making is based on the recursive nature of the cognitive process (Facione, 1993b). For instance, previous experience

and health habits not only influence health behavior, but may also influence one's consequential beliefs about the behavior.

When compared to the HBM and SRM models, Triandis's model more comprehensively address the understanding of social values and behaviors which is considered as an important variable in Thai culture. In general, the model aims to explain and predict a behavioral intention for single specific behaviors, such as the intention to use condoms, or to get a mammogram. For example, Burnett and colleagues (1995) conducted a study of barriers to breast and cervical cancer screening in underserved women. The key variables were personal attitudes toward breast and cervical cancer screening, subjective norms related to specific behavior, knowledge of breast and cervical cancer, and contextual factors. Most of the questions in the questionnaire were about the context of mammography use, breast self-examination, and Pap smear. Mostly, other life contexts such as conditions in their work (e.g., working double shifts) and the consequences of leaving work during business hours were not considered unless they directly related to the specific health behavior. Therefore, there may be some limitations in utilizing only this model for this study, since the study aims to explore and describe the patterns of health care seeking strategies in commercial sex work. Marginalized populations such as commercial sex workers may experience oppression and control over their bodies (Hall, 1999) by a third party such as owners of establishments. Thus, we may not understand the health behaviors of these workers unless we recognize the social, political and historical contexts of their lives. Furthermore, health behaviors may not be perceived in the same way as general behaviors and can be detached from personal ideas about health. In research study utilizing this model, the "habit" variable in the model tends to be narrowly operationalized as previous

self-breast exams for breast symptoms study (Lauver, Nabholz, Scott, & Tak, 1997). In fact, a "habit" that can influence health behavior might include practices related to health in general, such as lack of caution about health. Women might view their health as less of a priority than their role as mothers (Evans & Lambert, 1997). For example, women may consider acting on their health conditions based on the constraints of their social lives, such as maternal or work roles. Illnesses that do not interfere with work are not considered serious (Evans & Lambert, 1997). Women may not take any actions to manage their symptoms or seek medical care unless they interfere with daily responsibilities. In addition, some women may not seek care because it might interrupt their daily tasks.

For the purpose of the study, I have used a conceptual model derived from the health behaviors models including the Health Behavior Model, the Self-Regulation Model and Triansdis' Model and the role integration model of women's work and health. In the next section, the conceptual model for this study will be presented.

Conceptual Framework of the study

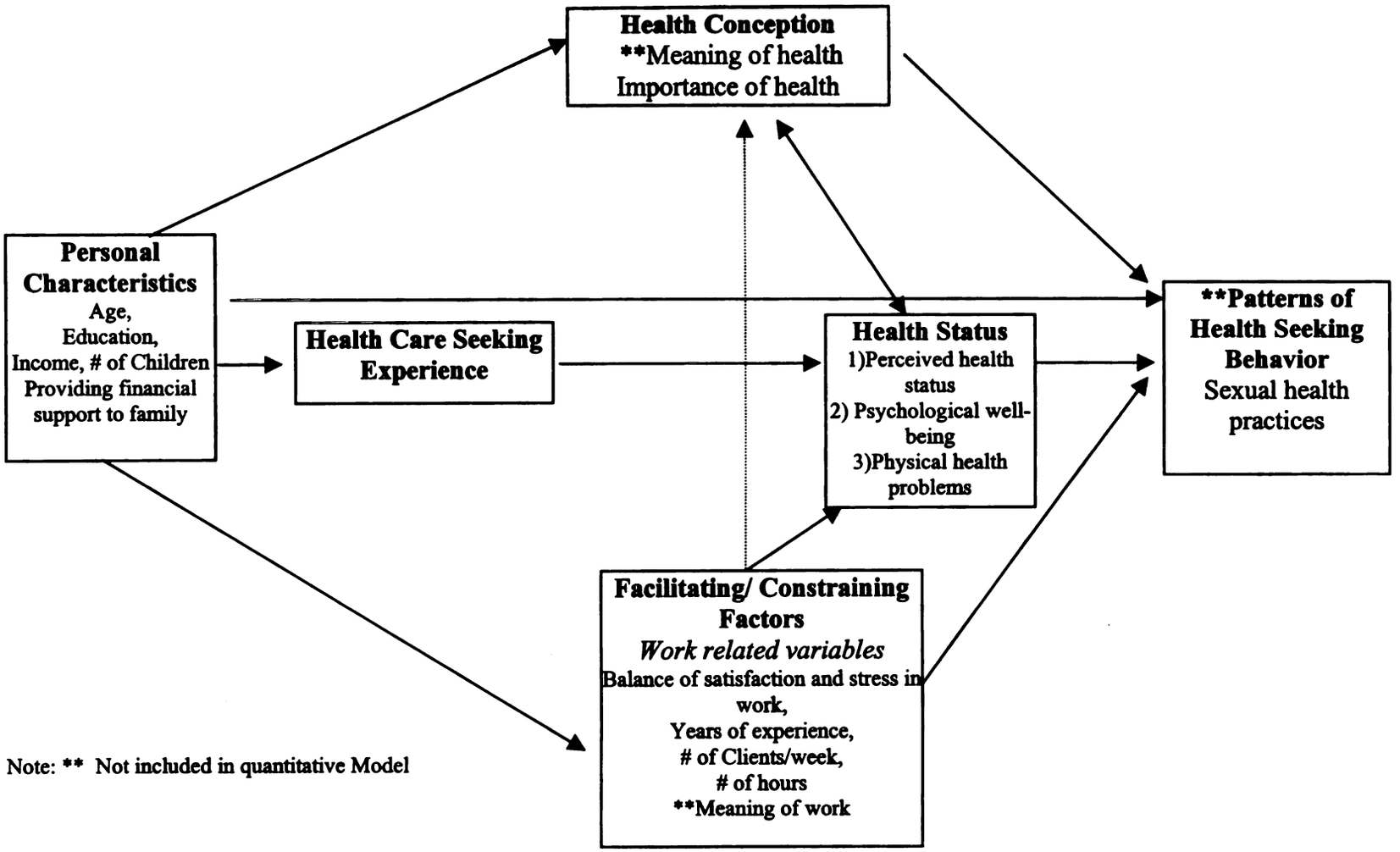
The conceptual framework of the study was based on the feminist assumptions that health needs to be understood within the context of women's daily lives; specifically, women who are commercial sex workers, and the constraints they face such as bias and stigma. The concepts from the health behaviors models such the Health Behavior Model, the Self-Regulation Model and Triansdis' Model, as well as the concept of role integration and health from the Role Integration Model of women's work were synthesized into a model of health care seeking behaviors in female commercial sex work for this study. The variables in the model were derived from the health behaviors models and the role integration model of

women's work. The conceptual model of health care seeking behaviors for female commercial sex workers for this study is presented in Figure 1.

Patterns of health care seeking behaviors refer to the strategies that people use to protect, promote, and maintain their health and/ or respond to their symptoms/illness. Patterns of health care seeking behaviors are influenced by personal characteristics, health care seeking experiences, work conditions, health conceptions and health status. Personal characteristics such as age, marital status, number of children at home, and being financially responsible for family support have been discussed as contextual variables influencing health care seeking experiences (Facione, 1993a). Other factors influencing health care seeking behaviors are attitudes toward health care seeking, health conception (Lau, Hartman, & Ware, 1986), and health status.

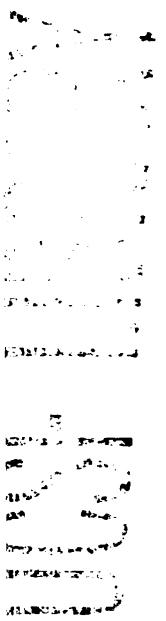
Health care seeking experience is the combination of affect (i.e., the emotions that the person links to behavior), perceived consequences (i.e., the beliefs of both positive and negative consequences of performing or not performing the behavior), and social factors (specific interpersonal agreements that the person makes with others regarding the behavior), as well as the perception of symptoms, illness and its treatment. Health care seeking experience may refer to the expectations that people have in seeking health care, such as expectations about the patient-doctor relationship, availability of health care resources, concerns about the cost of care, and other social consequences.

Figure 2-1: A Model Guiding the Study of Health Care Seeking in Commercial Sex Work (from chapter 2)



Note: ** Not included in quantitative Model

From a feminist perspective, health practices do not stand alone, but are incorporated into the life-world of the individual. Thus, the concepts of role integration and work conditions from the Role Integrative Model were added to the model. In this revised model, work-related variables are conceptualized as both facilitating and constraining conditions of health care seeking behaviors. Work-related variables (such as role integration and the balance between stress and satisfaction in work) can affect health status. From the literature on CSW, it is evident that work-related variables that affect health status and health care seeking behaviors in CSWs include stress and satisfaction in work, meaning of work, reasons for entering sex work, type of establishment, conditions of work such as number of hours in work, number of customers, violence in work, and choice about seeing customers.



Health status is one of the significant determinants of health behaviors (Gillis, 1993). The studies in the area of health promoting behaviors indicate that perceived health status is significantly correlated with health promoting activities (Frank-Stromborg, Pender, Walker, & Sechrist, 1990; Pender, Walker, Sechrist, & Frank-Stromborg, 1990). It is evidenced in the relationships between the level of psychological distress among female sex workers and reported rates of sexual health examinations and consistent condom use (Boyle et al., 1997; Farley et al., 1998).

However, instead of using the concept of 'habit' from Traindis' Model, the concept of *'health conception'* will be used. Health conception is defined as how women think about health in general. For example, women might think about health as being mentally peaceful. Women may either think health is important and that therefore they should take care of themselves, or they might think that health is something beyond their control and just visit the doctor only when they are sick. In this study, the variable *'health conception'* which

includes the importance of health and the meaning of health from the participants' perspective will be explored.

Personal meanings of health are culturally defined (Meleis, 1990; Tripp-Reimer, 1984). Although a scale has been developed to measure the meaning of health, this instrument may not be appropriate for Eastern cultures. In western cultures, the meaning of health may involve the notion of health as self-control. Health is represented as a goal, to be achieved by intentional actions, involving restraint, persistence, and the commitment of time and energy. On the other hand, women from Eastern cultures tend to see health in a more holistic way where health is related to various life circumstances (Evants & Lambert, 1997). Worries and family and relationship problems may be perceived as health problems (Meleis, 1990). The welfare of their children and their financial security are more likely to be addressed as a part of women's personal health concerns (Evants & Lambert, 1997). Health as bodily well-being tends to be less of a priority for women except when it is related to their main concerns. For instance, STD/HIV checks are perceived as an obligation of work rather than as personal health promotion. Thus, in order to access more culturally sensitive meanings of health among female commercial sex workers in Thailand, this issue was explored only in the qualitative interviews.

The value placed on health is another important concept to be considered in theoretical approaches to the study of health behavior (Frank-Stromberg, Pender, Walker, Sechrist, 1990; Laffrey, Isenberg, 1983; Lau, Hartman, & Ware, 1986). Health value is positively related to health promoting behaviors. A high value placed on health is a necessary prerequisite for the performance of certain health behaviors (Lau, Hartman, & Ware, 1986).

Assumptions underlying the conceptual framework

The following were underlying assumptions of this conceptual framework:

1. Perceived health status, mental health status, and physical health problems are all ways to measure health status;

2. Health conception is elicited through personal meanings of health and the importance of health;

3. The balance of perceived stress and perceived satisfaction in work is a subjective experience of the work conditions of commercial sex workers;

4. Frequency of getting STD checkups and using condoms are two ways of measuring health care seeking behaviors;

Due to the limitations of access to the population, time and budget, I selected only some of the variables in each concept to test in a quantitative model. The variables that were tested are presented in Figure 2.

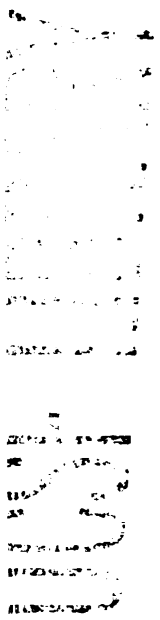
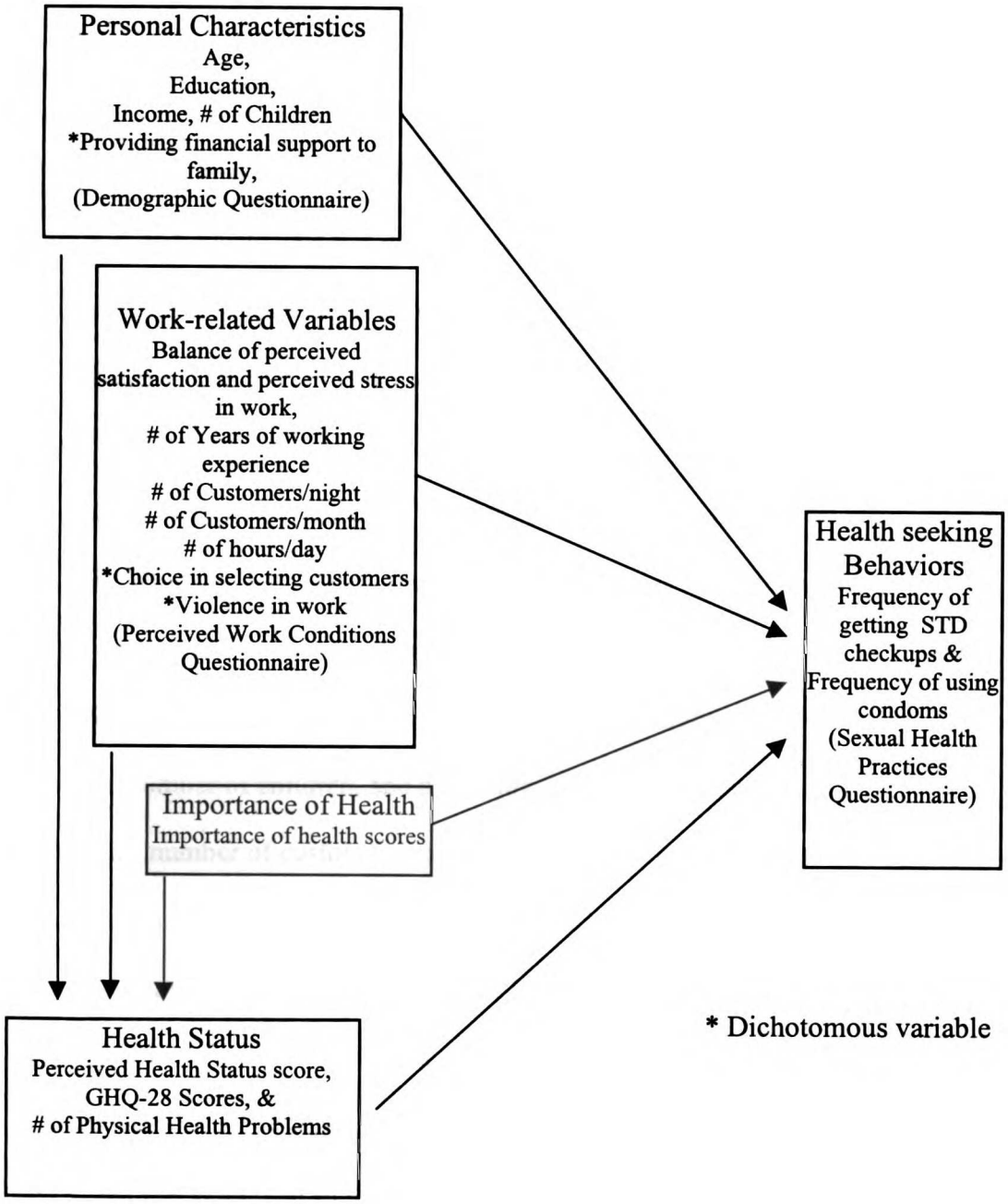


Figure 2: Model for Quantitative Analysis



Research Questions

The aims of the study were: (a) to describe patterns of health care seeking behaviors in CSWs; (b) to uncover the strategies that CSWs use to maintain their health; and (c) to describe the strategies they use to respond to illness. The major research questions to be answered are; how do commercial sex workers tend to define personal health and work conditions; and, what strategies do female commercial sex workers use to seek health care in Thailand? More specifically, the research sought to answer the following questions:

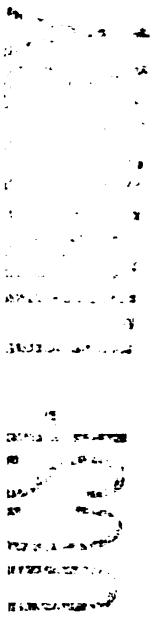
1. How do commercial sex workers describe the experience, meaning and conditions of their work?

2. How do commercial sex workers define personal health?

3. What are the patterns and associated strategies of health care seeking behaviors used by commercial sex workers in Thailand?

4. What are the relationships among personal characteristics (age, income, years of education, number of children, and providing financially support to family), number of years in sex work, number of customers per night, number of customers per month, perceived choice in selecting customers, violence in the work place, the balance of perceived stress and satisfaction in work, and the importance of health on health status?

5. What are the relationships among personal characteristics (age, income, years of education, number of children, and providing a financial support to the family), number of years in sex work, number of customers per night, number of customers per month, perceived choice in selecting customers, violence in the work place, the balance of perceived stress and satisfaction in work, the importance of health, and health status (i.e., perceived health status



scores, GHQ-total scores, and total number of symptoms) on the frequency of getting STD checkups?

6. What are the relationships among personal characteristics (age, income, years of education, number of children, and providing a financial support to the family), number of years in sex work, number of customers per night, number of customers per month, perceived choice in selecting customers, violence in the work place, the balance of perceived stress and satisfaction in work, the importance of health, and health status (i.e., perceived health status scores, GHQ-total scores, and total number of symptoms) on the frequency of using condoms?

Definition of the Variables in the Study

The following are definitions of the variables in this study:

1. **Health status** is a state or phase of wellness. Health status is evaluated by the levels of perceived health status, mental health status, and physical health problems;

2. **Physical health problems** refer to the number of health problems reported by CSWs on the physical health problem questionnaire;

3. **Sexual health practices** refer to a broad range of practices related to health maintenance and protection in family planning, sex work, risk and STDs/HIV;

4. **The frequency of getting internal evaluative exam** is the number of times reported by CSW that she seeks an internal evaluative exam;

5. **The frequency of using condoms** is the number of times during the last five times with a client that a condom was used;

6. **Patterns of health care seeking behaviors** refers to the strategies that the CSW used to protect, promote, and maintain her health and/ or response to her symptoms/illnesses;

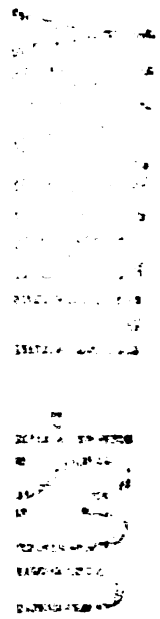
7. **Health care seeking experience** refers to the experiences of CSWs in seeking health care, such as the patient-doctor relationship, the availability of health care resources, concern for the cost of care, and the social consequences of seeking health care;

8. **Meaning of Health** refers to the CSWs' description of what it means to be healthy;

9. **Importance of health** refers to the degree to which women prioritize their health, as measured by the Importance of Health Scale.

10. **Meaning of work** is the evaluation of the negative, positive, or neutral adjective attributes of the sex work. It is also the extent to which they think of their work as an important factor in their definition of themselves;

11. **The balance of perceived stress and perceived satisfaction** is the combined scores of the perceived stress and satisfaction in work scales. The score reflects women's perception of stress and satisfaction from their work.



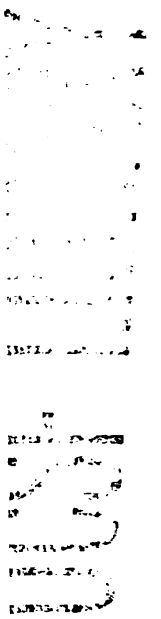
CHAPTER 3

METHODOLOGY

The purpose of this study was to describe health care seeking strategies of female commercial sex workers in Thailand within the context of the lived experiences of their work. In this chapter, I describe the research design, research participants, access to participants, data collection, data analysis, and the procedures used to ensure scientific rigor.

Research Design

This descriptive study used triangulation of quantitative and qualitative methods. Combining quantitative and qualitative data collection techniques has been used to strengthen the comprehensiveness, reliability, and validity of previous studies (Shih, 1998). Combining these methods in the same study allows the researcher to obtain more comprehensive and robust data than could be obtained by either method alone. Qualitative data about individuals' beliefs and perceptions through in-depth-interview may complement the quantitative data generated by a questionnaire. (Sim & Sharp, 1998). In this study, I gathered quantitative data from a structured questionnaire aimed at describing each participant's personal characteristics - perceived work conditions; meaning of health; perceived health status; physical health problems, and psychological well being. I also examined the relationships among these variables. I used qualitative methods to elicit patterns of health care seeking behaviors and personal meanings of health and work through in-depth interviews with women who were self-identified as commercial sex workers, and by participant observation in clinical and community based settings.



Setting

The research was carried out over a six-month period in Bangkok, which is located in Central Thailand. This city was selected because of its high number of entertainment establishments and sex workers. According to 1997 statistics, almost 40% of CSWs are located in Bangkok (Venereal Division, the Ministry of Public Health, 1997). The study was conducted in one clinic and several community-based settings.

Clinic-based setting. The Venereal Clinic, which is part of the Venereal Division of the Ministry of Public Health, was chosen as a research site for two significant reasons. First, it was specifically established to screen commercial sex workers for sexually transmitted diseases and to provide them with follow-up health care. The clinic was considered to be the major health care resource for commercial sex workers. Second, this clinic was located in the "Bangruk" region, which is the area of Bangkok with the highest number of CSWs (Venereal Division, the Ministry of Public Health, 1997). The majority of clients utilizing health care services from this clinic are the female commercial sex workers from various types of establishments, such as nightclubs, massage parlors, a-go-go bars, and beer bars. Only a small number of streetwalkers used this clinic.

Community based-settings. Entertainment establishments, which have been known as disguised sex-industrial businesses, were the community based-settings used in the study. According to the 1997 health statistics on sex establishments, there were 1207 sex work establishments and 24,466 CSWs in Bangkok (Venereal Division, the Ministry of Public Health, 1997). The types of establishments and number of sex workers in Bangkok are presented in the Table 3.1.

Table 3.1: Number of establishments and sex workers by types of establishment in Bangkok (Venereal Division, 1998)

Types of Establishments	Number of Establishments	Number of Sex Workers
Massage parlors	197	8230
Cafes	239	4686
Karaoke Bars	200	2597
Restaurants	195	2336
A-Go-Go bars	73	2174
Cocktail lounges	93	1892
Hotels	40	581
Tea-houses	12	351
Night-clubs	10	227
Beer Bars	30	201
Pubs	36	189
Brothels	9	79
Others	363	9,153
Total	1207	24,466

For this study, various types of entertainment establishments were visited to recruit research participants. These sites were expected to provide access to potential participants who do not come to the Venereal Clinic. Therefore, recruiting the participants from clinic-based and community-based settings helped maximize the variation of the data.

Research Participants

Recruitment of participants

In this study, the participants were recruited through purposive, snowball and theoretical sampling.

Inclusion criteria. A purposive sample of female commercial sex workers who met the inclusion criteria were recruited from both the clinic-based and the community-based settings. The inclusion criteria were: Women who agreed to participate; over age 18; able to

communicate in Thai; born, raised, and presently living in Thailand; and working in commercial sex work in the Bangkok area at the time of the study.

Purposive sampling. Due to limitations in access to the participants, a nonprobability sampling design was selected, since random sampling would have been far more expensive and complex. The participants were selected from the Venereal Clinic and different entertainment establishments, depending on the availability of contact through key informants. During my preliminary survey, I had established contact with several key informants including an epidemiologist from the Venereal Division, a local regional government officer, and several tourist guides. These key informants were contact persons who helped me access sex-work establishments through their connections either with sex workers or with the managers of the establishments.

Snowball sampling. Snowball sampling was also used in the study. After each interview, I asked the participant to tell other sex workers in their network about the research and ask them to participate in the study. An information sheet was given to the participants to distribute to friends in their network (Appendix H). I found that the snowball technique had limited usefulness in this population. I discuss this later in the data collection section.

One hundred four women who met the inclusion criteria were approached at both sites. Of the 104 women, two participants could not complete the interview because they were called to work during the interview, two participants (one from an a-go-go bar and one from a café) declined to discuss their experiences with going out with customers and using condoms. Therefore, the data from 100 participants were used in the data analysis. Of the total, 51 women were recruited from the clinic and 49 women from the community based settings. The number of participants and recruitment settings is reported in Table 3.2.

Table 3.2: Recruitment Table

	Clinic	Community	Total
Hotels & Tea-houses	6	14	20
Massage-parlors	7	15	22
Bars & cocktail-lounges	16	5	21
Beer Bars & A-go-go	11	8	19
Street walkers	6	4	10
Others	5	3	8
Total	51	49	100

Theoretical sampling. Ongoing analysis of the data suggested that the conditions under which women came to the clinic for a pelvic exam or to be checked for STDs are pivotal to the meanings of health and other health care strategies used by them. Therefore, women who did not use the clinic for regular exams or to be checked for STDs were targeted for recruitment. The effort to maximize the diversity of the data was quite successful (Table 3.3).

Table 3.3: Participants selected through theoretical sampling by establishment

Regular STDS Checkup	Hotels & Tea-houses	Massage-parlors	Bars & cocktail lounges	Beer bars & A-go-go	Street walkers	Others	Total
No	7	2	4	1	3	1	18
Yes	1	6	4	4	2	1	17
Total	8	8	8	5	5	2	35

Demographic Profile of Participants

The participants ranged in age from 18 to 56 years (mean = 29.24, S.D. = 8.43). Sixty five percent of the participants had six years of education or less. (See Table 3.4). All of the participants were Buddhists. Their monthly income ranged from 500 baht to 56,000 baht (USD $13 to $1514) (mean = 15,130 baht ($409), SD 10539.16). Eighty four percent of the participants reported that sex work was their only source of income. Fifteen percent

of the women reported insufficient or barely enough income to provide for their families. Of the participants who reported adequate income, 36% were not saving any of their income. Personal income and savings were used as the major source of payment for medical expenses for the majority of women (85%).

More than half of the participants (57%) were separated or divorced. Of the rest, 13% were single and never married, 27% were married or had a partner, and 3% were widowed. Fifty eighty percent had children. Approximately 80% of the 58 participants with children had them staying with their parents in their hometowns.

About 41% of participants came from the Northeastern Region, 26% were from the Northern region, 19% were from other provinces in the Central region, 12% were originally from Bangkok and 2% came from the Southern region. The majority of the participants lived in rental housing or apartments in Bangkok. Thirty nine percent lived alone and 36% lived with a partner or roommate who shared the rent. Eighty participants reported contact with their parents. Among the 72 participants who had parents living in their hometown, 94% still contacted their parents at least once a month. Seventy-eight of the participants reported that they financially supported their families, including their parents and children.

As noted in Table A.1 (See Appendix I), among the six types of establishments, participants from hotels, teahouses, and streetwalkers tended to have a higher average age, higher number of children, lower average years of education, and less income. In contrast, the participants from all types of bars were younger, had fewer children, more years of education, and higher average incomes.

Table 3.4: Demographic Profiles of Participants (N=100)

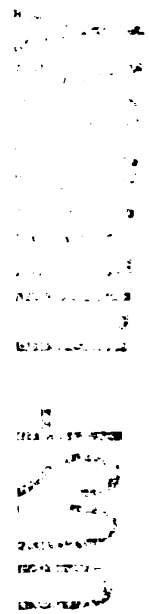
		Frequency	Percent
Place of origin	Northern Region	26	26.0
	Northeastern Region	41	41.0
	Central region	31	31.0
	Southern Region	2	2.0
Marital Status	Single and Never married	13	13.0
	Married	10	10.0
	Having partner	17	17.0
	Separated and Divorced	57	57.0
	Widowed	3	3.0
Sufficiency of income	Not enough income	8	8.0
	Barely enough income	7	7.0
	Adequate but no frills	36	36.0
	Adequate and some frills	49	49.0
Education	No education	5	5
	≤ Grade 6	60	60
	≤Completed Grades 9	24	24.0
	Junior collage or Vocation	11	11.00
Source of Medical payments	Support from work	4	4.0
	Use only free service	2	2.0
	Others	9	9.0
Parental contact	Yes	80	80.0
	No	20	20.0
Provide financial support to family	Yes	78	78.0
	No	22	22.0

	Min	Max	Mean	S.D.
Age	18	56	29.24	8.43
Number of children	0	5	1.01	1.12
Number of adults	1	10	2.10	1.45
Monthly income	500	56000	15130.00	10539.16

Instruments

The data were collected using several instruments. A summary of the variables and instruments is presented in Table 3.5.

Demographic data. Demographics included age, birthplace, current address, level of education, marital status, income, other source of income beside sex work, sufficiency of income, sources of payment for medical expenses, number of adults and children at home, contact with and financial responsibility for parents, and sources of social support. The demographic variables that were measured as continuous variables were age, years of education, income, and number of children and adults at home. The dichotomous variables were sources of income besides sex work, sufficiency of income, contact with and being financially responsible for parents. Marital status was treated as a categorical variable. For each dichotomous item, the participants were asked to give a "Yes" or "No" answer. The participants were also asked to give short answers for some questions, such as place of origin, current address, source of payment for medical expenses, and sources of social support (Appendix A). The demographic data were collected at the beginning of the interview because in Thai culture, asking personal information at the beginning of the conversation is considered as an appropriate way to get to know that person.



Demographic data were collected in order to describe the characteristics of the participants. Only some demographic variables (i.e., age, education, income, number of children at home, and being financially responsible for parents) were used as independent variables in the regression model.

Table 3.5: Summary of the Concepts, Variables, and Qualitative/ Quantitative Instruments.

Concepts &Variables	**Qualitative Instruments** (Appendix G)	**Quantitative Instruments**
Personal Characteristics: Demographic Variables	-	Demographic Questionnaire (Appendix A)
Work-Related Variables	Interview questions (e.g., What do you think about your work?)	Perceived Work Conditions Questionnaire (Appendix B)
Health Care Seeking Behaviors	Interview questions (e.g., What had you done in the first place when you had symptoms? When and where did you seek health care from professional health care providers?	Health Practices Questionnaire (Appendix C)
Health Conception: Meaning of Health	Interview questions (e.g., How do you think about health?, How do you take care of your health?)	-
Importance of health	-	Importance of Health Scale (Appendix D)
Attitudes toward Health Care Seeking	Interview question (Do you think sex workers receive health care differently from other women? How?	-
Health Status: Perceived Health Status	-	Perceived Health Status: Single scale item (Appendix D)
Mental Health Status	-	General Health Questionnaire-28 (GHQ-28) (Appendix E)
Physical Health Problems	-	Physical Health Problems Questionnaire (Appendix F)

Importance of Health. The Importance of Health Scale was modified from the Health Value Scale, which was developed to measure the concept of values placed on health (Lau, Hartman, and Ware, 1986). The original scale consisted of four Likert scale items, asking: *(1) If you don't have your health you don't have anything; (2) There are many things I care about more than my health; (3) Good health is of only minor importance in a happy life; (4) There are few things more important than good health.* The questions were rated on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). A higher score indicated a greater level of importance of health. In this study, a single 1 to 10 scale item asking *"how important is your health to you?"* was also added. The answer "1" indicated "strongly disagree" or "health is not important" and "10" indicated "strongly agree" or health is a top priority. Since there were two types of scales in this instrument, the scores for the five items were recoded as 100 point scores and were summed to form a single total importance of health score. The total score could range from 0 to 500.

The important of health scale was translated into Thai and the items were back-translated to English by a different translator and then checked for accuracy in translation. Face validity was evaluated by three Thai nurses and it was pilot tested on five Thai women who had similar characteristics to the participants in this study to assure that all statements in the instruments were clear and easy to read. However, during the study, the items were found to be complicated for the participants. The reliability coefficient of the five-scale importance of health was .47. Although, the reliability is considered to be low, the five items were conceptually expected to capture more variance about the importance of health to the women than was the one scale item asking about the importance of health to them. The scores from the five items were also used as independent variables in regression models.

Perceived Work Conditions. Perceived work conditions was a combined scale developed to obtain data for work-related variables such as work experience before entry to sex work, the reason and mode of entry into sex work, type of establishment, number of years of experience, number of hours of work per day, number of customers per night, number of customers per week, perceived choice to choose customers, violence at work, level of perceived stress, and perceived satisfaction in work. This scale was developed based on a literature review related to the studies on commercial sex workers, (Boonchalaksi & Guest, 1994) and women's work and health (Meleis, Norbeck, & Laffrey, 1989).

Two 10-point rating scales were used to measure levels of perceived satisfaction and perceived stress in work. The participants were asked to rate from 1 (not stressful/ satisfied at all) to 10 (very stressful/satisfied) how stressed or satisfied they were in their work. The stress rating was then subtracted from the satisfaction rating to yield a balance of perceived stress and perceived satisfaction score (Meleis et al., 1989). The balance score could range from –9 to 9. Work experience before entry to sex work, reasons and mode of entry, and type of establishment were also asked. Perceived choices about choosing customers and violence at work were two dichotomous items. Working condition variables that were used as independent variables included number of years of experience, number of hours of work per day, number of customers per night, number of customers per week, perceived choice about choosing customers, violence at work, and the balance of satisfaction and stress in work (Boonchalaksi & Guest, 1994; Meleis et al., 1989).

Health status. Three different quantitative instruments were used to measure health status; Perceived Health Status, General Health Questionnaire-28, and Physical Health Problems.

1. *Perceived Health Status.* Perceived health status was a single-item questionnaire which asked *"how would you rate your health right now?"* a scale of 1 to 10. Higher scores indicated a more positive perception of health. A single-item perceived health status question has been accepted as an effective indicator of health and has been previously used in the area of women's work and health (Douglas, Meleis, & Paul, 1997). The validity of this questionnaire also has been demonstrated by a significant correlation with other health measures, such as reported physical symptoms and psychological symptoms. The reliability of this measure has also been reported as satisfactory (Suchman, Phillips, & Streib, 1958).

2. *General Health Questionnaire.* The General Health Questionnaire-28(GHQ-28) was a 28-item self-reported screening instrument designed to detect current mental health problems. The GHQ-28 consisted of 4 subscales: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. The items were rated on a 4-point Likert scale, (Appendix C). The validity of the questionnaire has been well demonstrated (Goldberg & Hiller, 1979). The correlations of the overall score with the Clinical Interview Schedule was 0.76. Using a cutting point of 4/5, the sensitivity was 88% and the specificity was 84.2%. The response "no more than usual" was used as an indicator of a health problem for negative items such as difficulty staying asleep. The "no more than usual" response for positive items was interpreted as a healthy response. In a screening test, the cutting point for GHQ-28 was five positive answers.

The GHQ-28 was translated into Thai by Piyawatkul and colleagues (1995) and has been tested with 300 subjects. The internal consistency of the GHQ-28 Thai version was 0.91. The test-retest reliability was 0.62. When using a 4/5 cut point, the GHQ-28 obtained a sensitivity of 85% and a specificity of 71%. In this study, the GHQ-28 (Thai version) was

used to measure the level of mental health status as one indicator of the health status of the women. The score from 28 rating items was added to the total GHQ score. The total GHQ-28 score could range from 28 to 112. Missing data in all scales was managed by substituting the missing data with the mean of the scales. In this study, the reliability of GHQ-28 was .87.

3. *Physical health problems*. The Physical Health Problem Scale consisted of two questions asking how many physical health problems were present and the number of diagnosed diseases that the participant had had within the past three months (Appendix F). Each participant was given a list of health problems in the first question, and a list of diagnosed diseases, including sexually transmitted diseases and some other general diseases in the second question. The total number of health problems in the first question was added together to use in the regression model. The total number of symptoms could ranged from 0 to 18.

Health care seeking behaviors. Health care seeking behaviors were measured using the Health Practices Questionnaire which was developed by the researcher for this study. The questions were taken from other questionnaires that have been used in studies among commercial sex workers. In this questionnaire, the participants were asked to give an answer "Yes" or "No" for their general and sexual health practices. The sexual health practices questions addressed methods of pregnancy and STDs prevention, whether they asked their clients about STD status, getting STD checkups, and having regular pap smears. The general health practices questions included alcohol consumption, smoking, taking drugs, and exercise. The participants were also asked to respond about how often they performed particular health practices and what methods they used. Only the answers from question #11:

"How many times during the last five times with a client did you use a condom?" and question #12: *"how often do you get STD checkups?"* were used to assess health seeking behaviors.

The Qualitative Interview

In-depth interviews were used to explore patterns of health care seeking behaviors, attitudes toward health care seeking, and the meanings of health and work for female commercial sex workers. In order to systematically direct the in-depth interview, an interview guide (Appendix G) was used. The questions in this interview guide were developed based on a review of the literature. The following areas were included.

Health care seeking experiences. The interview probes about health care seeking strategies were developed to explore the strategies that women use to maintain health in their daily lives and to manage their illness-related symptoms. The interview questions focused on physical health problems. In order to describe health care seeking strategies, the participants were asked to talk about the types of medications they used, types of health care prevention services they utilized (both for general illness and for STDS/HIV), interpretation of their symptoms and causes of illness, sources of information, personal and health care resources, factors that influenced their health care seeking, impact of illness on their life and work, and the strategies they used to keep themselves in good health.

Meaning of health. Open-ended questions were used to explore the women's perceptions of health. The participants were asked: "Why did you rate your health as...(score from Perceive Health Status Score)?" "How do you think about health?" and "What does being healthy mean to you?"

Meaning of work. The interview questions on the meaning of work were developed to explore women's perceptions of work in their daily lives and how women situated their health in the line of work (Appendix G).

The clarity, adequacy and applicability of these questions were also tested. The researcher shared the interview guide with Thai colleagues to assure that the questions were both culturally relevant and correctly worded. The questions were modified in order to reflect the interests and personalities of each participant. All interviews were audio- taped. Throughout the data collection, field notes, memos, and participant observation notes were kept. In the field notes, the researcher's observations, reactions, problems, interview flow, decisions, and significant findings were recorded after each interview. In the coding memos, ideas related to coding and categories were kept. Discussion of linkage between the coding and categories was kept in theoretical memos. Participant observation notes included the situations, environments, and the interactions between participants and health care providers.

Data Collection

Human Subjects Provision

This research proposal was submitted to and approved by the Committee on Human Research at the University of California, San Francisco. An application for permission to conduct the research was also submitted to the Human Subjects Committee of the Division of Communicable Disease VI, the Ministry of Public Health in Thailand. Provisional permission was granted by the Director of CDC Division VI.

Because being identified as a commercial sex worker may present a risk to the participants in some social circumstances, the study procedures treated confidentiality as a critical component. Participants were given a written information sheet about the study's

purpose, procedures, risks, and plans for presenting the results. The participants were advised that participating in the interview indicated consent. Participants were also told that they could decline to answer any question, or choose not to participate at any time. Verbal rather than written consent was obtained. The participants' names were always treated confidentially. Data was identified anonymously with code numbers and pseudonyms. No individual identities were detectable in written reports or data shared with others for analysis and validation purposes. The information sheets, in both English and Thai, can be found in Appendix H.

Access to the Field

I was a new researcher in this field, and saw myself developing throughout the data collection process. I started the research with very limited experience with this population. I had never worked with a patient who identified herself as a commercial sex worker. As a middle-class Thai woman, I had no access to these establishments because of the cultural norm that a "good" woman should not go to these kinds of places. Going out to these entertainment areas is considered inappropriate and unsafe for Thai women. In addition, although there are many sex establishments operating in Bangkok, sex work is disclosed only to other sex workers or to male customers. To sex workers, conducting research about them could have been interpreted as making their secrets public. As a Thai female researcher, I was also limited in my access to sex establishments. It was not possible for me to make direct contact with sex-workers. In my preliminary survey, I had established collaborations with a group of key informants including an epidemiologist from the Venereal Division, a local regional government officer, and several tourist-guides. They helped me access women from different types of sex work establishments. During data collection, I was able to keep

contact with only two of these key informants. Therefore, I initiated contact with a new key informant, a nurse who was hired by one establishment to provide STD checkups for women in one cocktail lounge. In this situation, I had the chance to do participant observation during an exam, but was not allowed to approach any women for an interview.

Getting to know the field. Within the six months of data collection, I passed through three stages as a researcher: getting to know the field, getting along, and opening a new field. The first three weeks of data collection was the time that I started to learn about the field. I considered myself as knowing nothing. I opened myself to new information from everyone I contacted, especially my first key informant and my participants. During that time, I had the chance to meet with staff at the clinic and my key informant, where I was asked many questions. I was advised by my key informant about the words to use in the interview questions, and appropriate responses in the field. I was advised to cut off my interviews after an hour, and that the first section should be about 30 minutes long. He told me that I should finish my data collection by the end of the first month.

My first field note said that "*he also gave me some advice about what we should do when we go there. For example, we should treat them with respect. Sometimes they may bring us some drinks and ask us to join them for dinner (In Thai culture, Thai people always take a good care of their guests; a host always invite his guest to join them while they are eating), we should respond properly.*" For the first few interviews at a cocktail lounge bar, I had to do my interview while my key informant was sitting in the same room. I was interrupted many times. I noticed that although my key informant was sitting in the room, some of my participants did not notice his presence after fifteen minutes had passed.

Lack of control was the best word to describe my situation. I felt like the only thing over which I had control was focusing on my interview. I knew that there were many things that my participant did not tell me. My key informant sometimes asked me about my data. I had to risk sharing some parts of the data with him, while keeping the key data confidential.

Listening, taking time, explaining and being flexible were strategies I used to get through these structural barriers. I spent time getting to know my informants. I learned that my key informant also had frustrations in working in the field and did not understand what an in-depth interview entailed. At the end of the second week, I was surprised when my key informant commented that he could see that I was different from many researchers with whom he had worked. He thought that I paid more attention to women's stories by listening, asking and trying to understand their lives. He understood that I needed more time than general researchers and offered me the opportunity to access more participants. During this stage, I felt that I was an outsider and was allowed to be in the establishment only a limited time. I learned that most of the participants were vigilant and concerned about whether they had said some things that were different from their colleagues. I thought that asking the participants for permission to audiotape and paying some of them more money for an in-depth interview might create a resistance to participating in the research by others . Therefore, I changed my approach to be more unified. I reimbursed each participant the same amount of money and asked each one for permission to audiotape their interview. Most interviews in this stage lasted from 45 to 90 minutes.

Getting along. After getting to know people in the field and learning about the settings, I asked my key informant to leave the room during the interview. During this stage, I found myself feeling more comfortable in going to the field. Sometimes, I walked around

the area by myself. Around this time, I also started to recruit subjects from the clinic. There I could have a private room to use for interviews. However, the staff also expected me to recruit all my participants in a short period of time. There were fewer women using the clinic than I expected. The average number of patients was 250 to 300 a month, with about ten new patients coming every month. I recruited participants from this clinic during two time periods: First, from August 1999 to the middle of September, 1999; and, second, from October to November 1999. Between these two periods, I tried to contact other key informants, the two tourist guides, but I could not find them because they were out of the country.

From July until November1999, there were newspaper stories and debates on television about commercial sex services by University students. This publicity affected my recruitment because potential participants were concerned about disclosing themselves to others and being interviewed. However, another key informant introduced me to a café manager who helped me recruit another five women and also provided me a private room for interviews. Although going to the café by myself was a challenge, I had learned to be alone in this field.

This setting provided me with the chance for participant observation without the interference from the public health staff that occurred in the clinic setting. I could also spend as much time there as I wished each day. I found that there was no significant difference between the interview sites in the stories the women told me about their lives. More significant was how much they were willing to disclose to me.

The issue of being an insider or an outsider was always my concern. There were a few times that I was welcomed and treated as a part of the cafe, but it was only a limited time.

After spending a week in the café, people started to give me the feeling that I was an outsider. It was then that I knew it was the time to leave that site.

Opening a new field. It was during this period of data collection, that I started to understand that the frequency with which the participants got checked for STDs was a significant indicator of their perception of their health. Therefore, I decided to try to recruit more participants who tended not to use the clinic. I found that most streetwalkers were in this category, and was very frustrated about how to recruit a group of women to whom I had no access. When I began my data collection, my key informant frequently told me that I would never be able to recruit streetwalkers because access was too dangerous. No one had ever been successful in accessing this population. However, this group became a priority for me and I was willing to accept this challenge. I shared my concern to other staff at the VD Division and found some people who were willing to join me in recruiting participants. However, in order to maintain my relationship with my first key informant, and because of issues of respect and cultural sensitivity, I asked him to help me. I was surprised that this helped me feel more control over the situation as I sought new access and new experiences for both of us. Nonetheless, because of fear of this unknown situation, my key informant contacted a policeman to take us to the place where streetwalkers worked. As I expected, we initially failed in getting these women to talk to us. However, I decided to take the time to learn about the community and environment where they worked. I also distributed condoms to the women. I found that giving out condoms was an effective way to approach these women because they all needed condoms, and condoms were hard to obtain. Later in the day, I recruited one participant. I also became more confident about the possibility of talking to this group of women who were said to be too dangerous. I later returned to talk to them

and gave them condoms. I was finally able to recruit four more participants. For these interviews, I used a quiet area outside one of the government buildings or sometimes just sat on the sidewalk where there were no people around, as suggested by women. At the end of the data collection process, my key informant shared with me his own fear about this population and how his perspective had changed after this experience.

Procedures

As mentioned earlier, I was in contact with key informants at the identified sites (both the clinic-based setting and community-based settings) for recruitment of potential participants who met the inclusion criteria. After the key informant introduced me to the potential participants, I asked them to participate in the study. The participants were given a written information sheet. Prospective participants were asked to give verbal consent to participate in the study and to contact the researcher by phone (at a number given on the form) if they wished to participate in the study. Written consent was not requested because in the Thai tradition, being asked to sign one's name to indicate agreement to participate can be perceived as threatening. This could have been a significant barrier to participation in the study. After giving verbal consent, the participants then completed the questionnaires and the interview.

The procedures for collecting data were slightly different between the clinic-based and the community-based settings. The procedures for data collection in each setting are described separately.

Clinic-based setting. After obtaining the permission from the Director of the CDC Division VI, I collaborated with the clinic physician and nurse to determine the best time and place to approach potential participants. We decided that after the routine examination was

completed, I would approach the woman by introducing myself and explaining the research project. I gave or read the information sheet to the woman, and asked for her participation in the study. When the woman agreed to participate, I scheduled an interview at a time and place that was convenient for the participant. In this study, all of the participants elected to be interviewed right after their clinic visit.

The interview was separated into two sections. The participants were asked for permission to audiotape both sections. In the first section, the participant was asked all the questions in the quantitative questionnaires, which included the Perceived Health Status, Importance of Health, Demographics, General Health, Perceived Work Conditions, Physical Health Problems and Sexual Health Practices questionnaires. The approximate time required for this first section interview was about 30 to 45 minutes, including the approach time. After completing the first section, if the participant agreed to be interviewed, she was asked several questions related to her health care seeking behaviors, attitudes toward health care seeking, the meaning of health and the meaning of work (Appendix H). The second section of the interview lasted approximately 45 to 60 minutes. Of the total interviews, there were six that were not tape-recorded.

Community-based settings. In order to obtain the data from the community-based settings, I contacted other key informants. The key informants in the community-based setting included an epidemiologist from the Venereal Division, local regional government officers, and a café manager. I described the purpose and the process of the data collection and asked for their cooperation. A schedule for data collection was then planned. The establishments were selected depending on the availability of a key informant. I went to the establishments with the key informant or sometimes met him at the establishment. After the

key informant introduced me to the potential participants, I explained the research project, gave or read the information sheet to the women, and asked for their participation in the study. When they agreed to participate in the study, I scheduled the interviews at a mutually agreeable place and time. At community-based settings, the places of interview mostly were selected at the time of approach. However, the conditions in the interview were varied. In some establishments, the interviews were conducted in a private room or in a separate but open area. Sometimes they occurred in the presence of the key informant and sometimes he was not present. The interview process was the same as in the clinic-based setting and lasted approximately the same length of time.

With the group of streetwalkers that I identified, I approached them by distributing condoms and general talk. I introduced myself and explained my research project. When a woman agreed to participate in the study, the interview was scheduled. Mostly, the participants agreed to be interviewed on the day I approached them. The interviews took place at some places around the area chosen by the participants as described in the previous section.

A total of 108 participants were approached. I found out later that one's age was less than 18. Only three participants declined to be interviewed because of they had friends waiting outside the clinic. Those three tried to set up appointments for the following week. However, these interviews did not occur because of conflicts in schedules. Of the 104 participants, four were unable to complete the interview.

In both settings, each participant received a 100-baht in cash (approximately $ 2.70) after finishing the interview, although this may have represented an insignificant amount of

money for most of these workers when compared to the money they can earn from their work.

Limitations of the Snowball Technique

After the interview, each participant was asked to give information about this study to her friends who were sex workers. The purpose of this snowball technique was to recruit participants who did not come to the clinic and also to give them access to the staff from the VD division. I found that participants usually told their friends to participate in the study only when it was convenient for them, such as when I was already at the establishment or planned to be there the following day. There were a few participants who called me back and reported that none of their friends expected to be at the clinic or could find the time to schedule an interview. Some participants told me that their friends were skeptical about why they should help me find other participants.

I discussed the issues of the snowball technique with some of the participants during their interviews. They told me that there was little trust among the women in their network. They felt reluctant to try to persuade their colleagues to be interviewed, especially in-depth interviews, because of the risk of loss of confidentiality. Therefore, the snowball technique was found to have limited use in this population.

Participant Observation

During the data collection, I also did participant observations during STD checkups at the VD clinic. I both observed the process and also talked with the clinical staff about the procedure.

Data Analysis

In order to answer each of the research questions, I used different types of analysis for qualitative and quantitative data, which will be described separately in the following.

Analysis of qualitative data.

Qualitative data analysis was used to answer the following research questions: 1) *How do commercial sex workers describe meanings of their work?* 2) *How do commercial sex workers define personal health?* and 3) *What are the patterns and associated strategies of health care seeking behaviors used by commercial sex workers in Thailand?* Qualitative data analysis consisted of examining the transcripts of responses to the in-depth interviews, memos, field notes and developing codes. Coding of the data occurred concurrently with data collection throughout the study. Different types of coding were performed.

Open coding. In open coding, initial codes were formed and developed into categories that reflected more abstract concepts (Strauss & Corbin, 1990). Open coding is the analytical process through which concepts are identified. Their properties and dimensions are discovered in data (Strauss & Corbin, 1998). The techniques in the open coding include line-by-line, sentence-by sentence, and paragraph analysis. Through open coding, major categories around the concept of commercial sex work, health, and health practices emerged. One example is the code used for the women who brought the medication from the drug store for their health complaints - self-medication. The concepts that emerged from open coding provided a basis for the next step - axial coding.

Axial coding. Axial coding was used to relate the conceptual labels to one another. Axial coding allows identification of the properties and dimensions of the emerging concepts, causal conditions, strategies, and consequences (Strauss & Corbin, 1998). In axial

coding, categories are related to subcategories to form more precise and complete explanations about phenomena (Strauss & Corbin, 1998). For example, self-treatment, ignoring, and seeking professional care were identified as dimensions of the health practices after a condom break. I also found that there are strategies that the women used to cope with the stress that occurs in conjunction with a condom break. These coping strategies were then found to be conditions that shape the health practices of the women subsequent to a condom break.

Selective coding. Selective coding was used to identify the core category and relate it to other categories to explain variation and process in the core category. Selective coding is the process of integrating and refining categories (Strauss & Corbin, 1998). Systematic questioning and constant comparisons were performed to generate and validate the relationship among categories. As an illustration, work related health strategies emerged as a core concept. The categories under this concept included health practices after a condom break, health practices for sexual health problem, and health practices during menstruation. The categories were found to be influenced by both life and work conditions.

In addition to the coding of transcripts, writing memos were employed. For example, coding memos was used to explain the meanings of the concepts and to show how a concept was related to the raw data. Analytical memos were used to develop ideas about emerging concepts and to relate them to each other.

Analysis of quantitative data

Quantitative data analysis was used to answer the following research question # 2b: *How do commercial sex workers describe the experience and conditions of work in commercial sex work?* The quantitative data was analyzed using descriptive and inferential

statistics. Descriptive statistics were used to describe the characteristics of the sample and the data from the Perceived Work Conditions Questionnaire. The descriptive statistics were also used to describe the importance of health, health status, and health care seeking behaviors of the sample. The statistics used included the frequency, mean, standard deviation, and range. In describing the characteristics and perceived work conditions of the participants, an analysis of variance (ANOVA) was performed to compare differences between the ages, incomes, and the levels of education among the different types of establishments. The chi-square statistics were performed to compare the proportions of the participant in perceived choice to choose customers and violence in work in different types of establishments.

Simultaneous regression models were performed to answer research question #4: *What are the relationships among personal characteristics (age, income, years of education, number of children, and providing financially support to family), number of years in sex work, number of customers per night, number of customers per month, perceived choice in selecting customers, violence in the work place, the balance of perceived stress and satisfaction in work, and the importance of health on health status?* The independent variables entered into the model were personal characteristics (age, education, income, number of children at home, and financially supporting the parents), work conditions (number of hour worked per day, number of customers per night, number of customers per month, perceived choice in selecting customer, violence at work, and the balance of perceived stress and perceived satisfaction in work score) and the importance of health. The regression model was performed separately for each dependent variable (perceived health status, GHG scores, and number of physical health problems).

Simultaneous regression analyses were also performed to answer the following research questions: research question # 5 What are the relationships among personal characteristics (age, income, years of education, number of children, and providing a financial support to the family), number of years in sex work, number of customers per night, number of customers per month, perceived choice in selecting customers, violence in the work place, the balance of perceived stress and satisfaction in work, the importance of health, and health status (i.e., perceived health status scores, GHQ-total scores, and total number of symptoms) on the frequency of getting STD checkups? and research question #6 What are the relationships among personal characteristics (age, income, years of education, number of children, and providing a financial support to the family), number of years in sex work, number of customers per night, number of customers per month, perceived choice in selecting customers, violence in the work place, the balance of perceived stress and satisfaction in work, the importance of health, and health status (i.e., perceived health status scores, GHQ-total scores, and total number of symptoms) on the frequency of using condoms? SPSS Statistics Program, Version 9, was utilized to conduct the statistical analysis.

Sample size

Regression analysis was used to answer research question #6 testing how well personal characteristics, the importance of health, the balance of perceived stress and perceived satisfaction in work, and health status are related to the frequency of getting STD checkups. Ten independent variables - age, education, income, number of children at home, being financially responsible for parents, the balance of perceived stress and perceived satisfaction in work score, the importance of health scores, perceived health status, GHQ

scores, and physical health problem scores - were entered into the regression model. The limitations of accessibility, time, and budget meant that a maximum sample size of only 100 was possible. Based on a power analysis, this sample size may be close to adequate power to detect the significant contribution of each independent variable (R^2 change = .06, power = .80, at alpha level = .05) and more than enough power to test the overall equation (R^2 = .21, power = 1, at alpha level = .05). The effect size at .06 is between small effect size (.02) and medium (.13), which is a good effect size (Cohen, 1988).

Rigor of the study

In qualitative research, validity and reliability are not addressed in the same way as in quantitative approach. Reliability refers to the dependability or accuracy of the data observed or provided by the participants (Lincon & Guba, 1990). Since this study was based on feminist principles, the evaluation criteria of Hall and Stevens (1991) were used. The rigor of the study includes dependability, adequacy, insider/ outsider issues, reflexivity, rapport, honesty, empowerment, and mutuality.

Dependability

Systematically documenting all actions related to data collection, sampling, analysis, and dissemination of results is considered important for rigor in feminist qualitative studies. In this study, different types of memos were kept throughout the research process.

Adequacy

Adequacy implies that the research and outcomes are well grounded, cogent, relevant and meaningful (Hall & Stevens, 1991). I continually questioned my methods throughout the research process. During the data collection process, I wrote field notes about what had occurred during the interview. For instance, I observed what changes occurred in the level of

disclosure during the stories women told me if my key informant was there or when there were interruptions by clinical staff.

One of my concerns in conducting this research was the issue of being both an insider and outsider. As a Thai woman who was born and raised in Thai society, I could have been considered an "insider" for these women. However, there still might have been perceived differences between the participants and me such as age, class, type of work, and education. Being educated in the United States could have influenced how I perceived these women's experiences. It could also have meant that I was viewed as an "outsider" by women who worked as commercial sex workers (Reay, 1996). Some women might have felt uneasy about talking with me because of my position as a health professional or as a more highly educated woman. My strategy in addressing these issues was to let the voices of these women be heard. I attempted to increase my sensitivity and awareness in the interview process, and to create an empathic atmosphere in the interaction process (Acker, Barry, & Esseveld, 1983). I was honest in clearly presenting my identity as the researcher and the purpose of the study. Some participants shared with me that they would not have talked to me in such detail if I had not been a nurse.

Reflexivity

Reflexivity is another important issue for feminist researchers. Before coming to conclusions, we need to locate ourselves within our research by continually considering the ways in which our own social identity and values influence the data we gather (Reay, 1996). The questions that I always ask in a reflective process are *"Who is the researcher?" "What background do I have that may enhance or diminish my ability to achieve sensitivity and trust in the interview?" "What kind of information is likely to be withheld by my participants*

for insiders or for outsiders?" In addition, I also shared my experiences and discussed issues of being a researcher and the problems that occurred during data collection with my advisor and with my colleagues.

Bracketing, addressed by Kasper (1994), is a way to open the researcher to a range of unanticipated data and to allow the researcher to know each woman as an individual rather than as one of many women. My personal background means I probably made some assumptions that could affect how I listened to and interpreted my data. The notion of "bracketing" made me aware of stereotypical notions about prostitution that I might have had and helped me to avoid preconceived ideas about these women. I kept a research diary throughout the data collection and analysis process. The key questions that I asked myself were: *"What biases do I have in the way I interview and analyze the data?" "How do my personal ideas differ from those of my participants?"*

Rapport

Rapport is a criterion that reflects how well the participants' reality is accessed (Agar, 1980). Elements of rapport, such as the length of contact and the researcher's sensitivity to language and connotation, indicate the validity of the qualitative data (Danzin, 1989). To enhance rapport, the interviews took place in private settings. Rapport was evaluated in the verbal and nonverbal behaviors of participants, in their willingness to recruit other participants, and in the depth and specificity of their disclosures. A limitation to rapport in this study was that a single interview probably did not allow enough time for the researcher to form a relationship with the participant.

Central to feminist methodology is the belief that the essential meanings of women's lives can be grasped only by listening to the women themselves (Harding, 1993; Kasper,

1994). In qualitative research, the accuracy of listening and hearing may be as important as the openness of telling. Therefore, I used active listening and encouraged the exploration of connections between events, feelings, and beliefs (Kasper, 1994) to get an accurate picture of these women's experiences.

Credibility

Credibility of coding and categories was obtained by sharing the transcripts with members of my dissertation committee and with Thai colleagues to read and code. I also shared my coding and the interpretations with my colleagues to verify the logic of analysis and the comprehensiveness of the descriptions.

Honesty, empowerment, and mutuality

The reduction of the power inequality between the researcher and the participants was one strategy in the pursuit of more accurate data. It was a way to ensure the mutual exchange of dialogue. I gave feedback to participants who asked health-related questions during the interview. In some cases, I took time after the interview to listen to their specific concerns. For example, one of the participants was worried that she might have contracted HIV from a condom break and was afraid to get blood test. In this case, I provided her with information where to get a blood exam and treatment. I also helped her explore the costs and benefits of early treatment.

Consciousness raising is an essential component of the feminist movement. Feminist research is intended to empower oppressed people. One of my research goals was to enable these women to be active agents in their own right and to be free of destructive and unequal social constraints that limit their health care seeking. Changes in consciousness may occur

among the relatively powerless when women consider their situation in a new ways (Reinharz, 1992).

The results of this research will be presented in Chapter 4 and 5. The report of the results will be organized according to each research question proposed in the study. In Chapter 4, working as a commercial sex worker, the participants' experiences, and meanings and conditions of commercial sex work will be described and explored. In chapter 5, the results related to the health and health care seeking behaviors of commercial sex workers will be presented; more specifically the meanings of health, health care seeking strategies, and relationships between personal characteristics and work conditions on health and health behaviors will be discussed. Throughout research reports, pseudonyms of the women will be used.

CHAPTER 4

WORKING AS A COMMERCIAL SEX WORKER

In Chapter 4, I present the findings related to research question 1, which asked how commercial sex workers describe the experience, meaning, and conditions of their works. Basically, the aim of the presentation of these results is to provide a description of who commercial sex workers are in Thailand, why they became sex workers, how they perceived sex work-what it means to them and how they live with sex work. The results are organized into 3 sections: *entering sex work; becoming a sex worker; and being a sex worker.* The first section, *entering sex work*, describes the experience of women before working in sex work, reasons and facilitating conditions that led women into sex work. This section consists of three subsections, *work before entering sex work; reasons for entering sex work; and facilitating conditions to become a commercial sex worker.* The second section, *becoming a sex worker,* explains the process in which women learn to become a sex worker. In the third section, *being a commercial sex worker*, the conditions of sex work, the nature and meanings of sex work, stress and satisfaction in work, and coping strategies with sex work are presented.

Entering Sex Work

Works Before Entering Commercial Sex Industry

The majority of participants (94%) had engaged in various kinds of low pay work before becoming sex workers. They reported five major types of occupations before entering the sex work industry: saleswomen (19%), small business employees (18%), housemaid (13%), waitress (15%), and factory workers (14%). Only 6% of participants had no previous job before becoming a commercial sex worker. (See Table 4.1)

Reason for Entering Sex Work Industry

Reasons for entering into the sex work industry are displayed in Table 4.1. Major reasons include a responsibility to support family (e.g. parents, siblings) and raise children (53%), and the desire for a good income (43%). It is interesting response that more than one third of the participants (37%) reported that they could not give one definite reason for entering sex work and that there were multiple factors. The factors that led them into sex work are a combination of the following: the context of their life at that time; they felt that they had no choice or there were no other jobs available; they had responsibility for supporting their parents and raising children; and they needed to pay off their debts.

Table 4.1 Commercial sex work: Previous work experience and reason for entry (N=100)

		Frequency	Percent
Previous occupations	Salespersons	19	18.0
	Small business employees	18	18.0
	Waitress & Bartending	15	15.0
	Factory workers	14	14.0
	Housemaid	13	13.0
	Farmers	8	8.0
	Other	7	7.0
	Never worked	6	6.0
Reason for entry*	Helping family	53	53.0
	Obtaining good income	43	43.0
	Need money and No other choice/ Could not find other Job	21	21.0
	Self-defeating & being challenged	16	16.0
	Being Forced	2	2.0
Arrangement in entering	Introduced by friends	64	64.0
	Self-arranged	29	29.0
	Owner of establishment arranged	2	2.0
	Agent or Middle men	2	2.0
	Other	3	3.0

* The totals do not add up to 100%, because some participants give more than one answer.

Further understanding of reasons for entering sex work was derived from the in-depth interview data. According to the women's stories, there are three categories of facilitating

conditions that led them to become commercial sex workers: personal, family, and environmental conditions. Each facilitating condition is explained in the following section.

Facilitating Conditions in Becoming a Commercial Sex Worker

Personal Conditions

Being the only breadwinner in the family, lack of education or having low education were commonly found as personal conditions in sex workers lives. As family caregivers, these women tended to take on all responsibilities for the family without asking for any help from other family members, and to sacrifice their own needs in order to fulfill family needs. The participants gave the following examples:

> I am the eldest child. My sisters send money to our mother from time to time. I send 4000 baht every month. My kid is living with my mom. I support both my mother and my kid.
>
> (Orn: Cocktail lounge)

> I don't spend much money on my own health. Most of the money is spent on household expenses. My parents get sick very often and they also bought a lot of equipment for farming. I had to pay for those things. Whatever they want, I have to give them. I send them money. They don't know how hard it is for me to find 100K. I don't want them to know. I don't want them to worry.
>
> (Am: Streetwalker)

> I give money to them every month. This is money that is transferred to them every month, not including extra money that they asked for in emergency cases.
>
> (Tak: A-go-go Bar)

Not being a virgin was also mentioned as a personal condition that made it easier for them to accept sex work. The majority of the participants were married, had a partner or were separated before they began working in the sex industry. Due to the double standard, premarital sex in women is considered unacceptable in the Thai society. Most men believe that women who have premarital sexual experiences are dirty and worthless. Therefore, the participants perceived themselves as having nothing to lose if they decided to become a sex worker.

> Before this, I used to have a strong belief about virginity, but not anymore. It had some influence on my decision to do this work. But the first reason was money. I don't make enough money when I worked in my previous job. Another thing was that **it was like I already lost it, I have nothing to lose anymore**. I can accept it easier.
>
> (Kanda: Massage Parlor)

Family Conditions

Family conditions that made the participants enter the sex industry included having a failed marriage or a broken family (i.e., having an abusive or irresponsible father). Anger caused by their husbands' betrayal was another reason that made them decide to become sex workers, a decision they perceived as a way to take revenge on their husbands:

> I did not have any job at that time. I wanted to help my parents. They needed money. Besides, I was upset, because I just broke up with my husband. I decided to work in this job
>
> (Tak: A-go-go Bar).

> At first, I did not think about money. I just wanted to take revenge on my husband.
>
> (Khai: Teahouse)

Another reason related to family conditions was that there was *no one* else in the family that could take care of the family. When asked about what their siblings or other family members did for the family, the women frequently answered: "they already have their own family, my brothers, they don't think about our family anymore." Or "I have sister and she also have a child, but she can't even take care of herself, how can she take care of my mother?" In addition, other family conditions, such as having ill relatives at home who needed help with medical expenses or family debt, were also factors that stimulated these women to become sex workers.

Environmental Conditions

Environmental conditions refer to the cultural, social, and economic conditions that impacted the women. Cultural and social norms that dictate women are expected to take care of their parents' well-being. These norms influenced the women to consider becoming sex

workers in order to earn income to help support their families. In addition, most participants explained that the chance of finding other jobs in their hometown that gave them enough income was not high. Most participants had moved to Bangkok or other big cities to find jobs. Previous jobs that often did not give them enough compensation. Thus, the chance to become wealthy and to escape from poverty was another factor that encouraged women to enter sex work:

> I was pushed into this job by many factors. First, I don't have money. There is pressure from people in my hometown who look down on me, my parents who always complained about not having money. They wanted me to marry a rich man. And I didn't have high education. That is why I'm working in this job. These become pressures on me to earn much money. (Am: Streetwalker).

Another environmental condition refers to the social network that provides an access to sex work industry. As displayed in Table 4.1, 64% of all participants reported that they were introduced to sex work by a friend. Having a friend who is working as a sex worker is a major factor that brings women into the sex work industry. According to the women's stories, they tend to identify some commonality between themselves and their network.

> I had a friend who worked in this job. She introduced me to this job. First she told me that I did not have to go out with customers and they would not force me to do so. So I decided to work. (Jun: Drinking Bar)

Besides being introduced by a friend, working as waitress, bartender, or receptionists in sex establishments are other environmental conditions that stimulate women to become sex workers. Some participants reported that after having a hard time earning sufficient money, they gradually saw that sex work could be a better way for them to survive. Some participants were asked or persuaded by owners or managers of the establishments to change from non-sexually related jobs to providing sexual services:

> At first, I thought that I would be just a waitress. When I applied for this job, I applied for waitress position, not a dancer or customer escort. After working for 3 days, my boss made me dance and go out with customers. I told him I did not want that job. He asked me to help him, because there were no dancers. After that, I just do it... I think that is typical for anyone

> who works in this job. I think the boss was the one who encouraged us to dance. Because during the first 3 days, I just waited at tables. I did not go out with customers. But after 3 days, he asked me to dance for the bar. After that, I thought I earned quite good money, besides I got money from going out with customers too. Waitresses earn only 3400 baht. But dancers make 5000 baht
>
> (Toi: A-go-go Bar).

As a result of the interest in being sex workers, women also explained how they have learned to change themselves in order to do this work. In the next section, the process in becoming a sex worker, which derived from the in-depth interview data, will be described.

Becoming Commercial Sex Workers

In becoming commercial sex workers, women described the process that they had to go through as: (a) learning the trade, (b) dressing the part, and (c) learning negotiation. In the following section, each process will be explained.

Learning the Trade

Learning the trade is the process in which women try to identify themselves with sex work by learning about the work routine and considering how well they fit into this work Most participants indicated that in this process, they spent time *observing* and *comparing* themselves with other women before they decided to do this work. I found that a sense of being part of a reference group (i.e., a group of women who are in the same condition, having problems and risking their lives for family) had a major influence in drawing many of the participants into sex work and accepting themselves as sex workers.

> At first, I just sat and watched. Everyone has her/his problem. If they can do it, I can do it. Yes, I did try to find other jobs. But I could not find one....I walked by the bar and saw a sign looking for people. I applied for waitress position, but there was no vacant position, so I applied for dancer position. I observed the job for about a week. I felt embarrassed. After my first dance, I cried. **I thought if others could, I could do it too**. I talked to those girls, and they had problems as I did. They could do it; I could do it too. Some people were 40 years old, but they also had children and a mother that they had to be responsible for. They were like me. So I thought okay, I would do it.
>
> (Tak: A-go-go Bar)

Dressing the Part

Changing personal appearance and behavior is a marker of the process by which women transformed themselves into sex workers. Some participants explained that in the process of becoming sex workers, they had learned to accept doing things that they had never done before, such as wearing a nightdress, standing in front of a bar, talking to unknown people, or dancing in a swimming suit or bikini. The degree to which women changed themselves varied by the place they worked from the most extreme, such as naked dancing to no requirements. Some establishments required women to wear a specific dress and perform some activities with strict regulations. On the other hand, some participants revealed that they were not required to wear any particular dress. However, they learned to make themselves look more attractive through experience.

> Many things. First, I never knew that person before, but I have to sleep with him, talk to him and please him. I also have to dress like this, in nightdresses. I had never worn those dresses before...But I have to wear it and stand in front of the bar. I do not feel comfortable with it. Like women selling those kind of..I had never done that. Like service girls...those types of girls. Standing in front of the restaurant, walking the customers into the restaurant. Sometimes I feel ashamed of myself, when people walk by and look at us. I feel ashamed of the way they look at us. After a while, I got used to it and understand it. It is my job, and what else can I do? I have to do it. If I don't, I don't get any money.
>
> (Sorn: Drinking Bar)

Learning to Negotiate

One of the strategies used by commercial sex workers was to learn to negotiate. The women indicated that because of the nature of their work they had to be assertive in negotiating with customers. There is a dimension of time in negotiation: *taking time* and *not taking time*. In the case of *taking time*, women spend some time approaching and getting to know their customers' manners, screening unpleasant customers, and discussing condom use and payment. Sex workers who initiate contact tend to take time in approaching and

negotiating with customers. Among freelance sex workers (café), they will not go out with customer whom they have just met. Contact has to be initiated by the customer.

> I will negotiate with him first. Some pay in advance before going out. Some pay after. Sometimes I will go with him, sometimes I don't. Some customers are not polite, I am not going out with those..... I often choose customers that I will go out with. If customers do not look good, I am not going. Before I go out, he will have to agree that he will pay the amount that I request. If he says that 2000 baht is too expensive, then I will reconsider and see how much money he has. I might reduce the price to 1500 baht. But he has to promise to use a condom and not stay overnight. If he agrees on these points, then I will go with him
>
> (Porn: Café).

> But when I quote the price, I already add money for the room into it. Some customers ask if it is possible to include everything into the price. I will say yes, because I want to get money. Actually, I want to get the full amount.
>
> (Nun: Streetwalker).

In some cases, women may not negotiate about condom use until the need arises.

> I don't talk first. When we arrive at the hotel, I ask a waiter to give me a condom. And if they refuse to use it, I will say no... At some hotels, they will try to help girls if we are in trouble. They will help negotiate for girls. But some hotels don't help.
>
> (Sorn: Drinking Bar)

In case of '*not taking time,*' sex workers tend to limit their contact with customers. Only sex workers from massage parlors fall into this category. Most participants from massage parlors have only had a chance to negotiate about condom use with customers after they were in the room together and nobody could help them in negotiating. Negotiating for condom use is the first thing sex workers learn—it is seen as a strategy for survival in sex work. Participants also reported that they were supported by their establishment in refusing to provide sex services to customers who refuse to use condoms. However, dealing with customers who refuse to use condoms is a stressful situation for sex workers.

> I will try to persuade them that "it's not good, you can get disease." Mostly, they will defend themselves by saying, "No I don't have any disease." But I told them that you can't tell from the looks. I learned it by myself, nobody taught me this. I just have to protect myself, when I am alone with customers, nobody knows whether he uses condom. No one knows what's gonna happen, it depends on us.
>
> (Nun: Streetwalker)

> I asked him, "don't you love your life. If you get AIDS and die, don't you regret your life?" And he said that he trusted a woman. He looked at woman and thought that she did not look like a person with AIDS. I told him that it was not true. You can't tell if someone has AIDS from her/his look. If someone has AIDS, he/she won't tell you the truth. I try to scare some people about AIDS to make them use condoms.
>
> (Nid: Massage Parlor)

For the participants who worked with foreign customers, language was a major obstacle in approaching and negotiating with customers. Some participants explained that they felt stressed and inferior from not being able to communicate with their customers. However, they perceived that most foreign customers seemed to understand their language limitations and were less likely to take advantage of them. In order to overcome language obstacles, some participants learned English from reading books and listening to tapes, by memorizing what they have heard from co-workers and or by asking co-workers who had more experience.

> I can speak a little English; mostly I talk about the work. For example, "where do you come from? Do you like me? Do you need a girl? Where do you stay? Do you use condom?" I did not learn it. I heard girls at Patpong say it, so I just remember the sentences. When I talk to a foreigner, I will look at his gestures while he talks. It helps me understand better.
>
> (Am: Streetwalker)

A sense of empowerment is another important factor in negotiating with customers. Some participants perceived themselves as having more control in selecting and dealing with customers than did others. The sense of empowerment expressed by the participants may have come from personal strength, having good communication skills, having good support from the owner, or from personal appearance.

> I don't know. When I look at my colleagues and compare myself to them, I don't look as good as they do. Customers never look at me, so I rarely talk to customers. I don't think I look good. I once approached customer and he did not talk to me. If my first approach fails, I will not continue approaching customers the whole night. If I fail with the first customers, I will fail the whole night
>
> (Tak: A-go-go Bar).

> Yes. Massage is my main job. A job other than massage, I will have to decide. First, if the guest is clean. Second, will he follow my rule, meaning is that he agrees to use a condom. Third, will he give me some tip. I need to talk to them about those rules first.
>
> (Muk: Teahouse)

> Yes, if I think that customer is bad, I don't have to go out with him.... I won't go out with a drunken customer. There might some problems when you go out with drunken customers.
>
> (Toi: A-go-go Bar).

In some circumstances, the participants may have to find ways to get away from the unpleasant customers. The sex worker only has two acceptable excuses to use to get out of undesirable situations are condom refusal and being in her menstrual period.

> I need to have a good reason. But if I am healthy, then I can't avoid it. But if I am having a period, I can avoid it. Now there is another condition. If a customer, with whom you are going out, refused to use condom, you can just leave him and tell the employer so. That is the only condition that the employer will let you leave the customer. The owner arranges regular check-up for workers every 3 months. So all workers are afraid of it.
>
> (Tak: A-go-go Bar)

> ....In case I have a customer that I don't like, I will massage him for an hour, for which he has paid. But if he wants to sleep with me, I can avoid that by telling him that I have a period and that I will choose younger girl for him. I will find a way to talk to him. But mostly, I can choose, I just need to find my own way out.
>
> (Muk: Teahouse)

Being a Commercial Sex Worker

Commercial sex workers are not homogeneous. They work in a variety of conditions. From different experiences and conditions of work, women develop different perspectives about sex work. In the following section, the conditions of sex work are explored and described. Then, the women's perceptions of sex work including nature, naming and meanings of sex work will be described. Finally, stress and satisfaction in sex work, as well as coping strategies will be presented.

Conditions of Sex Work

As demonstrated in Table 4.2, the study participant's average number of years in the sex work industry was 4.24 years (SD = 5.31), with a range of one month to thirty-three

years. The average working hours per day was 8.5 hours (S.D. = 3.03) with a range of 4 to 24 hours a day. The number of customers per night ranged from one to six customers (mean = 1.7, S.D. = 1.11). The majority of women (64%) reported seeing only one customer a night. The number of customers per month ranged from 1 to 120 customers (mean = 28.49, S.D. = 27.22).

Levels of satisfaction and stress in sex work score ranged from 1 to 10 with a mean of 5.55 (S.D. = 2.66) for satisfaction level and a mean of 5.53 (S.D. = 2.60) for stress level. The Balance of satisfaction in and stress from work scores ranged from –9 to 9 with an average of -0.02 (S.D = 3.90). The majority of women perceived that they had a choice in selecting customers (74%). Of the 100 participants, 38% reported experiencing violence in work. About half of the women (51%) reported that they routinely got checkups for *sexually transmitted diseases* as required by the policy of their work establishments. STD checkups will be discussed in detail in the next chapter.

Table 4.2: Descriptive statistics for experiences and conditions of sex work

		N	Min	Max	Mean	S.D.
No. of years in sex work		100	.08	33.00	4.24	5.31
No. of hours/day		100	4.00	24.00	8.50	3.03
No. of customers/night		100	1	6	1.70	1.11
No. of customers/month		98	1	120	28.49	27.22
Level of stress in work		100	1	10	5.55	2.66
Level of satisfaction in work		100	1	10	5.53	2.60
Balance of satisfaction and stress in work		100	-9	9	-.02	3.90
				Frequency	Percent	
Policy for STD checkups	YES			51	51.0	
	NO			49	49.0	
Choice in selecting customers	YES			74	74.0	
	NO			22	22.0	
Experience of violence in work	YES			38	38.0	
	NO			62	62.0	

Diversity of Establishments

The types of establishments in which the women worked differed in terms of patterns of income, types of customers, types of work activities, places where sexual activity is performed, and regulations. For example, a massage parlor is operated by an owner or a manager and the sex workers had to provide massage and sexual activities inside the establishment. Participants' incomes come in a variety of forms, including salary, money paid per hour of service provided, and tips. Customers were mainly Thais from working and middle classes. Mostly, women sit inside a room with a glass window, and are selected by customers. Regulations of the establishments include health checks, which are available from onsite health care providers, and a limited number of working hours per day. Various types of work conditions are categorized by types of establishments in Appendix I. In the following section, each type of work condition is described.

Health Policies as Regulations

Streetwalkers, freelance sex workers and women who work in hotels and teahouses do not work under any regulations. In contrast, women working in drinking bars, cocktail lounges, beer-bars, a-go-go bars and massage parlors described that they had to work under many rules and regulations. Regulations mentioned by participants include mandatory health check reports, checking time-in and time-out, limited number of days off (i.e., taking days off during weekends or holidays is not allowed), and restrictions on the number of times a sex worker has to go out with customers. The level of restriction varied by each establishment. Generally, when the women violated the regulations, part of their income was withheld or their salary was cut.

A health check up for sexually transmitted diseases (STD checkup) is strict regulation for workers in massage parlors and a-go-go bars. Some owners of establishments have hired professional health care providers to provide STD checkups and blood checks their workers. The required frequency for obtaining STD checkups varied from once a week to once a month. The participants were required to present their health report to their managers or owners when they were paid. One participant talked about how she worked under the regulations:

> The work starts before 6:30 PM. If we punch the card after 6:30 PM, our salary will be deducted - one baht per minute. My salary was cut quiet often. When I can't get on the stage in time, and someone else has to get on the stage for me, my money will be deducted 10 baht... I was eating and talking during that time. ...If I take a day off, my money will be deducted for 300 baht. If I don't submit the examination form, I will be deducted 200-300 baht. I have to submit the form twice a month. They will deduct money if I take Friday and Saturday off. There are many customers coming on Friday and Saturday.
>
> (Tak: A-go-go Bar)

> They require us to come here for check-up. If it is a small place, they will not take care of employees. They don't care about what the girls do. Here, they require us to go for checkup; otherwise they will deduct 300 baht. I have to show them the record book. We have to come here to check if we have any disease.
>
> (Sorn: Drinking Bar)

Some participants mentioned that they have to go out with customers for a certain number of times in order to get a certain amount of money and to avoid money withheld by the establishment.

> Number of times that girls have to go out with customers depends on their salaries. For me, my salary is 1000 baht. It doesn't matter if I go out or not or if I can sell a drink, I still get 1000 baht. They don't force me. But if you get 6000 or 5500 baht as your salary, you have to go out with 10 customers. I went out with a customer for many days and he paid me. From that money, 300 baht goes to the bar. If I don't pay 300 to the bar, I will get deducted 300 baht a day.
>
> (Tak: A-go-go Bar)

In some establishments, there are dress requirements including the color of the dress and underwear for each day and the type of shoes. Many participants from a-go-go bars,

where all dancers have to wear boots, complained about back pain caused by the boots that they wore:

> ...The bar stipulates the height of the heel. I can't change. I have to stand it. I feel tired on some days. Lately, I take Brand's chicken soup; it makes me feel better.
>
> (Toi: A-go-go Bar)

Patterns of Income

As demonstrated in Table A.2 (See Appendix I), the income of sex workers comes from several sources including off, drinks, tips, and salaries. For women employed in an establishment, their income usually came from a combination of off, drinks, tip, and salaries. "Off" * is a term used among sex workers to refer to money obtained from customer as an exchange of sexual intercourse. The rate of off could be limited by establishments or personal negotiation between the woman and her customer. *Drink* is money that the woman gets as a commission when the customer she entertains orders a drink, usually about 20-30 baht. *Tip* is special money given by customers to the women as a courtesy for their services. *Tip* ranges from 100-3000 baht. Some women reported that the major part of their income is tips from customers. The patterns of income varied by the type of work establishment. Most women employed in establishments (i.e., beer bar, a-go-go bar, massage parlor, drinking-bar, and cocktail-lounge) have to share their profits with the owner, manager, and some staff.

The participants from massage parlors described their pattern of income as:

> Coupon and salary is 5000 baht. For each round, I got 290 and 72-baht coupon. Customer paid 800 baht, owner gets 510 and I got 290 with coupon. If I took days off, I may get only 4000 from coupon and salary together. For 290 baht, I received everyday, for example, if I got 2 round (2 customers) today, I will get 580 baht
>
> (Orathai: Massage Parlor).

* Off was first used as the term of compensation paid by a customer to the establishment owner or sex worker for taking women out from the bar for sexual activities, mainly for sexual intercourse. Lately, it was used as a term for the compensation for sexual intercourse.

For the same income, the amount or intensity of women's work may differ by establishment. For instance, women working in massage parlors see a lot more customers to earn the same amount as women from a-go-go bars. In a-go-go bars, the average amount of money they could make from providing sexual services was considerably higher than others establishments. An example is given in the following:

> About 20,000 baht, including my salary...5000 is salary. Tip from drinking with customers about 30 baht a night. So it is about 20,000 baht per month. Everything, including salary, is about 20,000 baht. When go out with a customer, if it is not for the whole night, maybe about one hour, I will get about 2000 baht. If I have to stay overnight with him, I will get about 4000 baht. .. If a customer wants me to go out with him, he will have to pay for taking me out. A customer pays 400 baht to the owner of the bar. If it is after working hours, it is okay. But normally, I go out with a customer, during working hours
>
> (Tak: A-go-go Bar)

Compared to the other types of establishments, streetwalkers earn much less than others. Besides, the amount of money is also depends on whether customers agree to use condoms.

> The price includes everything. For example, if the price is 70 baht. That includes 20 baht for a room and a condom for a customer. There is 40 baht left. I think that not every woman uses condom...Condom is very necessary. Some customers don't want to pay for it. So we have to pay for it using the little money that we could earn.
>
> (Nun: Streetwalker)

Some participants have to pay the establishment for other costs such as hairdressing, make-up and clothing. Salary is compensation for services paid by establishments on a regular basis. In order to avoid having to work under regulations, some women did not accept a salary from an establishment, but worked as freelance sex workers there.

The Types of Customers

In this study, the customers varied in age, class, and nationality (i.e., Thais vs. foreigners). Different types of establishments provided services to different types of customers. The participants who worked in hotels and teahouses reported that the customers tended to be Thai working class males ranging in age from 30 to 40 years old. The customers

of the participants who worked in massage parlors tended to be Thai males from the lower middle class; only three participants who worked in massage parlors also had foreign customers. The beer bar and a-go-go bar workers basically provided services to foreign customers. Some participants revealed that having a chance to meet foreigners was one reason that they decided to work in these types of establishments. There are two separate groups of drinking bars or cocktail lounges that provide services to either exclusively to Thai male customers or to foreign customers.

Types of Work Activities

As shown in Table A.2, in different types of establishments, participants may perform different kinds of work activities during working hours. Besides sexual activities, work activities may include massage, dancing, and being a companion (sitting, talking and drinking with customers). Sexual activities may be performed either inside or outside the establishment depending on the type of establishment. The participants who worked with foreign customers tended to be paid to go out and spend time as companions. Therefore, work activities for this group of participants sometimes took place outside an establishment. Three of the interviewees limited themselves only to work inside their work establishments.

> I am wearing bikini. I just dance. There are two rounds of dancing and there are two sets in one round, a big set and a small set. Big girls and small girls. And we will alternate dancing the whole night. Big girls dance four songs and they come down from the floor. Small girls dance after them for four songs. And we alternate this way for the whole night from 7:00 in the evening until 2:00 in the morning. After the dance, I will sit with customers. Or customers may ask me to sit with them. .If I go out with any customer, I don't have to dance. If I don't go out, then I have to dance until the bar closes.
>
> (Toi: A-go-go Bar)

The Nature of Commercial Sex Work

Sex workers perceived their work to include the following six characteristics: stigmatized, secret, isolated, uncertain, risky, and silent about violence. In the following section, each one is described.

Stigmatized Work

Participants described themselves as being rejected and condemned by society. In describing stigma, some participants explained it as how other people in the society view them. Some participants stigmatized themselves without condemnation from society. The source of stigma could come from both societal and personal levels.

> This job is not accepted by society. Suppose that there is a man who likes me, but he happens to know that I am working this job. What about his family? If his family knows that I am working like this, will they accept me as their daughter-in-law and sister-in-law? Everyone in the society looks at this job very negatively. No one will accept women like us. Even my own sisters and brother, if they know this, I am not sure if they can accept it.
>
> (Muk: Teahouse)

Although most participants perceived that sex work was stigmatized work, they did not perceive and respond to stigma in the same ways. Among participants, there were three types of responses to the stigma of sex work:

Living in stigma. The participants in this category tended to be concerned about stigma and had a negative self-perception, as a result.

> It's shameful, I feel ashamed of myself. Sometimes people look at me like I have done something bad. Working like this I don't think of myself as valuable because this is the lowest job, but I try not to make myself lower than this, I never smoke or drink alcohol or wear a short skirt
>
> (Noi: Beer Bar)

Ignoring stigma. The participants who ignore stigma explained that they realized that there is a stigma in commercial sex work, but decided not to think about it.

> I am living in a small society. I don't go out to see the world often. No one here ever talks about it. We forget about it... It is the road that I chose. Even though I quit this job, my past

> is still there. Let it be. I accept what I am and I don't even care about it... Sometimes when I see people from different society, it makes me think about myself. Sometimes when I heard people talk about this, I feel shocked
>
> (Supa: Teahouse).

Accepting stigma. Some participants explained that there is a stigma in being commercial sex workers, but it was their decision and they are willing to live with its consequences.

> We are night women. But if people call me I just let it go through my ears. I just don't think myself that way. I am who I am. I'm fine with my work, that's enough. Everybody wants to choose to be born, but nobody can do that. I've never been wrong.
>
> (Nid: Massage Parlor).

Some participants explained that '*Karma*' was the reason they had to work in a stigmatized occupation. However, the meaning of karma differed among the women. Some participants believed that they had done something wrong in their previous life; therefore they had to pay back by being a sex worker. For some participants, karma meant mistakes they had made in this life, such as being in debt.

> I think so too. Why do only I have to work in this job, while my sister did not have to? I could have stayed at home, and my sister could have worked in this job instead of me. So I think it is my Karma.
>
> (Supa: Teahouse)

> I thought why others' lives are so different from mine. I disliked sexual service women very much. I said that there were plenty of other jobs, why didn't they do it. Why did they have to do this kind of job? Why did they have to wear those erotic dresses to make people look at them? As I worked as a vendor, when a sexual service girl walked by, I would look at her from head to toe. I never thought that I would become one of them. So I think it might be Karma. Now I have to do things that used to disgust me.
>
> (Nun: Streetwalker)

Secret Work

Keeping their work secret from family or those they love is one of the characteristics of sex work discussed by the participants. Being a commercial sex worker was a secret issue for the majority of the women. This was also validated by when the women asked me for reassurance that nobody would hear their voices on the taped interviews, nobody would ever

find out from me that they worked as sex workers, and none of their family members would ever know their story. At the beginning of the interview, the women often would say, "Nobody knows that I'm working in this job;" "None of my family knows about this." The reasons that women kept sex work a secret from their family were (a) They were afraid to face the negative reactions from their family; and (b) They were concerned that their family would have to live with the same stigma as they did. To keep this work a secret, sometimes women left their families to live alone in a rental apartment or they pretended that they worked in another business.

> No one knows and I don't want them to know....I don't want anybody at home to know that I am working like this. I don't want my kid to know it. I don't think they can accept it. It will be a mess, if they know. Yes, I keep it a secret. No one knows.
>
> (Porn: Café)

> I had to leave my house. I had to work secretly, and kept my job confidential from my friends and everyone I cared about. I did not want anyone to know about this job. I had to keep it a secret all the time. For example, if someone asked me how good the business was today, I had to say that it was not very good. I had to make an excuse that I went to other fresh markets or to Bangkok. I don't want them to hate me....I made the decision by myself, no one forced me.
>
> (Nun: Streetwalker)

Isolated Work

This theme emerged when the participants were questioned about social support. The participants perceived that there were only superficial relationships among sex workers. Approximately, 40% of 100 participants reported either no social support or tend to share their problem with other. Sex workers might advise each other about places where they could find good customers and about treatment for some health problems. However, there was no trust in their relationship. Mostly, they felt a lack of social support and trust among co-workers.

> Among night women or sex workers, you cannot trust anyone. We may have a chat or knew that we are in the same network but I never really believe I can talk about my problems.
>
> (Orn: Cocktail lounge)

> No. I don't have close friends, because my colleagues are...Let's just say that I am not close to anyone in my neighborhood. I don't talk to anyone. If I am sick, I go to a doctor or go to a drug store to buy medicine... I have friends at my workplace, but not close. I know them by names but we are not close. We never have dinner together or do anything together. We are from different hometowns. I used to have a friend but she stabbed me in the back. So I stopped making friends. They just know each other superficially; each of them has their own lives.
>
> (Tak: A-go-go Bar)

This sense of isolation may be one of the consequences of trying to keep sex work secret from their families. Therefore, they do not open themselves to anyone, including their family.

> I am doing this job secretly. I rent another house to live in. I told him that I came here to sell and buy produce. I let him stay with the kids and I send money to my kids. My children think that my business goes well. They don't know about this job. They don't know how many troubles I have.
>
> (Nun: Streetwalker)

Uncertain Work

The participants also describe their work as insecure. The uncertainty of the work results from the vulnerability of their income from day to day and from the inadequacy of their income for the little more than daily living.

> Because money comes and goes easily. But money does not come regularly. One day I can make money and one day I cannot. What I earn is just enough for survival
>
> (Porn: Café).

Some of the participants who had worked in sex work more than three years, or who had returned to it after leaving it for awhile, described their work as "declining work." The chance to earn money was less than what they had earned before they took a break from sex work. The feelings of uncertainty and hopelessness were commonly found in the group.

> As I first started to work, I went out with customers about twice in a night, almost every day. That was in the first year because I still looked young at that time. In the second year, I went out less. In this year, I did not go out much. There are not many customers this year.
>
> (Tak: A-go-go Bar)

Risky Work

When I asked women what they thought about sex work, they said "Risky work, it's a risky work." Two major risks of commercial sex work were commonly cited-- contracting diseases, especially sexually transmitted diseases and AIDS, and violence and abuse by customers. Certain types of customers as well as violent sexual intercourse were each mentioned as major factors that increased the risk of contracting diseases.

> I think it's a dangerous job and also a low job. Dangerous is that if one day we are careless, or whenever condom break, or customer intentionally tear condom, and if that person have AIDS, that is dangerous.
>
> (Dang: Drinking Bar)

> I risk seeing bad and sadistic customers. Broken condoms are also a big problem for me, not for customers. They were not scared when condom broke. I am at risk when a condom breaks. Sometimes I made a worrying sound to make a customer feel worried too. But it did not work. He did not feel worried at all. He didn't care that I was terrified
>
> (Nun: Streetwalker).

Examples of violence and abusive experiences in sex work are rape, aggressive sexual intercourse, and verbal assaults from customers. Commercial sex workers who go out with customers tend to experience more violence than do sex workers who stay with their customers in the establishments. The following is an example of violence that one woman gave me.

> One time I went to a hotel with customer, my friend also went with his friend. After I finished my work, when I was sleeping, my customer's friend came into my room and told me to do such a thing (having sexual activities) for him. I begged him that I was very tired from his friend. But he did not listen, and threatened me by asking me, "do you want to be in the front page of the newspaper, you are not the first one who dies like this." Then he started to take off the window glass. I was so scared and I had to do what he wanted me to do.
>
> (Am: Streetwalker)

> Nobody hurt me, but violence happen sometimes during having sex. I just have to be patient. If I'm not patient, I won' t get money.
>
> (Nid: Massage Parlor)

> Yes, from this job, I was. I could not speak Chinese. And there was a girl who could speak Chinese. She told me that a customer liked me and wanted me to go with him. So we went to Klong Toey (name of one harbor in Bangkok). Actually, that girl was raped once. But she

did not tell me about it. She made me go and I did. They took me to a harbor and got me into a ship. The ship was full of Chinese people from Mainland China. I went into a room with a guy. I knew that something bad was going to happen. But that guy couldn't do it, because he was too old. He left the room and I knew that he was going to see his friends. So I ran away. It was raining and I was wet. But he already gave me 700 baht. A Thai guy was running after me and tried to catch me. He caught me and took my money away. And he slapped me. I ran away. I just wanted to save my own life. I was not afraid of being raped. I just wanted to save my life. I met a guard. He asked me what happened, but I didn't say any words to him. He called a cab for me to take me home. The taxi driver brought me to the bar. I told the bar owner and he fired that girl.

(Tak: A-go-go Bar)

Yes, I was mentally abused. Sometimes I told a customer to stop, but he did not stop. Sometimes I felt as if I was raped. I could not help myself, because I am just a woman... He did it too aggressively. I did not like it. I didn't like oral sex, because I was afraid of getting fungus from his mouth...Sometimes, I have to bear it.

(Nun: Streetwalker)

Silence about Violence.

Violence in commercial sex work is a critical issue but it rarely gets attention and is most commonly kept silent. The women who had experienced violence at work explained that they most commonly had to accept it, keeping their stories silent because no one would care about what had happened to anyone who was commercial sex worker.

There was one case. A customer took a girl to that place, but he also brought 4-5 friends. They raped her and then gave her sleeping pill. They put her in a bathtub filled with water. A maid found her and helped her. She was almost dead. We never go there. Mostly, we will come to... Maids working there will help us. There are many motels that we don't go to, because they are dangerous. I prefer to go to hotel, because there is someone to help you and a waiter will sit in front of the room... I dare not go to the police. I think they look down on us. We just let it go (laugh).... No, they (Manager and Mamasung) will not help. We decided to go with customers by ourselves. They did not have to be responsible for it. They just want money, they don't care for us.

(Som: Drinking Bar)

I told the police, but they laughed at me. I did not regret that money, I thought that I paid for a life lesson. That is why I always ask for money before going out. Some customers don't understand. But I will tell them that I was cheated by a customer before. They don't know what pressure I have to take and they don't know what I have been through.

(Porn: Café)

The Naming and Meanings of Commercial Sex Work

Naming of Sex Work

In order to understand the meanings that commercial sex workers attach to their work, the participants were asked, what do they called the work were doing? Other questions about meaning included what the work mean them; what it meant to be sex worker. It is interesting to note that during the interviews most of the participants used the phrase '*this work*' or did not use any term to refer to their work in conversation when they were talking about sex work. A few participants called themselves 'service women' and 'night women' without being asked by the researcher. As a response to the question about what they called their work, the women used the terms hostess, reception, night woman, masseuse, service woman (phu-ying-bo-ri-kan), commercial service woman (phu-ying-kai-bo-ri-kan), prostitute (so-pe-nee), hooker (phu-ying-kai-tau, phu-ying-ha-kin), and whore. The words they used to name their work were significantly related to the amount of stigma they perceived in commercial sex work.

> I think of myself as a night girl because I can choose to go out or not. I don't know how I should define "prostitute". But I consider myself a "night girl" or "service girl."
>
> (Jun: Drinking Bar)

> "Prostitute," I don't give it for free.
>
> (Nu: Massage Parlor)

> A whore. People call us sexual service girls too. ..How can I say this....I want money, so I have to do it.
>
> (Sorn: Drinking Bar)

> I don't know what I am working. No one ever asks me that question. If anybody I don't know asks me about that, I will lie....I don't think. I just do it...I think it is my job. I earn money from it. If I don't work, I don't get any money. It is my routine. Wake up, dress up and go to work... I don't know. I never think about it (word prostitute).
>
> (Supa: Teahouse)

> I am prostitue, am I not? That is how they call women like me. Prostitute is a polite word. There are also other words, e.g. Phu-Ying-Ha-Kin etc. In fact, the word "prostitute" hurts me; it is a painful word. I don't want to hear that word. Once I was doing my hair at a salon,

> and they were talking about sexual service girls. They did not know about my job. It hurts me when knowing what they think about sexual service girls.
>
> (Orathai: Massage Parlor)

Most of participants thought that the term prostitute was used only for woman who worked in a brothel, which were dirtier and where she was offered no choice in customers, and did not care for her health. Some of the participants differentiated themselves from prostitutes based on the place where she worked, activities that were performed, the level of concern about her health, and a perceived choice in selecting customers. Only a few women thought that every term used for commercial sex worker had the same meaning and level.

> They are different. Massage & Bath girls are of higher grade. But prostitutes are those working in a brothel. They are different grade. But I have never worked in a brothel before. I think that those girls don't know much about how to take care of their health. They might be infected with some germs or diseases. But these women know how to protect themselves from diseases. Doctors come to the place to check their health and test their blood.
>
> (Orathai: Massage Parlor)

> A prostitute must work in a brothel, but here I'm in a legal establishment, I pay taxes like other people. I think a brothel differs from a massage parlor. A brothel is dirty, but here we care about our health.
>
> (Nid: Massage Parlor)

It was noted that most participants often compared themselves as better off than other types of sex workers and differentiated themselves from their counterparts by names.

> We are a different class from those girls. But you can use the same word. Those words are the same. In my job, there are health-checks. And I will go out with customers whom I like and are clean. Those people don't choose, they just go out with customers. Those girls are the same as bath & massage girls. If a customer likes one of them, she has to go with him and has no choice. But we can choose. If I am not happy with this customer, I will not go out with him. I will go with someone else....They have no right to choose, just sitting in the glass room. If a customer chooses her, she has to go with him. If that customer is not clean or I don't like him, I won't go with him. Otherwise, I would be rich by now.
>
> (Som: Drinking Bar)

The participants tended not to include a word related to sex in a name they used, but rather used a more acceptable term such as a service woman.

> And I will call myself a service girl... If you say "sexual service," I would argue that not always. Sometimes I go out with customers as an escort for a drink. No hugging, no kissing,

> no touching at all. It is just a service that we provide to customers to make them happy and have fun. And that is all.
>
> (Jun: Drinking Bar)

Meaning of Commercial Sex Work

According to the stories, there were three meanings given to commercial sex work:

Earning a living. The majority of women perceived that sex work is just "work" that they did for money. Some participants described their work as having sex or sleeping with a customer in exchange for money. The range of services that women provided differed by the types of establishments in which they worked. Some women included being companions as part of their service.

> Women work for money means working just for money. It is the only thing that is important for women.
>
> (Nun: Streetwalker)

> This work means only money. I can make money as I plan and much more than from other jobs, such as jobs in companies, sales, and factories. I couldn't have any savings at all from those jobs. They are just for daily living.
>
> (Som: Massage Parlor).

> I give my sexual service for only those who pay. As soon as a customer pays me, I give him service. I do my job automatically; I give no thought to it. I just close my eyes and all I think about is the money that I will get in next hour and a half.
>
> (Nu: Massage Parlor)

> I think that this term (service girl) comes from when we go out with customers, we have to do anything that customers want us to in exchange for money. I think this is the meaning of selling services. For example, some customers take girls out with them simply as friends to talk to and drink with around other bars. Some customers take girls out for sexual intercourse
>
> (Jun: Drinking Bar).

Family survival. Many of the participants were proud of themselves because with this job they had helped to support their families. Therefore, many described sex work as a means for family survival. One participant elucidated what commercial sex work means to her:

> No, for me, it's for survival, not because I want to have a lot of money. If I want a lot of money, I have to work every day, every month. But in my case, sometimes I didn't work at all, because I don't like it, I am not happy with the job, I did it because I want money for

> supporting my parents and everything that is necessary. Like when my parents were sick and I had to take them to see the doctor, I had to use lot of money. ..... Nobody asked me to. I decided to do it by myself, I though about how to make my family survive.
>
> (Am: Streetwalker)

Lack of other options. When they compared sex work with other types of work, they found that it was a job that gave them higher pay in spite of little formal education and other work skills. Although commercial sex work was viewed as *risky work* by participants, it was seen as the only choice that allowed them to earn enough money to fulfill their family's needs; there was no other choice available. The following excerpts illustrate this theme:

> It is important to my life, because I am old. If I don't have this job, I don't think I can find other job. I am older than 35 years old. Who is going to hire me? I had only Grade 9 education. They need people with bachelor's degrees these days. I don't know what else I could do. I don't have money to start any business. So this job means a lot to me. .It is my way out. And I have to stick with it. I can't do find something else to do. It is hard to find a good location for small store. There are so many sellers and not enough customers. I think I'd better not do something else. If I had money, I'd better keep it.
>
> (Muk: Teahouse)

> It must be this work, because I could not earn this much money from other jobs. Because I didn't have high education, it has to be this work.
>
> (Am: Streetwalker)

As reported in an earlier section, the participants perceived that sex work was a stressful job. In the following section, the findings related to stress and satisfaction in work are reported.

Stress and Satisfaction in Sex Work

As noted in Table A.3, the women who were streetwalkers reported higher than average stress levels, but lower levels of satisfaction, and balance between satisfaction and stress in work than did the women in other types of establishments. In contrast, women from beer bars and A-go-go bars reported higher than average satisfaction in work. The women from hotels and teahouses reported lower stress levels in work when compared to other groups. It is of interest to note that streetwalkers had the highest level of stress and lowest

level of satisfaction in sex work. Streetwalkers also saw the highest average number of customers per night and had the longest hours of work per day. Women from massage parlors reported the highest number of customers per month. Streetwalkers and women in hotels and teahouses had worked as sex workers significantly longer than the women working in other venues.

Stress in Sex Work.

This study shows that condom breaks were among the most stressful experiences at work and have an impact on both mental health and physical health. The majority of women identified the fear of contracting STDS and HIV from a condom break. Most participants believed that condom use was the only way to protect themselves from getting diseases.

> I never feel safe, no matter how often we come for the exam or how much I protect myself, I never feel OK. In my mind, I always worry; fear that someday I might fail.
>
> (Jun: Drinking Bar)

In the in-depth interviews, the participants also mentioned that the stressors in sex work are money, dealing with customers, family, being disadvantaged by regulations/ situations, and being engaged in stigmatized and risky work. Not earning enough money to fulfill family needs and a lack of customers were major stressors mentioned by most participants. *Stress about money* was related to the fact that they were a major source of income for their families:

> I am stressed about money. It is hard to earn money these days. Because I don't spend money carelessly and I don't gamble, this is why I can still survive. But I am stressed when I think about my kid. How can I get out of this situation? I don't want to work in this job, but I have to. Each night I feel that I don't want to come to work. I want to do something else. When can I get out of this situation, but it seems that that day will never come. If I don't have money and I quit, I have no money to feed my kid and myself. I have to take it, and I don't know how long can I take this situation
>
> (Porn: Café).

> Most of the time I will worry, why there are no guests today? I think that if there are a lot of customers, my employer can stay in the business, and that means I can survive. Having guests is good because I can earn money. It is depressing not to have guests
>
> (Muk: Teahouse).

> I feel stressed because I have to think about what I have to do. Someday I got a job, someday I didn't. So I just worry whether I will have money to use. Sometimes I am stressed about my family, because I have a responsibility.
>
> (Kanda: Massage Parlor)

Dealing with customers who are rude, sadistic, drunk, refuse to use condoms, or force them into sexual activities with which they feel uncomfortable (i.e., forcing sexual intercourse or performing oral sexual intercourse) were the stressful situations most mentioned by participants.

> Sometimes, I got a bad customer, very rude. They cursed while they were sleeping with me. Someone was very nice when I first approach him, but when we were in the hotel, he just turned to be very rude, looked down on me, and said whatever he wanted to say.
>
> (Pam: Drinking Bar)

> Some guests are really bad. Most guests care for themselves only. They don't care about how woman feel. And it makes me tense. And when I feel tense, I feel like I was raped. I feel that way every time. I have to bite my teeth and squeeze my hands. Sometimes I feel like I want to push them away, but I can't do it
>
> (Orn: Cocktail lounge)

Being disadvantaged by regulations/ situations included: 1) lack of power to make decisions in selecting customers and 2) withholding money from participants if they did not follow the regulations (i.e., filling their quota of customers as expected by the establishment, provide health reports, or took days off only during weekday). The fear of contracting diseases from work and feeling compelled to continue working in a stigmatized and risky occupation were other stressors they were identified. They also feared that they could no longer work to feed their family. They described such stresses in this example.

> It is caused by the fact that you can choose if you want to go out or not. Sometimes we feel that it is dangerous to go out. This causes some stress. We don't have freedom.... I think that we share money half and half, we should have right to decide. It is quite stressful. I prefer to work at place where they don't have too many rules. Sometimes I feel like I want to quit this job and find something better to do. Most of the time, I am stressed with the job ...Another

> problem is money. I know that I am taken advantage of in terms of money. But I am not in the position to say anything about it. And I can't complain to anybody. So sometimes I have to swallow it. Sometime we don't get the money at all, because we don't go out with clients. If you go out just once, they will keep all the money, they don't have to share a half with you. .... This is what I meant by stressful. (Jun: Drinking Bar)

Satisfactions in sex work

The most prevalent answer regarding satisfaction was that there is no absolute satisfaction in sex work. The majority of participants indicated that they could not say that sex work is satisfying. For most of the participants, money was the most frequently cited reason for satisfaction. Besides providing satisfaction because of money, sex work was also viewed as a way out or a choice for survival for some participants. However, the satisfaction from money tended to be outweighed by such dissatisfactions as risk related to bad customers, contracting contagious diseases, and stigma.

> I'm not very satisfied, I gave 2, because it's a very risky job I am working. I am at risk of getting diseases. If it's not necessary, I would never do this because in every minute we sleep with a guy, we never know what gonna happen. He might have AIDS. The condom might break. Sometimes I met a bad customer, he even used a needle to make a hole at condom, just to break a condom. I found it myself, very risky to get AIDS. Women who work in this job have 50% chance of getting the disease, we must prepare our mind in case bad things happen. (Am: Streetwalker)

> I am happy with the income. I make a decent amount of money, not too much and not too little.... I am only happy with the income from this job.... The thing that makes me unhappy is customers...The society looks at women like us as something that doesn't deserve any respect and doesn't have any dignity.
>
> (Orathai: Massage Parlor)

It can be seen in these examples from the participants' stories that women's level of stress and satisfaction are related to their perceptions of the conditions and nature of sex work and their life situations.

Coping Strategies with Sex Work

Coping strategies used in dealing with stress and dissatisfaction from sex work included reminding themselves about the reasons for engaging in sex work, leaving the "self"

out of the work, "letting go", resorting to superstition, being alone, and using drug, alcohol and cigarettes.

Reminding oneself about the meaning of work. The participants used this strategy to remind themselves that the major reason for coming to work was for money and family survival. Some participants mentioned that they focused only on money and did not pay attention to unsatisfactory situations. Thinking about children and their future were ways to deal with the difficult times they faced in their work.

> So it is impossible to be serious with this job and be sincere to anyone. It is just impossible. It is more like what you want. If what you want is money, you just do your job, earn money and save money. Don't pay attention to anything and don't care for anyone. Just work until you have enough money that you want and leave. I dare not expect anything. I always think about my kid, he is the power that makes me go on (crying)
>
> (Porn: Cafe)

Leaving the "self" out of sex work. Leaving oneself out of sex work occurs on both cognitive and practical levels. At the cognitive level, women try to limit themselves regarding when and where they work so that they could forget for a while that they were sex workers.

> When I had a day-off, I went for a walk at a department store and shopped. When a customer asked me to go for a walk with him outside of my working place, I did not go. My job would be only in this working area. I never took a customer outside with me. I think doing my job within the working area is enough.... I think it is enough to limit my job within the working venue. It is not that I have made enough money. But I want my job to end here, at this place. I don't want to take my job outside. Outside is my life. I don't want to...I want to be able to pretend that I don't work in this job, when I am out of this place. Being able to think this way makes me feel comfortable. (Orathai: Massage Parlor)

On a practical level, the participants explained that sometimes they left work for a while, going back to visit their family when they felt too much stress, they came back to work again when they felt better.

> Whenever I meet a bad customer. Like I can't take it anymore, I quit (laughing), but I have nothing to do except this work, so I have to go back again. When I wasn't feeling well, I just didn't go out, and quit for a while until I felt OK then came back to work again. (Am: Streetwalker)

Letting go. Some participants described the way they used to deal with stress situations as 'I don't think too much,' 'I'm not serious,' or 'just think about here and now.' One participant described that she learned to let go of all unpleasant feelings by using the Buddhist teachings of living in the here and now, and knowing that nothing is certain.

> I am not stressed. I am taking things seriously, whether it is job, money, or working environment. I used to have everything, but now my life is like this, I don't want to think about it. Just let it go. (Muk: Teahouse).

Resorting to sacred spirit. In hopeless and stressful situations, some participants described that they would pray for the sacred spirit to protect them from contracting diseases. Some participants also made merit and wished for a better situation.

> When the condom broke, I was terrified. I was stressed and worried for a month. I thought why did this have to happen to me even when I tried so hard to protect myself? ..I wanted to quit this job immediately. I went to temple and asked for blessings. I asked the sacred spirit to protect me, to prevent any obstacles from happening in my life. Please don't let that customer have any diseases. Please let him be a good person as he told me. I used religion as my strength.
>
> (Nun: Streetwalker)

> It makes me feel happy, peaceful and not worried. I was very worried before coming to listen to the result of the test. After making merits, I felt better and less worried. I make some wishes, but they might be impossible.... I wish everything would be okay, no disease or sickness. ..I make a wish for a sum of money, and then I will stop working and go back to my hometown. But I never make a wish not to work.
>
> (Tak: A-go-go-Bar)

Being alone. Some participants liked to spend time thinking, writing, watching television, or listening to music by themselves. The participants who used this strategy tended to perceive themselves as lacking social support, having no one they could trust or who would listen to their problems. They wanted to keep their story to themselves.

> I locked myself alone in my room with the light turned off. I will think about it alone and not talk to anyone
>
> (Am: Streetwalker).

Using drugs, alcohol, and cigarettes. Some participants indicated that they use alcohol and cigarettes to help them release stress from work. Some participants used alcohol during work to help them in approaching customers. In contrast, some participants indicated that they never used alcohol during work because they had to be very cautious, but did use alcohol after work to help them forget everything. Among all participants, only a few acknowledged that they used drugs (i.e., ecstasy drugs) to help them in their work or for their pleasure.

> Some people in the bar take Ya-Maung (ecstasy drug). It is a purple tablet. I don't know the name of it. But they said that it makes you feel like you are drunk. But it should be different from getting drunk from alcohol. I saw some people take it and they became bold, their eyes changed too. It makes them feel bold to talk to customers. Some people drink alcohol from when the bar opens until the bar closes....For me, I have never smoked before, but I smoke after I work in this job. My colleagues smoke. When they smoke, they pass it on to me. Now I buy cigarettes myself. When I smoke, I feel like all exhaustion is gone. After one round of dancing, I have to smoke. Because after dancing, I get tired, and I have to smoke. I don't know if it is real or it is just my feeling. Everyone who works here smokes after she dances. (Toi: A-go-go Bar).

In the next chapter, the findings related to health and health care seeking in commercial sex workers will be presented.

CHAPTER 5

HEALTH AND HEALTH SEEKING BEHAVIORS

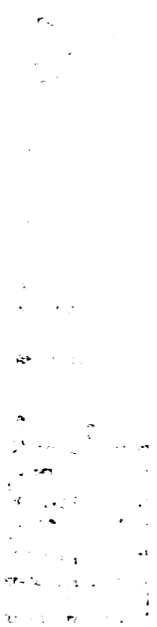
In this chapter, five research questions related to health and health care seeking behaviors are answered. The chapter is organized into 3 major subsections: perceived meanings of health, health care seeking strategies, and determinants of health and health care seeking behaviors. In the first subsection, *perceived meanings of health*, the meaning of health as perceived by commercial sex workers is described. In the second subsection, *health care seeking strategies* of commercial sex workers are identified and presented. Finally, in the determinants of health and health care seeking behaviors section, I present the regression models testing relationships among personal characteristics and work conditions on health and health care seeking behaviors.

Perceived Meanings of Health

Research question 2 was: *How do commercial sex workers define personal health?* To answer this research question the participants were asked why they gave a specific score for their health and what they thought about people who chose the highest score on the health status scale. They were asked about what it means to be healthy. The data from the in-depth interviews suggested that meanings of health were defined within the experiences of being a commercial sex worker. The meanings of health can be categorized into two categories: Health as externally validated and health as internally validated.

Health as Externally Validated

Health as an externally validated concept, existed when a health care provider told the woman that she had no disease or, more specifically, has tested as negative for any type of STD or HIV/AIDS. There were only 4 of 35 participants who defined their health as



externally validated. These four participants tended to more readily seek professional health care for their sexual health problems and to use medical terms such as herpes and fungus infection when they discussed their health problems. Two participants were currently diagnosed as HPV-positive and worried that they might have to stop working in spite of their family still needing their financial support. The following quotes illustrate why several women rated their health as they did:

> I think my health is '1' because it's really bad, I got one disease after another all the time, such as inflamed womb, herpes, those diseases that women are most likely to get.....and I'm not sure whether I'm having any serious disease that cannot be cured.
>
> (Am: Streetwalker).

> I gave myself 10 because I take a good care of myself. I think because, since I work, I never had anything. For my friend, sometimes they might be this and that every few months. At least inflamed womb or getting virus, but since I work here I never have anything.
>
> (Pam: Drinking Bar)

Health as Internally Validated

Health as an internally validated concept, exist when the participants themselves defined whether they were healthy. The indicators that the participants used to evaluate their health were: (a) feeling well or not feeling tired; (b) being able to work; (c) experiencing changes in body functions such as eating, and sleeping patterns or physical appearance; and (d) stress and worry about work and family. The majority of the study participants fell into this category:

> I decided from all symptoms I used to have. Nothing's wrong with my body, no headache, and no dizziness. I will check from these symptoms. Like, I have abdominal pain and period. But I don't know how bad it is, except knowing from I feel fine, I can eat, I can sleep
>
> (Saipin: Drinking Bar)

> There may be a few things that are not good. I mean I may have some stress, like when we want to spend money but I can't earn it. This may affect my health and now it is winter season. Sometimes it rains. So these may also affect my health. I may have a cold because I have to stay in the rain
>
> (Dang: Drinking Bar).

> It's not the best because I still had back pain and it's not worst either because my body still functions, still be able to work....I feel tired when I got up but I had to push myself to get up otherwise I would not have anything to eat...The best health means never getting sick and having money to spend, not suffering in seeking money, and not stressed. Just have money and permanent work... I am still able to work and don't have to beg someone for food
> (Bupha: Streetwalker)

In discussing how work affects their health in general, the participants said that the major work-related health concerns were mental health problems, Tok-khao (Leucorrhoea or vaginal discharge), and womb pain. The participants in this category tended to relate work conditions and their working life situations to their health and how they sought health care. Most participants stated that the major cause of mental health problems was work stresses including concerns about condom breaks, contracting diseases from work, uncertainty of work, facing bad customers, and suppressing emotional feelings. Sexual health complaints, such as uterine and vaginal pain, were viewed as a consequence of aggressive sexual intercourse.

Health Care Seeking Strategies

Research question 3 was: *What are the patterns and associated strategies of health care seeking behaviors used by commercial sex workers in Thailand?* To answer this research question, the participants were asked to answer questions about what they did when they had health problems. They were asked how they maintained their health and how they prevented all the work-related diseases. The themes that related to this research question are types and perceptions of health checkups, health protective strategies, general health complaints, health maintenance, sexual health complaints, sexual health practices, health care strategies for major health complaints, and factors affecting health care seeking. In the following each theme will be described.

Types and Perception of Health Check Up

Types of Health Check Up

As reported in Chapter 4, some establishments required women to have regular STD checkups. Basically, in an STD checkup, the commercial sex worker is required to get a pelvic examination in the lithotomy position. A health care provider use a vaginal speculum to check for any sign of cervicitis, abnormal vaginal discharge or bleeding, and then use a swab to collect a specimen to check for sexually transmitted diseases. In this study, it was found that there were four different types of health care settings where the participants could get STD checkups:

a) Onsite care provider. The onsite care provider is a health care provider hired by the owner of the establishment to provide exams for sex workers on site. However, the participants reported that they have to pay 40-baht for each checkup. The onsite health care provider could be a doctor, registered nurse, or technical nurse (two year training program). The establishments that have onsite providers include A-go-go bars and massage parlors. The participants reported getting STD checkups twice a week at massage parlors and once a week at A-go-go bars. Almost half of the participants who got a checkup from onsite providers revealed that they were not satisfied with the onsite service and often sought care from a private clinic nearby.

b) Private clinics. Most, private clinics were located near the establishments where the women worked. The participants usually paid about 40 baht per visit. The health care service fee was as high as up to 400 baht per visit in other locations. These private clinics were viewed as options for the women's health care needs.

In this health care setting, the participants felt less worry about disclosing their work. Most participants who used these services described the private clinics as "*It is a clinic for women who work in this work, we do not have to tell them again about our work. They know what we are doing and know what we need.*" Services received from these clinics were perceived as effective care because women could get immediate treatment for their health complaints.

c) Government VD Clinic. Most of the Government VD clinics were located in a specific area and had limited working hours- from 8:00 am to 4:00 pm. At these clinics, most of the care providers serving the participants were nurses who had special training in sexually transmitted diseases (STDs). When a patient needed to be treated, the nurses consulted with a doctor for a specific diagnosis and treatment. Most of the participants complained about the distance from the place they lived to the clinic and about the lack of time to use the clinic. The participants who used services at these clinics were more likely to come if their establishment required it.

d) Government hospital or private clinic in a remote area. These health care settings were described as services that were located far from the places where the women lived. Health care settings in remote areas were seen as a safe place for the participants to disclose their work status. It allowed them to keep their work secret.

The experiences of getting STD checkups differed among the health care settings. The setting and the regulations that governed them all had an impact on how the participants perceived STD checkups.

Perceptions of STD Checkups

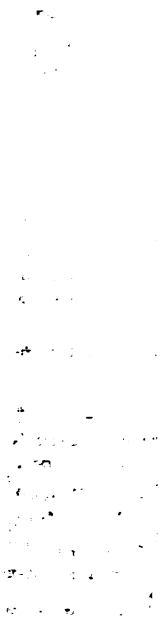
The participants had differing perceptions about STD checkups in terms of cost, benefits, and consequences. In the following, the perceptions about STD checkups by the women who were required to have them by their work establishments are presented.

Requested by establishment. Although the major reason for getting an STD checkup was because of an establishment regulation, the women also had different reasons for when, where, why, and how often they should come for an STD checkup. Among the participants who had STD checkups because of establishment regulations, their perceptions of health check up could be divided into two groups— "it's for my health," and "it's for my work."

a) *It's for my health*

These participants perceived the reason for getting an STD checkup as directly benefiting for their own health. Although it reduced their earnings, getting an STD checkup was viewed as a preventive health strategy. The goal was to find out whether or not they had disease and to receive early treatment. The perception that work put the women at high risk for contracting AIDS strongly influenced the perceived necessity of getting STD checkups.

> The owner of the bar said that we have to go for check-up every Monday and Tuesday. And we need to have a proof with clinic stamp to show that we have been there. ..I think they want us to take care of ourselves. They force us to have our health checked because they don't want us to have any diseases or AIDS. They also force us to have our blood checked once every three months; otherwise they will cut 1500 baht. And they will cut 300 for a regular STD checkup. I think they want us to take care of our health. But it is very rare that I don't come. In a month, I might miss only one week. Most of the time, I will come here either on Monday or Tuesday. ...When I go out with a customer, I have no idea if he is safe or not. Even though I use condom for protection, it is still not safe. I think it is good for us that they force us or set a rule to make us take care of our health. ... **I think it is good for our own health**. If I don't come, it will affect me. If I don't come here even though just one week, I might catch a disease in that week. Who knows? I think it is better to come for check-up.
>
> (Jun: Drinking Bar)



Some participants said that they did not rely only on the regulation, but also on personal judgment based on their perceived symptoms and conditions of work, such as how often they went out with customers.

> Twice every month. In my first year of working, I came for Painai (internal) check-up every week. But later, I come 2-3 times in a month. If I had symptoms, such as itchiness or burning pain, I would come every week. **But if I did not have any symptoms, I would not come**. It varied. But I came for check-up more than twice in a month, for sure. In the first year, I was scared. I was still motivated of coming, because I knew nothing. I had to come for check-up very week. But right now, **if we don't come, our salary will be deducted**. Some people don't want to come, because there are not many customers and so they don't go out with customers often. Right now, **I come here** twice in a month and give an examination form to the manager, **so that my salary will not be deducted.**
>
> (Khew: Hotel)

> Sometimes if I don't go out with customers, I might skip the checkup for that week. For example, if I go out just once, I am not coming here. Because I think if I don't go out with customers, I am not coming. But if I go out with customers every day or 2-3 times in that week, I will come. But I come here almost every week. I might skip only one week.
>
> (Toi: A-go-go Bar)

Besides seeing STD checkup as a way to detect diseases, the underlining reason for staying healthy was to be able to work and earn money for their family and children.

> The bar told us to have it checked once every week anywhere we want to go. Besides, I am afraid of getting diseases. I am afraid. I have seen it before. I am afraid of AIDS and other sexual diseases that I have read from the book. I come here every week for the sake of my own health. **I have to be healthy in order to keep working and earning money**. If I had disease, I had to stop working and earning money. So, I have to come here.
>
> (Som: Massage Parlor)

b) *It's for my work*

The establishments required the participants to have regular checkups. But the women also perceived that STD checkups were a part of health prevention and that early detection meant that they could get early treatment. They perceived STD checkups as a component of work safety, rather than something they did for their own health. One participant described STD checkups as a work requirement, checking for the health of the organs involved in sex work.

> For internal exam, I think it's good to have it checked for prevention. So we know if we have anything, anything's wrong, so we can consult. But I think it's about work, about work safety.
>
> (Joy: Drinking Bar)

> I think it's good. If we check it often, when we have anything, so we can get it treated soon. I just knew when my salary paid; they said I have to get an exam on the 5th and 20th of every month and show them a stamp on a health report card. I think it helpful for my own health too but it the part of my work too because we have to use this part of our body. I think it's more about work because we have to trade with our body; it's like a check-up for the health of working organ.
>
> (Suwanna: Massage Parlor)

Some participants in this group also viewed these exams as directly beneficial to the establishments and care providers, but not for their own health. Regular STD checkups by providers appointed by an establishment were not seen as a health care resource for them. The women tended to resort to health care based on their perception of symptoms. Some participants paid health care providers in order to get a health report required for their work although they were not examined.

> I think it's not good; it's too often. I think germs are still not incubated within a week. I think probably every other week or once a week, four times a month should be OK. If it's too often, it's not good...It's not good to me, because it hurts. It's not embarrassing. I know myself better. If I feel itchy, I will see a doctor right away, I'm not gonna wait until exam date. Yes, there is a health care provider coming here, but when I feel itchy, sometimes it's fungus or leucorrhoea I always go to see a doctor at private clinic around here. They are good, clean; if I have fungus, they will give me suppository medicine right away. If I feel hurt or have a scratch, they will paint some medicine, I feel better after only one day. An exam may benefit us, but it also benefits a doctor, it's 40 baht for one exam. And having an exam on Monday and then Friday is too often. I think that benefit is for the doctor because here we have 100 of women, at least 5,000 baht they get. But we also get a benefit to know if anything happens to us. .... I just give them money because I don't want to have an exam. I don't get an exam because I know myself whether I'm OK or not and sometimes, when they found nothing here, when I went to private clinic they found something.
>
> (Nid: Massage Parlor)

Not requested by establishment. Among the participants who had STD checkups without being required by their work establishments, about 50% identified having symptoms as the major reason. The symptoms described by the participants included odorous vaginal discharge, uterine pain, genital and vaginal itching, and genital rashes or wounds.

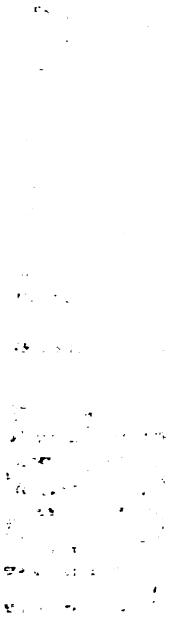
> Not often, just when I have time, maybe once every 2-3 months, or when I have symptoms or something wrong. I had an abortion once; I was not ready back then. Sometimes I have some smelly discharge, sometimes my womb hurts, and sometimes I have a pain in my lower abdomen, and itching rash in vagina
>
> (Am: Streetwalker)

Another reason cited for getting STD checkups was engaging in risky health practices, such as not using condoms or experiencing a condom break.

> When I first started working, I did not use any condom. I went out with customers and I forgot. And I thought it should have been okay, because he looked clean, so I did not use it. But in the morning, I could not sleep. I was worried. So I went to a doctor. The doctor said he could not do anything at that time and that I had to go back three months later.... On that day, I had internal exam and my blood checked. The doctor said everything is fine. And he asked me to go back three months later. After that I am always careful and protect myself. I think I am fine, so I have not gone for a check-up.
>
> (Porn: Café)

It is of interest to note that most of the participants differentiated their sexual health needs from their general health needs. In addition, they tended to seek care for their sexual health problems more than for general health problems such as eye or blood pressure problems. The women decided to seek care for sexual health problems because of their work and children:

> I think it is not the same thing. I think that I come here to have my internal exam, because I want to know if I have any sexual transmitted diseases, such as AIDS. If I had AIDS, I would be in big trouble, **because I have to worry about my child**. But when I knew that I have no AIDS, I felt relieved. Before I knew the result, I had been worried, because I had not had my blood checked for AIDS for a long time. I thought if I had AIDS, what would I do and how long could I live?
>
> (Yai: Streetwalker)



For the participants who had not had an exam within the last three months, their reasons included having no symptoms, using a condom every time, taking medicine to prevent sexually transmitted diseases, and not going out with customers.

> There have been no symptoms. Previously, I did not use a condom— that was why I went for a check-up. But now that I am using condom; I haven't gone for a check-up. ...Because there have been no symptoms at all, I have not gone for check-up lately. When a condom breaks, I will take cleaning medicine. There is no itchiness, nothing at all.
>
> (Supa:Teahouse)

Health Protective Strategies

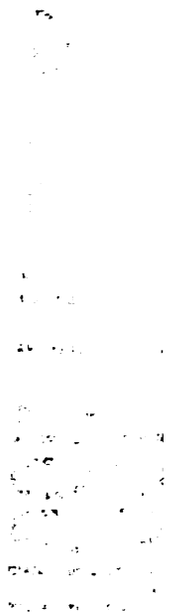
Because of the risky nature of their work, the majority of participants perceived that their health was at risk. The participants learned about safety as part of were trying to live with risky work.

> I have to know about safety in work. About customers, it depends on our service and our word because each customer is different. I myself never have any experience with customer who someone may call a "jerk" customer. Working at this point, I think we can protect ourselves, not only protect customers. Nowadays, I have to love myself because working here is like I'm on the tight rope; never know when it will be torn. I have to accept this. It's our responsibility how to make it safe for both customers and ourselves.
>
> (Kanda Massage Parlor)

When asked what types of methods they used to prevent work-related diseases, some participants talked about their concerns about contagious diseases beyond sexually transmitted diseases, such as skin diseases, tuberculosis, and intestinal problems. Preventive strategies used to protect themselves from any contagious diseases included using condoms, getting STD checkup and early treatment, cleaning oneself after intercourse, taking preventive medicines, and avoiding sexual intercourse by offering other sexual services.

Using Condoms

All the participants reported using condoms to prevent sexually transmitted diseases. About 91% of participants indicated that they used only condoms. Ninety one percent



reported using a condom every time in the last five times they were with a customer. These participants were focused only on preventing of sexually transmitted diseases.

> I think using condom is the best way. You can't judge people from their appearance. Some people look nice and clean, but you never know. Better use a condom.
>
> (Porn: Café)

> I use condom only. I don't use anything else as a disease protection. I use a condom when sleeping with a customer. Otherwise I do nothing for disease protection. And I take care of myself.
>
> (Tak: A-go-go Bar)

The participants who consistently used condoms were also aware they need to monitor their effectiveness by being vigilant:

> Only one way of prevention is condom use and also I had to see whether I could trust that person, before having sexual intercourse. Sometimes he might use a needle to punch the condom because some customers just want us to get their disease or some like to do without using condom....I notice customers' characters, I have to open the package of condom myself, and during sexual intercourse I have to check whether it breaks or slips off.
>
> (Supa: Teahouse)

Nine percent of all participants revealed that, besides using condoms, they also used some other method to prevent sexually transmitted diseases. The other methods that women used to prevent work-related diseases are discussed below.

Getting STD Checkups and Early Treatment.

As presented in the previous section, the participants mentioned getting STD checkups and early treatment for their sexual health problems as a way to protect themselves. Belief about getting STD checkups for disease prevention seem to occur at the cognitive level, which can be seen from the following excerpt:

> I come to get the test here at clinic, but I rarely come...I thought that is one way of prevention, if they find that I have gotten a disease, they will give me some medication. I use condoms, but they might break.
>
> (Am: Streetwalker)

Another participant consistently practiced disease prevention by coming to a clinic for STD checkup once a week because of her maternal role and responsibility for her children.

> For example, I came here for health check-up. If I have any disease, I will know it, right? So, I know what I should or should not do. Some people know that they have diseases, but still continue to work. And some diseases are transferable, even though you use condom, right? **So I think that I should take good care of myself. Besides, I have a child to feed. If something happens to me, who is going to take care of my kid? That is why I come here for check-up. It is a way to prevent diseases**. And if it is not necessary, I will not go out with customers. I try to avoid it, by talking to him.
>
> (Jun: Drinking Bar)

Cleaning Oneself After Sexual Intercourse

Many participants reported cleaning their vaginas after sexual intercourse by using soap or antiseptic solution as a preventive method. The participants who used this method developed a personal technique, which assured them that their vagina was intensively cleaned. The cleaning methods described by participants included inserting a tube and spurting water or diluted antiseptic solution inside their vagina, or inserting a sponge soaked with feminine hygiene detergent into the vagina. A sponge, called *'Lukkhai'* in Thai, is a well-known tool used by sex workers during menstruation. Some participants explained that besides sexually transmitted diseases they risked contracting skin diseases, therefore they tried to avoid skin contact with any customer who had any kind of skin lesion (if they could not cancel that customer).

> I'm afraid of skin disease too. As I told you, if I notice that some guests have a rash, I won't touch them. After I massage them, I will clean myself using germ-killing detergent. You can get the disease, when you touch him, so I will clean myself. I will take a bath.... I have everything, soap, talcum starch, Dethol (antiseptic solution), Vaseline, salt. Everything is in my bag. Cleanliness is most important. I clean my vagina too. Some girls here don't know how to clean theirs. It is bad. They need to know that vagina is very important and it need to be kept clean. It is easy to clean outside area. But you can't reach inside to clean it with soap. I have my own small plastic tube that I can insert into my vagina. I will let water pass the tube to clean it. It is my personal thing.
>
> (Muk: Teahouse)

> Normally, after sleeping with customers, I will clean my vagina. I have liquid detergent for cleaning. When I clean inside, I will soak a sponge (called luk-khai) with the liquid detergent, and I will put it in my vagina for about 10 minutes. I pull it out and clean it again. I do it myself. I don't know how else to clean it, I can't see it. I have to do it that way. I clean every time I go out with customers. ...I think it works well. My friend always got diseases very often. I don't know what it was. I took her here and they told us that she had fungus in her vagina. She felt itchy a lot. I suggested her to clean it as I am doing. And it was gone. I

> believe that it works. Maybe not much, 50-50. But if it is made of rubber, when I use condom, it might have negative impact on my womb. I use it every time I go out with customers. I change "Luk-khai" everyday too, it costs 20 baht per piece.
>
> (Toi: A-go-go Bar)

Taking Preventive Medicine

Many of the participants who worked in hotels, teahouses, or as streetwalkers they already protected themselves by using condoms and taking a medicine that they called 'Ya-Lang' or 'Ya-Khub' to wash the disease from their body through urination. Ya-Lang or Ya-khub is the diuretic drug called "Rifadin" that can be bought in drug stores. The participants who took this medication believed that the disease would be released from their body with copious urination or if their urine was turned red. Some participants believed that taking this medicine also helped clean all dirt and stains inside them that resulted from using condoms. Some participants explained that they bought 'Ya-Chut,' a set of drugs used by sex workers, considering of a diuretic drug, an antibiotic, and a vaginal suppository tablet to use once a week. The information regarding all these preventive medications was communicated through their social network.

> I tell the pharmacist that I want to buy a good medicine for vaginal cleaning, which costs about 100 baht. And I insert medicine into vagina, before I come to a doctor here. He asks me about that and I told him the truth.... **I don't know how well a condom can protect me, so I need to take the medicine to protect myself; take the medicine to clean** my vagina. There were medicine that I swallow and another medicine that I insert into vagina. I insert it when I go to bed. And it is dissolved when I wake up.....I use it once a week, every week. ...I use it every Sunday, because I don't work on Sunday. I took the medicine and insert the medicine before I go to bed. And on Monday, I come here
>
> (Yai: Streetwalker).

> I buy medicine to cure itchiness from a drug store. it is medicine to cure fungus disease, because customers like to do oral sex on me. I am so afraid of it. After oral sex, I will clean it immediately with Dethol's soap. Sometimes I used Ya-Sod (vaginal suppository medicine). I took medicine too. I bought it from a drug store. It is sold everywhere in Bangkok. The brand name is *Gano*. I don't know if it can kill the fungus. I heard about this medicine from a friend. So I bought it from a drug store at Yawaraj. It costs 5 baht a tablet
>
> (Nun: Streetwalker).

Avoiding Sexual Intercourse by Providing Other Sexual Services

There were a few participants who reported performing oral sex or masturbation on customers who refused to use condoms. The women also observed and checked whether their customers had any sign of contagious disease. For example, some participants revealed that they had learn some techniques from onsite care providers and friends for checking whether customers had any discharge from their genital organs or checking for skin lesions before performing sexual activities.

> To protect myself? No, I never take any medication, because I already protect myself when I work by looking and noticing the customers my way is different than others'. My opinion is different from those of other girls. All they want is money; they don't care about their health. They don't think about consequences. But I have to worry about that. No matter how clean a customer looks and how much money he offers, if he refuses to use a condom, I will offer him oral sex instead. I will use this way; I will try to find a way to avoid it. I will try to get away from it. But you still have to see if that customer is clean or not. And I won't swallow anything. I will avoid sleeping with him, if he refused to use condom. I don't want any disease from him into my body. But before they start oral sex, they should give their customers soap to clean it. It is even better to clean it by myself to make sure that it is really clean. Besides customers will think that we are pleasing them. But in fact we want to make sure that it is clean.
>
> (Muk: Teahouse)

General Health Complaints and Health Maintenance

General health complaints and the perceived causes of these complaints were also described by the participants. The general health complaints are reported in Table 5.1 and include fatigue (62%), headaches (61%), and low back pain (60%). The participants described headache as a cold symptoms and migraines, while they tended to associate fatigue and low back pain with their work conditions, such as lack of sleep, sitting for long periods of time in a glass room, and wearing heavy boots. When asked how they maintained their health, the participants said they tried to get enough sleep, eat good food, take good supplements, eat chicken soup called "Brand," and not to think too much.

> I think that stress has major effect on health. So I try not to think about things so much...and I sleep a lot. I think I am old, and I need to have enough sleep. I eat everything I want to eat

and nutritious. I like to eat fish, fruits and milk. My customers always say that I should lose some weight. I said that I am already 40, why do I have to lose my weight? If I were 20 or 30, I would have done that. I like fish and vegetables. But I don't like pork and chicken. I think it is good for my bowel system. I used to have a lot of pimples. I went to the doctor and he said that if I have a good bowel system, all pimples would go away. And he gave me some laxatives. He also told me to drink a lot of water

(Muk: Teahouse).

Table 5.1: General health complaints (N=100)

	YES (%)	NO (%)
FATIGUE	62	38
HEADACHE	61	39
LOW BACK PAIN	60	40
PEPTIC/STOMACH ACHE	31	69
DIFFICUTIES IN HEARING AND SEEING	27	73
DIFFICULTY IN BREATHING	25	75
CHEST PAIN	19	81
VARICOSE VEINS	13	87

Sexual Health Complaints

The sexual health complaints described by participants are presented in Table 5.2. The four major sexual health complaints were pain during sexual intercourse (49%), abnormal vaginal discharge (48%), uterine pain (47%), and vaginal itching (41%).

Table 5.2: Descriptive Statistics of Sexual Health Problems (N=100)

	YES %	NO %
PAIN IN THE UTERUS DURING SEXUAL INTERCOURSE	49	51
ABNORMAL VAGINAL DISCHARGE	48	52
PAIN IN UTERUS	47	53
VAGINAL ITCHING	41	59
VAGINAL PAIN DURING SEXUAL INTERCOURSE	36	64
INFECTION OF UTERUS	29	71
ABNORMAL MENSTRUATION	23	77
FREQUENT URINATION	25	75
GENITAL ULCER WITH RASH AND ITCHING	20	80
NEVER HAD SYMPTOM	04	96
BLOOD IN URINE	01	99

The participants described all their sexual health complaints as caused by work. They believed that abnormal vagina discharge or leucorrhoea called Tok-Khao were caused by a

chemical substance from condoms and personal hygiene. Some participants perceived Tok-Khao as a normal vaginal discharge that women have before their menstrual periods. For other participants, Tok-Khao meant abnormal vaginal discharge.

> It depends. The more often I go out, the more Tok-Khao I have and the more infected it gets. It is itchy. I have feeling that I am allergic to condoms. Or maybe it is fungus. I am not sure either. I never counted how many days.
>
> (Tak: A-go-go Bar)

> I have it almost every week (laugh). It depends on what type of Tok-Khao I have, I have it often. I think women have this because they don't clean internally thoroughly. Maybe it is caused by a chemical substance from condoms and we do not clean it well enough.
>
> (Ooy: Cocktail lounge)

Sexual Health Practices

Asking Customers About Sexually Transmitted Diseases

The statistics indicated that 56 % of the study participants reported asking customers whether they had any sexually transmitted diseases. The participants who never asked customers this question perceived that a) it was not appropriate to ask customers; b) it was not necessary to ask because they always used condoms; c) they had no right to ask; or d) observing was better than asking.

> I dare not ask them. I never did....I have the right to ask. But I think that he will ask me back if I have any. But I never asked, because before going out, I will look at the customers, touch them to feel if there is any rash on their skin. But that they have rash on their skin does not mean that they have AIDS. It could be skin disease. If their skin is too ugly, I am not going with them. I dare not ask them. **I am afraid that they will be mad. Rarely people ask. Just look at the customers, If they look clean and okay, I will go out with them.**
>
> (Ploy: A-go-go Bar)

> No, I don't ask. I myself put condom on for them (laugh). Never ask
>
> (Supa: Teahouse).

Contraceptive Use

As demonstrated in Table 5.3, the majority of the participants (79%) reported using at least one type of contraceptive method. The two major types of contraceptives used by the participants were contraceptive pills (37%) and condoms (16%).

Table 5.3: Types of contraceptives use (N= 100)

	Frequency	Percent
ORAL CONTRACEPTIVE	37	37.0
NONE	21	21.0
CONDOM	16	16.0
TUBAL LIGATION	13	13.0
INJECTION	8	8.0
COMBINED METHODS	3	3.0
NORPLANT	2	2.0

The reason for using the other types of contraceptive besides condoms such as oral or injection contraceptives was because of the chance of condom breaks during work. The participants who reported using norplant or tubal ligation indicated that they had received since a post-partum visit and before entering sex work. The participants who reported not using any type of contraception believed that they did not have to be concerned about pregnancy because they already used condoms. One participant explained the reason she used contraceptive pills:

> I take contraceptive pills, just in case. I think it is better to take contraceptive pill. It is a more certain way that you can protect yourself from being pregnant. I don't rely only on condoms. What if it breaks? It is better to take pills. Getting pregnant causes a lot of problems. If you have to do an abortion, you will feel sorrowful and sinful. I have to be prepared. I need protection.
>
> (Jun: Drinking Bar)

Some participants indicated that they used contraceptives to postpone menstruation in order to work more, rather than for birth control.

> I rarely take birth-control pills. I took it when I was about to have a period and I wanted to postpone it, because I wanted to work some more. Because I always used condoms anyway, when I slept with customers.
>
> (Orathai: Massage Parlor)

Sexual Health During Menstrual Period

The study participants reported several different sexual health practices during their menstrual periods. How women practice sex work during menstruation depended on customer preferences, the perceived consequences of their actions, and economic urgency.

Some participants accepted sexual intercourse during their periods if the customer requested it. In such cases, the women did not perceive any negative consequences as a result of having sexual intercourse. The participants who had sexual intercourse during their periods made their decisions based upon such personal judgments as whether the customer was a regular customer or under compelling circumstances such as an urgent need for money. The technique the women used was cleaning before and after sexual intercourse or using a sponge, called "Luk-Khai," inserted into the vagina to block the menstruation flow during intercourse. It was also found that some participants from A-go-go bars used Luk-Khai during dancing because they were not allowed to take days off during menstruation. Most participants reported having uterine pain as a consequence. On the other hand, there were some participants who took days off because they perceived that they might be at risk if they had sexual intercourse during menstrual periods.

> I take a break. If I don't stop working, I might have a chance of getting diseases, if a condom breaks... .
>
> (Nun: Streetwalker).

> No. I take days off. .. I saw my colleagues use luk-Khai. It is made of sponge. But I never use it. I saw a lot of people use it. They use it when they have a period but still have to take customers. I never use it. I am afraid that it might slip into the inside. (R: Why don't you yourself work when you have period?) Customers do not want to take me, if they know. It hurts my womb, when I work during that period. I also have headache when I have period. I don't know. Maybe it is not dangerous. I have period only three days.
>
> (Nu: Massage Parlor)

Health Care Seeking Strategies for Major Health Complaints

After coding the first five interviews, I found that the three major work related health concerns addressed by the participants were condom breaks, Tok-khao or abnormal vaginal discharge, and uterine pain. Therefore, in the later interviews, health practices and health care seeking strategies for these health concerns were specifically investigated. The

following section identifies the health care seeking strategies for each of the major work-related health concerns.

Health Practices After a Condom Break

The study participants viewed a condom break as a major work-related health threat based on either their own experiences of condom breaks or those of their coworkers. In general, the participants described their emotional reaction immediately after a condom break as fear of getting AIDS.

> I am freaking out. I am angry, especially if I use a condom with every customer and it breaks with the last customer....

In response to the fear of getting a serious disease, there were three different coping practices: comforting, ignoring, and seeking the truth.

Comforting oneself. After a condom break, some of the study participants sort self-medication as a way to comfort their emotional and psychological distress. The common self-treatments identified by the participants were *cleaning* with soap or antiseptic solution, using *Ya-Lang* (washing medicine) or *Ya-Khub* (releasing medicine), using vaginal suppository tablets, or drinking soda. Cleaning was usually the first response when perceiving that they were at risk. After cleaning, some of the participants used a diuretic, named *Rifadin* and/or drank soda to release urine, believing each to be ways to wash disease out of their bodies. The participants also reported using vaginal tablets provided by health care providers for fungal infection or for leucorrhoea.

> I use...well....when a condom breaks, I will buy Ya-Lang. After taking it, I will release red urine. And everything is fine. I don't feel itchy at all. ... Women around here use it. When condom breaks and they are afraid that they will get pregnant, they will take this cleaning medicine (Ya-lang). It costs 10 baht each set. So I keep taking it. I think it is good to take it, because I don't feel itchy at all. And it makes me urinate easily and release a lot of urine at one time. The urine has red color, like blood.
>
> (Khai: Teahouse)

One participant explained that she did not believe that taking a diuretic drug to release urine was effective. Instead, she applied the anti-fungal medication after a condom break.

> I cleaned it. I spurted water in and cleaned my vagina. When I got home, I cleaned it again with soap and Dethol's soap that the hospital gave me. I applied crème around that area and applied talcum power. I was afraid. I don't think it was enough. I was not sure if what I did was helping 100 percent. I was afraid of diseases from customer. Even though I chose the customer myself, I was still not sure about him... Actually, sexual service girls use Ya-Khab. But I never used it. I talked to some girls who used it. They told me that when they took the medicine, it released urine. Its color was red, like blood. But I did not use it. I don't know if it really helps. I don't understand how and how much it will help or it can protect me. I just heard that people used it
>
> (Nun: Streetwalker)

Ignoring. Some participants did nothing except cleaning after a condom break because they either denied the risk or lacked access to professional health care. In the following example, the participant said she had done nothing after a condom break because of lack of access to professional care, fear of finding out the truth about contracting a serious disease, and because she was embarrassed to tell the health care providers about her occupation.

> I just washed it, using a tube to push water inside to get it out. Then I just do nothing, never come for a test. I don't want to go for an exam. I don't know where to get an exam, Private clinic? I felt embarrassed, afraid to go. I dare not tell a doctor that I'm working in this work. I felt fear but did nothing; whatever happens, it happens. But it was only a couple days, and then I just work as normal
>
> (Som: Massage Parlor).

Another study participant did nothing because she did not want to deal with the fact that she might have contacted AIDS.

> I did nothing. I just cleaned it. I did not know what else to do. I couldn't sleep for 2-3 days. I thought that if that customer had AIDS, I would be dead. Then, I stopped thinking about it. I think that I would not be that unlucky. I went to have my blood checked sometimes. I am still okay, but it is very risky. I know that I am not always lucky.
>
> (Supa: Teahouse)

Seeking the truth. Some of the participants sought professional care for an examination and blood test for HIV/AIDS. They explained that they knew there was *nothing*

they could do without professional help. The only way to seek the truth about their conditions was to be examined by professional.

> Nothing, because I couldn't correct anything, because I don't know if it's gonna break. I just came to the clinic and had it checked, whether I got any disease or not.
>
> (Am: Streetwalker)

However, some participants tried to find other ways to comfort themselves before they sought professional health care. For example, one participant self-medicated and then got a blood test for HIV.

> Most of the time, I suggested that they to go to a doctor to have their internal exam and blood checked. For example, if guest's condom breaks, you can't tell within 24 hours if you get any disease. In that case, we will take Rifadin. It is a very effective Ya-Khab....A doctor recommended. The first thing we do when we have a broken condom is to take this medicine... and then 3 months later, you can go to a doctor to have your blood checked...I think girls here use this medicine for a long time, even before I came to work here. I think so. The girls took it whenever they had a condom break, and when they had their blood checked three months later, nothing was found. It could be because that guy might have no disease. I am not sure either. But everyone here will be serious if they happen to have a condom break. All I could do is to comfort them and suggest that they take the medicine and go to the doctor three months later
>
> (Muk: Teahouse).

> I rushed to the bathroom, and cleaned with warm water. Then I drank lots of soda and cleaned again. And then it would be better....Someone told me that drinking soda would help clean, because it will make us urinate. I was terrified. Even though he looked fine, but it is still dangerous. Then I went to a doctor
>
> (Tak: A-go-go Bar).

The participants also revealed that after the initial condom break they learned to protect themselves in the event of future breaks. One strategy was to always use double condoms when they suspected that there was a chance that the condom might break.

> I experienced a condom break. After that, if it's big, I will use double condoms or if he pushes too hard I also use double condoms. I know this from my work experience.

Health Care Seeking for Tok-khao

In relation to problem of Tok-khao, the participants in this study monitored their symptoms and tried their own methods of treatment before seeking medical care.

Observing symptoms. The participants who reported having Tok-khao said that they always paid attention to odor, color, and amount of vaginal discharge, as well as other symptoms such as itchiness and pain.

> I always pay attention to it. I will smell it. I don't feel disgusted to do so. I will notice if it is white or yellow. If it is white, it is normal. But, if it yellow and smells, it is infected. I keep noticing it all the time.

> I have leucorrhoea every month. I have it before I have my period. But I do not feel itchy and it has no smell. I was asked by people here about the symptoms. So I know the symptoms. But I don't feel itchy. It looks like sticky water.
>
> (Ooy: Cocktail Lounge)

Taking days off. Taking days off and resting were the first strategies that some of the women used to make themselves feel better.

> If I am having it, but still insist going out with guests, it will get worse. Sometimes when I have no feelings with it, it will hurt.
>
> (Nid: Massage Parlor)

Self-medication. Self-medication for Tok-khao using Ya-sod or vaginal suppository tablets was common. The women obtained this medication from a drug store or they used tablets left over from prior infections. The participants explained that buying this medication from a drug store was more convenient and comfortable because they could give a brief description of their symptoms and receive medication without going through an examination. Of the participants who sought professional care, many said that they used the vaginal tablets until their symptoms were gone and then kept the leftover medication for later episodes.

> When I feel the pain, that means it is infected and getting worse. I will have more Tokkhao than usual. And then I try to cure it by using Ya-Sod. ....So I just take care of myself. I often take antibiotics so that the leucorrhoea doesn't smell and I use vaginal tablets. It is the medicine that I bought. It says on the label that I have to use one tablet every day for 6 days consecutively. I followed the instructions.
>
> (Ooy: Cocktail lounge)

Seeking professional care. Some participants also relied on professional health care to deal with their abnormal symptoms. Many of them stated that they always sought care

when they noticed that there was something wrong, such as excessive discharge or a change in the odor and color of the discharge. Some participants sought professional health care if their symptoms persisted after self-medication.

> I went to see a doctor for an exam, when I have discharge, even though I didn't feel itchy. A doctor usually gave me a suppository medicine for a couple days, then it's gone. If I have an exam here (establishment), a doctor will say it's normal discharge, I don't need to get any treatment and it's not good to get use medicine too often. **But it flew like my period, so I went to see a doctor at private clinic.**
>
> (Nid: Massage Parlor)

Health Care Seeking for Uterine Pain

The participants who experienced uterine pain were asked to describe how they responded to the symptoms. The data revealed that the participants always related their uterine pain with their work. In genera, they used two major strategies to respond to their symptom—*observing and taking days off* and *self-medication.*

Observing and taking days off. Some participants perceived that their uterine pain was caused by aggressive or accumulated sexual intercourse. They noticed that their symptoms tended to occur when they had done too much work or seen too many customers. Most of them observed that their symptoms usually went away after resting until the pain was at a tolerable level. Therefore, some of the women waited and took a day off until their symptoms went away.

> I waited until it recovered by itself...I don't like taking medicine. It is just a slight pain, when I sleep with customer. And it will be gone after 2-3 days. Sometimes I asked for a day-off and then it was gone...It hurt, but not much
>
> (Supa: Teahouse).

Self-medication for uterus pain. Using antibiotics without a prescription for uterine pain was a typical health care practice among the sex workers interviewed for this study. The majority of the participants, who experienced uterine pain relied almost exclusively on self-medication, making the drug store a major health care resource for many of the women. The

women often called the clerk or pharmacist at the drug store "Mor" or Doctor. It was common for the women to receive antibiotics or anti-inflammatory drugs without any exam. I also found that they were given conflicting information about antibiotics and anti-inflammatory medicines. In the Thai language, women only used the term Ya-Kae-Auk-Seb when they talked about antibiotics and anti-inflammatory drugs. Self-medication with those drugs was often found in the group of participants who more commonly relied on their own perception of symptoms than on diagnosis by professional health care providers.

> I took antibiotic medicine, T.C.Mycin. I took a lot of it. I took a dozen in a month. I bought it from a drug store. ...No one suggested it to me. I told a doctor that I had an inflamed womb and asked him what I should do about it. And he said "just take antibiotic medicine." A doctor at a drug store told me to take antibiotic medicine. Its color is red and costs 5 baht for a tablet. I told him to give me cheaper ones. So he suggested T.C.Mycin, which costs 2 baht a tablet. It really helped. It got better as soon as I took it. So I took it quite often. If I took it continually, the pain would be gone. And that makes me not go to a doctor.
>
> (Nun: Streetwalker)

> When a doctor told me that my cervix was red and infected...I just took medicine by myself. I asked the doctor first if I needed to take medicine. He gave me a suggestion. Or I went to a doctor, so that he would prescribe me medicine that I needed to take. The doctor at the clinic would recheck it to see if the womb got infected and if I needed to take any medicine. If it was not serious, he just applied medicine on it and I didn't have to take medicine. But mostly, I took medicine. I always have medicine. It used to be difficult for me to take medicine. But now even a slight pain, I will take medicine.
>
> (Orathai: Massge Parlor)

> From the general drug store, I just told them I had lower abdominal pain, I just guessed what it might be, so I bought some medicine and tried. If it's not gone away, I just went to the clinic or come here. (R: When was the last time you had pain at your womb and bought some medicine by yourself?) Just last month. It's the kind of pain that I had before and the doctor at clinic told me that I had an inflamed womb. When I had the symptom again, I thought it must be an inflamed womb again, and just go and get some medication by myself from the drug store. I'm not quite cautious about my health, I knew it's important but I don't care about myself that much.
>
> (Am: Streetwalker)

Factors Affecting Health Care Seeking

There were a number of factors that influenced the health care seeking behaviors identified in this study. They were: (1) perceived seriousness of the illness or disease; (2) fear of finding out the truth, (3) the nature of the work as a constraining factor, (4) structural

barriers, and (5) the lack of female doctors. In the following sections, each factor will be described.

Perceived Seriousness of the Illness or Disease

The perceived seriousness of the condition influenced some women to seek health care. 'Am' (pseudonym) is an example of one woman who always delayed seeking care, and who came to the clinic only when she thought she might have a serious disease. The participants' stories demonstrated that they connected the seriousness with the consequences of an illness, worrying about which illnesses would limit work and thus, negatively affect their families.

> My health is very bad. I feel discouraged, I don't know whether I have any serious disease, or could it be cured? (Quiet for a while).. I worry about my blood test, the doctor hasn't told me the result, I have to wait for several days. I would like to know whether it could be cured. I'm afraid that if it's not treatable, my boyfriend might get it from me. Then he will say that he told me to quit but I still do not quit, and then he might break up with me, or hate me
>
> (Am: Streetwalker).

> I'm afraid that I might have serious disease...and that they won't let me work, if they know about it. I don't know if it is transmitted. I am afraid that they won't let me work, because they are afraid that the disease might spread to customers....I am afraid of everything. I am working in this job, I am afraid. But because my family is so poor, I have to work.
>
> (Add: A-go-go Bar)

Fear of Finding Out the Truth

While perceived seriousness prompted some women to seek health care, fear of finding out the truth about the severity of their symptoms, on the other hand, kept participants from seeking health care. Besides the fear of knowing that they may have serious diseases, the women were also concerned about whether the nature of their work and health conditions would be kept confidential.

> I am afraid that I might not be able to accept it. I am thinking about going to have my blood checked so many times, but I am waiting until I have my period because I will not work during that time. I plan to go to clinic here. I am afraid. I already had the phone number. I

> will call them...My last blood check was a year ago. I had it checked at my hometown, when I was pregnant. But I had a miscarriage. After that I have been here for about a year.
>
> (Supa: Teahouse)

> I am only afraid of cancer I still don't understand. If I have a lot of leucorrhoea, am I at risk of having cancer? I am scared but I still have no courage to have it checked. The doctor told me to go for check-up every 6 months. I used to go to a doctor at ..... She was a female doctor. She told me that my left ovary was swollen and that I should see her again in next 6 months for a second check. If it still grows, it could be cancer. I haven't been back there since. And now it is more than 6 months. I'm afraid to know the truth.
>
> (Ooy: Cocktail lounge)

Constrained by the Nature of the Work

The issues of secrecy and stigma in sex work had an important impact on delay in seeking care by the participants. Some participants stated that fear of being rejected or condemned by health care providers kept them from seeking health care. Feeling embarrassed to talk about their work was commonly mentioned.

> At first, I thought people here will be strict and not nice, but in fact they talk to me very nicely. And at first I felt ashamed. I am also worried about how others would look at me. When I walked here, they looked at me. It was just my feeling. I concerned how people would look at me.... Earlier, I worried about how would others think about me. Why do I come to this hospital and not go to other normal hospital?. But then I thought, it is a normal thing, I am here to have my health checked.
>
> (Jun: Drinking Bar)

> In my feeling, I feel ashamed to tell anybody about my job. If I have to tell the doctor that I went out with guests and it got infected. Well, I don't feel comfortable saying that. ...I don't know, if I tell the doctor the truth, what will they feel about me? If they look at me in a pitiful way, that is still okay. But if I tell them that I am doing this kind of job and they think about me in another way, such as I don't take care of myself and I deserve it. I am afraid that they will look down on me.
>
> (Ooy: Cocktail lounge)

One participant explained how secret work could limit sex workers, including herself, in seeking health care:

> Actually, I could have gone back to the same doctor. But I thought if I went there often, my relative might wonder what sickness did I have often. What job was I doing? And what if he asked a nurse there? He mentioned once that he was close to a nurse there. I would have been in big trouble. The nurse knew it from the doctor for sure. My relative might talk to the nurse. She might mention about me. I thought she might not intentionally talk about it, because it was nurse's ethic. But since my relative was close to her, words might slip. She might say that this person infected this disease, things like that. **I will be dead, if my relatives and my daughters know about my job.....I know that many sexual service**

> **girls do not have their health checked. Very few would go for health check-up. They conceal themselves**. That is because some people do this job secretly and because they can't let their husbands know about it. .. She was afraid to go to a doctor, because she was afraid that her husband might find out that she is working like this.
>
> (Nun: Streetwalker)

Structural Barriers

The health care system was also seen as a barrier in obtaining health care for some participants, especially those who had never sought health care. Limited service time and location were mentioned by participants as the primary obstacles.

> I might get diseases from those guys. I don't know who they are. I think we should go for a check-up. ....**But I have to sleep in the day time, so I haven't gone for a check-up**. But I am very clean. I use a chemical substance to clean myself. I am very careful.
>
> (Porn: Café)

> But I did not go to Bangrak. I had it checked in a clinic at this center. Sometimes I don't go to Bangrak, **it is too far**. Sometimes I go to a clinic. But most of the time, I go to Bangrak. I did not go for a check-up often lately. I will go when I feel something unusual, such as leucorrhoea.
>
> (Supa: Teahouse)

No Female Doctor Available.

Another concern related to the health care system was that there were no female doctors available. Some participants who not had STD checkups in the last three months stated that an intrusive procedure by a male doctor was one of their major concerns when coming in for pelvic exams.

> I don't know. The doctor is a male, and I don't like that. I don't know, I feel shy. The doctor reaches his hand inside.... I want to see a female doctor. But if I had to see a male doctor, I would not feel comfortable telling him about my symptoms. ..I will tell, if the doctor is a female. I saw a male doctor at a clinic once. I had to see him at that time (softly laugh). But I still had to lie. I told him that I was sleeping with my boyfriend. ..I don't know. If the doctor has ethics, it should be fine, but if he does not, then it is shameful...
>
> (Ooy: Cocktail lounge)

Medical expense was another a constraint that inhibited some of the women from seeing a doctor.

> Yes, it's very expensive to see a doctor, and I have to use lot of medication. To continue the treatment, I don't know how much I have to pay, but I think it's a lot ...I worry about my illness very much. Sometimes, I couldn't think what I'm going to do. Nowadays, it is bad enough. Having one illness after another, made me feel really discouraged. I want to fight

> but I don't know where should I start or what can be changed first. There must be a lot of expenses.....I don't want to spend money on myself but I can't help it. I cannot help my family if I don't save my life. I must keep my life first since it can still be cured
>
> (Am: Streetwalker)

Experiences with Professional Health Care Providers

There were types of circumstances that made the participants seek professional health care. They were: (a) personal circumstances (i.e., seeking health care for sexual health problems, a condom break, symptoms persisting after self-medication) and (b) a system circumstances or requirements (regulations of the establishments). Experiences with professional health care providers described by the participants included both direct and indirect encounters with government and private sectors.

Most participants who came to the VD clinic tended to be satisfied with the health care that they received. The satisfaction stemmed from the understanding caregivers and receiving effective treatment. They described understanding as health care providers knowing about their work and what health problem brought them to the clinic. There was no need for them to disclose to health care providers. In addition, the care provider in this clinic was considered to be a specialist in caring for STDs by the participants. However, in general, encounters with care providers were described by the participants as, "they are good, they are good enough to take care of us, I have nothing to complain about or suggest. They were busy enough taking care of a lot of patients already." There were only a few participants who suggested that there was a lack of privacy or time to discuss their symptoms with care providers during the exam.

The following themes came from the experiences of the participants when they sought professional health care.

Lack of Mutual Communication

A lack of mutual communication meant that there was no balance in the conversations between the women and their health care providers. During participant observation at the VD Clinic, I found that the care providers tended to make each clinic visit as short as possible, because most patients complained about the long waiting times. Therefore, there was only a brief period of time for each patient to see a doctor. Generally, the patients were first asked about their sexual activities, such whether they were sexually active and used a condom every time, or had any symptoms. Next, they had blood tests and a pelvic examination, and then waited to hear the result. In general, the women saw a different health care provider for each procedure. When they got the results, they got very limited information about what had been found that day and what kind of medication they needed to take. Some participants who suffered abnormal symptoms indicated that the limited information they received led them to believe that they might lose their jobs.

> No, I dare not ask him. I ask the people there when I give them the form. I ask them if they have medicine for Tok-khao, and how to cure it. That is all I can ask. I asked them today the same questions and they said that they would give medicine after the doctor checked it. My friend used to have Tok-khao, and she came here for treatment. After taking medicine she got from here, it is gone. I think that I have this disease because of Tok-khao. I heard that unusual Tok-khao will cause cancer of the cervix. I have a lot of Tok-khao.... I am very worried about it. It makes my underpants messy.
>
> (Add: Ago-go Bar)

Lack of Privacy

In the participant observation during women's STD checkups at both clinics and at one establishment, I found that there was no sense of privacy during the examinations. Most of the examination rooms were open; others in the area could hear all conversation during an exam. For the participants who had not had an STD checkup in the past three months,

talking about sexual health problems was private and difficult to discuss with other people, including health care providers.

> This is not an open issue and also shameful in general. It is even more shameful when you have to talk to someone else.
>
> (Ooy: Cocktail lounge)

In contrast, the participants who had STD checkups and other health exams on a regular schedule revealed that the issue of privacy did not really matter compared to the health care that they received. The health care providers were seen as experts who knew what was the best for the patients. The women indicated no need to withhold information from providers under any circumstance.

> I did not feel anything. I think it was good that he asked and I answered. I didn't feel ashamed because he was a doctor. If he were not a doctor, I would not have given him answers. If my friends asked me, I would not answer. But I had to tell everything to the doctor because he is a doctor. And I should trust a doctor. When you are sick, you go to a doctor, right? Our lives depend on doctors
>
> I told them directly about our job. I don't feel ashamed of it. I had to tell them to let them know the situation so that they know how to help us. With the doctor, I don't feel ashamed at all. If I think I have the disease, I will tell the doctor.
>
> (Porn: Café)

Determinants of Health and Health Seeking Behaviors

In the following section, the research questions testing the relationships among personal characteristics, work conditions, health status, on health care seeking behaviors are answered. First, a summary of the descriptive statistics for each of the independent and dependent variables in the model are presented. Then the regression model testing the relationships among the independent variables on health status and health care seeking behaviors are analyzed.

Summaries of Descriptive Statistics

Independent Variables

Summaries of the descriptive statistics of all the independent variables in the models are presented in Table 5.4. The mean age of the participants was 29.24 (S.D.= 8.43) with a range from 18 to 56 years of age. The average number of children was 1.01 (S.D= 1.12), with the highest number of children of 5. The mean of years of education was 6.43 (S.D.= 3.02). Income ranged from 500 to 56,000 baht with an average income of 15,130 baht (S.D= 10,539.16); 78% of the participants financially supported their families.

The average number of years worked in sex work was 4.24 years (SD = 5.31), with a range from one month to 33 years. The mean of number of hours worked per day was 8.5 hours (S.D. = 3.03) with a range of 4 to 24 hours a day. The number of customers per night ranged from one to six customers per night (mean = 1.7, S.D. = 1.11). The number of customers per month ranged from 1 to 120 (mean = 28.49, S.D. = 27.22). The balance of satisfaction and stress in work ranged from –9 to 9 with an average -.02 (S.D = 3.90). Seventy four percent of the participants perceived that they could select their customers. Of the 100 participants, 38% reported experiencing violence at work. The health importance scores ranged from 166.00 to 500.00, with an average of 357.77 and a standard deviation of 81.90. For the single 1 to 10 Importance of Health scale, scores ranged from 3 to 10, with an average score of 9.54 (S.D = 1.24).

Dependent Variables

Descriptive statistics for three health status variables, Perceived Health Status scores, GHQ-total scores, and total number of symptoms are presented in Table 5.5. GHQ –total scores ranged from 36.00 to 88.00, with a mean level of 52.77 (S.D. = 12.29). The mean

level of Perceived Health Status is 6.9 (S.D. 2.15). Total number of symptoms ranged from 0 to 13 (mean = 6.17, S.D. = 3.24).

Table 5.4: Descriptive statistics of independent variables

Variables	N	Min	Max	Mean	S.D.
Age	100	18	56	29.24	8.43
Number of Children	100	0	5	1.01	1.12
Education	100	0	14	6.43	3.02
Income	100	500	56000	15130.00	10539.16
Number of years in sex work	100	.08	33.00	4.2403	5.3053
Number of hours/day	100	4.00	24.00	8.5000	3.0318
Number of customers/night	100	1	6	1.70	1.11
Number of customers/month	98	1	120	28.49	27.22
Health Importance Total Score	100	166.00	500.00	357.77	81.90
Importance of Health	100	3	10	9.54	1.24
	N		Frequency	Percent	
Financial support	100	NO	22	22.0	
		YES	78	78.0	
Choice in selecting customers	100	NO	22	22.0	
		YES	74	74.0	
Experience violence in work	100	NO	62	62.0	
		YES	38	38.0	

Table 5.5: Descriptive statistics of dependent variables

Variables	N	Min	Max	Mean	S.D.
GHQ Total Score	100	36.00	88.00	52.77	12.29
Perceived Health Status Score	100	1	10	6.90	2.15
Total Number of Symptoms	100	0	13	6.17	3.24

As reported chapter 4, some of the establishments required that their workers get regularly scheduled STD checkups. Depending on the establishment, the schedule varied

from twice a week to at least once a month. The frequency of internal exams was not always the women's own decision. Therefore, the frequency of getting STD checkups was modified into a dichotomous variable (PVDI) with a 'Yes' if the participant had an exam when she had symptoms or at least once a month, and 'No' if she had never had an exam. The score was also adjusted if the participant had an exam because it was the policy of her establishment. If an STD checkup was requested by work policy, the score was coded as '0'. Only 20% of the women had an exam when they had symptoms or at least once a month.

For the variable rate of condom uses, 91 participants reported that they had used condoms every time in the last five times they were with customers. Only 9% reported that they did not use condoms consistently. Therefore, the rate of condom use was not considered to be a limiting dependent variable in the regression model.

In order to test the relationship of all the independent variables on the frequency of condom use, the rate of condom use was coded as a dichotomous variable consistent or inconsistent and used as a dependent variable in the logistic regression analysis.

Relationships between Health Status and Demographics

As demonstrated in Table A.4 (see appendix I), there was no significant relationship between the demographics and perceived health status. Education level was the only demographic variable that had a significantly negative relationship to the GHQ total score ($r = -.208$, $p < .05$). Likewise, being a financial support was found to be significantly correlated with the total number of symptoms ($r = .245$, $p < .05$). Women who were the financial support for family had a higher number of symptoms than those who were not responsible for family financial support.

Among demographics variables, age was found to have significant relationship to four other demographic variables—number of children ((r = .554, p < .01), education level (r = -.416, p < .01), income (r = -.344, p < .01), and being the financial support (r = -.227, p < .07). The participants who were younger reported having fewer children, and higher education and income levels. The participants who reported being the financial support for their family were younger than those who did not provide financial support. A higher income level was also significantly related to a higher education level (r = .375, p < .01), less number of children (r = -. 299, p < .01) and not providing financial support for family.

Relationships between Health Status and Work Conditions

Choice in selecting customer and health status

Perceived choice in selecting customers was significantly correlated with two health status variables, perceived health status (r = -.314, p < .01) and GHQ total score (r = .204, p < .05). The women who reported having choice in selecting their customers had lower perceived health status scores and higher GHQ total scores (see Table A.5)

Violence and health status

There were significant correlations between the incidence of violence in work and all three-health status variables—perceived health status (r = -.242, p < .05) and GHQ total score (r = .333, p < .01), and total number of symptoms (r = .425, p < .01). Women who experienced violence in work reported a lower perceived health status, a higher GHQ total score, and a higher number of total symptoms.

Balance in satisfaction and stress in work and health status

Higher balance in satisfaction and stress in work was significantly correlated with a lower GHQ total score (r = -.442, p < .01).

Determinants of Health

Research question #4 asked, *"What are the relationships among personal characteristics (age, income, years of education, number of children, and financially supporting the family), number of years in sex work, number of customers per night, number of customers per month, perceived choice in selecting customer, violence at work, the balance of perceived stress and satisfaction in work, and the importance of health on health status?"* To answer this research question, three regression models were performed for each of the health status variables - perceived health status scores, GHQ-total scores, and total number of symptoms

Table 5.6 describes the regression analysis in which all independent variables were simultaneously entered into the model to predict the perceived health status. The analysis indicated that approximately 28% of the overall variance of the Perceived Health Status score was explained by the independent variables ($F_{(13, 84)} = 2.503$; $p < .01$). Choice in selecting customers explained 5.6% of the variance ($t = -2.552$, $p < .05$) in perceived health status after controlling for all other independent variables. Although the number of customers per night and the number of customers per month were highly correlated ($r = .87$, $p < .01$), each of these variables still has a unique contribution to the model with an opposite direction of relationship to perceived health status. Number of customers per month explained 6.5 % of the variance ($t = -2.747$, $p = .007$) and number of customers per night explained 5.8% of the overall variance of the variance ($t = -2.601$, $p = .011$) in perceived health status.

Table 5.7 shows that the overall model predicting the GHQ-total score is statistically significant ($R^2 = .405$, $F_{(13, 84)} = 4.394$, $p < .01$). It indicated that there is a significant relationship among the independent variables and the dependent variable - GHQ-total score.

Approximately 40% of the variance in GHQ-total scores can be explained by this combination of the independent variables. A high the balance of satisfaction and stress in work is the strongest determinant of a lower GHQ-total score, and accounts for 12% of the variance in the GHQ-total score after controlling for other variables ($t = -4.095$, $p < .001$). Higher education ($t = -2.488$, $p < .05$) and a lack of violence at work ($t = 2.275$, $p < .05$) are also significant determinants for the lower GHQ-total score and explained about 9% of the variance in the GHQ-total score.

Table 5.8 describes the regression model for the dependent variable, total number of symptoms. The overall model is significant ($R^2 = .308$ ($F_{(13, 84)} = 2.878$; $p < .01$). The analysis indicates that there is a significant relationship among the independent variables and the total number of symptoms. It accounts for about 31% of the variance in total number of symptoms. However, only violence in work ($t = 3.839$, $p < .01$), being a financial support for family ($t = .2.060$, $p < .05$) and number of years in sex work ($t = 2.066$, $p < .05$) are significant determinants of total number of symptoms after controlling for all other variables. Violence in work explained 12.1% of the variance, while being a financial support for family and number of years in sex work explained 7% of the variance in total number of symptoms after controlling for all other independent variables.

Table 5.6: Multiple Regression Summary
Dependent Variable: Perceived Health Status Score

Variables	Beta	sr^2	95% Confidence Interval for B		t	P
			Lower	Upper		
Age	.064	.002	-.053	.086	.468	.641
Number of Children	.005	.000	-.473	.494	.044	.965
Education	-.143	.012	-.274	.070	-1.181	.241
Income	.019	.000	.000	.000	.152	.879
Financial support	-.069	.004	-1.409	.695	-.675	.502
Number of years in sex work	-.121	.008	-.150	.052	-.966	.337
Number of hours/day	-.033	.090	-.167	.120	-.324	.747
Number of customers/night	-.525	.065	-1.750	-.280	-2.747	.007*
Number of customers/month	.532	.058	.010	.074	2.601	.011*
Choice in selecting customers	-.251	.056	-2.262	-.281	-2.552	.013*
Violence in work	-.158	.021	-1.584	.191	-1.561	.122
Balance of satisfaction and stress at work	.114	.011	-.045	.170	1.151	.253
Importance of health total score	-.174	.000	-.010	.001	-1.788	.077

Overall $R^2 = .243$ ($F_{(13, 82)} = 2.020$; $p < .05$)

Table 5.7: Multiple Regression Summary
Dependent Variable: GHQ-Total Score

Variables	Beta	sr^2	95% Confidence Interval for B		t	P
			Lower	Upper		
Age	-.244	.027	-.717	.007	-1.951	.054
Number of Children	.004	.000	-2.455	2.552	.039	.969
Education	-.274	.044	-2.004	-.223	-2.488	.015*
Income	.021	.000	.000	.000	.185	.854
Financial support	-.031	.000	-6.363	4.528	-.335	.738
Number of years in sex work	.154	.013.	-.168	.880	1.349	.181
Number of hours/day	-.164	.007	-1.403	.085	-1.761	.082
Number of customers/night	.027	.013	-3.504	4.103	.156	.876
Number of customers/month	-.188	.000	-.252	.082	-1.015	.313
Choice in selecting customers	.082	.007	-2.768	7.486	.915	.363
Violence in work	.229	.044	1.150	10.334	2.487	.015*
Balance of satisfaction and stress at work	-.369	.120	-1.707	-.591	-4.095	.000*
Importance of health total score	.021	.000	-.023	.029	.240	.811

Overall $R^2 = .405$ ($F_{(13, 82)} = 4.394$; $p < .01$)

Table 5.8: Multiple Regression Summary
Dependent Variable: Total Number of Symptoms

Variables	Beta	sr^2	95% Confidence Interval for B		t	P
			Lower	Upper		
Age	-.237	.026	-.196	.012	-1.759	.082
Number of Children	.033	.000	-.618	.818	.277	.783
Education	-.039	.000	-.298	.213	-.330	.742
Income	.052	.001	.000	.000	.417	.678
Financial support	.208	.035	.056	3.178	2.060	.043*
Number of years in sex work	.255	.035	.006	.306	2.066	.042*
Number of hours/day	-.096	.008	-.316	.111	-.958	.341
Number of customers/night	.050	.000	-.943	1.238	.269	.789
Number of customers/month	.009	.000	-.047	.049	.045	.964
Choice in selecting customers	.098	.008	-.721	2.219	1.014	.314
Violence in work	.381	.121	1.225	3.858	3.839	.000*
Balance of satisfaction and stress at work	-.036	.001	-.190	.130	-.370	.712
Importance of health total score	-.097	.008	-.011	.004	-1.017	.312

Overall $R^2 = .308$ ($F_{(13, 82)} = 2.878$; $p < .01$)

Determinants of Health Care Seeking Behaviors

Research question #5 asked: *"What are the relationships among personal characteristics (age, income, years of education, number of children, and being a financial support for family), number of years in sex work, number of customers per night, number of customers per month, perceived choice in selecting customers, violence at work, the balance of perceived stress and satisfaction in work, the importance of health, and health status (i.e., perceived health status scores, GHQ-total scores, and total number of symptoms) on the frequency of getting STD checkups (which will be used as a dichotomous variable PVDI)?"* To answer this research question, the logistic regression analysis was performed.

Since the sample size (n=100) was not enough to begin the multivariate model with all independent variables, each variable was tested independently for association with dichotomous variable, PVDI, using appropriate univariate analysis (Hosmer & Lemeshow, 1989). Univariate analyses for continuous variables, such as age, income, years of education, number of children, number of years in sex work, number of customers per night, number of customers per month, the balance of perceived stress and satisfaction in work, the importance of health, and three health status variables (i.e., perceived health status scores, GHQ-total scores, and total number of symptoms) were performed by t-test analysis. The results of t-test analysis are presented in Table 5.1. Likewise, the Pearson χ^2 test was used with the dichotomous variables, being a financial support for family, perceived choice in selecting customers, and violence at work. Those variables whose univariate test had a p-value < 0.25 were selected for inclusion into the multivariate model (Hosmer & Lemeshow, 1989).

Based on the selected criterion, the variables included in the logistic regression model for the dichotomous dependent variable, getting STD checkups (PVDI), are number of children (t= -2.23, p= .04), education (t= 2.34, p= .02), number of years in sex work (t= -2.40, p= .03), number of hours per day (t= -1.28, p= .20), number of customers per night (t= -1.71, p= .09), balance of satisfaction and stress at work (t= 1.196, p= .24), perceived health status (t= 2.63, p= .01), GHQ-total score (t= -3.54, p= .001), total number of symptoms (t= -3.19, p= .002) and violence at work (χ^2 = 7.74, p= .005). Some of the participants who perceived that they did not have a choice in selecting customers did not get STD check ups. Therefore, this variable was not included in the model because it might have yielded a univariate point estimate for one of the odds ratios of either/or infinity (Hosmer & Lemeshow, 1989).

Table 5.10 shows the first multiple logistic regression for the dichotomous variable, getting STD check ups, when all independent variables were entered into the model. The results indicated that there was a significant correlation among the independent variables and the dichotomous variable of getting STD checkup (Model χ^2 = 38.08 (11df), p < .001). However, the goodness of fit chi-square (χ^2 = 14.604 (8 df), p = .07) indicated that this model does not provide a good fit for the data.

Table 5.9: Univariate statistics of dichotomous variable of getting STD checkup

Variable		Getting Internal exam	Not Getting Internal Exam	χ^2
Financial support	Yes	15	63	.131
	No	5	17	(p=.72)
Choice in selecting customer	Yes	20	57	7.47
	No	0	23	(p=.006)
Violence in work	Yes	13	25	7.74
	No	7	55	(p=.005)

Table 5.9: Univariate statistics of dichotomous variable of getting STD checkups (Cont.)

	Getting Internal Exam	N	Mean	S.D.	t	p-value
Age	NO	80	28.34	7.42	-1.72	.10*
	YES	20	32.85	11.13		
Number of Children	NO	80	.85	.94	-2.23	.04*
	YES	20	1.65	1.53		
Education	NO	80	6.78	3.17	2.34	.02*
	YES	20	5.05	1.79		
Income	NO	80	15200.00	8814.40	.094	.93
	YES	20	14850.00	15987.74		
Number of years in sex work	NO	80	3.3094	3.6794	-2.40	.03*
	YES	20	7.9635	8.4926		
Number of hours/day	NO	80	8.3063	3.0037	-1.28	.20*
	YES	20	9.2750	3.0970		
Number of customers/night	NO	80	1.61	.94	-1.71	.09*
	YES	20	2.08	1.59		
Number of customers/month	NO	79	27.12	24.83	-1.02	.31
	YES	19	34.21	35.75		
Balance of satisfaction and stress at work	NO	80	.21	3.57	1.196	.24*
	YES	20	-.95	5.01		
Importance of health	NO	80	9.49	1.27	-.84	.40
	YES	20	9.75	1.12		
Health importance total score	NO	80	353.8063	78.8676	-.97	.34
	YES	20	373.6375	93.5684		
Perceived health status	NO	80	7.18	1.99	2.63	.01*
	YES	20	5.80	2.48		
GHQ-total score	NO	80	50.7125	10.2243	-3.54	.001*
	YES	20	61.0000	16.2157		
Total number of symptoms	NO	80	5.68	3.03	-3.19	.002*
	YES	20	8.15	3.41		

* $p < .25$

Table: 5.10: Multiple Logistic Regression Summary
Dependent Variable: Dichotomous variable of getting STD checkups

Variables	β	S.E.	Wald	Significance	Odd Ratio	95%CI
Age	-.056	.068	.674	.412	.945	.83-1.08
Number of Children	.810	.406	3.982	.046*	2.247	1.102-4.98
Education	-.004	.173	.001	.980	.996	.71-1.40
Number of years in sex work	.194	.087	4.943	.026*	1.214	1.02-1.44
Number of hours/day	.111	.108	1.042	.307	1.117	.90-1.38
Number of customers/night	.660	.294	5.036	.025*	1.936	1.09-3.45
Balance of satisfaction and stress at work	.054	.100	.289	.591	1.055	.87-1.28
Violence in work	1.056	.766	1.900	.168	2.874	.64-12.90
Perceived health status	-.076	.202	.141	.708	.927	.62-.138
GHQ-total score	.060	.044	1.826	.177	1.062	.97-1.16
Total Number of symptoms	.104	.126	.691	.406	1.110	.87-1.42

Model $\chi^2 = 38.08$ (11df), $p < .001$
Goodness of Fit test $\chi^2 = 14.604$ (8 df), $p = .07$
Predicted probabilities and observed response = 88.0%

Research question #6 asked: *"What are the relationships among personal characteristics (age, income, years of education, number of children), number of years in sex work, number of customers per month, choice in selecting customers, violence in work, the balance of perceived stress and satisfaction in work, the importance of health, and health status (i.e., perceived health status, GHQ-28 total scores, and total number of symptoms) on the frequency of condom use?"* Univariate analyses for each independent variable was performed and is reported in Table 5.11.

Table 5.11: Univariate analyses of the dichotomous variable: Consistent condom use

Variable		Consistent use	Inconsistent Use	χ^2
Financial support	Yes	71	7	.000
	No	20	2	(p=.99)
Choice in selcting customer	Yes	70	7	.003
	No	21	2	(p=.95)
Violence in work	Yes	36	2	1.045
	No	55	7	(p=.31)

Table 5.11: Univariate analyses of the dichotomous variable: Consistent condom use (Cont.)

	Condom use	N	Mean	S.D.	t	p-value
Age	Consistent Use	91	29.33	8.42	.337	.74
	Inconsistent Use	9	28.33	8.96		
Number of Children	Consistent Use	91	1.02	1.13	.337	.74
	Inconsistent Use	9	.89	1.17		
Education	Consistent Use	91	6.45	2.99	.215	.83
	Inconsistent Use	9	6.22	3.49		
Income	Consistent Use	91	15450.55	10854.10	.967	.336
	Inconsistent Use	9	11888.89	6014.45		
Number of years in sex work	Consistent Use	91	4.2457	5.4190	.033	.974
	Inconsistent Use	9	4.1848	4.2363		
Number of hours/day	Consistent Use	91	8.5220	3.1251	.229	.819
	Inconsistent Use	9	8.2778	1.9543		
Number of customers/night	Consistent Use	91	1.75	1.14	2.768	.01*
	Inconsistent Use	9	1.22	.44		
Number of customers/month	Consistent Use	89	29.71	28.04	2.594	.02*
	Inconsistent Use	9	16.50	12.40		
Balance of satisfaction and stress at work	Consistent Use	91	-.09	3.92	-.552	.59
	Inconsistent Use	9	.67	3.84		
Importance of health	Consistent Use	91	9.60	1.16	1.148	.28
	Inconsistent Use	9	8.89	1.83		
Health importance total score	Consistent Use	91	361.2445	81.3867	1.354	.18*
	Inconsistent Use	9	322.6667	83.4386		
Perceived health status	Consistent Use	91	6.87	2.22	1.469	.64
	Inconsistent Use	9	7.22	1.39		
GHQ-total score	Consistent Use	91	52.5165	12.1622	-.654	.52
	Inconsistent Use	9	55.3333	14.0089		
Total number of symptoms	Consistent Use	91	6.04	3.26	-1.239	.22*
	Inconsistent Use	9	7.44	2.96		

* $p < .25$

Using p-value < 0.25 as a criteria, there are only four variables- number of customers per night, number of customers per month, health importance total score, and total number of symptoms - that were selected for entry into the logistic regression model for the dichotomous variable, consistent condom use. The results of the multiple logistic regression analysis indicate that there is no significant correlation among any of the independent variables and the dependent variable (Model $\chi^2 = 6.776$ (4df), p = .148) (Table 5.12).

Table 5.12: Multiple Logistic Regression Summary
Dependent Variable: Dichotomous variable of consistent condom use

Variables	β	S.E.	Sig.	Odd Ratio	95.0% C.I.
Number of customers/night	.705	1.134	.534	2.024	.219-18.70
Number of customers /month	.006	.039	.874	1.006	.932-1.09
Health importance total score	.006	.004	.164	1.006	.997-1.02
Total number of symptoms	-.165	.115	.152	.848	.6761.06

Model $\chi^2 = 6.776$ (4df), p = .148
Goodness of Fit test $\chi^2 = 4.576$ (8 df), p = .80

CHAPTER 6

HEALTH CARE SEEKING TO SURVIVE IN SEX WORK

In this chapter, the findings of this study are discussed. The purpose of the discussion is to integrate the findings into a model explaining health care seeking in the life context of commercial sex work. From the findings, themes related to work, health, and health care seeking were constructed. The chapter is organized into 5 sections: perception of sex work, perception of health by sex worker, conditions of work as constraints for health seeking behaviors, living with sex work, and a description of model of health care seeking in sex workers. In the first section, three themes related to the perception of sex work—*as constrained personal choice, as unproductive work, and as high-risk work to life and health*—are presented. In the second section, perception of health, two themes related to perceptions of health by sex workers—*being healthy as being able to work and focus on sexual health not general health*—are described. In the third section, four themes related to conditions of sex work that preclude health care seeking are presented— *stigma and secretiveness of work as health care seeking constraint, networks as sources of information but not support, health policies as disembodiment, and health care system: resource vs. control.* The next section of *living with sex work* discusses the relationship of work environment, role integration and health based on the results of regression model. Finally, the model of health care seeking in commercial sex work is presented and compared with the original model that guided the study.

Perceptions of Sex Work

According to the findings, perceptions of sex work described by the participants fell into three categories: a) constrained personal choice; b) unproductive work; and c) high risk work to life and health.

Constrained Personal Choice

The majority of the study participants came from the Northeastern and North regions of Thailand, 94% reported working in various kinds of work before entering sex work, and 78% of the participants reported being the financial support for their family. The reasons for entering sex work included having no choice or other jobs available, having the responsibility for supporting parents and raising children, and being in debt. Most participants also indicated that they chose to enter sex work to support their family. They considered sex work as a way to earn a living and to help their family survival. These findings are consistent with other research studies about Thai female commercial sex workers (Berer & Ray, 1993; Pongpaichit, 1982; Shih, 1994; Wawer et al., 1996). Lack of ability to provide for themselves because of poverty, and limited education, and the failure of family support were all found to be key factors in why women accepted being commercial sex workers (Sedyaningsih-Mamahit, 1999).

What do these findings reveal about the life of commercial sex workers in Thailand? We cannot ignore the fact that when women voluntarily engage in sex work, they are not simply, thoughtlessly getting into this risky work but they do see some substantial benefits from this work which assist them to survive their lives. Sex work is designed to sustain the family units of a rural economy, that are coming under pressure (Pongpichit, 1982). The fact that most Thai sex workers come from the North and Northeastern regions of the country

may be explained by the fact that most women decide to become sex workers because of poverty and their obligation to financially support their families (Pongpichit, 1982; Pongsapitch, 1997). Based on national statistics, the average income of the Northeastern and Northern regions are other regions (Tantiniramol & Pandey, 1997). The poverty of rural areas still forces people to migrate from these regions to centers of higher employment and opportunity in the big cities (Bell, 1997). In addition, the burden put on young girls in villages in the North and Northeastern regions to support the families have been strong. The daughters have always been expected to provide for the parents in the domestic domain of the household compound. Parents expect the young girls to be responsible for providing family support (Pongsapitch, 1997). When economic conditions at home are not sufficient to support the families, many young girls migrate to urban areas to find jobs. Many of them are forced into sex work because of this burden (Pongsapitch, 1997). The cultural norm of devoting their lives to their families, even to risk their life working in sex work, imposes sex work upon many young women.

Pressure to leave poverty was also mentioned by participants as a reason for entering sex work. Within the last three decades, there has been a significant change in Thai attitudes toward materialism. At the same time, socio-economic development based on capitalism has created more poverty. In addition, it is a common Thai characteristic for people not to want to work hard but to find an easy way to reach their goals. It is common to see that people are willing to take a risk if that risk could earn them more money and bring them more material things. Some women consider working in commercial sex work as a short cut out of poverty and toward family survival.

'Choice' in sex work is an important issue to be considered. Based on the moral judgment, choice may emerge as a determining factor in ascertaining whether a sex worker is a true 'victim' of circumstances, or whether she is an active agent in either her own moral degradation and objectification as a women, or in her empowerment. In discourse of prostitution, there seem to be two viewpoints. If the woman has no choice, then she is viewed as passive victim. If a sex worker claims to voluntarily decide to become sex worker, then she is seen as an agent of her own destiny and commonly described as lacking morality.

However, the results from this study support an additional characteristic that may play a vital role in becoming a sex worker. Thai women have strong ties and a high sense of responsibility for their extended family. This characteristic in Thai sex workers distinguish them from sex workers from other countries, such as in the United States, where sex workers tend to be distanced and alienated from their families. Even though Thai women may indicated that it was their choice, it was made based on the pressure of poverty and cultural values that dictated that women to take responsibility for their families and support or fulfill family needs. Therefore, simple moral judgment to judge toward sex workers may be misguided. To understand the life of a commercial sex worker means understanding that this work is not merely a personal choice, but may be necessitated by the constraints of cultural, socio-economic and political conditions.

Unproductive work

Sex work is considered unproductive work. Although, the sex industry was included as a part of national development, the profits it brings into the country have never been considered as part of societal revenues (Bishop & Robinson, 1998). On the personal level, sex workers often do not consider their work as productive work. According to the data,

women view this work as temporary and uncertain work. Women reported that although this work gave them a chance to find a way out and provide a chance to work for their families, there was only a limited level of hope for their own futures. Most women viewed this work as providing no advancement in the future. According to the findings, the reason that sex work is viewed as unproductive work may be related to stigma, invisibility of economic distribution of sex work, and contradicting attitudes toward sex workers.

Stigma. In this study, sex work is seen as a stigma at both the personal and societal levels. At the personal level, they described how "ashamed" they were of their work. They avoided developing friendships with other sex workers, in order to be able to detach themselves from stigma of being sex workers. At the societal level, there seems to be an acceptance that women sacrifice themselves for their families by working in sex work (Mueke, 1992; Wawer & et al, 1996), but they are still stigmatized. The women in this study expressed a need for understanding from society not to stigmatize them for being commercial sex workers.

Invisibility of economic distribution. Economically, the sex industry in Thailand is tied to tourism and entertainment. It is difficult to estimate the financial impact of the sex industry on either local or national level (Bishop & Robinson, 1998). Women in sex work earn approximately five times more than domestic or factory workers. However, 78% of the women in this study reported sending money home on a regular basis to support their families and were barely able to save money for themselves. On the average, these women sent between one third to one half of their earnings to their families with some sending additional lump sums for special occasions. Other parties who share a proportion of their

income are the owners of establishments. These issues contribute to the difficulty in estimating how much the incomes sex work contribute to the national income.

Inequality in gender relations is another factor that undermines the role of women. Thai women are economically active and possess wider occupational role opportunities than to women in other countries in South East Asia. However, while women are now working in paying jobs, they are regarded more as supplementary income producers for their families than as major bread-winners (Setheaput & Yoddumnern-Attig, 1997). The oppression of women is rooted in intricate relationship between social, economic and political factors. There is a complex interconnection between poverty and patriarchy, and globalization, and how they impact upon sex industry.

Contradicting attitudes toward sex workers. There are also contradictory responses to prostitution at the societal and governmental levels in Thailand (Ford & Koetsawang, 1999). Commercial sex work has been treated as a necessary evil to prevent rape and to provide men with release for their sexual desires (Castaaneda et al., 1996). The law supports entertainment establishments, and national development plans implicitly accept the sex industry as an attraction for international tourists. Sex workers who work in establishments such as massage parlors or a-go-go bars are accepted as legal. However, prostitution in Thailand is still illegal. Streetwalkers are still treated as lawbreakers and are occasionally arrested when they stand on the street waiting for their customers. Sex work is also still considered as immoral and "good women' are never expected to engage in this work.

In addition to the contradictions in societal attitudes and public policy about prostitution, there are also ambiguities in public health policy In Thailand (Ford & Koetsawang, 1999). Public health plans that try to promote condom use by commercial sex

workers imply that sex work is acceptable in some level. However, public health policy tends to control and constrain women by using their regulations to force them to get STD checkups. Instead of supporting and promoting the use of health care services for their health, these regulations give a power to owners to control and oppress women. These conflicts have made women go underground and limit their utilization of the health care system. In summary, sex workers are stigmatized and they are not considered as an asset to societal revenues nor are they considered as productive workers. As a result, women have to live in stigma and be secretive about their work.

Although sex work is viewed as a way to earn a living, women also perceive sex work as risky work. In the following section, the theme of sex work as highly risky to life and health is discussed in the context of the existing literature.

High Risk Work to Life and Health

According to the participants in this study, sex work is risky because it threatens both women's live and health. Two important health risks viewed by participants in this study are violence and condom breaks. Even though both can be significantly as life and health threatening, they tend to be unseen as public health problems.

Violence as salience versus silence. Although it tends to be invisible to society, one significant characteristic of sex work is violence. There are many incidences and forms of violence in sex work, which tends to be accepted as part of the nature of work. Sexual and other types of violence are found to be normative for women in sex work as reported in many previous studies (Alexander, 1998; Barnard, 1993; Farley & Barkan, 1998; Vanwesenbeeck et al., 1994; Ward, Day, & Weber, 1999; Weiner, 1996). In this study, violence in the context of commercial sex work included verbal assault, robbery, rape, physical attack, and

murder. Violence existed in the relationships among the women and their customers, colleagues and strangers. From the women's accounts it is apparent that rape by customers is not unusual. For example, a customer could refuse to pay and then try to force women to provide sex or in the worse cases, sex workers could be raped by the group of customer's friends. However, none of the participants in this study described situation of rape. The word "rape" is rarely used by sex workers to identify sexual assaults. Instead of using the phrase "*gang rape,*" women tended to use words such as "*group attack.*" Violence in sex work is viewed as a compromise because: (a) the conditions and the nature of their work, put women at risk of violence; (b) the work is considered by others as immoral as well as illegal; and (c) the type of violence experienced by sex workers is viewed as synonymous to the type of activities that occur in their work; and (d) violence seen as a form of punishment for engaging in low and unacceptable work (Barnard, 1993; Farley & Barkan, 1998; Vanwesenbeeck et al., 1994).

Prostitution law considered commercial sex work as a criminal activities rather than a form of work. The aim of prostitution law in Thailand was to suppress number of sex workers and prevent child prostitution (Ministry of Labour and Social Welfare, 1996). Therefore, instead of protecting women from abusive or violent situation, the law has criminalized the women in prostitution and enhanced their vulnerability (Sanghara, 1998). Therefore, commercial sex workers are vulnerable not simply because of the work they do but also because they have no access to legal protection (Barnard, 1993). Reporting cases to the police requires that women confront the stigma of being labeled as prostitutes and risk disclosing their work status. Besides, sex workers are not considered as being raped since they are in the business of providing sex anyway. Sex workers who encounter violent clients

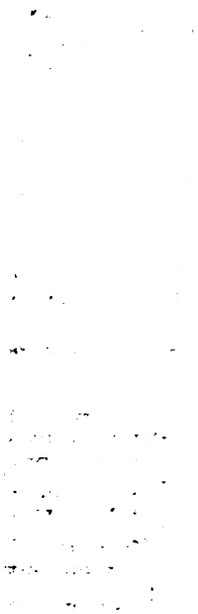
dare not report them to the police and tend to be silent about their stories. They often feel they must respond to threat on their own and try to learn new strategies to deal with violent situations.

As a consequence, women use all their strategies and power to avoid such situations. Due to the nature of their work they have to confront strangers, and must use a variety of ways to determine whether or not a client is safe. In recognition of the potential danger posed by their customers, the participants reported that they sought to avoid customers and situations that might be dangerous to them, such as avoiding going out with drunk or rude customers. Taking time to learn about clients was one of the strategies described in this study. Some women learned to take an assertive stance by setting the terms of the interaction, such as "*no condom, no sexual intercourse.*" However, the process of negotiation appears to be dynamic rather than a static interaction between the women and their customers (Vanwesenbeeck et al., 1994). In addition, negotiating and screening out potential violence may also affected women's life and work conditions. For example, women who work in massage parlors tend to experience less violence and have more confidence in the protection provided by their establishment owner. On the other hand, streetwalkers, and other sex workers from low class establishments reported higher rates of violence. This higher incidence may be caused by the fact that streetwalkers and low-class establishment sex workers tend to see more customers and work longer hours. In addition, there may be some constraints to the amount of time that can be spent in negotiating because of a need for money for children or fear of being arrested.

Condom breaks as a major health risk. A second major health risk for participants in this study is related to condom breaks. According to an HIV prevention plan, condom use is

a key strategy tin preventing HIV/AIDS throughout Thailand, especially in Thai female commercial sex workers (Ford & Koetsawang, 1999; van Griensven, Limanonda, Ngaokeow, Ayuthaya, & Poshyachinda, 1998). Condoms are available to sex workers at VD clinics under administered by the Ministry of Public Health. A review of studies about HIV prevention strategies for condom use in other countries indicated that Thailand has been far more successful in promoting condom use (Ford & Koetsawang, 1999; Kilmarx et al., 1999; van Griensven et al., 1998). The participants in the present study also indicated that condom use is accepted as a major health protection from STDs/HIV. The VD Division also attempts to reach out to this population by consistently providing them with condoms. However, their focus is to promote condom use by increasing awareness and effectiveness of use. Most studies indicated that public health policy aims to control disease not to promote health or protect women from the illness. Therefore, the problem of condom breaks was never discussed in the condom promotion project.

The findings reveal that after a condom break most of the women feared contracting a sexually transmitted disease and were concerned about the future of their families. Condom failures cause tremendous stress for the women. In this study, more than one fourth of the women reported experiencing a condom break. Health policy does not address what women should do after a condom break. They perceived that they have nowhere to go for comfort and seek protection with self-medication. Information about self-medication after condom breaks is shared among women, and they believe that self-medication is the better alternative than seeking help from professional care providers. Moreover, many of women feared seeking professional health care because of potentially learning that they had contracted a fatal disease.



Most participants who reported condom breaks were streetwalkers, and hotel and teahouse sex workers. The high rate of condom breaks in these two groups may be because they tend to see more customers. This finding corresponds to a previous study by Ford and Koetsawang (1999) which find that there was higher risk of contracting HIV in the lower-income settings. Therefore, streetwalkers and sex workers in low-income settings such as hotels and teahouses should be major targets for health promotion in the future.

Perception of Health

Being Healthy is Being Able to Work

The findings indicated that women defined the meaning of health within the context of their sex work experiences. Being healthy for sex workers is considered as a dynamic interactive process among personal, work, socio-economic, cultural, and political conditions (Meleis, 1989). Being healthy for commercial sex workers in this study meant being able to work for their families or for their establishment (i.e., not having any sexually transmitted diseases). This finding was congruent with studies of commercial sex workers in other countries (Evans & Lambert, 1997; Sedyaningsih-Mamahit, 1999). In a previous study, Evan and Lambert (1997) found that commercial sex workers related their health to various life circumstances, and defined their health problems in the context with worries about the welfare of their children and their own financial security. In relation to sexual health, an absence of STDs/HIV was viewed in relationship to potential employment rather than as tied to their own health. The seriousness of an illness or the decision to seek health care is tied to conditions that limit them from working or interfere with the welfare of significant others.

Focus on Sexual Health Not General Health

Because being healthy means being able to work, most participants pay more attention to their sexual health than to their general health. This was inferred from the in-depth interview data in which the women described their health status by addressing sexual health such as womb pain or fungus infection, more often than general health problems. Women also indicated that they would like to know more about how to take care of their womb or how to observe their vaginal discharge. Major sexual health complaints were perceived to have been caused by work, such as aggressive sexual intercourse and an accumulation of substances from condoms. The findings indicate several reasons why women focus on sexual health rather than general health: a) women have sexual health symptoms such as womb pain, after work; b) they are among colleagues that experience sexual health problems; c) their work regulations require that women have STDs checkups regularly; and d) the focus of Health Care Service for commercial sex workers is only STD checkups for women.

Conditions of Sex Work as Constraints for Health Seeking Behaviors

Several studies found that work conditions such as excessive work regulations, time pressures, and customer demands were considered as work stressors for women (Collins et al., 1997; Collins, 1990; Walcott-McQuigg, 1994). Low control and low job satisfaction were associated with health problems (Hemingway, Shipley, Stansfeld, & Marmot, 1997). Messias and colleagues (1997) proposed that in relation to health, women's work needs to be considered in terms of the multiplicity of its contexts, properties, and dimensions. Therefore, commercial sex work needs to be understood within the multiple social, cultural, emotional, structural, and environmental contexts. In relations to health care seeking, the nature of sex

work (i.e., stigmatized, isolation, secret) and the conditions of sex work (i.e., regulations for STD checkup) were important factors impacting health care seeking in commercial sex workers. In the following sections, the significant themes related to the nature and conditions of sex work influencing the health seeking behaviors of sex workers are presented including: stigma and secretiveness of sex work as a health care seeking constraint; social networks as a sources of information but not support; health policies as disembodiment; and the health care system: resource vs. control.

Stigma and Secretiveness of Work as a Health Care Seeking Constraint.

Dealing and living with stigma is a major issue for these women. It is also has major consequences in how women perceive health and seek health care. Many participants in this study gave clear examples of how the stigma of work has shaped their health-seeking patterns. Because of the stigma and secretiveness of sex work, the participants revealed that they felt fearful about disclosing themselves to health care providers. Disclosure about the nature of their work was found to be a barrier in accessing health services by commercial sex workers (Chattopadhyay, Bandyopadhyay, & Duttagupta, 1994). The women who did not access health service regularly tended to believe that they would be disrespected, or degraded if they disclosed their work status to a care provider. As a consequence, they tended to ignore their health problems and delayed in seeking professional care. Similar to the other studies in health care seeking in commercial sex work, women tended to seek health care only when their symptoms were more than they could tolerate (Evans & Lambert, 1997). In such cases, women would try to find a health service, such as a private clinic, where they could keep their secret. The participants tended to seek care from a clinic that was located in an area far away from where they lived.

Networks as Sources of Information but Not Support

The nature of social relations among commercial sex workers is paradoxical. Having a social network facilitates becoming a sex worker (Sophonkanaporn, 1996). A social network also plays an important role in information exchange about work and health (Campbell, 2000). It is commonly found that women discuss illness, symptoms, what types of treatment and when, where, how to access treatment with their colleagues. However, an intriguing finding about the nature of these social networks was that there were no real friendships among the sex workers in this study. This finding is consistent with the findings of previous studies in Thailand (Nareumol, 1987; Tritrakan, 1997) but contradicted other studies from different cultures (Campbell, 2000; Vanwesenbeeck et al., 1994). For example, Vanwesenbeeck and colleagues (1994) found that women worked as streetwalkers stayed in pairs to watch over each other and prevent violence.

The nature of social networks in this study might have been due to difference in how the women in this study deal with their work conditions and the unique nature of sex work that happen in Thailand. First, the women in this study viewed sex work as a stigma and kept it a secret from their families. Denying that they are the part of this network was one way to cope with the stress of the work. As a result, there was no source of friends at work. In addition, sometimes work violence course by their colleagues. Finally, because of the uncertain nature of the work, there was a sense of competition among the women. Arguing and fighting for customers is not unusual among sex workers. The result was that 39% of the participants reported that they have no social support and that they tend to keep their problems with themselves.

Health Policies as Disembodiment

According to public health policy, some establishments have set up rules that require the sex worker to have an STD checkup regularly. However, the finding in this study indicated that there are different perspectives and practices regarding STD checkups among sex workers, and between health care providers and sex workers. While the health care providers try to check for STDs in the population for the purpose of controlling diseases, women try to keep themselves healthy for work but rely on their own perceptions of their symptoms. Some of the participants in this study stated that they have regular checkups for STDs only because it is a criterion for them to continue their work. The focus of these checkups is on contagious diseases that could harm their male customers. Therefore, for some women, a regular STD checkup is not the same as seeking care for their health complaints. Most women in this group defined their health as an internal validation, believing that in their perception of their own symptoms often differs from the diagnosis of a health care provider. This could be considered as an emic-etic distinction of meaning of health (Tripp-Reimer, 1984). Some women perceived that such checkup does not benefit their health; mistrustful relationships between them and health care providers could be developed. Distancing from their body combined with distrusting relationship between the women and their health care providers has a very important consequence in how women seek health care.

In addition, being constantly investigated by health care providers also contributes to feeling a lack of control over one's own body. Consequently, some participants gradually developed the idea that their health status should only be validated by care provider and that it was synonymous with the lack of an STD. However, the regulation about STD checkups

still not apply to all sex workers, such as streetwalker and freelance sex workers who are not employed in any establishment. Thus there is nothing to force a streetwalker to come in for regular STD checkups. These women tend to rely on their own symptom perceptions and do not to come to clinic. They may come only when they have symptoms that more than they can tolerate in order to keep on working. It was found that most of the women in these groups delayed or did not seek health care at all, instead relying on self-medication.

Health Care System: Resource vs. Control.

As discussed in the previous section, there is ambiguity in public health policy in Thailand. Although the government provided the Health Care Service for sex workers, it operates under a disease control rather than a health promotion model. It seems to ignore the reality of extensive abuse, discrimination, and exploitation of these women.

During data collection, some staff of establishment asked my key informant and I *what would you like to check today?* According to the stories of the participants in this study, as well as data from participant observation, health care facilities are very controlling. In some work establishments, STD checkups are included as part of routine preparation before starting to work, similar to other workers who punch a timecard or get dressed in a uniform. The participants viewed health care providers as controllers who have power to investigate them, rather than resources for them.

Sex workers are situated at the margins of society and many health care providers label them in their dealing with the women. The women's stories indicated that their real health care needs are still invisible to health care workers. Participants who are marginalized often viewed themselves distanced from society (Hall, Stevens, & Meleis, 1994). Their experiences demonstrate that they are ignored and labeled during health care encounters. For

example, pelvic exam are often performed with a lack of privacy. The health care providers tend to assume that sex worker do not care for the other to see them during the exam or know about their problems. In addition, some care providers may trivialize the symptoms and refuse to care for women's health problems beyond routine service. Health care providers tend to take control and decide how and what kind of service women should receive.

Overtreatment or undertreatment might be a result of lack of clear communication between the women and the health care provider. For example, during the interview, one participant mentioned that a care provider yelled at her because she did not complete a course of medication, because she was told not to drink alcohol while taking this medication. The participant had to drink during work and therefore she stopped taking the medication. This encounter could be seen as a consequence of a lack of mutual communication.

Health care providers are not inclined to question, observe, or investigate patient and very rarely take the time to explain the potential side effects or the importance of completing courses of antibiotic therapy (Evans & Lambert, 1997). Women may be afraid to ask questions of health care provider and must rely on the information that volunteered by the care providers. Women are made to feel that they should be grateful that health care providers have taken time to discuss their care.

Because obtaining health care is such a negative experience for sex workers, women react to the health care system by protecting their own safety and acting on their health care needs according to how they define their own health. Self-medication as an example of how these women seek health care. In addition they screen potential health care providers, control information about themselves, and select health care services that meet their health care needs. Excessively seeking health care was also found to occur when there was a

discrepancy between a woman's perception of her illness and the health care provider's diagnosis. Using multiple sources of treatment is commonly found in commercial sex workers. Sources of treatment included private clinics, drug stores, co-workers, and managers of establishments.

Living with Sex work

According to the findings of this study, after becoming a commercial sex worker, women have to learn to live with the realities of commercial sex work. Conceptually, the factors that have impact on living with sex work are the relationships between the work environment and health, and role integration between in their roles as sex workers and family caregivers. In the following sections, the results of the regression models analyses of the relationships among personal and work conditions on health status will be discussed.

Relationship between Work Environment and Health

Determinants of health. The regression analysis testing predicting model for three-health status variables (i.e., perceived health status, GHQ total score, and total number of symptoms) yielded three significant predictive models. The significant determinants for perceived health status were perceived choice in work, number of customers per night and number of customers per month. Lack of perceived choice in work, a lower number of customers per night, and a higher number of customers per moth predicted the better-perceived health status. The combination of these three variables explains about 18% of the variance of perceived health status. This finding was consistent with a previous study conducted by Tritrakan (1997) where the number of customers per night had a significant role in determining the health status of commercial sex workers. The interesting finding in this model was that the direction of the relationships between number of customers per

month and number customers per night on the perceived health status was different. The explanation of the results may result from confounding factors such as different patterns of income in different types of establishment. For example, for the same income, the participants from massage parlors may work in average 7 hours a day and see three customer per night, work 5 to 6 days in a week, while streetwalkers work longer hours with 5-7 customers per night, and then quit working for a week before coming back to work again. Thus, the number of customers per month has significant meaning as earning money. In contrast, the number customers per night could be viewed as work intensity for these women, and seeing more customers per night means that they are at risk for encountering bad customers.

For the model predicting GHQ-total score, it was found that the greater the balance of satisfaction and stress in work, the higher the number of years of education, and a lack of violence in work are the determinants of a lower GHQ-total score and the combination of these three variables account for 21% of the variance in GHQ-total score after controlling for other variables. This finding is congruent with previous studies in the area of women's work and health, and violence in sex work. These findings provide support for the argument that role integration is a significant variable affecting health status in women (Meleis et al., 1989) and also support the contention that violence in commercial sex work has a significant impact on the mental health status of commercial sex workers (Boyle, 1997; Farley & Barkan, 1998; Vanwesenbeeck, 1994).

The total number of symptoms, violence in the work place, being a financial support for family and higher number of years in sex work are significant determinants of a higher total number of symptoms. The significant relationship between violence and total number

of symptoms was similar to a previous study on violence in prostitution. Farley (1999) found that post-traumatic symptoms were correlated to the incidence of violence in sex work.

Although, the regression models provided us three different models for three-health status variable, it could be seen that work environment or work conditions are important determinants of health status (Amick et al., 1998; Collins, Hollander, Koffman, Reeve, & Seidler, 1997). The work environment may help in facilitating or constraining women's ability to integrate and deal with their various roles (Meleiss et al., 1989). In addition, it also provided us the picture that: a) women are living under constraint of work and life conditions and b) women are balancing satisfaction (being able to work for family) and stress from violence from work.

Determinants of health care seeking behavior. Results from the first logistic regression analysis predicted that the chance of getting an STD checkup for women who work without regulations increases as the number of children, number of years in sex work, and number of customers per night increases. However, result from the goodness of fit test indicated that this model did not provide a good fit for the data. This may have resulted from a lack of understanding of the nature of the population or from limited how I operationalized and measured the variables in this study. The way that I operationalized the variables may have given ambiguous meaning to these findings or have captured or may capture something that had a different meaning for the participants. For example, number of customers per month did not mean intensity of work for the women. For them, it meant the money they could earn from their work. My limited understanding about the nature of their work was also reflected in how I chose treat the variable "getting an STD checkup" as "a decision to seek health care" when, in fact, it is an act forced by the regulation. Nonetheless, the in-depth

interviews suggested that women who have children are more likely to be concerned about their health. Women described their reasons for seeking STD checkups to include protecting their children. One participant said, "*I have a children to feed. If something happens to me, who will take care of my child? That's why I came for a checkup.*"

The logistic regression predicting consistent condom use found that there is no significant relationship among independent variables (i.e., age, income, years of education, number of children, number of years in sex work, number of customers per month, choice in selecting customers, violence in work, the balance of perceived stress and satisfaction in work, the importance of health, and health statuses) and dependent variables, consistent with condom use. This might be explained because most of the study participants indicated that they used condoms every time because establishments supported them in doing so. An earlier study found that support from the manager or establishment was a significant factor in consistency of condom use (van Griensvan et al., 1998). Women also indicated that they used condom consistently because they were afraid of acquiring HIV/AIDS. In this study's in-depth interviews, women explained that they had to keep themselves free from HIV/AIDS, in order to be able to work to fulfill their responsibilities for their families. In a previous study, it was found that inconsistent condom use was not primarily caused by lack of health consideration but by the context of their lives and the significance the work that had for them (Vanwesenbeeck, & et al, 1995). It was concluded that among sex workers their personal situation were important factors in condom use. Practicing unsafe sex was found to be strongly related to the women's level of satisfaction in sex work (Vanwesenbeeck et al., 1995).

It is evident that such health behavior such as condom use are influenced by the life contexts of sex workers and how they integrate their work and other life roles. In the following section, the integration of the work and other life roles of sex workers will be discussed.

Role Integration

Balancing stress and satisfaction in work. According to role integration theory, women tend to meaningfully organize their multiple roles into a larger whole (Hall, Stevens, & Meleis, 1992). Most participants in this study indicated that there is no satisfaction in their work, except that it allows for the survival of them and their family. Most women perceived that sex work is stigmatized, risky, uncertain and stressful work. On the other hand, this work has given them a chance to earn money not for only themselves but for their whole family, especially their children. Therefore, living with sex work is finding balance between the stress they experience as commercial sex workers and more satisfactory aspects of this work role and their other roles. For example, women may balance the rewards of being able to earn money with the risks in their work.

Evaluating life conditions and work status. Additionally, the majority of the participants perceived that sex work was not a secured job. Some women believed that there was neither a real future in this work nor a hope to leave this work. Women often asked themselves why they were in this work. They constantly evaluated their life conditions (i.e., current financial need and family situation), work conditions (i.e., chance to earn money, pressure from establishment regulations, and other stresses from work), and their hope for the future (i.e., a chance for starting a new job and permanent source of support). The stories in this study indicated that there are different ways that women situate themselves in sex work:

1) having a vivid plan for their future that helps to release them from the stress of work; 2) trying to survive and pushing themselves to meet their personal goal; 3) having an ideal plan but lacking any possibility of meeting their goal; and 4) knowing that there is no hope and no other way than to struggle in this work.

Living with sex work was influenced by the perceptions and conditions of sex work. The findings of this study indicated that the conditions of work could depend on the type of establishments in which women worked. For example, women who were employed in establishments with regulations which required them to have an STD checkup twice a week, had only two days off a month, had to check in at a certain time, could not take a day off during a holiday, had to go out with customers at least four times a month. Otherwise, their salary was withheld or cut off. On the other hand, women who were streetwalkers or freelance sex workers who worked at certain places like café or karaoke bar did not have to work under these regulations. They had more freedom in when and how much they wanted to work. However, they also seemed to have unsafe work environments, experienced more violence in work, got lower paid, and were more frequent arrested.

Based on the findings, the perceptions of work also confined women to a limited work environment. For instance, women who needed money for medical expenses for their parents might decide to work longer hours and take more customers in one night. How women lived with sex work seems to be a balance between work satisfactions in form of monetary reward can be used to fulfill family needs, and work stress resulting from isolation, stigma, and risk. Thus, for women, living with sex work means evaluating life conditions, work conditions, status of work, and hope for the future, as well as integrating the satisfaction and stress from work and family caregiver roles.

Patterns of Health Care Seeking Strategies

This study found three significant health care seeking strategies practiced by commercial sex works: self-medication; ignoring health concerns; and seeking professional health care.

Self-Medication

According to the findings, commercial sex workers were situated within a socio-economic context where they are poor, always limited by time, have limited social support, and have to rely on their own risky work to survive. In this study, women from lower class establishments such as streetwalkers and hotel and teahouse workers tend to use antibiotics as a protective method more often than do the workers in other types of establishments. The participants in this study practiced self-medication in: a) STD/HIV protection after a condom break; b) a general health protection method; and c) for sexual health complaints such as Tok-khao, uterus pain or an inflamed womb. Women tended to use the same medications they received for STDs from professional health care providers for these protective proposes. These findings about self-medication reflect the findings of previous studies both in Thailand ((Kilmarx et al., 1997)) and in other countries (Abellanosa & Nichter, 1996; Faxelid, Ahlberg, Ndulo, & et al., 1998; Roy, Bhargava, Bapna, & Reddy, 1998; Sedyaningsih-Mamahit, 1999). According to the literature, the use of antibiotic as prophylaxis against STDs is common among sex workers (Abellanosa & Nichter, 1996; Kilmarx et al., 1997). Both routine and occasional antibiotic use was reported and was related to lack of condom use and higher numbers of customers. Women used antibiotics before or after having sex with customers, once or twice a month prophylacticly, or when feeling like they were coming down with an illness. Abellanosa and Nichter (1996) reported that unregistered sex workers

tended to use antibiotics as a prophylactic medicine. No significant relationship has been found between antibiotic use and perception of risk for STDs and HIV.

Protective health strategies may demonstrate an awareness that they are at risk of contacting STDs and HIV. However, they can lead women to a false sense of security about safety from the disease and can delay in seeking appropriate health care (Manhart, Dialmy, Ryan, & Mahjour, 2000). The false sense of security can also come from a lack of knowledge about diseases and medication. The antibiotic, 'Rifadin' (generic name 'Rifampicin') is used to treat tuberculosis in Thailand but have also been used as diuretic drug among sex workers. The study participants explained that the red color in their urine subsequent to taking this medicine indicate that any STD/HIV that was in their body after a condom break had been excreted. This misunderstanding may have come because the word that they used for STDs, HIV, AIDS, and sperm is the same word as "germ." Women may use this word with their colleagues and misunderstood what it takes to protect themselves from diseases. This finding was similar to a study about STDs in Morocco by Manhart and colleagues (2000), which found that women believed that STDs came from the cold water. They tended to use traditional preventive methods rather than seeking professional health care, as well.

Ignoring Health Concerns

In this study, because of their responsibility for the financial support of their whole family, the women sent most of their income to their family. They kept little for use in their own daily life. Whenever women had to choose between their own health care needs and their family's needs, they very often put off the own health care needs and ignored their

symptoms. Streetwalkers and others who do not had access to health service, tended to delay seeking professional health care and utilized more self-medication.

The themes of *reprioritizing family and health care needs* that emerged from the in-depth interviews. In asking the women about the importance of health, I found it was not an easy question for the women to answer. While the questions were not only too complicate to understand, it was hard for them to answer how much health really meant to them within the context of their own lives. The women in this study explained that health should be one of the most important things in their life, but if there were urgent family needs, they might put off their health to fulfill those needs. However their response to health problems varied depending on the problem. For instance, if they had a serious illness—defined as not being able to work—then treatment became their priority. Thus how sex workers prioritize their health depends on how they evaluate situation in their work and life.

Seeking Professional Health Care

This research indicated that these women seek professional health care only for sexual health problems and tend to ignore general health concerns such as diabetes, hypertension, and thyroid, eye and back problems. The women also clearly indicated clearly that their most important health care need from health care provider was to know how to take care of their *'womb'*, in order to be able to work. In general, seeking professional health care was a choice only after all self-medication had failed. According to the women's stories, they want a specialist who they can see for all their sexual health concerns, not just to check for STDs. For example, a woman might have vaginitis caused by sexual intercourse and need to have some advice beyond consistent use of condoms.

The Model of Health Care Seeking in Commercial Sex Work

It is clear that health care seeking behaviors in commercial sex workers may be influenced by the women's perceptions of work and health, work conditions that constrain women from health care seeking, and the lived experiences of sex work. A model of health care seeking in commercial sex work is presenting in figure 6-1. The model shows that to understand health care seeking strategies:

1) How women perceive sex work—whether it is a personal choice, under constraint, high risk to their life and health, and/ or perceived as unproductive work that did not gave hope for the future.
2) Commercial sex workers view being healthy as being able to work for their family. The major health care need for them is sexual health not general health because it is sexual health that enables them to continue to earn a living to support their families.
3) The nature and conditions of sex work play important roles in shaping health care seeking strategies and also how women live with sex work. For example the stigma and secretiveness of sex work are major constraints in seeking health care. Social network are sources of information about self medication, but not real social support for the women
4) Public health policy that tries to control disease rather than promote women's health. This contribute to the disembodiment that women feel. It leads them to view the health care system as a controlling center rather than a support to them.
5) How women integrate and balance the role of sex work with the role of caregiver has a significant influence on how they seek health care. Different work environments (i.e., number of customers per night, number of customers per month, violence in

work, choice in selecting customers, number of years working in sex work) and personal conditions (i.e., being the financial support for the family) may also impact how women live with sex work.

In the next section, a new model of health care seeking in commercial sex work will be compared with the model that guided this study.

Comparing a New Model of Health Care Seeking with the Model that Guided this Study

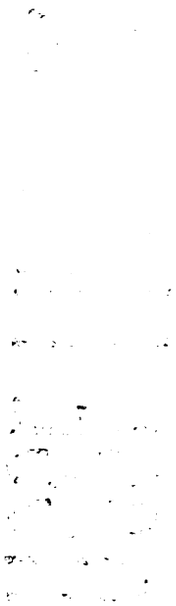
When comparing the model of health care seeking developed from the study findings with the model that originally guided this study, it is apparent that there are some similarities and differences between them. Both models emphasized the influence of personal characteristics, social factors, facilitating/ constraining conditions from work conditions, health care seeking experiences, health perception, and health statuses on patterns of health care seeking.

In the original model, patterns of health status and health care seeking behaviors are assumed to be influenced by personal characteristics, health care seeking experience, health conception, and work-related variables. Because the original model was derived from the social (health) behavior models, it focused mainly personal cognitive experiences and their impact of health care seeking (Leventhal et al., 1984), such as symptom interpretation and perceived consequences of symptoms and health care seeking. Social factors, such as what significant persons have suggested, were considered as a part of the health care seeking experience. The work related variables (i.e., number of years in sex work, number of customers per month, number of customers per night, number of hours working per night and balance of satisfaction and stress in work) were considered as facilitating and constraining factors. These work-related factors all influence health care seeking among sex workers

(Triandis, 1980). Basically, the original model regarded persons as active problem solvers regarding health problems (Leventhal, Nerenz, & Steele, 1984; Rosenstock, 1974; Triandis, 1980).

In the new model, perception of sex work is considered as a separate factor from conditions of work. Both of these factors can impact how women live with sex work. There is a reciprocal relationship between perceptions and the conditions of work that constrain women from seeking health care, unlike the direct relationship proposed in the previous model. Perceptions of health in the new model implicitly provide more specific direction in the type of health care services (i.e., sexual health) that women need to carry out their sex work. For example, because being healthy means being able to work for their families, many sex workers will self-medicate with prophylactic antibiotics to protect themselves. Health behaviors including ignoring health concerns, self-medication, and seeking professional health care when their ability to work is impaired all help them to fulfill their work roles.

Conditions of sex work that are regarded as constraints to health care seeking include the nature of sex work (i.e., stigma, secret, and isolation), health policies regarding STD checkups, and interactions with health care system that control rather than support. The new model expands on the original model by separating work conditions into two categories—the conditions of work that constrain health care seeking behaviors, and work conditions that integrate living with sex work into daily experiences. The new model differs from original model in considering all factors as existing within the life context of sex work. Health care seeking experiences that have significant impact on health behaviors are produce of interaction between personal and work conditions. For example, social networks give information that influence the direction of health care seeking behaviors. Health care

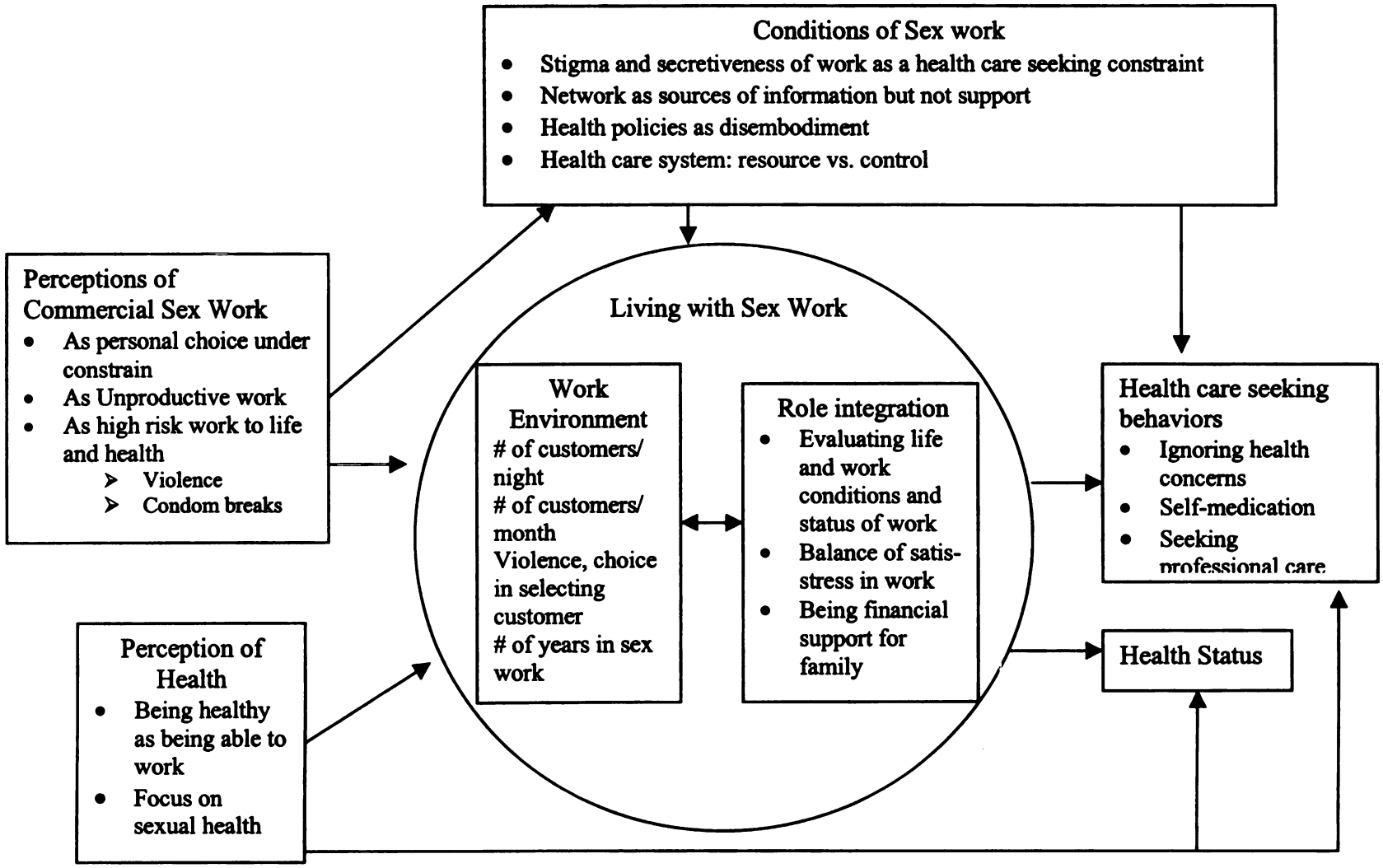


experiences that are linked with work conditions, such as *health policies that result in disembodiment; a health care system that controls rather than supports,* are facilitating/ constraining conditions of health care seeking experience. Onsite health care providers could be seen as a condition that makes it easy for women to access service. However, women may not be active agents in decision making in such situations.

Understanding how women live with sex work is more complex than simply considering conditions of work or personal characteristics that impact women's health behavior. The findings of this study suggest that how women integrate their different roles (i.e., mother, family caregiver, sex worker), evaluate their life conditions and interact with their work environment (i.e., number of working hours, number of customers per month, and number of years working in sex work) all influence how women seek health care. The findings indicate that the women constantly evaluate their life situations and balance the stress and satisfaction of their work and family caregiver roles. Women tend to practice health care seeking behaviors that correspond to their current life situation.. For instance, a woman may go to a clinic to get an STD checkup if she is assured that she can still work for her family. On the other hand, a woman may decide to get preventive medication from a drug store if it gives her more time to work, instead of wasting time going to a clinic.

In summary, the new model provides insight about women such as commercial sex workers, who are marginalized and may not have many choices about their health care. Health care seeking by commercial sex workers occurs under oppressed social and health care policies and is limited by stigma and the secret nature of sex work.

Figure 6-1: A Model of Health Care Seeking in Commercial Sex Work



CHAPTER 7

SUMMARY AND IMPLICATIONS

In this chapter, the research findings are summarized and the limitations of the study are discussed. Finally, the implications for future research, clinical practice, and health policy are presented.

Research Summary

The purpose of the study was: (a) to describe patterns of health care seeking behaviors in female commercial sex workers in Thailand; (b) to uncover the strategies that the women use to maintain their health and respond to their illness; and (c) to describe determinants of their health seeking behaviors. Six research questions were answered using triagulation of quantitative and qualitative methods.

The findings indicated that there were a combination of personal, family and environment conditions that influenced women's decisions to become sex workers. Powerful personal conditions included being the only breadwinner in family, having limited education, coming from poor or broken families and having no other family member who could take on responsibility for the family. Among environmental conditions such as cultural, socio-economic and political factors, social networks were found to be a preeminent factor in determining how women entered sex work. Commercial sex workers are not homogeneous. They work in different types of work establishments. The conditions of their work including patterns of incomes, regulations, types of customers, and types of work activities vary by establishment.

The six characteristics of sex work described by commercial sex workers were: stigmatized work, secret work, isolated work, uncertain work, risky work, and the silence

of violence. The women perceived the meanings of commercial sex work as: earning a living; ensuring family survival; and being only choice they can do.

The process of becoming a commercial sex worker includes: learning the trade, dressing the part, and learning negotiation. Living with sex work was perceived as stressful. The major stresses of sex work were identified by the participants as condom breakage, worry about earning money, and dealing with customers. The major satisfaction in the work was being able to support their families. Coping strategies used in sex work included reminding oneself about the meaning of work; leaving the "self' out of sex work; letting go; asking for protection from sacred spirits; being alone; and using drugs, alcohol, and cigarettes. Among commercial sex workers, streetwalkers tended to be at highest risk for violence.

The meanings of health in commercial sex work fall into two categories: externally validated meaning and internally validated meaning. Health was externally validated by health care providers. Women internally validated their own health as feeling well, being able to work, and managing their levels of stress and worry about work and family. Mainly, both internal and external validation of health resulted in being able to work. Because women related their health to their work, their primary health concern focused on sexual health rather than general health.

The findings from the in-depth interviews indicated that commercial sex workers had a variety of perspectives regarding STDs checkups. Some women perceived that checkups were for their own health while others perceived that they were only for their work. Protective health strategies used by the women included using condoms, getting early STD checkups and treatment, cleaning oneself after sexual intercourse, taking

preventive medicine, and avoiding sexual intercourse by providing other sexual services. Three major sexual health complaints reported by participants were pain during sexual intercourse, Tok-khao or pain in the uterus, and vaginal itching. Health care seeking strategies used by the women for their sexual health problems included self-medication, ignoring symptoms, and seeking professional health care. Finally, factors affecting the women's health care seeking strategies included personal factors, the conditions and nature of sex work, and previous experiences in seeking health care.

Findings from the regression analyses predicting health status also indicated that there were significant relationships among work conditions and personal characteristics, and their impact on health status. However, work condition variables were better predictors of health status. The work condition variables predicting health status differed among three health status variables. Higher number of customers per night, lower number of customers per month and perceived choice in work were found to be significant predictors of lower perceived health status. The greater the balance of perceived stress and satisfaction in work, lack of violence at work, and higher level of education were significant predictors for better mental health status. Finally, higher number of years in work and experiencing violence in work and being the financial support for family were significant predictors for higher total number of symptoms. Results from the logistic regression predicting the chance of getting an STD checkup in the absence of regulations suggested that women who have children, have more experience and see more customers are more likely to come in for an STD checkup. However, the model does not provide a good fit for the data. The last logistic regression revealed that there was no significant relationship among personal characteristics or work conditions on consistent condom use.

Finally, a model explaining health care seeking in commercial sex work was developed. The major theme related to health care seeking behavior in commercial sex work was constructed as "*health care seeking to survive in sex work.*" The model explained that health care seeking strategies in commercial sex work are influenced by perceptions of being a commercial sex worker, perceptions of health, the nature and conditions in sex work, and the experiences of living with sex work.

Limitations of the study

Sampling bias was the main limitation of this study. Since there were significant difficulties in accessing the population, most of the participants had to be recruited from the clinic and establishments with which my key informant from VD Division had a good connection. This method recruitment may have led to selection bias. The participants recruited from the establishments connected with the VD Division may have had better access to health services. This selection bias may have limited their answers to specific questions such as their experiences with care providers. Furthermore, the sample may not represent commercial sex workers who are working in other areas of the country, who do not attend this specific clinic, and who work in establishments where inaccessible for me. Although this nonprobability sampling design may reduce the internal validity of the study, the findings may still provide significant information about the health and patterns of health care seeking behaviors of this group of women.

Another limitation rests in the disproportionate data. There were few women from some groups, such as streetwalkers and freelance sex workers in cafés. These specific groups of commercial sex workers apparently tend not to interact with the health care providers from the government sectors and were not been recruited in previous

studies. With the limited data of the study, it was difficult to compare some conditions among sex workers and to identify the frequency of some of the specific conditions.

Although the snowball technique has been used as an effective strategy in recruiting participants in some studies, there were some limitations in using this technique with this population. Because of the secret nature of sex work, women tend not to develop friendships among sex workers; there was no trust among them. Therefore, when they were asked to tell other women in their network about the interview, they were concerned that they might have to share the interview experience with their colleagues. Because of the protective instinct arising from being in risky work, these women felt that other women might feel afraid to participate in the study.

There were also limitations in the measurement tools. First, the Importance of Health Scale was modified from the Health Value Scale, which had been developed in the United States. When this instrument was translated into Thai and used in this population, the questions were too complicated for the participants to answer. Each item required that the women think about two constructs—how important health was to them, and with what other life events compared with their health and in what situations. For example, in the question, "*there are many things I care about more than my health*," the women had to think what *'things'* they considered and compared with their own health. There could be more than one answer in different situations. The unclear meaning of some items was a threat to validity and reliability of the data. Another problem of measurement that occurred in the study resulted from a lack of clear understanding in the nature of the population. For example, various work conditions exist that lead to different types and levels of constraint in sex work, these workers from each

establishment may work at different levels of intensity in order to earn the same amount of income. Therefore, the questions about number of customers per month and customers per night which where I meant to evaluate only the level of constraint in work' (i.e., seeing more number of customers means higher constraints in work) may also capture other unexpected construct, such as a satisfaction in having enough income from a certain number of customers per night. This issue could lead to a threat to the construct validity.

The issue of power inequity was also a concern. Recruiting participants through clinics and contact persons who work as government officials could have led the participants to believe that I was part of the clinic staff or that I was 'on the other side.' This may have had an impact on the accuracy of my data. The participants might have withheld information that they did not want their care provider to know. However, recruiting other participants from community-based settings through different contact persons who did not work for the government may have allowed those participants to be more open in their answers.

There were also some limitations in the data collection process. Most of the interviews in the community-based settings were conducted in the establishments. Most of the interviews were conducted in the late afternoon or evening and before or during working hours. Both the interviewer and the participants were sometimes interrupted during the interview. Participants were sometimes distracted by what was going on around us. In some cases, the interviews were conducted in an open area where other people walked by. The time limitation and conditions of the interview may have affected the reliability and accuracy of the data. In addition, each participant was only interviewed one time. There were some limitations in developing rapport between the

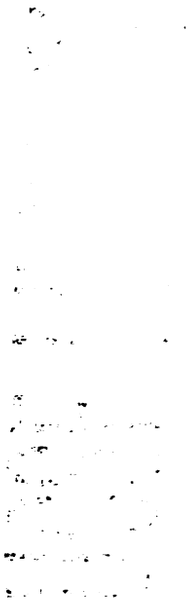
participants and researcher, which restricted the chance to ask follow up questions, and may have affected the depth of the data. Finally, although I tried to remain reflective as a researcher, I still maintained a privileged voice. The active voices of participants construct the report, but the excerpts were selected and organized by researcher.

Implications for future research

The results from this study suggest several directions for future research which are discussed in the following section.

Increasing Need for Diverse Research Programs

According to the research findings, it is indicated that commercial sex workers are not homogenous. Their working conditions differ, as do the perceptions of work and health, and the health strategies they perform. Although sex workers who work in an establishment are usually protected them from seeing violent customers, they may be vulnerable to exploitation by the establishment owner or be oppressed by the regulations that control them. On the other hand, there are some sex workers who are self-employed, such as streetwalkers, and who work without any regulations. They are vulnerable to poorer working conditions such as violent customers. As a result, the health care needs of commercial sex workers may vary depending on the conditions of their work. Therefore, a single type of health prevention or health promotion program may not meet every woman's health care needs. In order to develop a health promotion research program that meets women's needs, understanding of the various forms of sex worker will be important (Vanwesenbeech, 1994). The research may have to start by exploring the health care needs and work environment of different types of sex workers before developing specific health promotion interventions for the various settings.



Including Women's Participation in Planning for Intervention.

Knowledge based on women's experiences holds a great deal of promise for the empowerment of women and the enhancement of their health. The findings from this study indicated that women's well being, risk and health seeking behaviors could be explained within the context of being a commercial sex worker. For marginalized populations who are oppressed by social system such as commercial sex workers, their health care seeking strategies may not come from their decision, but come from the constraints of the work environment and the health care system (Hall, 1999). At the same time, we cannot ignore the fact that women are the ones who decide why, when, and how they should seek health care, based on the contextual conditions in their life. Self-medication and ignoring health concerns are health-strategies used to survive living with sex work and dealing with health care system. Thus, it is crucial to incorporate women's ideas, experiences, and participation in planning for health care access in research about health promotion and health preventive interventions in this population. Research programs that allow us to incorporate women's voices, such as participatory action research, might be an appropriate research design for this population.

Targeting Populations and Areas for Future Research

According to the research findings, streetwalkers and freelance sex workers from cafés and low-income settings were the groups of sex workers at highest. These groups of women tended to work without regulations and to move from place to place. They tended to delay seeking professional health care, have less access to health care services and were more likely to use prophylactic antibiotics with a false sense of protection. In addition, although they are considered at higher risk, there is still limited research and

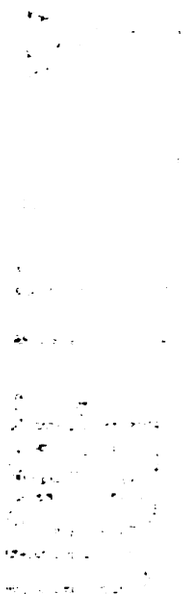
statistical information available regarding streetwalker and freelance sex workers. Development of a research program that explored the health care experiences and work conditions of these higher risk sex workers is clearly needed.

In addition, a previous study in the Philippines found that self-medication is associated with the highest rate of antibiotic resistance in STD treatment for gonorrhea and syphilis. Irregular use of broad-spectrum antibiotics may also increase the prevalence of vaginitis in sex workers. Therefore, the effect of self-medication as an informal STD preventive strategy is another area that needs to be explored.

Implications for Clinical Practice

Shifting from Controlling for STDs to Delivering Health Care Services

The data from this study highlights a health care policy monitors the health of sex workers for the purpose of protecting male customers and society at large from the risk of infection, rather than providing health care services for the women's benefit. The women are checked for the prevalence of STD and HIV infection as if they were checked for the quality assurance of the commodity for the consumer. In response, commercial sex workers have developed the perception that accessing the health care system for an STD checkup alienates them from their bodies. Some women indicated that checking for the presence of STDs is only one part of thoroughly accessing a woman's health. It is not uncommon to find a lack of concern regarding abnormal vaginal discharge by health care providers if there is no sign of a sexually transmitted disease. Although the women expected to receive an explanation about their symptom, they were often informed that nothing was found on the exam. Therefore, they perceived that their health problems did not received the full attention of the health care provider. As a consequence, women



tried to seek health care from other resources, such as drug stores, or tried to practice self-medication, or stayed away from the health care system. This suggests that health care services for commercial sex workers need to change from controlling and checking for sexually transmitted diseases to supporting and advocating health promotion activities of these women.

The focus of health care workers should expand from checking for STDs and HIV to all aspects of sexual health. In addition to screening and receiving treatment for STDs, and health education about condom use, commercial sex workers also need information regarding their sexual health problems. Some participants indicated that "I want to know how to take care of my womb" and "I want to know how should I observe my vaginal discharge." Sexual health specialists should be accessible to these women if their health needs are to be met.

Expanding beyond Sexual Health to Occupational Illness

The issues of violence and mental health also need to be addressed as the part of health care services for commercial sex workers. In this study, it was found that experiencing violence is a significant predictor of lower mental health status. However, the women did not have any place to go and talk about this problem. They had to learn to accept violence as a part of their work. It was also found that violence and the mental health problems affecting commercial sex workers are still invisible in society. The issue of violence is normalized as the part of prostitution. It is not viewed as a work condition that can be changed. However, violence, in addition to sexually transmitted diseases including HIV/AIDS, should be considered as occupational health problems. The services available to this population need to be broadened and based on the needs of

women. Mental health services should be accessible to the women. Health care providers should encourage women to talk about their experiences of violence because of the impact on their health.

Providing Health Service Based on the Understanding of Sex Work

According to this study, the issues of stigma and secrecy in sex work are major barriers that kept women from seeking health care. Women health care professionals should be educated about these issues in order to address the needs of commercial sex workers. Health care providers need to be more sensitive and understand women's problems within the context of the cultural, social, and political realities of their lives. In order to establish trustworthy relationships with sex workers and thus provide them with appropriate health care, confidentiality and privacy need to be assured when the women come for service.

Implications for Health Policy

Accepting Sex Work as a Work

The participants in this study indicated that they engage in sex work to earn a living for the families. For this reason, health policy makers must recognize sex work as work. Commercial sex work like any type of work, must be considered in terms of activity, energy, time, resources, results, meanings and values attached to it (Messias, et al., 1997). Health problems that occur during their work need to be treated as occupational illnesses. The health and health practices of commercial sex workers are shaped by the nature and conditions of their work. In order to promote health in commercial sex workers, the impact of meanings and the nature of sex work should be taken into account. Commercial sex work may provide a good income but there is a high

cost to be paid, as well when the time and place that they work, the lack of social support, the stigma that is attached to sex work, the risk of contracting diseases, and their effort in keeping their work secret from their family are all taken into account.

Recognizing Women's Right

Because of the ambiguities in health policy and the legal interpretations regarding prostitution, commercial sex work is still stigmatized and invisible in the health care system. While there are extensive programs that promote women's use of condoms to prevent HIV, commercial sex work is still illegal in Thailand. Women have to live with the conflict of becoming a sex worker and then being trapped in the stigma that cause them to keep their work secret. Not surprisingly, the findings showed that women feared disclosing information about themselves and their work status. As a consequence, women tend to ignore their health problems and delay seeking care. Thus, a health care policy should be developed for this population based upon recognition of women's rights and an understanding of the nature and conditions of sex work. Health policies need to change from control to support. This may assist women to come out of hiding and seek health care without the fear of disclosing themselves as sex workers.

Advocating Community Health Care Providers

In addition, policy makers need to give more credit to staff who work with this population in the community. During data collection, participant observation, and discussion with the staff, I found that these community caregivers were conflicted about the way they provided services to sex workers. They were unclear about whether they should support and advocate for commercial sex workers or control them in order to protect the image of the country. They were limited in their ability to articulate and share

in-depth or inside data with policy makers. In my contact with caregivers who worked with commercial sex workers, I found that most of them went out on their own time to distribute condoms because they felt that the women needed their assistance. They also wished to maintain government contact with these women and their establishments. However, they have never been acknowledged by policy makers for their efforts to continue to access this population. Therefore, there is a need for policy makers to acknowledge the community staff.

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APPENDIX A

DEMOGRAPHIC QUESTIONNAIRES

1. How old are you?.....
2. Originally, where were you from?.....(Province/City)
3. What is your marital status?
   - A Single/ Never married
   - B Married
   - C Have partner
   - D Separated/ Divorced
   - E Widowed
4. Where do you live now?.....In what type of housing do you live?.....
5. How many children currently live in your household?.....
6. How many adults (including yourself) currently live in your household?.....
7. Do you still contact you parents/ family? YES/ NO
   How often?.....which way? .....
8. How many years of education have you had?
   - No education
   - Primary school 1 2 3 4 5 6
   - High school 1 2 3 4 5 6
   - College/ Vocational 1 2 3 4
   - University 1 2 3 4
   - Other.....
9. What is your religion?.....what kind of religious activities do you do?.....
10. What is your monthly income?.....
11. Do you have other sources of income besides this work ? YES / NO
12. Is your income sufficient to meet your basic requirements?
    - A. Not enough income for family need
    - B. Barely enough income for family
    - C. Adequate income but no frills
    - D. Adequate income and some frills
    - E. More than adequate income
13. Do you have to give financial support to your parent? YES / NO
14. What is the source of medical expense that you have?.....
15 When you are in troubles or need any help, who do you talk/ go to?.....
16. Who do you go to when you have health problems?.....

ข้อมูลส่วนตัวทั่วไป

1. ตอนนี้อายุเท่าไร
2. บ้านเดิมอยู่จังหวัดอะไร(บ้านเกิดจังหวัดเดียวกันหรือเปล่า?, ถ้าไม่ใช่ จังหวัด...)
3. สถานภาพสมรส
    1. โสด / ไม่เคยแต่งงาน
    2. แต่งงานแล้ว มีลูก...คน
    3. อยู่ด้วยกัน
    4. แยก / หย่า
    5. หม้าย
4. ขณะนี้พักอยู่ที่ไหน...บ้านที่พักเป็นแบบไหน?
5. จำนวนบุตรที่พักอยู่ร่วมกับท่านในบ้านเดียวกัน...คน เด็กอื่น(ที่ไม่ใช่บุตร)...คน
6. จำนวนผู้ใหญ่ที่พักอยู่กับท่านในบ้านเดียวกัน (รวมตัวท่านเอง)...คน
7. กรณีที่ไม่อยู่กับ พ่อแม่, ท่านยังติดต่อกับ พ่อ แม่ อยู่หรือไม่ ☐ติดต่อ ☐ไม่ติดต่อ บ่อยแค่ไหน...ติดต่อด้วยวิธีใด
8. เรียนหนังสือจบชั้นอะไร
    - ไม่เคยเรียน
    - ระดับประถม 1 2 3 4 5 6
    - ระดับมัธยม 1 2 3 4 5 6
    - วิทยาลัย / อาชีวะ 1 2 3 4
    - มหาวิทยาลัย 1 2 3 4
    - อื่นๆ...
9. นับถือศาสนาอะไร...ทำกิจกรรมอะไรทางศาสนาบ้าง...
10. รายได้ส่วนตัวจากงานนี้เดือนละประมาณ...บาท
11. มีแหล่งรายได้จากที่อื่นอีกหรือไม่ ☐มี ☐ไม่มี
12. รายได้ทั้งหมดแต่ละเดือนเพียงพอกับค่าใช้จ่ายหรือไม่
    1. รายได้ไม่พอ
    2. รายได้เกือบไม่พอ
    3. รายได้พอเพียง แต่ไม่มีเงินเก็บ
    4. รายได้เกินพอ และมีเหลือเก็บ
    5. รายได้เกินพอ

13 ต้องส่งเสีย พ่อ แม่ หรือพี่น้องหรือไม่ ☐ ส่งเสีย ☐ ไม่ส่งเสีย

14 เวลาไม่สบาย ใช้เงินจากส่วนไหนมาหาหมอ

15 เวลาที่มีเรื่องเดือดร้อนไม่สบายใจท่านปรึกษา หรือได้รับความช่วยเหลือจากใคร...

16 เวลาที่ไม่สบาย/ มีปัญหาเรื่องสุขภาพท่านปรึกษาหรือได้รับความช่วยเหลือจากใคร...

APPENDIX B

PERCIEVED WORK CONDITIONS

1. What made you decide to work in sex work?
   - A. Helping parent
   - B. Helping siblings
   - C. Raising children
   - D. Obtaining good income
   - E. Being forced
   - 11. Other.....
2. In what did you work before working as a commercial sex worker?
   - A. Never worked
   - B. Agriculture
   - C. Construction
   - D. Factory
   - E. Sales
   - F. Waitress
   - G. others.....
3. How do you get to this work?
   - A. Introduced by friends
   - B. Self-arranged
   - C. Owner of establishment arranged
   - D. Agent or Middle men
   - E. Forced
   - F. Other.....
4. What types of establishment do you work in?
   - A. Local brothel
   - B. Hotels and motels
   - C. Tea-room
   - D. Massage-parlors
   - E. Bars, night-clubs, A-GO-Go bars, cocktail-lounges
   - F. Street walker
   - E. Other places.....
5. Is this establishment the first place you worked? YES/NO
6. Why do you have to change the place you work?.....
7. How long have you been working as a CSW?.....
8. What time you usually work? From.....To..... How many hours per day?.....
9. How many customers do you have to see per night?.....Per month?.....
10. Can you make a choice to see or not to see your customer? YES/ NO
11. Have you ever experienced violence in your work? YES/ NO
    By whom?.....
    How ?.....
    How often?.....
12. On the scale of one to ten, how stressed are you in your work ?

1	2	3	4	5	6	7	8	9	10

Not at all Very Stressed

13. How satisfied are you in your work?

1	2	3	4	5	6	7	8	9	10

Not at all Very Satisfied

14. Do you think this is a secure job? YES/ NO

ข้อมูลด้านอาชีพ

1. ทำไมมาทำงานนี้ (ถ้ามีมากกว่า 1 ข้ออะไรคือเหตุผลที่สำคัญที่สุดที่ทำให้ตัดสินใจมาทำงานในอาชีพนี้)
   1. ช่วยเหลือพ่อแม่
   2. ช่วยเหลือพี่น้อง
   3. เลี้ยงดูบุตร
   4. มีรายได้ดี
   5. ถูกบังคับ, ล่อลวง
   6. อื่นๆ...
2. เคยทำงานอะไรมาก่อนที่จะมาทำงานนี้
   1. ไม่เคยทำงาน
   2. เกษตรกรรม
   3. ก่อสร้าง
   4. โรงงาน
   5. ขายของ
   6. พนักงานเสริฟ์
   7. อื่น(ระบุ)...
3. เข้ามาทำงานนี้ได้อย่างไร
   1. เพื่อนแนะนำ
   2. ตัดสินใจทำเอง
   3. เจ้าของสถานประกอบการ
   4. นายหน้า หรือ คนกลาง
   5. ถูกบังคับ
   6. อื่นๆ(ระบุ)...
4. ประเภทสถานบริการที่ทำอยู่
   1. สำนักค้าประเวณี
   2. โรงแรม/ โมเต็ล
   3. โรงน้ำชา
   4. สถานบริการอาบ อบ นวด
   5. บาร์,ไนต์คลับ,บาร์อโกโก้,คอคเทลเล้าจ์
   6. เตร็ดเตร่ตามถนน
   7. อื่นๆ(ระบุ)
5. ทำงานที่นี่เป็นแห่งแรก ☐ ใช่ ☐ ไม่ใช่
6. เปลี่ยนที่ทำงานเนื่องจาก...
7. ทำงานอาชีพนี้มานาน...
8. โดยทั่วไปคุณทำงานตอนไหน ... ถึง...วันละ...ชั่วโมง
9. ในช่วง 1 เดือนที่ผ่านมา รับแขกโดยเฉลี่ยวันละ... คน
10. คุณเลือกที่จะรับแขก ได้หรือไม่ ☐ได้ ☐ไม่ได้
11. เคยถูกทำร้าย หรือถูกรังแก จากการทำงานหรือไม่ ☐ เคย ☐ ไม่เคย
    จากใคร_____อย่างไร_____ บ่อยแค่ไหน_____
12. จากคะแนน 1 ถึง 10 ท่านรู้สึกเครียดในงานที่ทำอยู่ ในระดับใด

1	2	3	4	5	6	7	8	9	10

ไม่เครียดเลย เครียดมากที่สุด

13. จากคะแนน 1 ถึง 10 ท่านรู้สึกพึงพอใจในงานบริการที่ทำอยู่ ในระดับใด

1	2	3	4	5	6	7	8	9	10

ไม่พึงพอใจเลย พึงพอใจมากที่สุด

14. คุณคิดว่างานนี้มั่นคงหรือไม่ ☐ มั่นคง ☐ ไม่มั่นคง

APPENDIX C

HEALTH PRACTICES

Within the past three months Have you	YES	NO	if answer "yes" How often? And Amount?
1. Drink alcohol			
2. Smoke			
3. Take a drug to help you relax or sleep			
4. Exercise			
5. Use any methods of pregnancy/ sexually transmitted disease prevention			if answer 'yes,' ask question 10, if answer 'No' skip question 10
6. Get evaluative internal exam (Only for participants from community)			if answer 'yes' ask question 12
7. Ask your clients if they've had sexually transmitted disease			-
8. Had pap smear			When is the last time?

10. What types of contraceptive methods that did you use?
    A. None
    B. Pill
    C. Injection
    D. IUD
    E. Norplant
    F. Condom
    G. Other.....
11. What types of STDs prevention methods that did you use?
    A. None
    B. Pill
    C. Injection
    D. IUD
    E. Norplant
    F. Condom
    G. Other.....
12. How many times during the last five times with a client that did you use a condom? .....
13. How often you get evaluative internal exam?
    A. One a week or more
    B. Less than once a week but more than once a month
    C. Once a month
    D. Only when having symptoms
    E. Never
14. Have you ever gotten pregnant? Yes/ no,
15 Number of pregnancies.....
16. Have you ever had abortion? Yes/ no
17. Number of abortions.....

พฤติกรรมสุขภาพ

ในช่วง 3 เดือนที่ผ่านมา	YES	NO	ถ้าตอบYES, บ่อยแค่ไหน? จำนวนเท่าไหร่?
1.ดื่มแอลกอฮอล์			
2.สูบบุหรี่			
3.ใช้ยาเพื่อช่วยให้ผ่อนคลายหรือนอนหลับ			
4.ออกกำลังกาย			
5.ใช้วิธีคุมกำเนิด/ป้องกันการติดโรคทางเพศสัมพันธ์			ถ้าตอบ YES ถามคำถามข้อ 10
6.ตรวจภายใน			ถ้าตอบ YES ถามคำถามข้อ 12
7.ถามแขกเกี่ยวกับการมีโรคทางเพศสัมพันธ์			
8.ตรวจมะเร็ง			

10. ท่านใช้วิธีใดในการคุมกำเนิด
    1. ไม่ได้ใช้ 5. ฝังเข็ม
    2. ยากิน 6. ถุงยางอนามัย
    3. ยาฉีด 7. อื่นๆ...
    4. ใส่ห่วง
11 ท่านใช้วิธีใดในการป้องกันการติดโรคทางเพศสัมพันธ์
    1. ไม่ได้ใช้ 5. ฝังเข็ม
    2. ยากิน 6. ถุงยางอนามัย
    3. ยาฉีด 7. อื่นๆ...
    4 ใส่ห่วง
12. ในช่วงที่รับแขก (มีเพศสัมพันธ์) 5 ครั้งล่าสุด ได้ใช้ถุงยางอนามัยกี่ครั้ง...
13. ท่านไปตรวจภายในบ่อยแค่ไหน
    1. อาทิตย์ละครั้งหรือมากกว่า
    2. น้อยกว่าอาทิตย์ละครั้ง แต่มากกว่าเดือนละครั้ง
    3. เดือนละครั้ง
    4. เฉพาะตอนที่มีอาการ
    5. ไม่เคยตรวจ
13. เคยตั้งครรภ์หรือไม่ ☐ เคย ☐ ไม่เคย
14. จำนวนการตั้งครรภ์..ครั้ง
15. เคยแท้งหรือไม่ ☐ เคย ☐ ไม่เคย
16. จำนวนที่แท้ง...ครั้ง

APPENDIX D

IMPORTANCE OF HEALTH

On the same scale, how important is your health to you?

1 2 3 4 5 6 7 8 9 10

Not at all Extremely Important

How much do you agree with these following statements?

If you don't have your health you don't have anything

Strongly disagree	Disagree	Somewhat disagree	Uncertain	Somewhat agree	Agree	Strongly agree

There are many things I care about more than my health.

Strongly disagree	Disagree	Somewhat disagree	Uncertain	Somewhat agree	Agree	Strongly agree

Good health is of only minor importance in a happy life.

Strongly disagree	Disagree	Somewhat disagree	Uncertain	Somewhat agree	Agree	Strongly agree

There are a few things more important than good health.

Strongly disagree	Disagree	Somewhat disagree	Uncertain	Somewhat agree	Agree	Strongly agree

ความสำคัญของสุขภาพ

1. จากคะแนน 1 ถึง 10 เช่นเดิม ท่านคิดว่าสุขภาพมีความสำคัญต่อท่านมากเพียงใด?

1	2	3	4	5	6	7	8	9	10

ไม่สำคัญเลย — สำคัญมากที่สุด

ท่านเห็นด้วยแค่ไหนกับข้อความต่อไปนี้

2. ถ้าสุขภาพไม่ดี ชีวิตก็หมดความหมาย

เห็นด้วยอย่างยิ่ง	เห็นด้วย	ค่อนข้างเห็นด้วย	ไม่แน่ใจ	ไม่ค่อยเห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง

3. ในชีวิตฉัน มีเรื่องอื่นที่ต้องนึกถึงก่อนเรื่องสุขภาพตัวเอง

เห็นด้วยอย่างยิ่ง	เห็นด้วย	ค่อนข้างเห็นด้วย	ไม่แน่ใจ	ไม่ค่อยเห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง

4. สุขภาพที่ดี มีความสำคัญน้อยกว่าเรื่องอื่นในชีวิตเรา

เห็นด้วยอย่างยิ่ง	เห็นด้วย	ค่อนข้างเห็นด้วย	ไม่แน่ใจ	ไม่ค่อยเห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง

5. แทบไม่มีอะไรเลยในชีวิตฉันที่สำคัญเท่าการมีสุขภาพที่ดี

เห็นด้วยอย่างยิ่ง	เห็นด้วย	ค่อนข้างเห็นด้วย	ไม่แน่ใจ	ไม่ค่อยเห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง

APPENDIX E

GENERAL HEALTH QUESTIONNAIRES

Have you recently:				
1. Been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
2. Been feeling in need of a good tonic?	Not at all	nomore than usual	Rather more than usual	Much more than usual
3. Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
4. Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
5. Been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
6. Been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
7. Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
8. Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
9. Had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
11. Been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
13. Found everything getting on top og you?	Not at all	No more than usual	Rather more than usual	Much more than usual
14. Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
15. Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
16. Been taking longer over the things your do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
17. Felt on the whole you were doing thing well?	Better than usual	About the same	Less well than usual	Much less well

18. Been satisfied with the way you've carried out your task?	More satisfied	About the same as usual	Less satisfied than usual	Much less satisfied
19. Felt that you're playing a useful part in things?	More so than usual	Same as usual	Les useful than usual	Much less useful
20. Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
21. Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
22. Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
23. Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
24. Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
25. Thought of the possibility that you might make do with your self?	Definitely not	I don't think so	Has crossed my mind	Definitely has
26. Found at times you couldn't do anything because you nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
27. Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
28. Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A_____ B_____ C_____ D_____ Total_____

แบบสอบถามสุขภาพทั่วไป GHQ-28

คำชี้แจง เราต้องการทราบว่าท่านเคยมีอาการอย่างใดอย่างหนึ่งหรือไม่ และสุขภาพของท่านเป็นอย่างไรในช่วง *สองสามสัปดาห์ที่ผ่านมามิใช่ผ่านมาในอดีต* โปรดตอบคำถามทุกข้อโดยบอกคำตอบที่ท่านเห็นว่าเป็นความจริงสำหรับท่านมากที่สุด

ในระยะนี้ท่าน				
1. รู้สึกว่าสุขภาพของท่าน	ดีกว่าเดิม	เหมือนเดิม	แย่กว่าเดิม	แย่กว่าเดิมมาก
2. รู้สึกว่าโดยทั่วไปท่านทำกิจกรรมต่างๆได้	ดีกว่าเดิม	เหมือนเดิม	แย่กว่าเดิม	แย่กว่าเดิมมาก
3. รู้สึกว่าต้องการยาบำรุง	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
4. รู้สึกอ่อนแอและทรุดโทรมลง	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
5. รู้สึกว่าไม่สบาย	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
6. มีอาการปวดศรีษะ	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
7. รู้สึกหนักหรือมึนศรีษะ	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
8. มีอาการหนาวๆร้อนๆเป็นพักๆ	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
9. นอนไม่หลับเพราะว่ากังวล	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
10. ตื่นแล้วไม่สามารถหลับต่อได้	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
11. รู้สึกตึงเครียดตลอดเวลา	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
12. รู้สึกฉุนเฉียวและอารมณ์ไม่ดี	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
13. กลัวหรือตื่นตระหนกโดยไม่มีเหตุผล	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
14. รู้สึกว่าทุกสิ่งทุกอย่างสุมทับเข้ามา	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
15. รู้สึกหงุดหงิดและกระวนกระวายตลอดเวลา	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
16. มีกิจกรรมทำและไม่อยู่ว่าง	มากกว่าเดิม	เท่าเดิม	น้อยกว่าเดิมเล็กน้อย	น้อยกว่าเดิมมาก
17. ใช้เวลานานในการทำกิจกรรมต่างๆ	มากกว่าเดิม	เท่าเดิม	น้อยกว่าเดิมเล็กน้อย	น้อยกว่าเดิมมาก
18. พอใจในวิธีปฏิบัติงานที่ทำไปแล้ว	มากกว่าเดิม	เท่าเดิม	น้อยกว่าเดิมเล็กน้อย	น้อยกว่าเดิมมาก
19. รู้สึกว่าตนเองเป็นประโยชน์ในกิจกรรมต่างๆ	มากกว่าเดิม	เท่าเดิม	น้อยกว่าเดิมเล็กน้อย	น้อยกว่าเดิมมาก
20. รู้สึกว่าตนเองมีความสามารถในการตัดสินใจ	มากกว่าเดิม	เท่าเดิม	น้อยกว่าเดิมเล็กน้อย	น้อยกว่าเดิมมาก
21. มีความสุขในกิจวัตรประจำวัน	มากกว่าเดิม	เท่าเดิม	น้อยกว่าเดิมเล็กน้อย	น้อยกว่าเดิมมาก
22. รู้สึกว่าตนเองเป็นคนไม่มีค่า	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
23. รู้สึกว่าชีวิตหมดความหวังโดยสิ้นเชิง	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
24. รู้สึกว่าชีวิตไม่น่าอยู่	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
25. มีความคิดว่าเป็นไปได้เหมือนกับที่ท่านจะฆ่าตัวตาย	ไม่คิดแน่นอน	ไม่คิดอย่างนั้น	คิดบ้าง	คิดแน่นอน
26. บางครั้งท่านไม่สามารถทำอะไรได้เพราะสภาพจิตใจแย่มาก	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
27. อยากตายให้พ้นๆไป	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม
28. มีความคิดฆ่าตัวตายเข้ามารบกวนใจอยู่เรื่อยๆ	ไม่เลย	ไม่มากกว่าเดิม	มากกว่าเดิมเล็กน้อย	มากกว่าเดิม

คะแนน A [ ] B [ ] C [ ] D [ ] รวม [ ]

APPENDIX F

PHYSICAL HEALTH PROBLEMS

Now I would like to ask you more about your health?
Within the past three-month, did you have any illness or health problem?
1. Have you ever had any of these problems?

1. Headache
2. Peptic/ stomachache
3. Low Back Pain
4. Difficulty in breathing
5. Chest pain
6. Varicose veins
7. Fatigue
8. Difficulties in hearing and seeing
9. Abnormal menstruation
10. Abnormal vaginal discharge
11. Vaginal itching
12. Genital ulcer with rash and itching
13. Pain in uterus
14. Infection of the uterus
15. Pain in the uterus during sexual intercourse
16. Vaginal pain during sexual intercourse
17. Frequent urination
18. Blood in urine
19. Never had symptom

2. Within the last three months, have you ever had these diseases or have you ever been told by the doctor that you have these diseases?

1. Cold
2. Peptic Ulcer
3. Heart Disease
4. Diabetes
5. Thyroid
6. Kidney disease
7. Liver Disease
8. Seizures
9. Neurological Problems
10. Orthopedics
11. Syphilis
12. Herpes
13. Gonorrhea
14. Genital warts
15. Pelvic Inflammatory Disease
16. Trichomonias
17. canchoi
18. HIV
19. Other STDs (Chlamydia)
20. No disease diagnosis
21. Sick but never see a doctor

Perceived Health Status

I would like to ask some questions about your health

On the scale of one to ten, how would you rate your health right now?

1	2	3	4	5	6	7	8	9	10
My health is poor								My health is excellent	

ปัญหาสุขภาพ

ตอนนี้จะขอถามเพิ่มเติมเกี่ยวกับเรื่องสุขภาพในช่วง 3 เดือน ที่ผ่านมา

1. เคยป่วย หรือ มีปัญหาอะไรบ้าง (ตามความรู้สึกของตัวเอง)

1. ปวดศรีษะ
2. โรคกระเพาะ / ปวดท้อง
3. ปวดหลัง
4. หายใจลำบาก
5. เจ็บหน้าอก
6. เส้นเลือดขอด
7. อ่อนเพลีย (อ่อนล้า)
8. มีความลำบากในการได้ยิน และการมองเห็น
9. ประจำเดือนผิดปกติ
10. มีสิ่งขับหลั่งผิดปกติออกทางช่องคลอด
11. คันในช่องคลอด
12. มีผื่นคันที่บริเวณอวัยวะสืบพันธุ์
13. ปวดมดลูก (ปวดท้องน้อย)
14. มดลูกอักเสบ
15. เจ็บ หรือ ปวดระหว่างที่มีเพศสัมพันธ์
16. เจ็บในช่องคลอดระหว่างที่มีเพศสัมพันธ์
17. ถ่ายปัสสาวะบ่อย
18. มีเลือดออกในปัสสาวะ
19. ไม่เคยมีอาการผิดปกติ

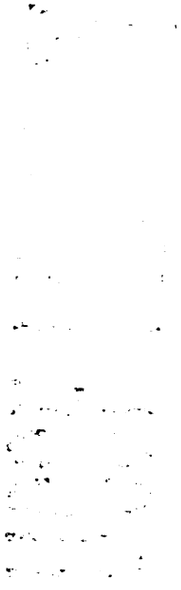
2. ในช่วง 3 เดือนที่ผ่านมา เคยป่วยด้วยโรค หรือ หมอวินิจฉัยว่าเป็นโรคต่อไปนี้หรือไม่

1. ไข้หวัด
2. โรคกระเพาะ
3. โรคหัวใจ
4. เบาหวาน
5. โรคไทรอยด์
6. โรคไต
7. โรคตับ
8. โรคลมชัก
9. โรคทางระบบประสาท / สมอง
10. โรคกระดูก
11. ซิฟิลิส
12. เริม
13. หนองใน
14. หูดที่อวัยวะสืบพันธุ์
15. พยาธิในช่องคลอด
16. อุ้งเชิงกรานอักเสบ
17. แผลริมอ่อน
18. เอช ไอ วี
19. โรคอื่นๆ...
20. ไม่เคยป่วยด้วยโรคใดๆ
21. ป่วยแต่ไม่ได้พบแพทย์

จากคะแนน 1 ถึง 10 สุขภาพของท่านอยู่ในระดับไหน?

1 2 3 4 5 6 7 8 9 10

แย่, ไม่ดีที่สุด ดีเยี่ยม



APPENDIX G

INTERVIEW GUIDE

The interview will start with referring to the health problems that women have. For example, you said you have stomach pain

1. How many times have you had this?
2. When was the last time?
3. A) Is there some thing that made it easy for you to get this illness?
   B) Why do you think you got it?
   C) How did you get it?
4. What did you think when you first experience that symptoms? And Why?
5. What do you think caused these symptoms?
6. What did you do in the first place? And why?
   -Did you contact anyone else about your health/ illness?
   -What did they tell you or expect you to do?
7. What did you do next? Anything made it better or worse?
8. Have you ever self-medicated?
9. How did you get this medication and the information about it?
10. Where do you usually get care for health problems?
11. What would stop you from seeking care for a health problem that you might be having?
12. When and where did you decide to seek care from health professional? And what made you decide?
13. How has the illness/ symptoms affected your work?
14. How has the illness/symptoms affected your life?
15. Who do you talk to about health or health problems?

Refer to the score in the first question then ask

16. You said, your rate your health at....., can you tell me why?
17. What does being healthy mean to you?
18. How do you take care of your health? Or What do you do to keep yourself healthy?
    -Do you take any medicine, herbs, vitamins, or nutrition supplement for your health?
19. Is there any thing you do to try to prevent illness?
20. How do you prevent yourself from getting STDS/HIV?

<u>Meaning of work</u>

21. How do you think about your work?
22. Do your family know about your work? What does your family think about your work?
23. What do you have to do as part of this job?.....
24. In general, compared to your health before entering sex work, do you think your health is better or worse now?
25. What caused that change?
26. Compared to women in other professions, Do you think your health is better, worse or the same as their health? And in what way? And why?
27. How do you think sex workers receive care differently from other women?
28. What would you like me to tell the person who may provide health care to you?

แบบสัมภาษณ์ ตอนที่สอง

INTERVIEW GUIDE

การสัมภาษณ์เริ่มโดยอ้างถึงปัญหาสุขภาพที่ตอบไว้ในช่วงแรก ตัวอย่างเช่น

คุณบอกว่ามีอาการปวดท้อง

1. มีอาการนี้มากี่ครั้งแล้ว?
2. เป็นครั้งสุดท้ายเมื่อไหร่?
3. คิดว่ามีอะไรทำให้เป็นโรคนี้ได้ง่าย, ทำไมถึงคิดว่าเป็นโรคนี้ ?, เป็นได้อย่างไร?
4. คิดอย่างไรตอนที่มีอาการครั้งแรก? ทำไม?
5. คิดว่าอาการนี้มีสาเหตุมาจากอะไร?
6. ทำอะไรเป็นอย่างแรก? ทำไม?
   - ติดต่อหรือปรึกษาใครเกี่ยวกับสุขภาพ/ อาการเจ็บป่วยที่เป็นอยู่บ้าง?
   - เขาบอก หรือ เขาคาดหวังว่าคุณต้องทำอะไรบ้าง
7. แล้วทำอย่างไรต่อ? (เมื่อไม่ได้ผล) มีอะไรทำให้อาการ/ โรคที่เป็นอยู่แย่ลงหรือไม่?
8. ท่านเคยหายามากินเอง/ รักษาตัวเองหรือไม่?
9. ได้ยา หรือข้อมูลเกี่ยวกับยานี้มาจากไหน?
10. โดยทั่วไปไปหาหมอ หรือไปรักษาที่ไหนเวลาที่มีปัญหาสุขภาพ?
11. อะไรทำให้เลิก, หยุดการรักษาอาการที่เป็นอยู่
12. คิดว่าจะไปรักษา หรือหาหมอ เมื่อไหร่ และที่ไหน? ใช้อะไรเป็นเกณฑ์ในการตัดสินใจ
13. โรค/ อาการที่เป็นอยู่มีผลกระทบต่องานที่ทำอยู่หรือไม่? อย่างไร?
14. โรค/ อาการที่เป็นอยู่มีผลกระทบต่อชีวิต หรือไม่? อย่างไร?
15. ใครบ้างที่ท่านคุยด้วยในเรื่องสุขภาพ หรือปัญหาสุขภาพ

อ้างถึงคะแนนในการสัมภาษณ์ช่วงแรก

16. คุณบอกว่า สุขภาพทั่วไปอยู่ในระดับ..... บอกได้ไหมว่าทำไม?
17. สุขภาพดีสำหรับคุณ หมายความว่าอย่างไร?
18. คุณดูแลสุขภาพตนเองอย่างไร?
19. มีวิธี/ อะไรบ้างที่พยายามทำเพื่อป้องกันความเจ็บป่วย?
20. คุณป้องกันตนเองอย่างไรไม่ให้ได้รับโรคติดต่อทางเพศสัมพันธ์/ เอช ไอ วี

Meaning of Work

21. คุณคิดอย่างไรบ้างเกี่ยวกับงานที่ทำอยู่?
22. ครอบครัวรู้รือไม่เกี่ยวกับงานที่ทำ? ครอบครัวคุณคิดอย่างไรบ้างเกี่ยวกับงานที่ทำอยู่?
23. คุณต้องทำอะไรบ้างในงานที่ทำอยู่?
24. โดยทั่วๆไป, เปรียบเทียบกับตอนก่อนที่จะมาทำงานขายบริการทางเพศ, คุณคิดว่าสุขภาพของตัวเองในตอนนี้ ดีขึ้น หรือว่าแย่ลง?
25. อะไรเป็นสาเหตุที่ทำให้เปลี่ยน?
26. เมื่อเปรียบเทียบกับผู้หญิงที่ทำงานอาชีพอื่นๆ, คุณคิดว่าสุขภาพของตัวเองดีกว่า, แย่กว่า หรือว่าเหมือนๆสุขภาพของเขา? ในด้านไหน? ทำไม?
27. คิดว่าผู้หญิงที่ให้บริการทางเพศได้รับการดูแล/ บริการทางด้านสุขภาพต่างจากผู้หญิงอื่นๆ หรือไม่ อย่างไร? ในแง่ไหน?
28. มีอะไรที่อยากให้บอกกับคนที่อาจจะให้การดูแลคุณทางด้านสุขภาพ?

APPENDIX H

INFORMATION SHEET

My name is Ameporn Ratinthorn. I was born, raised, and educated in Thailand. Currently, I am a doctoral student in the School of Nursing, University of California-San Francisco, U.S.A.. Dr. Afaf Meleis, a professor of at School of Nursing, University of California-San Francisco, U.S.A. and I are conducting a study on the experience of health care among female commercial sex workers, to understand how women take care of their health and how they seek and receive health care. The researchers hope that knowledge gained from this study may help nurses and other health care providers give better care to women who are sex workers in the future. To complete this study, we need your participation.

Your participation in this study is completely voluntary. You may decline to answer any questions that make you feel uneasy and/or withdraw from interview at any time.

If you agree to participate in this study, you should call Ms Ameporn at # 877-7198 to make an appointment for an interview. The interview consists of two parts will last approximately an hour and a half to two hours. You may decide to participate only in the first part or in both parts.

During the interview, you will be asked several questions about yourself, your work and your health care seeking experience. This interview will be tape recorded and transcribed.

Participation in the research may involve a loss of privacy. However, all information obtained from the interviews will be treated as confidentially as possible. No record will be kept of your name.

Your name will not be stated on the tape and the tape will be destroyed after the study is completed. No names or individual identities will be used in any reports or publications resulting from the study.

The results from this study may not benefit you directly but may be useful to many other sex workers and health care providers in the future. This study will help us understand what women like you think about health and how they seek health care.

You will not be charged for your participation but will receive one-hundred-baht in cash when you complete the interview.

If you have questions or concerns about this study, you can call me at 877-7198. If you need to know the advantage and disadvantage of the interview or to have a comments about your participation, you can contact Dr. Tassana Boontong, Dean of Faculty of Nursing Siriraj, or Dr. Siriorn Sindhu, Assistant Dean at 419-5017 during 8.00-16.00 from Monday to Friday.

การเสาะหาวิธีการดูแลรักษาสุขภาพในกลุ่มหญิงบริการ

ดิฉัน นางสาวเอมพร รตินธร ดิฉันเป็นพยาบาลที่เกิดและได้รับการศึกษาในเมืองไทย ขณะนี้กำลังศึกษาอยู่ในระดับปริญญาเอกสาขาพยาบาลที่มหาวิทยาลัยแคลิฟอร์เนีย-ซานฟรานซิสโก ดิฉันได้ร่วมมือกับศาสตราจารย์ ดร. เมลลิส อาจารย์ผู้ทรงคุณวุฒิในสาขาพยาบาลที่มหาวิทยาลัยแห่งเดียวกันนี้ ทำการวิจัยในหัวข้อเรื่อง "แบบแผนพฤติกรรมการเสาะหาวิธีการดูแลทางด้านสุขภาพในกลุ่มหญิงบริการ" โดยความรู้ที่ได้จากการทำวิจัยครั้งนี้คาดว่าจะเป็นประโยชน์อย่างยิ่งต่อพยาบาลและผู้ให้การดูแลทางด้านสุขภาพที่จะนำไปใช้ในการดูแลรักษาหญิงบริการได้ดีขึ้นในอนาคต เพื่อที่จะทำให้บรรลุวัตถุประสงค์ดังกล่าว การวิจัยนี้ต้องการความร่วมจากท่านเป็นอย่างยิ่ง

การให้ความร่วมมือครั้งนี้ขึ้นอยู่กับความสมัครใจของท่าน โดยท่านมีสิทธิที่จะปฏิเสธที่จะตอบคำถามใดๆ ที่ทำให้ท่านรู้สึกอึดอัด หรือไม่สะดวกใจ

หากท่านสนใจที่จะให้ความร่วมมือในการวิจัยครั้งนี้ กรุณาติดต่อดิฉัน นางสาวเอมพร รตินธร ที่หมายเลข 877-7198 เพื่อนัดหมายเวลาในการสัมภาษณ์ การสัมภาษณ์มีอยู่ด้วยกันสองตอน โดยการสัมภาษณ์จะใช้เวลาประมาณ 1.30-2.00 ชั่วโมง ท่านสามารถเลือกให้สัมภาษณ์เพียงตอนที่ 1 หรือทั้งสองตอนของแบบสอบถาม

ท่านจะต้องตอบคำถามหลายคำถามเกี่ยวกับประสบการณ์ในการทำงานและ การเสาะหาวิธีการดูแลรักษาสุขภาพของท่าน การสัมภาษณ์ทั้งสองตอนจะถูกบันทึกไว้ และนำมาถอดเทปในภายหลัง

คำถามบางคำถามในการสัมภาษณ์อาจล่วงล้ำเรื่องราวส่วนตัวของท่าน อย่างไรก็ตามข้อมูลที่ได้จากการสัมภาษณ์จะถูกเก็บไว้เป็นความลับ จะไม่มีการบันทึกชื่อของท่าน และเราจะทำลายเทปบันทึกหลังจากการวิจัยสิ้นสุดลงจะไม่มีการอ้างถึงชื่อของท่านในรายงานหรือการเผยแพร่ข้อมูลใดๆ ที่ได้มาจากการศึกษาในครั้งนี้

ผลที่ได้จากการวิจัยในครั้งนี้ถึงแม้มิได้เป็นประโยชน์ต่อท่านโดยตรง แต่จะเป็นประโยชน์อย่างยิ่งต่อผู้ให้การการดูแลทางด้านสุขภาพ และหญิงบริการท่านอื่นๆในอนาคต เพราะการศึกษาในครั้งนี้จะช่วยให้เราเข้าใจถึงความคิดเกี่ยวกับสุขภาพ และการเสาะหาวิธีการดูแลรักษาสุขภาพของหญิงบริการ

การร่วมมือในการวิจัยครั้งนี้ ท่านจะไม่เสียค่าใช้จ่ายใดๆทั้งสิ้น แต่จะได้รับการตอบแทนเป็นเงินสดจำนวน 100 บาทหากท่านให้ความร่วมมือในการตอบแบบสอบถาม และให้สัมภาษณ์ในการวิจัย

ในกรณีที่ท่านมีคำถามหรือข้อสงสัยใดๆเกี่ยวกับการวิจัยนี้ ท่านสามารถติดต่อสอบถามดิฉันได้ที่หมายเลข 877-7198 ถ้าท่านต้องการปรึกษาถึงข้อดี ข้อเสีย ต้องการขอความเห็นหรือมีข้อคับข้องใจในการร่วมมือครั้งนี้ ท่านสามารถติดต่อ ดร. ทัศนา บุญทอง คณบดีคณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดลหรือ ดร. ศิริอร สินธุ ผู้ช่วยคณบดีได้ที่หมายเลข 419-5017 ในระหว่างเวลา 8.00-16.00 ทุกวันจันทร์-ศุกร์

เอมพร รตินธร

วันที่.....

APPENDIX I

SUMMARY TABLES OF DEMOGRAPHIC AND WORK CONDITIONS

Table A.1: Demographic profiles of participants by type of establishment

		N	Mean	S.D.	Min	Max
Age	Hotels & Tea-houses	20	37.40	9.32	25	56
	Massage-parlors	22	29.45	8.51	18	48
	Bars & cocktail-lounges	21	25.29	5.20	18	36
	Beer bars & A-go-go	19	24.68	4.81	18	39
	Street walkers	10	30.00	7.72	18	42
	Others	8	28.50	6.57	22	40
	Total	100	29.24	8.43	18	56
Number of Children	Hotels & Tea-houses	20	1.65	1.35	0	5
	Massage-parlors	22	.77	.92	0	3
	Bars & cocktail-lounges	21	.86	1.06	0	4
	Beer bars & A-go-go	19	.47	.77	0	2
	Street walkers	10	1.30	1.06	0	3
	Others	8	1.38	1.30	0	4
	Total	100	1.01	1.12	0	5
Education	Hotels & Tea-houses	20	4.45	2.68	0	9
	Massage-parlors	22	6.45	2.79	2	12
	Bars & cocktail-lounges	21	8.67	2.56	6	14
	Beer bars & A-go-go	19	6.89	2.58	0	12
	Street walkers	10	4.00	1.70	0	6
	Others	8	7.38	3.20	2	12
	Total	100	6.43	3.02	0	14
Income	Hotels & Tea-houses	20	9325.00	6947.69	500	30000
	Massage-parlors	22	19113.64	10197.96	5000	36000
	Bars & cocktail-lounges	21	16452.38	8390.33	7000	40000
	Beer bars & A-go-go	19	15868.42	8455.51	2000	36000
	Street walkers	10	10800.00	14053.86	3000	50000
	Others	8	18875.00	17125.07	5000	56000
	Total	100	15130.00	10539.16	500	56000

Table A.2: Structural Descriptions of Sex Work Establishments

Types of establishment	Types of activities	Patterns of incomes	Place sexual activities performed	Customers	Risk involved	Initiating contact	Regulations
Hotel	Only sexual activities	"Off", Tip Not direct sharing profit (mean = 9,500 Bht)	Inside or another hotel nearby	Thai male-working class,	Condom breaks; Refusal to pay, stealing, and sadistic customers	By sex worker	None
Teahouse	Sexual activities and Massage (in some cases)	"Off" and Tip Sharing profit (170/ 70) (mean = 9,181 Bht)	Inside establishment	Thai male-working class	Condom breaks; Rude and drunk customers	Being select by customers from glass-window	None
Massage Parlor	Massage and sexual activities	Salaries and Hour service paid (share profit with owner) and Tip (mean = 19,113 Bht)	Inside establishment	Thai males working to middle class and foreigners	Drunk and sadistic; refusal to pay; condom breaks	Being selected by customers from glass-window	Health check & # of working hours
Bars & Cocktail lounge	Providing company by sitting and drinking and/ or sexual activities	Salaries, "Off", Tip, Drinks Share profit with owner for Off, and drink (mean = 16,175 Bht)	Outside establishment at hotels nearby	Thai male middle class and foreigners	Sadistic; refusal to use condom; condom breaks	By sex workers	Health check, limited day off & No. of working hours, required No. of time of "Off"
Bar-beer & A-go-go bar	Providing company by sitting and drinking and/ or sexual activities and dance only in A-go-go bar	Salaries, "Off", Tip, Drinks Share profit with owner for "Off" (mean = 10,850 Bht)	Outside establishment at hotels nearby	Foreigners	Condom breaks; Sexual assault; sadistic; rude; and drunk customers	By sex worker	Health check, limited day off & # of working hour, require # of time of "Off"
Streetwalker	Sexual activities or providing company	"Off", Tip (mean = 10,800 Bht)	Hotel nearby the area	Thai male working class and foreigners	Being raped, rude, sadistic and drunk customers; condom breaks	By sex worker	None
Other Freelance	Singing (only in café group), providing company, and sexual activities	"Off", Tip (mean = 18,875 Bht)	Outside establishment at hotels nearby	Thai male middle class and foreigner	Customers refuse to pay	Either by sex worker or customer	None

"Off" is a term used among sex workers to refer to money obtained from a customer in exchange for sexual intercourse

Table A.3: Experience and Conditions of Work by Types of Establishment

		N	Mean	S.D.	Min	Max
Number of years in Sex work	Hotel & Tea-house	20	8.24	8.15	.08	33.00
	Massage-parlors	22	3.40	3.28	.08	11.00
	Bar & cocktail-lounge	21	1.30	1.27	.08	5.75
	Bar-beers & A-go-go	19	3.17	3.82	.17	12.00
	Street walker	10	7.80	5.67	2.00	18.00
	Others	8	2.35	1.69	.08	4.50
Number of hours/day	Hotel & Tea-house	20	9.58	3.07	5.00	15.00
	Massage-parlors	22	7.16	1.60	5.50	13.00
	Bar & cocktail-lounge	21	9.36	3.24	5.50	19.00
	Bar-beers & A-go-go	19	7.42	1.30	4.00	11.00
	Street walker	10	10.00	5.64	4.00	24.00
	Others	8	7.94	1.90	6.00	11.00
Number of customers /night	Hotel & Tea-house	20	2.08	1.36	1	5
	Massage-parlors	22	2.27	1.08	1	4
	Bar & cocktail-lounge	21	1.10	.30	1	2
	Bar-beers & A-go-go	19	1.00	.00	1	1
	Street walker	10	2.55	1.54	1	6
	Others	8	1.38	.74	1	3
Number of customers /month	Hotel & Tea-house	20	40.65	32.77	2	120
	Massage-parlors	22	46.41	26.21	4	90
	Bar & cocktail-lounge	21	10.81	5.22	4	20
	Bar-beers & A-go-go	18	9.58	6.25	1	20
	Street walker	10	41.50	28.87	5	100
	Others	7	20.57	23.01	2	60
Level of stress in Work	Hotel & Tea-house	20	4.50	2.37	1	10
	Massage-parlors	22	5.27	2.21	1	10
	Bar & cocktail-lounge	21	5.81	1.94	2	10
	Bar-beers & A-go-go	19	5.63	3.22	1	10
	Street walker	10	6.80	3.55	1	10
	Others	8	6.50	3.16	1	10
Level of satisfaction in work	Hotel & Tea-house	20	5.30	3.05	1	10
	Massage-parlors	22	5.95	2.44	1	10
	Bar & cocktail-lounge	21	5.38	2.60	1	10
	Bar-beers & A-go-go	19	6.32	2.06	3	10
	Street walker	10	3.70	2.83	1	10
	Others	8	5.75	2.12	3	10
Balance of satisfaction and stress in work	Hotel & Tea-house	20	.80	3.86	-9	9
	Massage-parlors	22	.68	3.80	-8	9
	Bar & cocktail-lounge	21	-.43	3.06	-6	5
	Bar-beers & A-go-go	19	.68	3.59	-5	9
	Street walker	10	-3.10	4.58	-9	3
	Others	8	-.75	4.98	-6	9

Table A.4 : Pearson Correlation: Demographic and Health Status Variables

		AGE	NUMCHIL	EDUCATE	INCOME	PARSUP	PHS	GHQTOTAL	SYMPTOT
AGE	Correlation	1.000	.554**	-.416**	-.344**	-.227	.044	-.081	-.138
	Sig. (2-tailed)	.	.000	.000	.000	.023	.666	.425	.172
	N	100	100	100	100	100	100	100	100
NUMCHIL	Correlation	.554**	1.000	-.299**	-.193	.048	.000	.003	.011
	Sig. (2-tailed)	.000	.	.003	.055	.636	.997	.976	.917
	N	100	100	100	100	100	100	100	100
EDUCATE	Correlation	-.416**	-.299**	1.000	.375**	.124	-.079	-.208	-.053
	Sig. (2-tailed)	.000	.003	.	.000	.218	.436	.038	.601
	N	100	100	100	100	100	100	100	100
INCOME	Correlation	-.344**	-.193	.375**	1.000	.249	.037	-.034	.116
	Sig. (2-tailed)	.000	.055	.000	.	.012	.716	.739	.248
	N	100	100	100	100	100	100	100	100
PARSUP	Correlation	-.227	.048	.124	.249	1.000	-.059	.000	.245
	Sig. (2-tailed)	.023	.636	.218	.012	.	.563	.999	.014
	N	100	100	100	100	100	100	100	100
PHS	Correlation	.044	.000	-.079	.037	-.059	1.000	-.553**	-.402**
	Sig. (2-tailed)	.666	.997	.436	.716	.563	.	.000	.000
	N	100	100	100	100	100	100	100	100
GHQTOTAL	Correlation	-.081	.003	-.208	-.034	.000	-.553**	1.000	.538**
	Sig. (2-tailed)	.425	.976	.038	.739	.999	.000	.	.000
	N	100	100	100	100	100	100	100	100
SYMPTOT	Correlation	-.138	.011	-.053	.116	.245	-.402**	.538**	1.000
	Sig. (2-tailed)	.172	.917	.601	.248	.014	.000	.000	.
	N	100	100	100	100	100	100	100	100

**. Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

Table A.5: Pearson Correlation: Work condition and Health Status Variables

		EXTIME	HOUR	NUMCUSN	NUMCUSM	CHOICE	VIOLENCE	BALANCE	PHS	GHQTOTAL	SYMPTOT
EXTIME	Correlation	1.000	.096	-.049	-.008	.215*	-.027	.105	-.062	.100	.048
	Sig. (2-tailed)	.	.344	.629	.936	.032	.788	.297	.537	.320	.635
	N	100	100	100	98	100	100	100	100	100	100
HOUR	Correlation	.096	1.000	.023	.053	.016	.075	.091	.026	-.196	-.084
	Sig. (2-tailed)	.344	.	.824	.605	.876	.458	.368	.795	.050	.405
	N	100	100	100	98	100	100	100	100	100	100
NUMCUSN	Correlation	-.049	.023	1.000	.866	-.041	.045	.029	-.042	-.099	.094
	Sig. (2-tailed)	.629	.824	.	.000	.686	.658	.775	.676	.325	.350
	N	100	100	100	98	100	100	100	100	100	100
NUMCUSM	Correlation	-.008	.053	.866	1.000	-.055	-.018	.011	.099	-.126	.077
	Sig. (2-tailed)	.936	.605	.000	.	.592	.857	.915	.335	.216	.452
	N	98	98	98	98	98	98	98	98	98	98
CHOICE	Correlation	.215*	.016	-.041	-.055	1.000	.183	-.082	-.314	.204*	.154
	Sig. (2-tailed)	.032	.876	.686	.592	.	.068	.415	.001	.042	.126
	N	100	100	100	98	100	100	100	100	100	100
VIOLENCE	Correlation	-.027	.075	.045	-.018	.183	1.000	-.267	-.242*	.333	.425
	Sig. (2-tailed)	.788	.458	.658	.857	.068	.	.007	.015	.001	.000
	N	100	100	100	98	100	100	100	100	100	100
BALANCE	Correlation	.105	.091	.029	.011	-.082	-.267	1.000	.191	-.442	-.159
	Sig. (2-tailed)	.297	.368	.775	.915	.415	.007	.	.057	.000	.113
	N	100	100	100	98	100	100	100	100	100	100
PHS	Correlation	-.062	.026	-.042	.099	-.314	-.242*	.191	1.000	-.553	-.402
	Sig. (2-tailed)	.537	.795	.676	.335	.001	.015	.057	.	.000	.000
	N	100	100	100	98	100	100	100	100	100	100
GHQTOTAL	Correlation	.100	-.196	-.099	-.126	.204*	.333	-.442	-.553	1.000	.538
	Sig. (2-tailed)	.320	.050	.325	.216	.042	.001	.000	.000	.	.000
	N	100	100	100	98	100	100	100	100	100	100
SYMPTOT	Correlation	.048	-.084	.094	.077	.154	.425	-.159	-.402	.538	1.000
	Sig. (2-tailed)	.635	.405	.350	.452	.126	.000	.113	.000	.000	.
	N	100	100	100	98	100	100	100	100	100	100

*. Correlation is significant at the 0.05 level (2-tailed). **. Correlation is significant at the 0.01 level (2-tailed).

APPENDIX J

Human Subjects Approval

COMMITTEE ON HUMAN RESEARCH
OFFICE OF RESEARCH AFFAIRS, Box 0962
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
http://www.ucsf.edu/ora

CHR APPROVAL LETTER

TO: Afaf I. Meleis, Ph.D.
Box 0608

Ameporn Ratinthorn
1560 8th Ave. Apt.#A
San Francisco, CA 94122

RE: The Patterns of Health Care Seeking Behavior: Female Commercial Sex Workers in Thailand

The Committee on Human Research (CHR), the UCSF Institutional Review Board (IRB) holding Department of Health and Human Services Multiple Project Assurance #M-1169, has reviewed this application to involve humans as research subjects. All items attached to the blue original copy of this letter were reviewed. The study was approved with the conditions described below.

CONDITION: Please respond in writing in a timely manner. First, the members approved a waiver of signed consent for this study. Second, when other institutions or departments are involved in a study, letters of support from those sites, indicating knowledge and endorsement of the project, are requested. In this case, letters from the clinic or community based sites used for subject recruitment should be submitted to the CHR before begins at each site. Third, the members asked that you provide more detailed information about how data from study will be analyzed. Please submit two copies of your response and letters of support to Box 0962. Once these copies have been received and accepted, the status of this protocol will be changed from Conditional Approval to Approval.

APPROVAL NUMBER: H879-16341-01.This number is a UCSF CHR number and should be used on all correspondence, consent forms and patient charts as appropriate.

APPROVAL DATE: May 13, 1999. **Expedited Review**

EXPIRATION DATE: May 13, 2000. If the project is to continue, it must be renewed *by the expiration date*. See reverse side for details.

ADVERSE EVENT REPORTING: All problems having to do with subject safety must be reported to the CHR within ten working days. All deaths, whether or not they are directly related to study procedures, must be reported. Please review Appendix A of the CHR *Guidelines* for additional examples of adverse events or incidents which must be reported.

MODIFICATIONS: Prior CHR approval is required before implementing any changes in the consent documents or any changes in the protocol which affect subjects.

QUESTIONS: Please contact the office of the Committee on Human Research at (415) 476-1814 or campus mail stop, Box 0962, or by electronic mail at chr@itsa.ucsf.edu.

Sincerely,

Arthur Ablin

Arthur R. Ablin, M.D.
Chairman
Committee on Human Research

COMMITTEE ON HUMAN RESEARCH
OFFICE OF RESEARCH ADMINISTRATION, Box 0962
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
www.ucsf.edu/ora/chr

CHR APPROVAL LETTER

TO: Afaf I. Meleis, Ph.D.
Box 0608

Ameporn Ratinthorn
1560 8th Ave. Apt.#A
San Francisco, CA 94122

RE: The Patterns of Health Care Seeking Behavior: Female Commercial Sex Workers in Thailand

The Committee on Human Research (CHR), the UCSF Institutional Review Board (IRB) holding Department of Health and Human Services Multiple Project Assurance #M-1169, has reviewed and approved this application to involve humans as research subjects. This included a review of all documents attached to the original copy of this letter.

APPROVAL NUMBER: H879-16341-02 .This number is a UCSF CHR number and should be used on all correspondence, consent forms and patient charts as appropriate.

APPROVAL DATE: April 26, 2000. **Expedited Review**

EXPIRATION DATE: April 26, 2001. If the project is to continue, it must be renewed *by the expiration date*. See reverse side for details.

ADVERSE EVENT REPORTING: All problems having to do with subject safety must be reported to the CHR within ten working days. All deaths, whether or not they are directly related to study procedures, must be reported. Please review Appendix A of the CHR *Guidelines* for additional examples of adverse events or incidents which must be reported.

MODIFICATIONS: Prior CHR approval is required before implementing any changes in the consent documents or any changes in the protocol which affect subjects.

QUESTIONS: Please contact the office of the Committee on Human Research at (415) 476-1814 or campus mail stop, Box 0962, or by electronic mail at chr@itsa.ucsf.edu.

Sincerely,

Reese Jones

Reese T. Jones, M.D.
Chair
Committee on Human Research