A Focused Ethnography of Indigenous Women Accessing Healthcare Services in Northern and Rural Thailand

by

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Abstract

There is far ranging evidence indicating that access to healthcare services is not equitable in Thailand, particularly among disadvantaged populations like Indigenous women. What has yet to be explored is Indigenous women's access to, and experiences of, the Thai healthcare system. In particular, the impact of multiple intersecting influences and the ways in which these intersecting identities and structural barriers interlock to affect healthcare decisions, and the ability of Indigenous women to obtain the care they need, has not been well documented in the literature. The purpose of this focused ethnographic research study was to explore the experiences of Indigenous women's access to healthcare in northern and rural Thailand, in order to acquire a deeper understanding of the complexity of culture and the effects of multiple intersecting influences, including structural forces, on a given phenomenon.

Findings suggest that many if not most Indigenous women experience difficulties and challenges accessing healthcare, which occurred both at the individual and structural levels. The impact of influences within the context of the women's lives—gender norms and roles, race/ethnicity, socioeconomic status, citizenship, rural geography, cultural discrimination and insensitivity, and previous negative experiences with the healthcare system – was understood as intersecting and shaping women's decisions to seek healthcare in ways that deterred access. Given the magnitude of the issue and of the unique difficulties and challenges in accessing equitable healthcare reported by women in this study, the recommended policy, practice, education, and research directions and strategies set forth in this study will affect change and give voice to this underserved population.

Preface

This dissertation is an original work by Onouma Thummapol. The research project, of which this thesis and manuscripts are a part, received ethics approval from the University of Alberta Research Ethics Board, Project Name “A Focused Ethnography of Indigenous Women Accessing Healthcare Services in Northern Thailand,” No. Pro00070620_REN1 (Renewal), February 27, 2017 -February 14, 2019. Furthermore, ethics approval was obtained from Assumption University in Bangkok, Thailand. The three manuscripts contained herein were prepared by Onouma Thummapol and at this time, one is published (Chapter 2), and the other two are in various stages of peer review for publication, with the supervisory committee as co-authors. Chapter 2 of this thesis has been published as O. Thummapol, T. Park, and S. Barton, “Exploring Health Services Accessibility by Indigenous Women in Asia and Identifying Actions to Improve It: A Scoping Review, *Ethnicity & Health*, 1-20. O. Thummapol designed and led drafting and revisions of the manuscript. T. Park and S. Barton substantially contributed to the design of the study and revisions of the manuscript for intellectual content.

Dedication

This dissertation is dedicated to Indigenous women in Thailand who have participated in this study. Thank you for sharing many intimate experiences of your lives and trusting me with your stories.

กิตติกรรมประกาศ

ความสำเร็จของวิทยานิพนธ์ฉบับบนี้ ผู้วิจัยขอมอบแด่หญิงชนเผ่าพื้นเมืองไทใหญ่ในประเทศไทยที่เข้าร่วมโครงการวิจัยในครั้งนี้
และขอขอบพระคุณผู้เข้าร่วมโครงการวิจัยทุกท่านที่ให้ความไว้ใจและกรุณาแบ่งปันเรื่องราวชีวิตและประสบการณ์ของท่านที่เป็นประโยชน์สำหรับการวิจัยครั้งนี้ เป็นผลให้วิทยานิพนธ์ฉบับนี้สำเร็จลุล่วงได้

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They say, “It takes a village to raise a child.” The significance of this statement never really resonated with me until I got into the heat of a PhD program. I have come to understand that although writing a dissertation and finishing a PhD is a very substantial piece of independent work, it also takes a whole village or even universe to succeed in it. I would like to acknowledge those individuals who were a part of my village and shared in this journey with me.

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List of Abbreviations

AIPP	Asia Indigenous Peoples Pact
CEDAW	Committee on Elimination of Discrimination Against Women
CMA	Canadian Medical Association
HCTSC	Harvard Clinical and Translational Science
ICESCR	International Covenant on Economic, Social, and Cultural Rights
IWNT	Indigenous Women Network of Thailand
IASG	Inter-Agency Support Group
NCCAH	National Collaborating Centre for Aboriginal Health
NIPT	Network of Indigenous Peoples in Thailand
NMBA	Nursing and Midwifery Board of Australia
OHCHR	Office of the High Commissioner for Human Rights
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UN IASGIS	United Nations Inter-Agency Support Group on Indigenous Peoples’ Issues
UNPFII	United Nations Permanent Forum on Indigenous Issues
WHO	World Health Organization

Glossary of Terms

Access to Healthcare:	The ability of an individual to gain access to and timely use of appropriate healthcare (World Health Organization [WHO], 2015a), encompassing the quality of services provided at point of care (Cameron et al., 2014).
Culture:	The patterns of beliefs, values, and way of life that are learned and transmitted by a particular group of people and guides their behaviors and norms (Leininger & McFarland, 2010).
Cultural Safety:	A concept first developed in New Zealand to acknowledge and address inequities in healthcare status and delivery among Indigenous populations (Ramsden, 2002). This concept has continued to evolve and expand beyond Indigenous peoples to address the needs of a wide range of individuals from diverse cultural backgrounds, ethnic minority, disadvantaged and oppressed groups (De & Richardson, 2008; McCall & Pauly, 2012; Wilson & Neville, 2009).
Culturally Safe Practice:	Actions that represent the importance of respecting and accepting difference and an understanding of power differentials inherent in the delivery of health services (Nursing and Midwifery Board of Australia [NMBA], 2018).
Ethnicity:	Ethnicity refers to “the shared social, cultural, and historical experiences, stemming from common national or regional backgrounds, that make [individuals or groups] different from one another” (Barkan, 2012, p. 107).
Equity of Access:	The fair and just distribution of resources, whereby the care provided is based on need and does not vary in quality (Bowen, 2001).
Gender Equality:	It implies the full and equal realization of women’s and girls’ rights and commitment to eliminate all forms of discrimination contributing to health risks and lack of access to resources essential for health attainment (United Nations SDGs [UN SDGs], 2015; UN Women, 2018; WHO, 2015b).

Health Equity:	The absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO, 2016).
Health Inequity:	Inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes and a failure to avoid or overcome inequalities that infringe on fairness and human rights norms (WHO, 2016).
Indigenous Women/People in Northern Thailand:	Peoples who are officially labeled as 'hill tribes or ethnic minorities' by the Thai government (Roy, 2005; UN, 2015).
Intersectionality:	A theoretical perspective that deepens an understanding of the influence of various social characteristics/identities (e.g., race, ethnicity, gender, class, and socioeconomic status) on individuals and groups; and aids in examining the interrelating social relations of domination and oppression, and how they operate along different axes to shape health experiences and outcomes (Hankivsky et al., 2010).
Marginalized:	Marginalization refers to "a sense of being overlooked, categorized or misrepresented," in which creates conditions contributing to vulnerabilities and influences the capacity of individuals to access and utilize resources for health (Lynam & Cowley, 2007, p. 146).
Race:	This term refers to "a category of people who share certain inherited physical characteristics, such as skin color, facial features, and stature" (Barkan, 2012, p. 101).
Racism:	National Collaborating Centre for Aboriginal Health (NCCAH) (2014) argues that racism is "a social injustice based on falsely constructed, but deeply embedded, assumptions about people and their social value; it is often used to justify [inequities] in the distribution of resources" (p. 1). More specifically, structural racism found within healthcare systems causes harm to Indigenous peoples' health and well-being and often translates

	into delay and diminished utilization of health services.
Right to Health:	Grounded within a broad definition of health, and rooted in human rights and the ethical principles of dignity, equality and non-discrimination, this right implies legal obligations of countries to provide equality of opportunity for everyone to enjoy the highest attainable level of health, including access to healthcare services and resources (UN, 2000; WHO, 2008).
Underserved:	Underserved, in this paper, implies a lack of adequate provision of health services to individuals and groups who belong to a certain population (Bowen, 2001).
Vulnerability/ Vulnerable Populations:	Individuals and groups who are "…susceptible to being harmed, wronged, exploited, mistreated, discriminated against or taken advantage of in the context of health and research" (Ganguli-Mitra & Biller-Andorno, 2011, p. 239).
Statelessness:	A condition whereby a person is not considered a national by any State under the operation of its law (United Nations High Commission for Refugees [UNHCR], 2010, p. 2).

Chapter 1: Introduction

> Imagine being born in Thailand but having no national identity.... Imagine your application to be a person with rights and civil liberties just left on the desk of a provincial officer for twenty years, collecting dust. Imagine the lives of over 100,000 [Indigenous peoples] living in Thailand – a home that still sees them as a threat to national security.
>
> --Stuart, 2016

Thailand is a Southeast Asian country well known as a holiday destination for many people. Thailand has 76 provinces covering an area of 513,120 square kilometers, with a population of approximately 68 million people. Of the total population, there are about one million Indigenous peoples living in rural areas of northern Thailand. In the capital city of Bangkok where 14 million people live, is where I grew up.

Growing up in Bangkok and living in a poor urban area where many of our neighbors were marginalized, committed crimes or sold drugs, and had children out of wedlock, I felt I had been as exposed to distress and traumatic events to some degree. I am the middle child in my family, I have an older sister and a younger sister, and my parents worked extremely hard and long hours each day so that we could go to school. I was fortunate enough to finish high school, to attend university, and to secure decent employment. I was also able to obtain medical care when needed. In relation to our community neighbors, about ten percent were from diverse cultural and ethnic backgrounds, and most if not all, had illegally moved from northern rural villages to seek work. At the time, I had minimal interactions with them, yet I witnessed their struggles settling within the city, while simultaneously having limited or no access to education, employment, and health services. This situation was noticeably worse among the women, many of whom lived in poverty, were vulnerable to violence and mistreatment, and subjected to forced labor and sexual exploitation. They had much less than the relatively ‘poor’ within the dominant residential community. This led me to consider the lives of socially and economically disadvantaged peoples more deeply, especially those of Indigenous women. Most recently, I realized that having experienced my early life beginnings in a relatively poor and culturally diverse community had inspired and shaped my chosen career and research path of today.

Upon the completion of my undergraduate nursing degree, I worked in healthcare in Thailand as a registered nurse. I also traveled to northern Thailand whenever possible because I enjoyed visiting the mountains. I worked in a large maternity hospital in Bangkok where people would come from all over Thailand to receive maternal health services. It was during this time that I met Thai women from the northern villages. I began to appreciate that when caring for them, not all northern village women were receiving equitable healthcare. Based on my perceptions of working with these women, they tended to have low income and health literacy, experienced a disproportionate burden of poor health and living conditions, and faced greater difficulties in obtaining the healthcare they needed compared to the mainstream Thai population. Most, if not all, of the women sought medical care late in their illness trajectory and often failed to return for any follow-up care. In addition, women from diverse racial/ethnic groups, generally, were most likely to experience discriminatory attitudes or behaviors from healthcare providers across the healthcare system, contributing to their experience of negative relational encounters. Such negative healthcare experiences can prevent or deter Indigenous patients from seeking necessary care and subsequently create dire consequences (UN, 2015). Thus, I came to understand that many Thai Indigenous women in my own country are unable to reach their full enjoyment of life through the rights to health. Their voices, views, and experiences are not being heard.

Not many people travel from major Thai cities to the rural villages bordering the areas between Thailand and Myanmar, where the majority of Indigenous peoples live in poor conditions. It is in these highlands, where isolated villages are located, public transportation is not available, and basic healthcare and social services are not sufficiently provided or accessible, that provided the context of my PhD work. I conducted my research in Mae Hong Son, the second most northern province of Thailand. I had chosen to focus the study on northern Thailand because of my interest in the rich cultural diversity and traditions of its hill tribe peoples, whom comprise the largest share of Indigenous peoples and ethnic groups in Thailand (Network of Indigenous Peoples in Thailand [NIPT], 2010). Specifically, the study focuses on the Tai-Yai village community, because it has been the most ignored and under researched group of people compared to other ethnic groups in Thailand (Cadchumsang, 2011). In addition, information on the health status and illness experiences of Tai-Yai people are scarce (Cadchumsang, 2011). Although previous studies have examined the health status or health outcomes of Indigenous peoples in northern Thailand (Apidechkul, 2016; Duangtep et al., 2010; Kritpetcharat et al., 2012; Phonklieng, 1999; Krit et al., 2015), these studies are largely quantitative in focus and do not necessarily include Tai-Yai village women. The non-inclusion of these women raises alarms related to the existence of health inequities experienced by this disadvantaged group within Thai healthcare systems.

In this study, my aim was to understand and gain deeper insights into the experience of Indigenous (Tai-Yai) women's access to healthcare services, the facilitators and barriers that exist, and the influence of cultural beliefs and practices on these experiences. My goal was to empower Indigenous women through a research engagement process that resulted in them understanding their experiences, gaining insightful knowledge into their human rights (including the right to healthcare and gender equality), and acting on strategies to improve their health. My research contributes to the literature through knowledge that informs greater comprehension and awareness of Indigenous women's health issues, of the complexity of culture, of access obstacles they face, and of specific healthcare services needed. By giving this at-risk population a voice, my research will assist stakeholders, such as policymakers and healthcare professionals who are responsible for the delivery of health services and the development of health interventions, to understand what is required, in order to provide non-discriminatory and equitable access to Thai Indigenous women. Thus, with improved healthcare access, beneficial health outcomes should follow for Indigenous women living in geographically isolated northern areas.

Background

According to WHO (2015a), everyone has "the right to [obtain] the highest attainable standard of health," which includes "access to timely, acceptable, and affordable healthcare of appropriate quality". Access to healthcare refers to the ability of an individual to gain access to and use of timely and appropriate healthcare, in order to achieve or improve health outcomes (WHO, 2015a). When it comes to culturally diverse and ethnic populations, access to healthcare also encompasses the quality of services provided at point of care (Cameron et al., 2014; Goddard & Smith, 2001). Yet, in contemporary society, the significant inequities in accessing health services that exist between Indigenous and non-Indigenous populations are widely recognized (UN, 2015). In other words, health inequities disproportionately affect Indigenous groups and pose serious public health threats (WHO, 2015a).

Health inequities, according to WHO (2016), "involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health, or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms". It is important to note that the terms health disparities and health inequities are used interchangeably, depending on the country. Health inequities is a term used throughout this paper because it: 1) focuses attention on the distribution of resources and, 2) carries ethical content and human rights in relation to health (Braveman, 2014). The terms health inequalities and health inequities are often confused and used synonymously; yet these terms are not interchangeable (Braveman & Gruskin, 2003). Definitions and distinctions between these terms can be found in the Glossary of Terms section at the beginning of this dissertation.

The greater burden of disease and rates of ill health fall more heavily on Indigenous populations in many parts of the world (WHO, 2015a). However, they are often less likely to enjoy the right to basic health services, while simultaneously facing a myriad of obstacles in accessing quality and equitable healthcare (UN, 2015; WHO, 2015a). While access to equitable and effective healthcare for Indigenous peoples remains a critical issue globally, the substantial disadvantage that Indigenous women face in accessing healthcare is far greater compared to Indigenous men (Van Herk, Smith, & Andrew, 2011). Indigenous women continue to be marginalized and discriminated against based on their gender, race, ethnicity, and poverty status (UN, 2007), in addition to other existing access barriers to health services.

Research suggests that there are significant differences in Indigenous women's access and utilization of health services in comparison to the rest of the population (Jose et al., 2014; Schooley, Mundt, Fullerton, & O'Donnell, 2009; Shah & Belanger, 2011). A recent UN's report (2015) reveals the growing gaps in health and healthcare access for Indigenous women in both developing and developed nations, with calls for urgent action to improve the quality of healthcare for women and to curb health inequities. Whereas some countries are gradually increasing and ensuring Indigenous women's access to quality and equitable healthcare, in general most countries are still lagging behind, particularly in Asia (Thummapol et al., 2018; UN, 2015).

Influence of Culture on Indigenous Women and Access to Healthcare

Culture is the patterns of behaviors, beliefs, values, and the way of life that are learned and transmitted by a particular group of people, which guide their norms and behaviors (Leininger & McFarland, 2010). Culture plays a significant role in the health and wellbeing of the population (Bussey-Jones & Genao, 2003; Napier et al., 2014). For instance, culture affects perceptions of health and illness, beliefs about the causes of illness or disease, health practices and health seeking-behaviors, and attitudes towards healthcare providers (Bussey-Jones & Genao, 2003; Harvey & Park, 2015; Russell & Jewell, 1992; Napier et al., 2014; Surood & Lai, 2010; Szczepura, 2005). For Indigenous peoples, it is widely recognized that cultural beliefs and practices are deeply linked to their overall health and wellbeing (UN, 2015; WHO, 2007). According to WHO (2007), it is estimated that about 80 percent of the Indigenous population, particularly in developing countries, rely heavily on traditional healing systems (e.g., traditional plants) and methods as their primary source of healthcare. In particular, culture plays a critical role in women's health practices, as well as their ability to seek medical attention (WHO, 2007; UN, 2015).

It is important, however, to recognize that Indigenous women are highly heterogeneous, representing great variations of culture; therefore, they often have different health needs, concerns, and interests. There are several important cultural beliefs and practices that can affect health and decisions to seek healthcare among Indigenous women (UN, 2015). For instance, in many Asian Indigenous communities, women are considered inferior to men and are often excluded from participation in decision-making processes (Asia Indigenous Peoples Pact [AIPP], 2014). The exclusion of women to participate in decision making within the family and community creates difficulties for Indigenous women to voice their concerns and needs, particularly in relation to their health and access to healthcare resources. As highlighted by the UN (2015), Indigenous women in Asia suffer disproportionately from poorer health than their male counterparts. However, they are less likely than men to access and seek needed care and treatment when they are ill, and are generally considered underserved by the healthcare system (UN, 2015).

The 1948 WHO definition of health, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," provides a clear explanation and is still relevant, today. For Indigenous peoples, health is often viewed from a holistic perspective that includes spiritual, mental, emotional, and physical health (UN, 2010). However, the holistic perspective is often the missing piece, particularly in relation to health and wellbeing. As Napier and colleagues (2014) proposed, the discarding of culture is the single biggest barrier to the improvement of health worldwide. Indeed, health cannot be improved without careful consideration of the context that people live in, and its effects on their health and desire to seek or not to seek healthcare (Hill, 2009; Libbey, 2007). To effectively and efficiently address the unique healthcare needs of ethnic groups, the cultural beliefs and practices of the people served should be better understood and acknowledged (Napier et al., 2014).

Given this, it is vitally important that nurses and allied healthcare providers, specifically those who are responsible for the delivery of healthcare services and working with Indigenous communities, to "become informed about and be sensitive to the culturally diverse subjective meanings of health, illness, caring, and healing practices” (Harvey & Park, 2015, p. 351). In addition, to improve the health situations of Indigenous women, their particular health needs, concerns and cultures should be central to the design of state health systems or programs. Understanding the complexity and differences of culture and its influence on the attitudes, beliefs, and practices of minority ethnic populations in particular, has the potential to eliminate inequities, increase access to quality healthcare, and ultimately improve health outcomes (Thomas, Fine, & Ibrahim, 2004).

The Current Health Status of and Access to Healthcare among Indigenous Women in Thailand

The concept of Indigenous peoples is not fully acknowledged in Thailand and some of the marginalized, ethnic minorities have not yet been fully recognized by the government (Dhir, 2015). This lack of recognition means that the disaggregated data on the status and health of Indigenous peoples in Thailand is hard to find. In addition, the majority of Indigenous peoples in Thailand live in rural and hard to reach areas with poor infrastructure (Dhir, 2015), where data collection may be considered difficult and expensive. The lack of disaggregated data makes it difficult to provide a detailed description of the health situation of the Indigenous peoples of Thailand. An important glimpse into this, however, is drawn from data available that helps to highlight their health status.

Indigenous women in Thailand are marginalized and excluded due to historical and contemporary experiences, and by being ethnic women who do not belong to the dominant groups (Indigenous Women’s Network of Thailand [IWNT], 2014). In fact, Indigenous women of Thailand are among the poorest in the population, living extremely below the poverty line and experiencing rising inequality (Dhir, 2015). They have traditionally been regarded and treated as dependents of their male relatives (Phonklieng, 1999; IWNT, 2014). As Phonklieng (1999) argued, Indigenous women of Thailand have less access to resources and opportunities (e.g., education, healthcare resources, and training activities), and are much less likely to have autonomy to make decisions, even when those decisions have a direct influence on themselves. Evidence suggests that Indigenous women in Thailand are more vulnerable to discrimination and violence in conflict situations (IWNT, 2014; UN, 2015). As noted by Kamler (2015), many Indigenous women in Thailand are subject to forced labor and sex trafficking. In fact, the trafficking of Indigenous women and its associated health problems of sexually transmitted diseases are of higher severity in Thailand (Kamler, 2015).

As with other Indigenous women across the globe, Indigenous women of Thailand experience multiple forms of discrimination and often have difficulties in obtaining full and timely access and use of healthcare services (Apidechkul, 2016; Cadchumsang, 2011). More specifically, Indigenous women of Thailand continue to suffer from a range of issues related to violations of their rights, such as lack of participation in decision-making processes; lack of control over income; lack of land rights; and lack of, or limited access to, education and healthcare services, which impose serious health consequences on them (IWNT, 2014; Kamler, 2015). A study conducted by Phonklieng (1999) on the health of Indigenous women in Thailand, for example, suggested that they tend to have lower life expectancy, and have higher rates of respiratory diseases, digestive problems, mental health disorders, drug addictions, and increasing incidence and prevalence of HIV/AIDS. Recent research by Apidechkul (2016) found that Indigenous peoples in Thailand, particularly women, are more vulnerable to infectious diseases such as HIV and tuberculosis. This largely stems from the discrimination that they experience, due to their status as Indigenous women, and lack of access to clinics where they could receive antiretroviral medication (Apidechkul, 2016).

In relation to health and culture, the majority of Indigenous peoples in Thailand still rely on traditional medicines and practices for their primary care needs (Srithi et al., 2012). This is especially notable among Indigenous women, for instance, where there are many traditional practices that are commonly used during pregnancy and the postpartum phase, such as dietary restrictions, herbal steam baths, and mother roasting (Srithi et al., 2012). In addition, the use of traditional medicinal plants to treat women's health conditions, such as dysmenorrhea, menorrhea, and female fertility are highly prevalent among Indigenous women residing in northern Thailand (Srithi et al., 2012). Yet, this traditional knowledge and these practices are largely ignored and undervalued by the public health sector (Srithi et al., 2012), as there has been little or no effort in recognizing or integrating Indigenous peoples' traditional knowledge and practices into mainstream healthcare systems.

In Thailand, it is suffice to say that healthcare is not uniformly accessible, as many health services are not equally distributed across the country. For Indigenous peoples, this is even worse as they often live in geographically isolated, rural areas where access to healthcare is limited or simply not available (Dhir, 2015). According to the UN (2015), over 100,000 Indigenous peoples in Thailand have no access to healthcare services. Similarly, the UNHCR's report (2010) reveals that 99 percent of Indigenous peoples living in northern Thailand are less likely than are dominant populations to access public health services, and 73 percent have not completed primary school. This demonstrates the inequity between Indigenous and the dominant population groups in Thailand. Indigenous women in particular disproportionately face an alarmingly high risk of experiencing inequities in health and access to healthcare, as they continue to be marginalized and discriminated against, while their particular concerns and perspectives have yet to be recognized (IWNT, 2014). In other words, in spite of the multiple challenges and difficulties facing Indigenous women, scant attention has been given to examining the experiences of those who are most affected by inequities in relation to healthcare access. As Peiris et al. (2008) asserted, “Indigenous perspectives on access barriers are poorly represented and undervalued in the scientific literature” (p. 985).

In recent years, there has been increased attention to the conditions contributing to poor health outcomes among socioeconomically challenged groups (Apidechkul, 2016; Duangtep et al., 2010; Kritpetcharat et al., 2012; Krit et al., 2015). However, previous research tends to be framed by a generic biomedical model and quantitative measurements that has not addressed the importance of culture and its influence. While this has partially allowed for a small window into understanding the status of Indigenous health, attention needs to be drawn to a broader approach; in order to sufficiently capture and understand Indigenous health that includes the influence of culture, as well as the root causes of inequities in health and access to healthcare. According to the UN’s report on the state of the world’s Indigenous peoples (2010), “The emphasis on quantitative measurements and the considerably less attention given to subjective judgments and cultural perceptions make these measurements less insightful and relevant” (p. 29).

Though Indigenous women are more vulnerable to inequities in health and experience access barriers to healthcare services, no research to date has focused on the perspectives of Thai Indigenous women. This dissertation explores the healthcare access experiences of Thai Indigenous women who are living within the complexities of culture, employing a focused ethnography. It also pays attention to issues related to the intersection of inequities in health and healthcare access based on the multiple influences (i.e., gender, cultural discrimination, citizenship, ethnicity, and geography) by utilizing an intersectionality perspective.

Significance of the Issue

As in other countries, Thailand is a nation where health inequities exist for different population groups, especially among ethnic minorities and Indigenous peoples (Dhir, 2015; Lutvey, 2014). Indigenous women, in particular, are more likely to experience multiple forms of cultural discrimination and oppression largely because of their Indigenous identity and gender, a so-called ‘double burden’ (Lutvey, 2014), creating an even greater barrier in their ability to access healthcare services. Despite that persistent inequities in health status and access to healthcare for Indigenous women represent serious concerns, there have been little or no efforts made to examine the experiences of those most affected by health inequities, including the influence of culture on, and the barriers preventing access to, healthcare (Cadchumsang, 2011; Dhir, 2015). Not only do the inequities in health and access to healthcare affect entrenched marginalized and disadvantaged groups, they also limit overall progress to improvements related to health outcomes and quality of care for the Thai population, generally (Artiga, 2016). As the population becomes more diverse, with people of ethnic minority and disadvantaged groups at higher risk of having poorer health outcomes, addressing inequities in health and healthcare access could not be more timely (Artiga, 2016; UN, 2015).

There have been increasing calls for health researchers to focus attention on such heavy health burdens among marginalized and disadvantaged groups like Indigenous women, in order to find ways to address multiple forms of discrimination, promote gender equality, and ultimately, reduce health inequities (UN, 2015). My doctoral work fits perfectly with the UN-Women global mandate to explore women’s rights to health (UN, 2014) and aligns with Sustainable Development Goal (SDGs) # 5, to reduce gender inequality and eliminate all forms of discrimination against women (UN SDGs, 2015), which is discussed in detail in the

Theoretical Perspectives section. The findings of my dissertation research study provide an understanding of the complexities inherent in the lives of Indigenous women, the intersection of discrimination based on multiple axes, and the obstacles faced in accessing needed healthcare services through the lens of subjective experience.

Understanding women’s perspectives and the multiplicity of intersecting influences on health status and access to healthcare provides culturally-specific knowledge for nurses and allied healthcare professionals, by which to develop culturally appropriate healthcare interventions and support services that may also increase access and utilization among Indigenous populations living in geographically rural areas. Thus, by providing culturally safe care that is valued by Indigenous populations may, in turn, increase services uptake, promote health outcomes, reduce unnecessary costs to healthcare, eliminate discrimination and inequities, and subsequently enhance the provision of healthcare.

Purpose of the Study

The purpose of this study was to explore the experiences of Indigenous women’s access to healthcare in northern and rural Thailand, in order to acquire a deeper understanding of the complexity of culture and the multiple intersecting influences on a given phenomenon.

Research Questions

This research study used questions to elicit an understanding of the inequities in health, and of the challenges in accessing healthcare services, for economically and socially marginalized Indigenous women living in northern and rural Thailand. The questions and resulting data are intended to add to the body of knowledge concerning access to healthcare and the influence of multiple intersecting components (e.g., lack of citizenship, health beliefs/practices, cultural discrimination, ethnicity, gender, geographical restrictions, and socioeconomic status) experienced by Indigenous Thai women. The primary research question guiding this study was: What are the experiences/perspectives of Indigenous women accessing healthcare services in rural and northern Thailand? Specifically, I was interested in further examining: (a) How do cultural beliefs and practices influence access to healthcare for Indigenous women?; (b) What do Indigenous women believe are the facilitators and the impediments to accessing quality healthcare?; (c) How do Indigenous women experience efforts to engage with healthcare providers in the healthcare system?; and (d) What are the challenges encountered in carrying out research with Indigenous women, particularly in relation to qualitative enquiry?

Context of the Study

Indigenous (Tai-Yai) People in Northern Thailand

There are many different Indigenous groups residing in rural highland areas of the northern parts of the country. However, the government has legally recognized only ten ethnic groups, leaving almost half of Thai Indigenous peoples, including Tai-Yai, stateless and subject to discrimination and the denial of basic human rights and social services (Dhir, 2015). It is important to note that, due to a lack of data specific to Tai-Yai women living in northern Thailand, I was only able to gather scarce information from limited source materials to briefly describe a demographic picture and characteristics of the Tai-Yai group living in Mae Hong Son province, the setting of my research.

Tai-Yai, generally known as the Shan - meaning big Thai, belongs to the well-established Tai ethnic groups of Southeast Asia. Though it appears that there is no clear history or legitimate evidence regarding the origin of the Tai-Yai, these people are believed to have originated in Yunnan, China (Cadchumsang, 2011). Tai-Yai people primarily lived and formed the largest group of Tai in the Shan State of North East Myanmar; therefore, they have been commonly referred to as ‘Shan’ (Conway, 2006). However, over the past few centuries (starting in the 13th and continuing sporadically through the 18th and 19th centuries), the Tai-Yai people have been forced to flee their lands and migrate to the border areas of present day northern Thailand (e.g., Mae Hong Son, Chiang Mai, Chiang Rai, and Tak provinces), mainly because of conflicts between the military’s government and ethnic minority insurgents in Myanmar (previously known as Burma) (Cadchumsang, 2011). These people had occupied the lands and, over time, established a permanent residence and community in northern Thailand (Cadchumsang, 2011). Figure 1.1 displays Tai-Yai villages across northern Thailand.

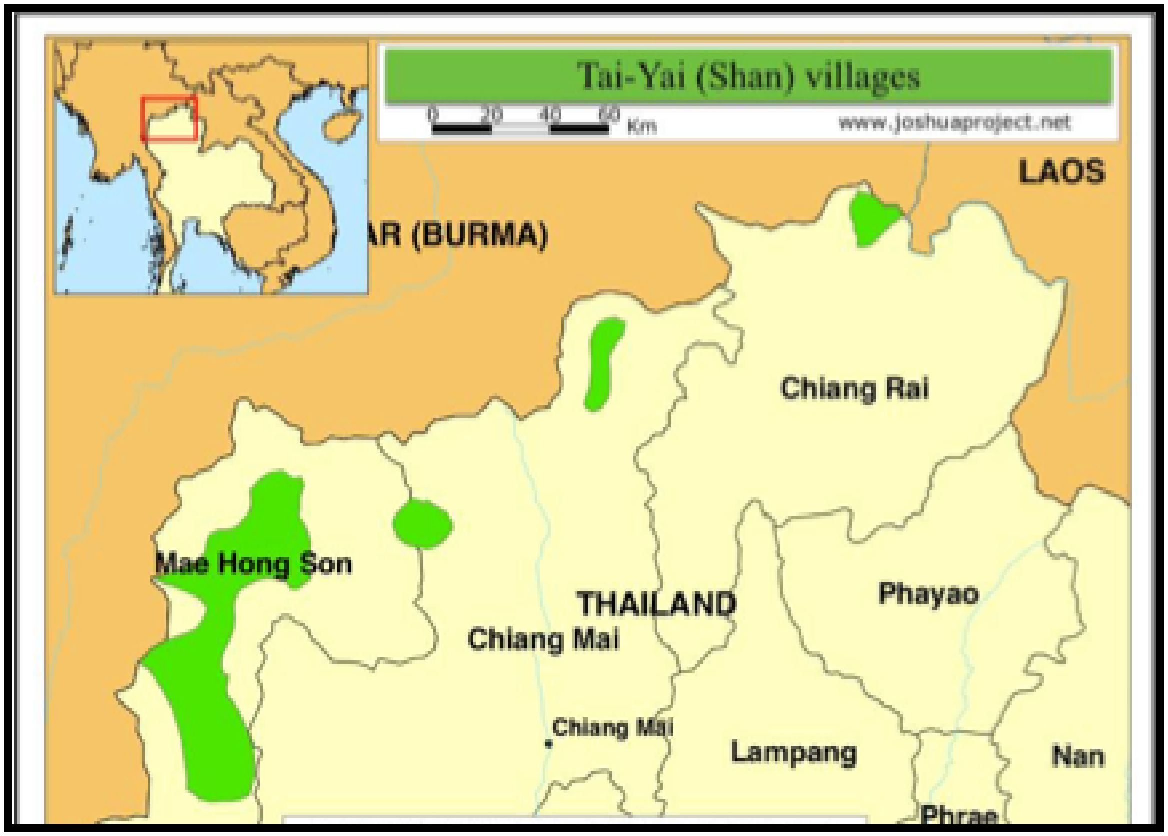

Figure 1.1. Tai-Yai (Shan) villages across northern Thailand
Source: Adapted from Global Mapping International, 2003

Mae Hong Son province of Thailand is home to ethnically and culturally diverse populations, particularly the Tai-Yai people, and has become one of the most desirable destinations for migration due to: 1) the favorably perceived geographical conditions at the border between Thailand and Myanmar - facilitating illegal and massive movements; and 2) the growth of the economy and labor shortages in Thailand - creating the pull conditions for people seeking employment (Cadchumsang, 2011). Although most of the Tai-Yai have migrated to Thailand over different periods of time, some are descended from original inhabitants prior to the creation of the Thai-Myanmar border, controlled by the present day Thailand government (Cadchumsang, 2011).

The arrival of most Tai-Yai people, however, did not comply with the regulatory arrangements for Thailand's immigration control. Consequently, they are excluded and left stateless, creating serious consequences for their existence. Even with a legitimate claim to Thai citizenship, in many cases this ethnic group is left without a nationality and is frequently classified into different non-Thai categories, mostly displaced people[1], in accordance with their migration background and survey registration periods (Cadchumsang, 2011). This is because they frequently have trouble proving their link to the country, and do not possess official documents tying them to Thailand, like birth registration (Cadchumsang, 2011). In fact, Indigenous women living and giving birth in the frontier areas, like Mae Hong Son province, where the government does not invest in basic healthcare services, are more likely to depend on a traditional midwife, due to their villages being too remote from which to travel to the hospital. As a result, they are particularly at-risk for not being registered at birth and for not being issued

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[1] Displaced people, issued a pink ID card, reference to those who are members of the following ethnic groups: the Mon, the Karen, the Tai-Yai, and the Burmese, and reside in Thai border provinces, including Mae Hong Son (Cadchumsang, 2011).

identity documents (UNHCR, 2010). Most, if not all, of undocumented Tai-Yai people without Thai citizenship have difficulties living in Thailand; as they are not governed by the provisions to freedom of movement within a country, of seeking civil service jobs, or enjoying equal access to healthcare (Cadchumsang, 2011).

The Tai-Yai people generally speak a dialect of the Tai Kadai language family and still preserve their traditional customs, dialect, and clothing (Khuankaew et al., 2014). They base their economy and income on shifting cultivation, primarily in the production of rice and garlic (Khuankaew et al., 2014). They practice Buddhism - a philosophy and/or religion that was greatly influenced by the Burmese Buddhists. According to their traditions, an ordination ceremony called 'Poy Sang Long' is celebrated in honor of their religious beliefs each year, which is deemed important to their way of life (Thailand's World, 2016).

The right to self-identification. Indigenous peoples in Thailand are commonly referred to as 'hill tribes' or 'ethnic minorities' (Roy 2005; UN, 2015). Despite vigorous efforts of Indigenous groups to promote the use of the terms 'chon phao phuen mueang', meaning 'Indigenous peoples', this has been denied by the government of Thailand (Dhir, 2015). In recognition of the right to self-identification declared in the United Nations Declaration on the Rights of Indigenous Peoples (2015), this dissertation primarily uses the terms 'Indigenous women' and/or 'Indigenous peoples' to represent those who are officially labeled as 'hill tribes or ethnic minorities' by the Thai government. I completely agree with the claims made by the United Nations Declaration on the Rights of Indigenous Peoples, below, that place more emphasis on the broader contexts of peoples regarded as 'Indigenous' or what makes a group 'Indigenous'. According to the reports of the Working Group on Indigenous Populations:

> The focus should be on more recent approaches focusing on self-definition as Indigenous and distinctly different from other groups within a state; on a special attachment to and use of their traditional land whereby ancestral land and territory has a fundamental importance for their collective physical and cultural survival as peoples; on an experience of subjugation, marginalization, dispossession, exclusion or discrimination because these peoples have different cultures, ways of life or modes of production than the national hegemonic and dominant model (UN, 2015, p. 6).

Under these circumstances, the so-called ‘hill tribe’ peoples in Thailand should be considered ‘Indigenous’ on account of their long connection with the geographical regions in which they live; on the (historical) experiences of marginalization, oppression, and discrimination; and on self-identification as a distinct ethnic group. In addition to these circumstances, the reasons I chose to use the label ‘Indigenous’ rather than ‘hill tribe’ include:

1. The commonly used term ‘hill tribe’, meaning ‘chao khao’ in Thai, literally refers to non-Thai minority groups. It also has a negative connotation of the word ‘wild’, which is generally conceived as ‘uncivilized’ (Kamler, 2015; NIPT, 2010). In addition, with a widespread misconception about those living in the highland areas, hill tribes have been viewed as drug producers, destroyers of forests, and threats both to the national security and to the environment (Kamler, 2015; NIPT, 2010). As a result, Indigenous organizations and advocacy groups in Thailand have continued to promote the use of the term ‘Indigenous peoples’, literally meaning ‘chon phao phuen mueang’ (NIPT, 2010). From my perspective, this indicates that Thai Indigenous peoples wish to retain a distinct identity.

2. The historical, constant stereotyping and discrimination against ‘chao khao’ or ‘hill tribe’ has negatively affected the lives of Indigenous peoples, particularly in relation to the rights to health (NIPT, 2010). With no formal constitutional recognition as ‘Indigenous’, little attention has been paid to the challenges faced by these marginalized and disadvantaged peoples. More specifically, health policies and programs in Thailand are neither designed to be responsive to the health needs of Indigenous peoples nor promote their rights to health (Dhir, 2015).

The Study Setting

The site for the study was the Na Pu Pom community (village) located in the rural highland areas of Mae Hong Son province. Mae Hong Son is one of the northern most provinces and the most mountainous province of Thailand, bordering with Myanmar. The province is approximately 924 kilometers (574 miles) away from the national capital city of Bangkok (Figure 1.2). According to the Department of Provincial Affairs of Thailand (2014), ethnic groups represent approximately 63 % of the Mae Hong Son’s population. More specifically, the Tai-Yai (also known as Shan) group has inhabited the rural highland areas of Mae Hong Son for generations and makes up the majority of the provinces’ populations (Ord, 2011).

The Na Pu Pom village is located in the rural and mountainous areas of Mae Hong Son province, approximately 55 kilometers from the closet hospital, with poor road conditions and no access to public transportation. The village has a land area of 13.23 km^2. The population of the village according to its 2016 village development plan is 457 living in 115 dwellings; 53 percent (242) of the population is male while 47 percent (215) is female (Table 1.1). According to the 2016 Village Development Plan, all village residents belong to the Tai-Yai group and practice

Buddhism.

Table 1.1

Population of the Village in 2016

Gender	**Percentage (number)**
Male	53 (242)
Female	47 (215)

Source: Na Pu Pom Development Plan, 2016

Figure 1.2. Mae Hong Son, the second most northern province in Thailand
Source: Google Maps, Mae Hong Son, 2016

Theoretical Perspectives

Intersectionality

The choice to use this theoretical perspective was derived from an early personal motivation I had in contemplating this study, which was to explore the healthcare access experiences of underserved and marginalized women, as informed by the work of feminist postcolonial theorist Kimberle Crenshaw. Crenshaw‘s idea (1989) of the intersections of multiple axes, and the interlocking systems of oppression and discrimination that create health differences, led me to an interest in one of the most vulnerable and marginalized groups within healthcare discourse, and their experiences and challenges in accessing mainstream healthcare services. This interest also led me to aligning a deeper understanding of Indigenous Thai women with the UN and WHO's mission, with what is at the heart of the SDGs, and with further reasoning why reaching out to a disadvantaged and marginalized group is considered the first step in addressing health inequities (Magar, 2015; UN SDGs, 2015; WHO, 2017).

In the next section, I provide an overview of intersectionality and discuss the relevance and contribution of an intersectionality perspective to my study.

An overview.

Historically, the term 'intersectionality' emerged from United States black feminism, Indigenous feminism, third world feminism, and postcolonial theory. It was officially coined by an African-American feminist scholar in 1989, to describe the exclusion of Black women from White feminist and antiracist discourse (Hankivsky & Cormier, 2009). Rooted in postcolonial feminism and other critical theories (Hankivsky, 2012; Van Herk et al., 2011), an intersectionality perspective "moves beyond single or typically favored categories of analysis (e.g. gender, race, and class) to consider simultaneous interactions between different aspects of social identity…as well as the impact of systems and processes of oppression and domination" (Hankivsky & Cormier, 2009, p. 3). In other words, an intersectionality approach is not additive—simply adding categories to one another, but rather strives to understand the influences of multiple intersections such as gender, ethnicity, cultural discrimination, geography, and immigration status.

An intersectionality perspective also examines the interrelating social relations of domination and oppression, and how they operate along different axes to shape health experiences and outcomes (Guruge & Khanlou, 2004; Hankivsky et al., 2010; Van Herk et al., 2011). Additionally, it extended my thinking to the analytical boundaries of postcolonial feminism by "recognizing that these [multiple dimensions of social identity] come together in distinct ways and lead to distinct health outcomes for individuals/groups, providing context to health experiences and drawing attention to the dynamic interplay between different system levels" (Van Herk et al., 2011, p. 30).

Relevance of intersectionality theoretical perspective to this study.

I discovered that there were important key tenets within the intersectionality perspective that characterized how I wanted to view and develop my research. I drew on Bowleg (2012) to demonstrate the core tenets of intersectionality most relevant to women's health, and how these were used to guide my research project that explored the experiences of access to healthcare for Indigenous women. The core tenets included: (1) multiple and intersecting influences, (2) issues related to power, and (3) the interplay of multiple identities at the macro structural level.

Multiple and intersecting dimensions.

At the core of the intersectionality perspective is the notion that human lives and experiences cannot be reduced to single characteristics. Intersectionality perspective also cannot be accurately understood by prioritizing any one category of social location (e.g., ethnicity, socioeconomic status, and gender). That is, social categories are "multiple interdependent, and mutually constitutive" (Bowleg, 2012, p. 1268). From an intersectionality perspective, no one category is necessarily more important than any other and cannot sufficiently explain disparate health experiences and outcomes. It must be noted, however, that "specific identities can be more or less salient depending on the historical or situational context," (Hankivsky & Cormier, 2009, p. 5) within which human experience is embedded.

Instead of viewing women's experiences solely within a single analytic frame, intersectionality provided a basis for analysis of the complex issues at the intersections of social identities and the interactions of these dimensions at both micro and macro levels. Thus, it has the potential to advance an understanding of experiences of women of marginalized groups for whom adverse health outcomes are most disproportionate. This research project reveals inequities in health and access to healthcare at the intersections of culture and the multiple social categories.

Issues related to power.

Another central tenet of intersectionality is its emphasis on power, that operates at both micro and macro levels to exclude some types of knowledge and experience of people from "historically marginalized and oppressed groups such as racial/ethnic minorities, low-income people, [lesbian, gay, bisexual, and transgender] people, and those with disability" (Bowleg, 2012, p. 1268). In addition, subject positions (e.g. race) are also shaped by relations of power, and these processes (i.e., the exclusion of historically oppressed and marginalized groups and subject positions) operate together to shape experiences of domination, oppression, and marginalization (Hankivsky, 2014). In order to gain recognition, evidence of economic resources and political support are instrumental elements; an intersectionality perspective assisted me to take this into account in the lives of marginalized and disadvantaged groups, as well as the multiple forms of oppression that contribute to inequities in health (Van Herk et al., 2011). In other words, I discovered that intersectionality perspective moves beyond an additive approach in the examination of privilege and oppression, with an explicit focus on intersecting processes in which power operates, maintains, and reproduces (Hankivsky, 2014).

There is a complete lack of appropriate research on healthcare experiences and access to health services among women from diverse cultural backgrounds, as they remain largely understudied by health researchers (UN, 2015). Indigenous women in Thailand are no different. They have been excluded, denied access, and are subject to marginalization and subjugation both at the local and national levels (IWNT, 2014). This exclusion or discrimination, and subjugation of Indigenous women, is considered relevant to understanding the processes of power that converge to shape their experiences, according to Hankivsky and Cormier (2009). An intersectionality perspective allowed me to understand and explicate the experiences of a previously ignored and excluded population, Indigenous Thai women, whose stories have been shaped by the systems of oppression and domination, and by intersecting power relations. In particular, an intersectionality perspective introduced a new approach to understanding Indigenous women's experiences of accessing healthcare, as they described themselves to me within the particular contexts of their lives related to history, culture, socioeconomic status, geography, and discrimination (Hankivsky & Cormier, 2009). This, in turn, facilitates and informs appropriate and cost effective actions, interventions, and policies responsive to the health needs and priorities of these sub-populations (Van Herk et al., 2011).

The interplay of multiple identities at the macro structural level.

Another core tenet of intersectionality is how the intersection of multiple identities at the micro level reflects multiple and interlocking forms of privilege and oppression (i.e., racism and sexism) at the macro level to influence health and healthcare experiences (Bowleg, 2012). In particular, intersectionality takes into account the substantial effects of social-structural influences beyond the level of individual health; thus facilitating a greater understanding of fundamental roots of social inequalities in health (i.e., racism and discrimination).

An intersectionality perspective permitted me to see how some of the systemic practices and structural barriers influence the distribution of healthcare resources and accessibility of healthcare services for women of disadvantaged groups. My research findings, for example, showed that healthcare services were not equally distributed due to geographical factors. In addition, structural barriers experienced within healthcare facilities were mentioned by women multiple times, including longer wait times and disrespectful relational engagement. These experiences of the study participants introduced additional barriers associated with access which further disadvantaged the women, leading to the delay or avoidance of healthcare services and ultimately, the perpetuation of health inequities.

Cultural Safety

The second theoretical underpinning of this research was cultural safety, which primarily served to inform the engagement process with members of Indigenous communities in Thailand. Note that the notion of cultural safety and its importance for and application to the provision of healthcare services for Indigenous peoples is discussed in Chapter 5. In this section, the integration of cultural safety into the research project, and in particular into the design of an engagement approach with participants, is discussed.

An overview.

There has been a growing interest in the concept of culture and health, globally, particularly for a healthcare approach that is culturally appropriate for Indigenous peoples. Literature focused on the health of Indigenous peoples is generally encouraging as it relates to the development of Indigenous cultural training or culturally safe care approaches for mainstream healthcare professionals, specifically those who are working in Indigenous communities (Downing & Kowal, 2010). However, there is still evidence that non-Indigenous healthcare providers have limited knowledge and skills when responding to the needs of Indigenous clients, and still report difficulty interacting (Downing & Kowal, 2010). Interestingly, the notion of cultural safety is not commonly known within healthcare in Thailand, despite increasing attention to issues of cultural diversity in healthcare practices.

By acknowledging inequities in healthcare status and delivery among Indigenous populations, the concept of cultural safety was initially developed from the early research of Ramsden (2002), a Maori Indigenous nurse leader in New Zealand. This concept has been further developed after Ramsdens death in 2003 by the Nursing Council of New Zealand (2005), and is currently defined within a nursing context in terms of the awareness and practices of nurses and midwives.

An important principle of cultural safety is that it places power into the hands of people who are receiving healthcare services (De & Richardson, 2008). Significantly, cultural safety "finds expression in caring spaces that are equality seeking and right oriented" (Stout & Downey, 2006, p. 327). The notion of cultural safety has continued to evolve and expand beyond Maori people to include other ethnic minority groups (Wilson & Neville, 2009). Cultural safety has been used extensively in a variety of ways in the practice setting, with the aims of addressing issues such as stigma, discrimination, and inequitable access to quality care, particularly among Indigenous patients. Nurses working at an injection site in Canada, for example, found the concept of cultural safety to be a promising tool in working effectively and respectfully with Indigenous peoples (Pauly et al., 2013). Cultural safety has been particularly useful to understand the tangible effects of historical trauma and ongoing patterns of institutionalized racial discrimination on the overall health status of Indigenous peoples, their healthcare experiences, and the levels of access to healthcare (Pauly et al., 2013).

Integration of cultural safety into research involving Indigenous peoples.

The notion of cultural safety as part of the research process has gained traction in recent years (Harrowing et al., 2010; Wilson & Neville, 2009). As Harrowing and colleagues (2010) asserted, cultural safety is an essential aspect of research design. Researchers are increasingly required to have a better understanding of cultural differences among diverse population groups of interest (Harvard Clinical and Translational Science Center [HCTSC], 2010). In particular, cultural safety is critical for researchers undertaking research with vulnerable and marginalized groups, as it can help to ensure effective engagement and improve participation with ethnic minority populations (HCTSC, 2010; Wilson & Neville, 2009).

There is considerable evidence of increasing inequities in health status and access to healthcare among members of ethnic minority groups, particularly Indigenous peoples (UN, 2015). This highlights the need for health researchers to develop partnerships that lead to insights by working together to understand the sociocultural aspects of Indigenous health experiences, and to find ways to improve their health and wellbeing. It must be noted, however, that "research outcomes may be compromised due to the way in which the research has been conducted, with researchers unwittingly transgressing cultural boundaries, and drawing conclusions that inaccurately portray the experiences of those researched" (Wilson & Neville, 2009, p. 69). For instance, many Indigenous groups have historically been voluntarily or involuntarily researched to their detriment, often with little or no benefit to the study participants and their communities (Wilson & Neville, 2009). Most specifically, research findings have been "interpreted and portrayed through the cultural lens of the researchers resulting in the portrayal of unhelpful stereotypes and deficit explanations" (Wilson & Neville, 2009, p. 71). Therefore, in order to enhance the efficacy of research and to ensure that the research is conducted in an acceptable and appropriate manner, especially when undertaking research with Indigenous peoples, there is a crucial need to embrace the concepts of cultural safety in the design of the research (Wilson & Neville, 2009).

When applied to research, cultural safety requires that researchers possess self-awareness and self-understanding, as well as be able to think honestly and reflect upon their personal views of race and cultural diversity. Researchers also need to understand their own cultural beliefs, values, and norms and how these may affect the research process, as well as relationships with those being researched. Importantly, since the interpretation and process of inquiry can be influenced by the researcher's point of view, it is imperative that researchers have insight into the epistemological foundations underpinning their research and constantly analyze their prejudices and biases (Wilson & Neville, 2009). Cultural safety provides researchers with a better understanding of sociopolitical realities of the studied population, in order to avoid issues surrounding misinterpretation, misrepresentation, and misinformation, and to generate research findings that can be used in more meaningful ways and that are culturally accurate (Durie, 2004). Given this, I have considered my social positioning using reflexive practices and during discussions with my supervisory committee members, as discussed in the Study Design section.

In the context of my research, it is important to note that Indigenous women in Thailand have been marginalized and discriminated against based on their gender, ethnicity, and socioeconomic status (IWNT, 2014). Consequently, it might be difficult for them to establish trusting relationships with those who do not share the same ethnic identity and who are predominantly in the position of power and authority. I was aware that I represented a position of power, and in order to begin establishing trusting relationships, I visited the Indigenous (Tai-Yai) community in August of 2016. It was in this particular context that cultural safety had such a crucial role to play. Integration of cultural safety into the study design helped to ensure that I was fully aware of my actions in the process of conducting the study, and that the research was carried out in a culturally safe way. A detailed account of a feasibility trip prior to carrying out the study can be found in both the Study Design section and the third manuscript (Chapter 4).

Designing an engagement approach with Indigenous peoples.

The main idea of culturally safe research is that study participants feel "included, respected, and that they can trust the researchers and what they will do with the information shared with them" (Wilson & Neville, 2009, p. 72). The researcher's commitment to honor the inherent rights of a research participant as a human being and to genuinely work with and involve the study participant is of particular importance (Wilson & Neville, 2009). This implies duties of respect and adherence in the use of cultural safety knowledge and professional ethics.

By ensuring that the research processes and outcomes were culturally safe and that the desires of research participants were upheld and respected, I drew on the principles of Wilson and Neville (2009)'s 4 Ps framework: Partnership, Participation, Protection, and Power; as a means to specifically guide me during the engagement and research phases with Indigenous women and the community they lived in. Note that these cultural considerations informed the engagement process during data collection and are discussed in the third manuscript (Chapter 4).

Partnership.

Partnership during a study requires that researchers "create a space where the building of meaningful and ongoing relationships with those being researched can be established and maintained throughout the research process" (Wilson & Neville, 2009, p. 73). This is crucial to the success and efficacy of any research project. However, it is more salient when undertaking research with Indigenous women who are marginalized and at-risk in so many ways. As Smith (2008) claimed, Indigenous women are identified as needing substantial and consistent support and encouragement to participate in studies. The hesitation to participate in research, in part, may be due to the lack of trust in researchers and/or past abuses related to the research experience (Suzanne, Vanessa, & Sara, 2008). As Sixsmith, Boneham, and Goldring (2003) proposed, establishing and maintaining trust within the community is of crucial significance. Without such relationships, researchers cannot genuinely come to know about a group's cultural beliefs; and thus meaningful and sustainable health improvements cannot occur (Kelly, 2006; Wilson & Neville, 2009).

Building and maintaining trust is an ongoing process and thus requires a considerable amount of time and effort to establish. To effectively form and maintain trustworthy relationships with Indigenous communities, I employed the strategies of building and maintaining trust with Indigenous community members developed by Suzanne and colleagues (2008) including: (1) acknowledge personal (research related) and institutional histories; (2) understand the historical context of the research; (3) be present in the community and listen to community members; (4) acknowledge the expertise of all partners (including acknowledgement that they are the true experts of their experience and factors that shape those experiences); and (5) be upfront about expectations and intentions. It is particularly important to note that developing and maintaining professional trusting relationships is an integral part of nursing practice. In order to gain a deeper understanding of client problems and needs, and to create a safe, effective and ethical care environment, the nurse must develop a trusting relationship with clients. My knowledge and experience as a nurse assisted me in this process and gave me expertise at establishing and maintaining relationships with research participants (Roper & Shapira, 2000). However, just because I was a nurse, I could not assume that obstacles and barriers related to engaging with study participants was going to be easily overcome. During my visit in August of 2016 (study feasibility trip), I was able to start establishing trust and rapport with potential participants (Liamputtong, 2007). This trip enabled me to be welcomed with open arms to the village. Detailed information on establishing and maintaining trust during fieldwork is discussed in the third manuscript (Chapter 4).

Participation.

Participation involves the meaningful inclusion of key members of the groups being researched, with the goal of obtaining valuable advice and guidance in relation to engagement of potential study participants, and other aspects of the research. It also includes strategies that are useful for recruiting and retaining members of cultural groups to participate in the study (Wilson & Neville, 2009).

To gain access to potential research participants, I met and shared my research questions with a range of local key Indigenous people when I visited the research field of Tai-Yai village in August of 2016, which included community leaders, Indigenous women, and healthcare professionals working at the community clinic. They showed keen interest in this research project and were willing to introduce me to more community members and potential participants. More specifically, I approached key community members (e.g., schoolteachers and local Indigenous women) who were interested in my research to be my Indigenous mentors (Wilson & Neville, 2009). The female schoolteacher who has an Indigenous ancestry agreed to be my Indigenous mentor. This key person provided valuable guidance throughout the research process, and more importantly, helped me to develop important links with the community to identify and respond to important issues and situations within the community (Wilson & Neville, 2009). Strategies that were used to recruit and retain participants are discussed in the Study Design section.

Protection.

According to Wilson and Neville (2009), the notion of protection "…entails safeguarding [Indigenous] populations from the potential for exploitation and the danger of research results further reinforcing negative depictions or explanations that do little to benefit them" (p. 75).

It was my obligation to ensure that the research participants were not adversely affected by participating in the research and that they were not underrepresented (Liamputtong, 2008; Wilson & Neville, 2009). When approaching and recruiting potential participants, I ensured that they clearly understood their participation and rights and that they were given sufficient opportunities to ask questions and provide consent before the interview took place (Liamputtong, 2008). It was recognized that research participants may become emotionally or psychologically distressed or disturbed by taking part in this study (Dickson-Swift, 2005). A debrief session after the interview or a referral to counselling was offered, if necessary. Detailed information of participants' safeguards is discussed in Ethics Considerations section.

Power.

Power imbalances and power inequities are inevitable and unavoidable during the research process (Ben-Ari & Enosh, 2013). The researcher is predominantly in the position of power as an academic or professional, guiding and directing the research process, wherein the possibility of exploitation and abuse of this power may exist. Wilson and Neville (2009) proposed that researchers should employ a 'power with' approach rather than a 'power over' approach, where in the first requirement is that researchers recognize the imbalances of power and are willing to engage in power sharing.

I argue that acknowledging power inequities that exist in the relationship between research parties is fundamental to the success of any research project. An understanding of the potential for these power inequities was crucial and served as the basis for activities that I engaged in to minimize these inequities/inequalities. Literature shows that reflexivity is essential to address the distortions or preconceptions researchers unwittingly introduce in a study (Alex & Hammarstrom, 2008; Cruz & Higginbottom, 2013; Hammersley & Atkinson 2007. In fact, engaging in reflexive thoughts and addressing power relations are critical and congruent with assumptions underpinning an intersectionality perspective (Hunting, 2014), as well as with notions inherent in cultural safety (Wilson & Neville (2009). Throughout the entire research process, I consistently examined and engaged in the reflexive process with the notion of creating transparency and maintaining the integrity of the research. This is evident in the third manuscript (Chapter 4), where I provide my personal reflections on the research process and fieldwork experiences. Reflexivity allowed me to acknowledge not only my own values, beliefs, knowledge, and biases, but also how these may affect the relationships with participants and the creation of knowledge (Alex & Hammarstrom, 2008). Further, having regular supervisory committee meetings to discuss power relationships helped to ensure that all research participants were treated fairly and respectfully. The role of reflexivity is discussed in detail in the Study Design section.

Human Rights and Sustainable Development Goals (SDGs)

Humans rights, in and of themselves, are a huge issue outlining the thirty basic rights. In this paper, I focus on a specific fundamental human right, which is the right to health. Further, I provide the link between the right to health and the SDG 5 on gender equality. The notion of human rights, particularly in relation to health and gender equality, deepened my understanding of the nature and meaning of these rights and its implications for cultural and ethnic minority groups, especially for Indigenous women.

Human rights, as stated in the Universal Declaration of Human Rights and formally adopted by the United Nations in 1948, are “rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status.” Human rights encompass a broad range of internally accepted rights, such as the right to life and liberty, freedom of movement, the right to a nationality, or the right to medical care (herein after referred to as the right to health). The right to health was first affirmed in the 1946 Constitution of the WHO, providing that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” The right to health was again recognized as a human right in the 1948 Universal Declaration of Human Rights (Article 25) and in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) (Article 12). The ICESCR’s definition of the right to health, envisaging “…the highest attainable standard of physical and mental health,” has been the most widely used (UN, 1966). The committee on Economic, Social and Cultural Rights further clarified and expanded the right to health to include the principles of non-discrimination and equality in access to facilities and services, as well as to the underlying determinants of health (UN, 2000; WHO, 2008).

Since then, the right to health has been recognized by other international human right treaties, as well as by national constitutions around the world, including Thailand (UN, 2008). This, according to WHO (2017), creates legal obligations and causes states to ensure appropriate conditions for the enjoyment of the highest attainable level of health for all people without discrimination. However, it is widely recognized that disadvantaged and vulnerable groups, including Indigenous populations, still experience social exclusion, discrimination, and poor access to health services (Thummapol et al., 2018; Van Herk et al., 2011; UN, 2015; WHO, 2015a, 2017), reflecting the failure of the states to respect and protect the right to health for all.

In recent years, increased attention has been paid to the principles of ‘leaving no one behind’ and ‘reaching the furthest behind first’ (WHO, 2017). The result is an emerging universal development agenda, comprising a broad set of 17 Sustainable Development Goals (SDGs) and 167 targets (UN Human Rights, 2015). The SDGs put human rights principles and standards at its core and strengthened all efforts to eliminate forms of discrimination and widespread inequity and inequality (UN Human Rights, 2015). Specifically, women’s right to health is strongly reflected in Goal # 5 of the SDG, to ‘achieve gender equality and empower all women and girls’, highlighting health-related targets that aim to address discrimination in healthcare and to ensure access to a full range of high quality and affordable healthcare, including sexual and reproductive services (UN SDGs, 2015). This SDG calls for more vigorous efforts to address many root causes of discrimination and to prioritize human rights through health for women. For example, discriminatory laws, policies, and practices that prohibit women from equal access to a number of resources need to be changed or eliminated (UN SDGs, 2015; UN Women, 2018).

Access to healthcare is central to the acquisition of the highest attainable standard of health recognized in international human rights law. The realization of women’s rights and its core values, including non-discrimination and equality, further imply that nations must take into account the differences of individuals and groups and strive to provide services that are responsive to the diverse needs and issues related to health and access to healthcare. In Thailand, the right to health is recognized in the 2002 National Health Security Act, Section 5, providing that “Every person shall enjoy the right to a standard and efficient health service…” Thailand provides universal health coverage (UHC) to all its citizens under the terms of the National Health Security Act (National Health Security Office, 2002). Thailand’s system of UHC has largely addressed financial barriers to healthcare access for all citizens. However, persistent inequities in health status and access to healthcare for certain underserved groups, including Indigenous peoples, remain (Dhir, 2015; Lutvey, 2014; UN, 2015; UNHCR, 2010).

Study Design

The overarching goal of this study was to gain deeper insight into, and provide rich accounts of, the experiences of Indigenous women accessing healthcare services in northern and rural Thailand. Given this, qualitative research approaches are the most suitable, placing emphasis on the meanings, lived experiences, and views of the participants (Al-Busaidi, 2008). In particular, because this study sought to unveil a distinct inquiry within a particular cultural group (i.e., Tai-Yai Indigenous women’s experiences of accessing healthcare services in northern Thailand), a focused ethnography was chosen as the most appropriate qualitative approach for examining this phenomenon.

I begin this section by providing a brief overview of ethnography and outline focused ethnography and its key characteristics. Then, the rationale for selecting a focused ethnographic approach is revealed. Next, I identify the role of reflexivity within focused ethnographic research. I then discuss the practical considerations, data analysis and management, rigors of the study, and ethical considerations. Following this, I describe the dissemination of findings and outline the four dissertation papers.

An Overview of Ethnography

Although it is not the aim of this chapter to present a detailed description of traditional ethnography, it is nonetheless important to have an understanding of ethnography, as it is considerably useful in gaining an appreciation of focused ethnography. Ethnography originated in comparative cultural anthropology conducted by early 20th century anthropologists, who sought to uncover cultural knowledge by understanding patterns of social interaction among people who live together and share similar experiences (Cruz & Higginbottom, 2013). Ethnography, developed mainly within the disciplines of anthropology and sociology, offers a qualitative research design by which researchers describe, analyze, and interpret a culture-sharing group's shared patterns of behavior, beliefs, and language that evolve over time (Cruz & Higginbottom, 2013; Lambert, Glacken, & McCarron, 2011). It fundamentally focuses on an entire cultural group. According to Cruz and Higginbottom (2013), ethnography is "an effort on the part of a researcher to generate a credible, rigorous and authentic account of people's perspectives of their culture or a specific aspect of it" (p. 43).

Ethnography is the method of choice when the goal is to understand, present, and explain a specific phenomenon from the standpoint of a culture, both spoken and unspoken, to 'outsiders' or people who are not part of the culture. The primary method associated with ethnography is fieldwork, which consists of extended periods of living with the people being studied, in order to learn about them and fully understand as much as possible about the cultural phenomena, looking out from the inside (De Chesnay, 2014). Once in the field, the ethnographer gets close to people, gains rapport, watches what happens, listens to what is said, and learns to act so that people go about their business as usual, making it possible to observe actions and behaviors of people in the natural setting (Hammersley & Atkinson, 2007).

Historically, early ethnographers were viewed as ‘professional strangers’ or those who were not well accepted by Indigenous peoples around the world, as their reality, culture, traditions, and experiences were considered bizarre and inferior (Cruz & Higginbottom, 2013). However, ethnography gradually gained recognition and wider acceptance with researchers and participants, particularly following an awareness of the ethical issues around this type of research, and the development of suitable safeguards (Cruz & Higginbottom, 2013). More specifically, ethnography gained in popularity and appears to be well suited to healthcare research, particularly in nursing, as nurse researchers “value its ability to generate understandings about health and illness phenomena studied in a cultural context” (Cruz & Higginbottom, 2013, p. 37).

Although traditional ethnography has flourished in sociology and other fields, efforts have been made by researchers to develop ethnography into “highly adaptable methods for diverse purposes” (De Chesnay, 2014, p. 4). As a result of philosophical reflections on the processes and purposes of the traditional ethnographic approach (e.g., taking on an entire cultural field and extended periods of immersion in entirely foreign cultures), focused ethnography has emerged as an alternative methodological approach.

Focused Ethnography

Historical roots of focused ethnography.

Focused ethnography can be traced back to early researchers, such as Goffman (1952), Gumperz and Dell (1964), and Festinger et al., (1956) “who focused on the life of a small group and utilized the revolutionary tape recorder” (Knoblauch, 2005, p. 4). It was initially introduced and described by Knoblauch (2005), a professor of General Sociology at the Technical University of Berlin. As Knoblauch (2005) has noted, focused ethnography is based on the premise that extended periods of immersion in rural settings is neither necessary nor desirable, in order to gain rich cultural understandings. Focused ethnography—a so-called ‘microethnography’ (Werner & Schoepfle, 1987) or ‘mini-ethnography’ (Leininger, 1985), is a legitimate tool in the field of ethnographic research, which focuses on “more narrowly defined culture,” (Cruz & Higginbottom, 2013, p. 38). Thus, it shares a fundamental purpose with traditional ethnography—to understand and describe culture and cultural phenomenon. It is an applied research methodology that is complementary to traditional ethnography, particularly in fields specific to “contemporary society, which is socially and culturally highly differentiated and fragmented” (Knoblauch, 2005, p. 1). Moreover, focused ethnography allows for the exploration of experiences from an insider’s view or ‘emic perspective', as experienced by the studied population, while bringing the outsider’s concepts or ‘etic perspective’ to the study (Cruz & Higginbottom, 2013; Hjelm et al., 2015; Roper & Shapira, 2000).

Key distinct features of focused ethnography.

Focused ethnography shares a fundamental purpose with traditional ethnography - a commitment to conduct intensive activities within the naturalistic setting (Roper & Shapira, 2000). However, focused ethnography differs from traditional ethnography in that it seeks to unveil information on “a distinct issue, situation or problem within a specific context among a small group of people living in a bigger society” (Cruz & Higginbottom, 2013, p. 38). Focused ethnography appears to have some different and distinct key characteristics in comparison to traditional ethnography. In traditional ethnography, longterm field visits, field notes, and document analysis are regarded as classic features. In addition, traditional ethnographers typically do not enter the field with a formally structured or specified research question (Wall, 2015). Focused ethnography, on the other hand, is characterized by relatively short term field visits, and is problem-focused and context-specific. The intensity of data collection and data analysis (e.g. the intensive use of audiovisual technologies such as tape-recorders, videos, and photo-cameras) focus on social interactions among people of cultural groups as the investigation seeks to answer specific questions, which are also key features of focused ethnography (De Chesnay, 2014; Higginbottom, Pillay, & Boadu, 2013; Knoblauch, 2005). Specifically, focused ethnography tends to have preselected topics of enquiry, whereby the researchers enter the field using interview topics that are highly structured around particular issues. Therefore, the approach allows the researcher to focus and gain a better understanding about the complexities of the situation and of the "experiences of specific aspects of people's ways of life and being" (Cruz & Higginbottom, 2013, p. 38).

The Rationale for Selecting a Focused Ethnographic Approach

There has been a significant shift towards more qualitative approaches, particularly in nursing and other health science disciplines, as nurse scholars and researchers have become increasingly interested in exploring and gaining a better understanding of the lived experience of people and complex phenomena (Munhall, 1989; Parse, 2001; Sofaer, 1999). Although conventional qualitative approaches have the potential to contribute significantly to the development of nursing and health knowledge, modifications or adaptations of these approaches are often made to meet the requirements of the research questions, participants, and contexts (Morse, 2007). Focused ethnography in particular has developed as an alternative methodological approach that allows researchers to focus and capture a distinct cultural perspective in a particular context in different populations and groups of people (Roper & Shapira, 2000).

Focused ethnography is considered to be useful to practice disciplines, particularly in nursing (De Chesnay, 2014). Because of its nature, focused ethnography allows the researcher to critically look at cultural or contextual influences within a narrower scope of enquiry rather than trying to understand the culture as a whole in all its aspects. Roper and Shapira (2000) highlighted the following three main purposes of focused ethnography of the genre in nursing literature, exploring: (a) “specific health practices among diverse cultural groups”, (b) “specific community as sites of supportive activities”, and (c) “the practice of nursing as a cultural phenomenon” (p. 7). As nurse researchers endeavor to better understand a specific phenomenon or shared experience within particular cultures or subcultures and “among a small group of people” (Roper & Shapira, 2000, p. 7), the use of focused ethnography in nursing research has been extensively applied in various research contexts.

A focused ethnographic approach best fits my research interests, where the focus was on gaining, as complete as possible, an understanding from the perspectives of participants, of the facilitators and barriers, and significant sociocultural aspects that influence Indigenous women’s experiences of accessing healthcare services. It is, however, acknowledged that the claims could be made for phenomenology as the qualitative method of choice. Phenomenology is commonly used to describe the meaning of lived experiences, while ethnography describes experiences within the sociocultural context (Roper & Shapira, 2000). The decision to frame the qualitative portion of this study as ethnography was based on the researcher’s interest in how culture influences health and access to healthcare. Ethnography has the potential to shed light on the influences of culture that may otherwise have remained invisible to members of the cultural group (Roper & Shapira, 2000). In particular, I selected focused ethnography as a method of choice because it: 1) was appropriate for research questions that were narrowly focused in scope (Wall, 2015); 2) allowed me to understand and discover the salient cultural beliefs, health practices, values, behaviors, and their influences on health status and access to healthcare for women from diverse cultural groups (Roper & Shapira, 2000); 3) required background knowledge (e.g. through literature reviews) rather than insider knowledge (Higginbottom et al., 2013; Knoblauch, 2005); 4) was a legitimate and flexible method suitable for financial and time constraints (De Chesnay, 2014); and 5) had been recommended by scholars as a suitable method that created significant outcomes on economically and socially marginalized groups (Hansen, Holmes, & Lindemann, 2013).

The Role of Reflexivity in Focused Ethnographic Research

Reflexivity is considered an important dimension of ethnography, and is commonly used in qualitative research (Cruz & Higginbottom, 2013; Hammersley & Atkinson 2007). According to Probst (2015), reflexivity is “generally understood as awareness of the influence the researcher has on the people or topic being studied, while simultaneously recognizing how the research experience is affecting the researcher” (p. 37). Reflexivity is an important part of transparency within a study and can be used as a tool to minimize or eradicate the effects of the researcher on the study (Lambert, Jomeen, & McSherry, 2010). In reflexivity, the researcher is not only reflecting on her thoughts, but also thinking about influences related to the way she thinks, and accordingly, alters the way she reaches decisions. In other words, reflexivity is one such effort whereby the researcher can acknowledge her own values, beliefs, knowledge and biases, as well as power inequities/inequalities that exist in the relationship between the researcher and participant (Alex & Hammarstrom, 2008). In fact, engaging in reflexive thoughts and addressing power relations are critical and congruent with assumptions underpinning an intersectionality perspective (Hunting, 2014), as well as with notions inherent in culturally safe practices (Cameron et al., 2014; McCall & Pauly, 2012; NMBA, 2018; Richardson & Williams, 2007).

In this study, I engaged in the reflexive nature of conducting qualitative research throughout the study, from the conceptual phase to dissemination of research findings. For example, when writing my PhD proposal, I thoroughly examined the influence I may have on the research process and participants, such as my characteristics (e.g., age and gender), beliefs, attitudes, background, education, and social class. During fieldwork and data collection, field notes were maintained during all interviews and a reflexive journal was used to document my thoughts, questions, feelings and emotions, dilemmas, interactions with people, and challenges that arose in the field. These notes fostered self-reflection and understanding, provided a heightened perspective of the data, and contributed to the iterative process of data analysis (Higginbottom et al., 2013; Roper & Shapira, 2000). By engaging in reflexive practice, it provided me with an opportunity to: 1) strengthen my research expertise, 2) be fully aware of the impact I may have on the creation of knowledge and relationships with women, and 3) create transparency and maintain research integrity - holding true to capturing the participant's point of view (Cruz & Higginbottom, 2013; Karnieli-Miller, Strier & Pessach, 2009).

Practical Considerations

Selecting a Field Site and Acquiring Access

As Roper and Shapira (2000) suggested, the researcher should meet with the gatekeepers or people who have the authority to allow access to settings and to participants early in the study's development. The study feasibility trip was conducted in August of 2016, in order to meet with the community leaders—the 'real gatekeepers', who held positions of authority and high respect to open up the access and introduce me to group members and participants (Liamputtong, 2008; Roper & Shapira, 2000). It is important to note that accessing Tai-Yai Indigenous women required gaining the trust of respected community leaders who were gatekeepers.

I initially approached and selected two field sites suitable for recruiting potential participants for this focused ethnographic study (Murphy et al., 1992) - the Na Pu Pom and the Ban Rak Tai villages. These two Tai-Yai villages were located in the rural areas of Mae Hong Son province, approximately 55 kilometers from the closet hospital with poor road conditions and limited access to public transportation. The community leaders of both field sites happily granted me access to the communities, and agreed to introduce me to community members (Figure 1.3). Through previous personal contacts with schoolteachers in the villages who were known and trusted by village residents, I was amazed at how quickly I established relationships and rapport with some women when being introduced to the communities and felt that I could fit in easily.

After the study feasibility trip, it was apparent that these two locations were appropriate field sites for recruiting and observing Tai-Yai women who had experiences with mainstream healthcare systems. However, the Na Pu Pom village became the main research site for this study, as the majority of community residents was Tai-Yai, while the other village was more diverse, consisting of approximately 40 percent of Tai-Yai people. Therefore, the Ban Rak Tai village was a backup plan for recruitment, if necessary. I was transparent with the process and informed the community leader of the second village about my intentions (Murphy et al., 1992). Note that I recruited all participants from the main research site.

Participants and Recruitment

Sample size. In focused ethnographic research, according to Higginbottom and colleagues (2013), there is no minimum right number of participants to include in a study, given that data saturation will dictate the actual sample size. Data saturation is reached when adequate and quality data is collected to replicate the study (O'Reilly & Parker, 2012), and when additional interviews do not generate new patterns or themes (Guest, Bunce & Johnson, 2006). However, based on a review of health-related focus ethnographies (Dupuis-Blanchard et al., 2009; Garcia & Saewyc, 2007; Graham & Connelly, 2013; Higginbottom, 2011; Hjelm et al., 2015; Pasco et al., 2004), a range of 13 to 23 research participants would be adequate to meet the goals of this study, and more specifically achieve the depth of understanding required. In this study, data saturation occurred after 21 interviews.

Sampling and recruitment strategies. The choice of an appropriate sampling method is of particular importance in intersectionality (Hunting, 2014). From an intersectionality perspective, it requires that sample populations be representative as possible, allowing for more nuanced and in-depth understanding of the phenomenon under scrutiny (Hunting, 2014). To ensure a selection of participants that result in a sample that was information rich, purposive and snowball samplings were used (Cohen, Manion, & Morrison, 2011; Higginbottom et al., 2013). Purposive sampling includes people (key informants) who are knowledgeable about the identified cultural group and have directly experienced the phenomenon of interest (Higginbottom et al., 2013; Roper & Shapira, 2000). In particular, criterion sampling as a form of purposive sampling, whereby participants are selected based on the inclusion criteria identified prior to participant recruitment (Maxwell, 2006), was employed. Snowballing occurs when key informants (participants) are able to directly recruit or refer potential participants for the study (Higginbottom et al., 2013). Snowballing is appropriate, particularly when undertaking research with vulnerable and marginalized groups (Liamputtong, 2008).

Potential participants included:

- Women who self-identified as Indigenous (Tai-Yai)
- Over the age of 18 and had the capacity to consent to participate in the study
- Had at least three experiences with the healthcare system
- Willing and able to share their experiences about access to healthcare in Thailand and able to communicate in Thai.

Figure 1.3. Community leaders of both field sites[2]
Source: Thummapol, O., Personal pictures, 2016

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[2] Permission (verbal) given by the community leaders to use these photos.

Note that I approached two Tai-Yai female schoolteachers who were interested in my study and had specific knowledge and experience of the phenomenon under study, during my visit in August of 2016 (Figure 1.4). One schoolteacher agreed to be my Indigenous mentor and another happily assisted in the recruitment processes.

Multiple recruitment strategies guided by the literature were used (Bonevski et al., 2014; Higginbottom et al., 2013; Liamputtong, 2007; Roper & Shapira, 2000; Sixsmith et al., 2003). I identified and recruited participants using purposive sampling, as well as through the researcher's personal networks, an Indigenous mentor, face-to-face, study posters (Appendix A), and snowballing. Initially, I described the research questions, purpose, and the process of the study to personal networks (i.e., a schoolteacher) and to an Indigenous mentor, providing them with study flyers. Personal network members and an Indigenous mentor assisted in the identification of Indigenous women who met the inclusion criteria, and obtained permission from potential participants for me to contact them. Potential participants identified through informal gatekeepers (i.e., personal networks and an Indigenous mentor) were then contacted in person to provide further information about the study and ascertain their willingness to participate. I also recruited participants face-to-face at the village's grocery shops where people commonly congregate. In order to recruit participants from a wider range in the village, I placed study flyers at various locations such as the village center, school, and grocery shops. To enhance the variety of my sample, and at the end of the interview, I asked all participants to see if they had friends or acquaintances who also met the inclusion criteria, and whom they could refer the study to (snowball sampling) (Higginbottom et al., 2013; Sixsmith et al., 2003). In total, twenty-one women agreed to participate in the in-depth interviews.

Data Collection

Data collection occurred over a two-month period during 2017 (March to April). It is important to note that the decision to leave the field was dependent on data saturation (Roper & Shapira, 2000). Guided by the principles of an ethnographic approach (Roper & Shapira, 2000), face to face in-depth interviews with each participant who gave consent was the main data collection method, in order to explore Indigenous women's healthcare access experiences. Demographic data was collected from each participant at the beginning of the interview (Appendix B). Specifically, information, such as age at time of the interview, place of birth, citizenship status, marital status, highest educational level achieved, occupation, income, and health insurance were asked. This information was used to describe the characteristics of study participants.

Figure 1.4. Approaching a key member of the group (Tai-Yai school teacher)[3]
Source: Thummapol, O., Personal pictures, 2016

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[3] Permission (verbal) given by the schoolteacher to use this photo.

Interview notes were written following each interview to record the process of the interview, as well as any and observational data such as information about the setting and non-verbal behavior of participants (e.g., tone of voice, posture, facial expressions, eye movements, forcefulness of speech, and body postures). These notes acted as reminders at a later time, facilitating the researcher's memory of the session being observed; and to provide a heightened perspective of the data, determining what needs clarification or informing preparation for subsequent interviews (Higginbottom et al., 2013; Roper & Shapira, 2000). In addition, a reflexive journal (e.g., the researcher's thoughts and questions, reactions to people and the setting, or personal feelings and emotions) was maintained during the course of research and used in the iterative process of data analysis (Ortlipp, 2008; Roper & Shapira, 2000).

Interviews. An interviewing strategy within ethnography serves to validate observations, provide direction for future observations, and gather data related to phenomenon under study that cannot be ascertained by observation (e.g., the perspectives of participants) (Roper & Shapira, 2000). In order to understand women's experiences of accessing healthcare services within the particular contexts of their lives, participants were asked to engage in face-to-face, in-depth interviews lasting approximately 45 minutes. The choice of a comfortable and convenient location for the interviews was discussed with each participant.

Congruent with a focused ethnography, the interviews were tape-recorded with consent. Each of the interviews was conducted in Thai, which was the participants' preferred language and my native language. The interviews focused on participants' past and current experiences with the healthcare system; specifically pertaining to their experiences accessing healthcare, their decisions to seek or not seek healthcare, what facilitators and barriers they encountered as they experienced the healthcare system, and what kinds of reactions they received from their health professionals. The interviews were semi- structured, with some prepared open-ended questions that had been developed based on the ethnographic interview (Spradley, 1979), in order to elicit information that described Indigenous women's healthcare access experiences.

The interviews were moving from broad questions to specific queries, in order to explore issues in more depth. The way in which questions were posed was a central consideration of intersectionality, as it can shape participants' responses (Bowleg, 2008). From an intersectionality perspective, "broader queries that allow for a participant to speak to the salient intersections in their lives can allow for data that best reflects the complexity of experience" (Hunting, 2014, p. 12). Guided by the ethnographic interview and intersectional lines of questioning, examples of interview questions and probes included: Where do you usually go for healthcare? Can you tell me about your last (or last two) healthcare visits? What influenced your decision to seek healthcare? How was it for you to get the healthcare services you needed? How was that in terms of being an Indigenous women and living in a rural area? (Appendix C).

Data Analysis and Management

Data collection and analysis proceeded concurrently from the first interview. As the researcher, I engaged in an iterative, cyclic, and self-reflexive process (Higginbottom et al., 2013). The recorded interviews were transcribed verbatim by the researcher and transcriber (who had signed a confidentiality agreement) in Thai (Appendix D). I thoroughly reviewed all of the interview transcripts by listening to the audio recordings and comparing them to the transcripts, in order to verify the accuracy of the transcription and to correct any transcription errors. Pseudonyms were substituted for the real names of the participants, in order to ensure confidentiality.

The analysis of data was done in the original language (Thai), because the researcher's first language was Thai. More importantly, evidence suggests that analyzing the data in the original language is faster and more accurate than in the translated data; therefore, improving the quality of the analysis (Fenna et al., 2010; Nurjannah et al., 2014). However, English was the language used with the supervisory committee members and to report the findings. Therefore, translation of the interviews conducted was required. I transcribed and translated the first three interviews into English for review and analysis with the supervisory committee members. The rest of the transcripts were kept in Thai. Roper and Shapira (2000)'s ethnographic analytic framework was used to guide the analysis. A detailed data analysis, including the translation and back translation process, is discussed in Chapter 3.

According to Hunting (2014), there is no set method as to how qualitative data can be analyzed through intersectionality. An intersectionality perspective was incorporated into the analysis process, with regards to how multiple social locations (e.g., gender, ethnicity, culture, rural geography, and citizenship status) intersected to differentially shape Indigenous women's experiences of accessing healthcare; and the way in which the broader systems of privilege and oppression (e.g., the experience of discrimination, structural barriers, including racism) affected them. Using an intersectionality perspective, I was able to identify the relevant intersections and processes that were most significant in a given context (Hunting, 2014).

Rigor of the Study

The establishment of trustworthiness or rigor is critical in qualitative research, in order to ensure the integrity of research findings (Lincoln & Guba, 1985). The trustworthiness of this study was ensured by using the following criteria: creditability, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Creditability refers to the criterion used to ensure the truth of research findings, reflecting participants' views (Lincoln & Guba, 1985). In this study, creditability was attained by the triangulation of methods of data collection, use of peer debriefing (e.g., constant support/feedback from the supervisory team), and member checking (Boswell & Cannon, 2014). Member checking is particularly relevant with intersectionality in addressing the issue of voice (Hunting, 2014). In this study, member checking occurred following transcription, in order to allow the study participants to read the transcription of their recorded interviews for the purposes of ensuring accuracy and creditability, as recommended by Houghton and colleagues (2013). Additionally, creditability was attained through the process of translation and back-translation (Al-Amer et al., 2015; Chen & Boore, 2010).

Transferability refers to the extent to which research findings have applicability in similar contexts or situations (Boswell & Cannon, 2014). Transferability of the findings of this study was addressed using the detailed and rich accounts of the phenomenon under inquiry (thick description) (Bitsch, 2005).

Dependability is defined as the stability of inquiry processes over time (Bitsch, 2005). For this study, dependability was addressed using an audit trail (a record of decisions made throughout the research process) and reflexivity (Houghton et al., 2013). Reflexivity is critical and inherent in intersectionality-informed qualitative research, in order to avoid the unnecessary and potentially incorrect assumptions about the particular phenomenon, and to better address the complexities of health and social issues (Hunting, 2014).

Confirmability refers to the extent to which the findings and interpretations are the results of the informants' views and experiences, and that are independent of the researcher (Lincoln &

Guba, 1985; Schwandt et al., 2007). The strategies used to establish confirmability were the use of quotes, an audit trail, and reflexivity (Houghton et al., 2013).

Ethical Considerations

This study received ethical approval from the following Ethics Review Boards (Appendix E):

- University of Alberta
- Assumption University of Thailand

Informed consent (Appendix F) was obtained prior to conducting all of the interviews, which included a request to audio-record the interview, and to return after the interview had been transcribed to check that the participants' responses were reflective of their experiences (member checking). When obtaining informed consent, I ensured that participants fully understood the purpose of the research, procedures, potential risks, and benefits associated with research participation[4]. In addition, they could make a voluntary decision to participate in the study or withdraw at any time, as well as to choose not to answer any questions (Appendix G).

There were no obvious dangers for participants that would necessitate withdrawal of participation. Confidentiality of the data was maintained through password-protected data collection software. Any identifying information was stripped from the data prior to analysis. Individual participant's anonymity was maintained to the fullest extent possible, and data was stored separately from any personal identifiers. All data was housed within the Health Research

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[4] To assess participants' understanding, I asked the potential participant to describe the purpose of the study, what the participant needs to do, the risks and benefits of participation, and how the participant may withdraw from the study. Inconsistencies were discovered and corrected at this time. If the potential participant was able to relate this information back to the researcher, then understanding of the project had been demonstrated, and they were invited to participate in the study.

Data Repository (HRDR), a secure and confidential online repository, located in the Faculty of Nursing at the University of Alberta.

Organization of Dissertation Papers

I organized this dissertation into the introduction, three papers written for publication, and a concluding chapter. The three papers are co-authored with my supervisory committee, who contributed substantially to the development and revisions of the papers, and deepened my understanding of the healthcare access challenges experienced by Indigenous women. I also include a number of footnotes, which focus on my own learning. These footnotes demonstrate reflexivity, provide background information, and thread these papers together as a whole.

In the first manuscript, I review the literature on health services accessibility experienced by Indigenous women in Asia; more specifically the facilitators, barriers, and cultural influences, using the scoping review methodology proposed by Arksey and O'Malley (2005). Much of the literature on healthcare access has focused on Indigenous populations, globally. Despite evidence that suggests health inequities disproportionately affect Indigenous women and that they continue to experience multiple forms of discrimination, there is a paucity of research exploring the experiences of Indigenous women in Asia, especially as it relates to healthcare access.

Through the use of focused ethnography (Knoblauch, 2005), in the second paper I explore the perspectives of Indigenous women associated with accessing healthcare in northern and rural Thailand, and uncover within these experiences how women integrated cultural beliefs and practices into their lives and self-care. To my knowledge, there has not been any research that has examined the healthcare access challenges experienced by Indigenous women living in a northern and rural Thai village. The ethnographic immersion in the field, with 21 in-depth interviews for over two months, allowed me to develop meaningful connections with the women, make sense of their culture, and gain a better understanding of the complexities surrounding issues of this inquiry; thus generating rich and in-depth accounts of participants’ experiences regarding access to healthcare (Roper & Shapira, 2000; Cruz & Higginbottom, 2013) .

In the third manuscript, I present a reflective account of the methodological challenges I encountered while engaging in this research. Four of these challenges pertained to selecting a field site and acquiring access, recruiting and building trust, maintaining privacy and confidentiality, and being vulnerable as a researcher. I found that, although the reflections of my research experiences offer a valuable opportunity for other researchers to consider how to engage in a final self-debrief, as well as how to use reflexivity as a useful tool in the planning and implementation of research with vulnerable populations, it is often not standard practice and remains largely invisible in the literature (Sherry, 2013; Thomson & Walker, 2010). Thus, the impetus to write about issues related to the methodological process of carrying out my research in such a manuscript was deemed necessary.

Dissemination of Findings

Findings of the three papers have been shared at several qualitative and health conferences, and social media (i.e., twitter). Each paper has been written for a specific journal; the first manuscript (Chapter 2) has been published in the Ethnicity and Health Journal, the second paper (Chapter 3) has been reviewed by the Central Asian Journal of Global Health with the invitation to complete reviewer revisions and resubmit, and the third manuscript (Chapter 4) has been submitted to the International Journal of Qualitative Methods (IJQM).

The findings of the first manuscript related to healthcare accessibility among Indigenous women in Asia was presented at the 31st Margaret Scott Wright Research Day in November 2017 and published in May 2018. The results of the second manuscript on healthcare access experiences of Thai Indigenous women was presented at both the Annual Qualitative Health Research (QHR) Conference and the Women and Children Health Research Institute's (WCHRI) 10th Annual Research Day in October 2017; with the focus of the latter presentation emphasizing the cultural aspects and its influences on health and access to healthcare. As mentioned above, this second manuscript has been peer-reviewed by four reviewers whose feedback will be integrated into the revision and resubmitted shortly after the final defense. The findings of this paper will also be disseminated widely to knowledge users and the Indigenous community in northern Thailand. Executive summary reports will be given to the Mae Hong Son Provincial Public Health Office, village leaders, and healthcare professionals responsible for the delivery of health services and the development of health interventions for Indigenous communities. The findings of the third manuscript related to methodological challenges encountered during the course of the research was presented at the 16th Qualitative Methods Conference in May 2018. This manuscript has been submitted to IJQM and is currently in review.

Conclusion of the Dissertation

The concluding section of this dissertation begins with a discussion of the findings, with reference to theoretical perspectives and relevant literature. Recommendations for policy, practice, education, and research are then discussed as a means to prompt further reflection on ways to improve non-discriminatory access to, and quality of, healthcare for Indigenous women. Last, this chapter presents the limitations of the study and concludes the dissertation with some important final remarks.

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Chapter 2: Paper 1: Exploring Health Services Accessibility by Indigenous Women in Asia and Identifying Actions to Improve It: A Scoping Review

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Abstract

Objectives: The aim of this scoping review was to uncover and summarize what is known in the literature about the experiences of Indigenous women in Asia regarding access to health services.

Design: The study was informed by the scoping review methodology proposed by Arksey and O'Malley (2005). A comprehensive search of the databases for peer-reviewed studies and grey literature was conducted between January 2000 and December 2016. The data of selected papers and abstracts were analyzed by three independent researchers through a protocol of data charting, descriptive numerical summary, and thematic analysis.

Results: Sixteen articles and two abstracts met the inclusion criteria for this scoping review. These 18 peer-reviewed documents consisted of eight qualitative studies, seven quantitative studies, and three mixed-method studies, which included the peer-reviewed poster and oral presentation abstracts from international conferences. The findings were sorted and grouped under the following themes: healthcare access for Indigenous women in Asia, facilitators to accessing healthcare services, barriers to accessing healthcare services, and cultural contexts impacting health and access.

Conclusion: There is limited information about the experiences, facilitators, barriers, and cultural contexts faced by Indigenous women in Asia related to health services accessibility, and even less information related to improving health services accessibility and health outcomes. This scoping review in particular highlights the dearth of literature relating to Indigenous women's postpartum health and access to postnatal supports and services. Generally, it indicates that Indigenous women in Asia are more vulnerable to poor health in comparison to non-Indigenous women, and continue to face challenges and barriers in accessing quality and equitable health services. The barriers identified in this review are useful in explaining why inequities in health and access to healthcare for Indigenous women living in Asia continue to exist. Recommendations for future research directions are described.

Keywords: Indigenous women in Asia; ethnic minority; health services accessibility; equitable healthcare; gender equality; human rights

Introduction

There has been considerable debate over the definition or understanding of ‘Indigenous peoples’ and ‘tribal peoples’ and to date, the United Nations does not recommend one definition. After many years of debate, in 1997 the Working Group on Indigenous Populations finally concluded that it was neither desirable nor necessary to elaborate on a definition of Indigenous peoples at the global level, “given that a single definition will inevitably be either over- or under-inclusive, making sense in some societies but not in others” (UN, 2015, p. 5). Instead of offering a single universal definition of Indigenous peoples, the United Nations Declaration on the Rights of Indigenous Peoples (Article 33) recognizes the right of people to self-identification, “that Indigenous peoples themselves define their own identity as Indigenous” (UN, 2015, p. 4).

The concept of Indigenous peoples in many parts of Asia did not exclusively emerge from the colonial experience (UN, 2015). Indigenous peoples in Asia are those who have a long connection with the lands and an experience of marginalization or discrimination, largely because they have a distinct and different cultural tradition and history compared to other groups within a state (UN, 2015). These disadvantaged and marginalized groups have been oppressed and suppressed by the dominant population within a given country (UN, 2015). This is different from places such as the Americas, Russia, the Arctic, and many parts of the Pacific, where the colonial powers displaced the original inhabitants, replacing them with white settlers (UN, 2015). Nonetheless, there are significant experiences that are potentially common across Indigenous groups, irrespective of their colonial experience such as discrimination, poverty, and marginalization (UN, 2015). Although it is argued that Indigenous identity should be defined exclusively by European colonization, the Working Group on Indigenous Populations proposed that the concept of Indigenous peoples “must be understood in a wider context [such as self-identification as an Indigenous individual] than only the colonial experience" (UN, 2015, p. 5).

Although the term 'Indigenous peoples' is now the most commonly used term, in the context of Asia its applicability remains contentious (AIPP, 2014; Dhir, 2015). There are a variety of terms that have been used by governments to refer to Indigenous peoples, such as Scheduled Tribes (India), Minority Nationality (China), Ethnic Minorities (Laos and Vietnam), and Hill Tribes and Ethnic Minorities (Thailand) (Roy, 2005; UN, 2015). According to the United Nations Permanent Forum on Indigenous Issues (UNPFII) (2006), all such terms can be used interchangeably with the modern understanding of the term 'Indigenous'. In recognition of the right to self-identification, this paper primarily uses the term 'Indigenous women' throughout.

It is estimated that there are about 370 million Indigenous peoples inhabiting the world (Gracey & King, 2009; UN, 2010, 2015). While Indigenous peoples account for approximately five percent of the world's population, they make up 15 per cent of the world's poor people (UN, 2010). Of the world's Indigenous populations, two-thirds (approximately 70%) reside in Asia, enriching the continent's fruitful diversity of cultures and languages (AIPP, 2014; UN, 2015). In Asia, there is a lack of disaggregated data specific to Indigenous peoples or minorities as a whole. This makes it difficult to assess accurately the health and living situations of Indigenous peoples, and to address the needs of this marginalized group. Even when health information is available, it does not represent a comprehensive view of the Asian region and is mainly focused on the health of the general population (UN, 2015). Although the data on Indigenous people in Asia are limited, recent studies and reports heavily draw attention to the poor health outcomes of Indigenous peoples and the extensive inequities they experience when accessing health services (Dhir, 2015; Jose et al., 2014; Shah & Belanger, 2011; UN, 2010, 2015).

Access to Health Services

Across many nations, people experience marginalization and discrimination based on their gender, race, ethnicity, and poverty levels (UN, 2007). Indigenous women are known to be one of the most marginalized groups (UN, 2007). In particular, access to equitable and appropriate health services for many people remains a critical global issue. Indigenous women also face substantial disadvantages when trying to access health services (Denison, Varcoe, & Browne, 2014; Van Herk, Smith, & Andrew, 2010). A growing body of research suggests that there are significant differences in Indigenous women's access and use of health services in comparison to the rest of the population (Denison, Varcoe,& Browne, 2014; Jose et al., 2014; Morgan & Wabie, 2012; Schooley et al., 2009; Shah & Belanger, 2011).

Indigenous peoples in Asia, in particular, are most likely to receive poorer quality of care and face more difficulties in accessing quality and appropriate healthcare in comparison to their non-Indigenous counterparts (Dang, 2012; Dhir, 2015; Jose et al., 2014; Shah & Belanger, 2011; UN, 2015). According to Rakić (2008), Indigenous people in Asia bear a triple burden, described as "persisting infectious diseases, increasing chronic conditions, and a growing recognition of injuries and violence" (p. 728). They continue to suffer a disproportionate burden of poor health and as a result, have a much higher premature mortality rate (UN, 2015). In fact, the health of Indigenous people in Asia is not often prioritized by national governments, leading to unmet healthcare needs among these disadvantaged groups (Dang, 2012; Dhir, 2015; Jose et al., 2014; Shah & Belanger, 2011; UN, 2015). Indigenous peoples in Asia die younger and have restricted access to appropriate health services (Dhir, 2015; UN, 2015). Specifically, Indigenous women in Asia face the highest level of vulnerability to health disparity, including access to health services (Dhir, 2015; UN, 2010, 2015). They are less likely to seek health services or benefit from health prevention services (Dang, 2012; Dhir, 2015; Jose et al., 2014; Shah & Belanger 2011; UN, 2015).

The growing gaps in health and healthcare access for Indigenous women continue to rise, becoming a critical concern in many Asian countries. In India, for instance, the use of antenatal services and delivery care among Indigenous women is much lower when compared with non-Indigenous women (International Institute for Population Sciences and Macro International, 2007; Jose et al., 2014; Shah & Belanger 2011). This is similar to Bangladesh, where only 30% of Indigenous women receive antenatal care, compared to 47.6% of the general population (Chowdhury, 2017). Indigenous women in Vietnam are 16 percent less likely to receive or seek treatment when they are ill (Dang, 2012).

The abovementioned findings reveal inequities in health and access to healthcare services among Indigenous women living in Asia. However, there are gaps in empirical and comprehensive data on the experiences of Indigenous women and/or healthcare providers regarding health service accessibility. Understanding the perspectives of Indigenous women and healthcare providers whose practices include ethnic minority and culturally diverse groups is important to improve healthcare access and, ultimately, achieve health equity. This information is also imperative for policy makers as they allocate resources and formulate policies to address the unique health needs of Indigenous women in Asia.

Research Question

This scoping review seeks to answer the following question: What is currently known about Indigenous women's access to health services in Asia in terms of facilitators, barriers, and cultural influences? Through this scoping review, knowledge gaps in the existing literature were identified and suggestions for future studies are discussed.

Methods

This study used the scoping review methodology proposed by Arksey and O’Malley (2005) and included recommendations made by Levac et al. (2010) to guide the review. No single universal definition of the scoping review methodology exists. However, Levac et al. (2010) offered the following definition of the scoping review as “mapping, a process of summarizing a range of [available] evidence in order to convey the breadth and depth of a field [of interest]” (p. 1). According to Arksey and O'Malley (2005), a scoping review is commonly undertaken for the following reasons: to examine the extent, range, and nature of research activity in a field of interest; to determine the value and potential costs of conducting a full systematic review; to summarize and disseminate research findings; and to identify gaps in the existing research literature. Arksey and O’Malley’s (2005) framework (which was followed in this review) for conducting a scoping study includes: (i) identifying the research question; (ii) identifying relevant literature; (iii) selection of the research articles; (iv) charting the data; (v) collating, summarizing, and reporting the results; and (vi) an optional consultation exercise. Given the financial and time constraints, an optional consultation exercise was not conducted in this scoping review. It is worth noting that quality appraisal of the included literature is not a component of the scoping review process given the intention of the review to convey the depth and breadth of the field of interest (Arksey & O’Malley, 2005; Levac et al., 2010; Schick-Makaroff et al., 2016). The aim of this scoping review was undertaken to uncover and summarize what is known in the literature about the experiences of Indigenous women in Asia regarding access to health services, and to identify research gaps in the existing literature.

Identifying the Research Question

In line with Arksey and O’Malley (2005), a broad research question was developed:

- What is currently known about Indigenous women's access to health services in Asia in terms of facilitators, barriers, and cultural influences?

Identifying Relevant Literature

This stage involved identifying relevant articles through database searches. A research librarian was consulted to refine the search terms and to identify appropriate databases most relevant to the research topic. The search terms used were in English and are listed in Table 2.1. The following bibliographic databases were searched: MEDLINE, EMBASE, CINAHL, Scopus, PROQUEST Dissertations & Theses Global, and reviews of reference lists. In line with a scoping review method, a comprehensive search of the databases was conducted for peer-reviewed articles (either qualitative and/or quantitative) and grey literature (i.e., conference abstracts, dissertation reports), using time limits of January 2000 to December 2016. The search was conducted in December 2016. The language limit was used to restrict the search to documents written in English and Thai (the first author is Thai); however, no papers written in Thai were found. The search results were exported into Refworks and duplicate articles were then removed.

Table 2.1

Search Terms

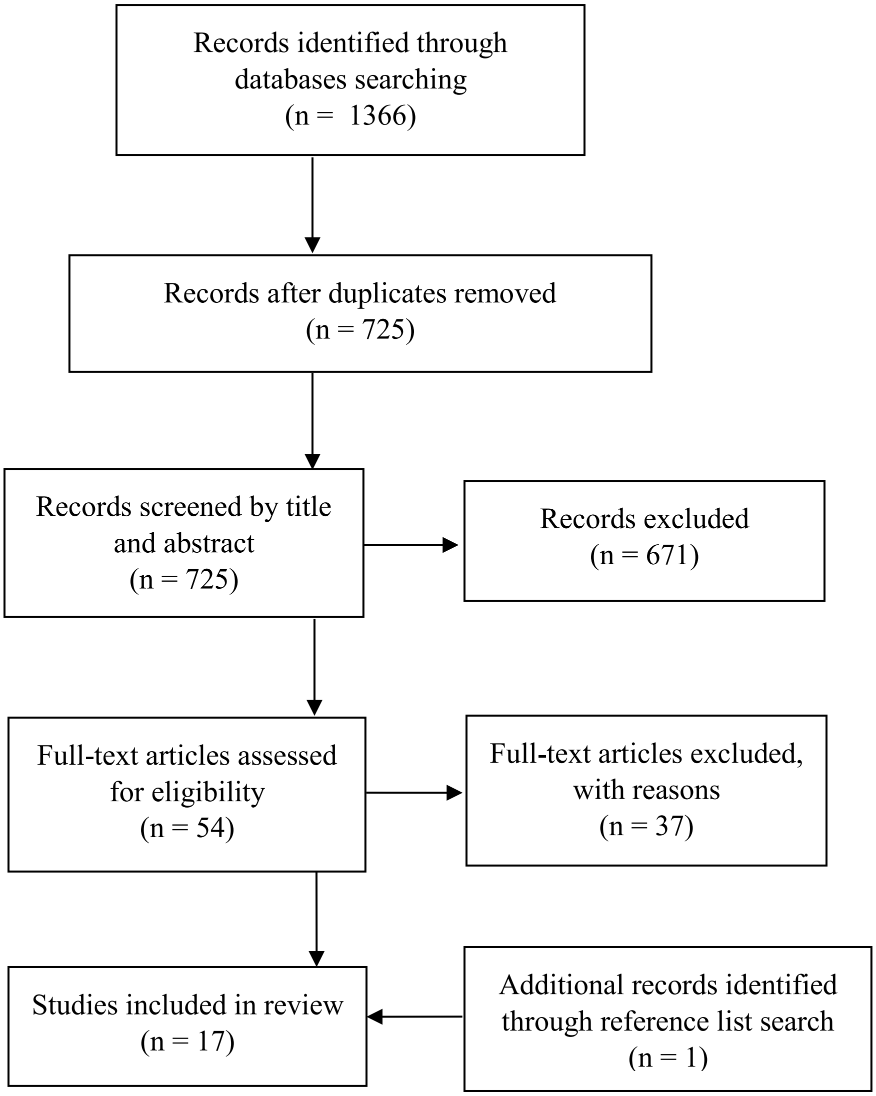
Asian Continental Ancestry Group
Upajati, jumma, hillmen, minzu, chuncheat daoem pheak tech, masyarakat adat, Yazidis Assyrian* or Ladakhi or Kinnaur* or Lepcha or Bhutia or Naga or "Karbi Bodo" or Munda or Mizo or Kodava or Toda or Kurumba or Kota or Irula* or Jat* or Nivkh or Ainu or "Dzungar Oirat*" or Pamiri* or Ryukyuan or Cham or Degar or "Khmer Krom" or Javanese or Sundanese or Bantenese or Betawi or Tengger or Osing or Badui or Madurese or Malays or Batak or Minangkabau or Acehnese or Lampung or Kubu or Dayak or Banjar or Makassarese or Buginese or Mandar or Minahasa or Buton or Gorontalo or Toraja or Bajau or Balinese or Sasak or Nuaulu or Manusela or Wemale or Dani or Bauzi or Asmat or Igorot or Lumad or Moro or kurd* or hmong
indigenous or aboriginal* or native or "ethnic minority" or "ethnic group*" or tribe* or tribal
asia or china or japan or korea or malaysia or indonesia or laos or vietnam or thailand or cambodia or india or indian subcontinent or pakistan or sri lanka or bangladesh or sikkim or

nepal or tibet or bhutan or brunei or Mongolia or afghanistan or armenia or azerbaijan or bahrain or cambodia or cyprus or georgia or iran or iraq or Israel or jordan or kazakhstan or kuwait or Kyrgyzstan or lebanon or maldives or myanmar or burma or ceylon or oman palestine or philipines or qatar or "saudi arabia" or singapore or syria or taiwan or Tajikistan or "Timor-Leste" or turkey or turkmenistan or "united arab emirates" or uae or uzbekistan or yemen
health services accessibility or healthcare disparities or access* or inaccess* or equit* or inequit* or disparit* or equal* or inequal* and care or service*
women or female*

Selection of the Research Articles

This stage involved selecting relevant articles, regardless of the study designs (Figure 2.1). Two researchers independently reviewed the titles, then the abstracts and finally the full articles for inclusion. In cases of disagreements in article selection, a third reviewer was involved to examine such studies and results discussed until a consensus was reached among the three reviewers. This approach to study selection helped ensure consistency between researchers and with the research question and purpose (Levac et al., 2010). Studies were eligible for the review if they met the inclusion criteria (Table 2.2). The inclusion criteria were developed based on increasing familiarity with the literature (Arksey & O'Malley, 2005). The inclusion criteria were used to determine and capture the relevance of studies related to access to health services, healthcare experiences, factors influencing access to health services, and health outcomes for Indigenous women in Asia. We included peer-reviewed qualitative and/or quantitative studies. Conference abstracts (poster and/or oral), dissertations, and theses were considered eligible for inclusion in line with the scoping review methodology (Arksey & O'Malley 2005). Reports and review articles were excluded. The data of selected papers and abstracts were analysed by three independent researchers through a protocol of data charting, descriptive numerical summary, and thematic analysis.

Figure 2.1. Flow diagram of article review (Adapted from Moher et al., 2009)



Charting the Data

This stage involved extracting data from each included study. All studies included in the review were sorted and charted according to key issues and themes (Arksey & O'Malley 2005). The following data were extracted and entered into a table: (i) author; (ii) publication year; (iii) countries where studies were conducted; (iv) study purpose; (v) study design; and (vi) findings.

Table 2.2

Inclusion and Exclusion Criteria

Inclusion	Exclusion
(1) Studies that have been conducted in Asia (countries as identified by the 2015 United Nations' report on the State of the World's Indigenous Peoples) and focused on one of the following aspects: (i) healthcare access; disparities in access to healthcare; and/or related health impacts/outcomes among Indigenous women; (ii) factors affecting Indigenous women's access to healthcare (including facilitators and barriers, the influence of culture, or health beliefs and practices); (iii) discussion of practitioner perspectives on Indigenous women and healthcare access (e.g., discriminatory/negative attitudes, being culturally insensitive, marginalizing, evidencing discomfort, or lacking sufficient knowledge about a group's needs); (iv) perspectives/experiences of Indigenous women regarding access to healthcare services; and (2) Studies written in English or Thai between January 2000 and December 2016 (2000 was chosen in order to best reflect current healthcare access trends in Asia and up to December 2016, which was the time the review was conducted)	Studies that reported health or access to healthcare among indigenous population in general or include family members or children (<18 years old), given children do not generally have capacity to make their own healthcare decisions

Collating, Summarizing and Reporting the Results

This stage included a descriptive numerical summary and a thematic analysis as suggested by Arksey & O'Malley (2005) and Levac et al. (2010). A descriptive numerical summary includes describing the characteristics of articles included in the review, such as the overall number of studies included and types of study design (Arksey & O'Malley, 2005). Thematic analytical techniques, according to Braun and Clarke (2006), involve becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and writing the report. The study findings are articulated using themes (repeated patterns of meaning across the data) and linked to the aim of this scoping review (Levac et al., 2010; Braun & Clarke, 2006).

Results

Description of Included Studies

Our initial search yielded 1366 potentially relevant peer-reviewed studies and grey literature papers (Figure 2.1). After final examination, sixteen articles and two abstracts met the inclusion criteria for this scoping review. The included studies varied in terms of purpose and methodology in that eight were qualitative studies (44%), seven were quantitative studies (39%), and three were mixed-methods studies (17%). Of these, five studies were conducted in India, three in China, two in Vietnam and Israel, and one each in Sri Lanka, Nepal, Lebanon, Indonesia, Malaysia, and Thailand.

Of the included papers, two papers were peer-reviewed published abstracts (one poster and one oral presentation) from international conferences. The poster abstract was titled m[mobile]MOM-improving maternal and child health for ethnic minority people in mountainous region of Thai Nguyen province of Vietnam through integration of mHealth in HMIS and user-provider interaction (Nguyen et al., 2015). The aim of this study was to improve maternal and child health in mountain areas through the development of a low cost mHealth behavior-change-communication (BCC) model. This pilot model was developed to mitigate access barriers (e.g., geographical restrictions) and improve patient-provider interactions. Data collection included pre- and post-intervention surveys with local health workers and Indigenous women. The women provided positive feedback for the mHealth model. Local health workers reported reduced workloads, allowing them to perform their jobs in a more integrated way. The oral presentation abstract focused on end-of-life beliefs and cancer health practices among Indigenous women in Northeast India (Carrion et al., 2015). Guided by a grounded-theory approach, six focus groups were conducted with 42 women in Hindi and Idu Mishmi languages and transcribed into English. The authors highlighted findings pertaining to barriers and cultural influences associated with access to health services. Distance to health facilities, lack of transportation, insufficient allocation of resources (financial and human), and use of herbal and traditional medicines when experiencing symptoms of illnesses were all issues identified in this study.

Most studies (17) included in this review considered Indigenous women's perspectives, attitudes, knowledge, or practices specific to healthcare access, while one study represented views solely from healthcare providers. Of the included studies (18), six gained perspectives from both Indigenous women and practicing healthcare professionals or traditional birth attendants. The majority of studies (11) focused on reproductive health, while two discussed preventive health screening practices among Indigenous women. Of the included studies, two studies focused on psychological issues relating to factors associated with suicidal thoughts and end-of-life beliefs and practices of Indigenous women living in rural and isolated areas. Three studies evaluated the effectiveness of community programs in improving access and use of maternal health services, and reducing disparities among Indigenous women.

Among the included studies, eight studies reported study limitations (44 %). The most frequent limitation of the included studies was participant recruitments (Chen et al., 2008; Gipson et al., 2015; Gyaltsen et al., 2015; Pati et al., 2014; Sidney et al., 2016). Recruiting participants from a single setting, for instance, was reported as a potential shortcoming (Pati et al., 2014). The authors noted that the generalizability of the study may be limited by the characteristics and diversity of the study participants. Ratzon, Sheiner, and Shoham-Vardi (2011) reported not including information on participants' socioeconomic status and lifestyles as a potential study limitation, affecting the analysis. A small sample size was reported as a limitation in three studies, potentially limiting the generalisability of the findings (Binder-Finnema et al., 2015; Gipson et al., 2015; Gyaltsen et al., 2015). Self-reported data were reported as a limitation in the study by Norsa'adah and Wnorlida (2014). The authors stated that data obtained from self-reporting may be subject to bias. The summary of articles reviewed are shown in Table 2.3.

Below, we present the findings of the thematic analysis of the scoping review. The findings are presented under the following themes: healthcare access for Indigenous women in Asia, facilitators to accessing health services, barriers to accessing health services, and cultural contexts impacting health and access.

Healthcare Access for Indigenous Women in Asia

Access to quality and appropriate healthcare remains a challenge for Indigenous women living in many parts of Asia due to a range of influences. Increasing attention in the literature has been given to issues surrounding access to health services among Indigenous women in some Asian countries such as India (Carrion et al., 2015; Pati et al., 2014; Sharma et al., 2013; Sidney et al., 2016; Towle, 2009), China (Chen et al., 2008; Gipson et al., 2015; Gyaltsen et al., 2015),

Table 2.3 *Summary of Articles Reviewed*

Authors	**Year**	**Country**	**Purpose**	**Study design (method, participants, setting)**	**Findings**
Binder-Finnema et al.	2015	Vietnam	To reveal underlying structural barriers to equitable maternal health services	Focus groups IW, HCP CHC, DH	Barriers Cultural influences
Carrion et al.	2015	India	To explore healthcare disparities (end-of-life issues and cancer care) among indigenous communities	Focus groups IW IC	Barriers Cultural influences
Chen et al.	2008	Taiwan	To investigate the prevalence of suicidal thoughts among a population of elderly aboriginal women and to examine the risks factors for suicidal thinking	A cross-sectional survey IW IC	Barriers Cultural influences
Gipson et al.	2015	China	To identify socio-demographic characteristics and factors involved in Tibetan women's decisions to deliver at the Tibetan Birth and Training Center (TBTC)	A mixed-methods IW CHC	Facilitators Barriers Cultural influences
Gyaltsen et al.	2015	China	To examine if and how first users of a Tibetan Birth and Training Center (TBTC) differ from women in the boarder community and how this information may inform subsequent maternal healthcare intervention	A face-to-face questionnaire IW IC, CHC	Facilitators Barriers Cultural influences
Kottegoda et al.	2008	Sri Lanka	To highlight some of the reproductive health concerns of Indigenous women living in situations of armed conflict	A mixed-methods IW IC	Barriers Cultural influences
Lama et al.	2014	Nepal	To explore the barriers in utilization of maternal healthcare services, including the reasons for not using available services	Focus groups IW IC, CHC	Barriers Cultural influences
Mansour, N.	2010	Lebanon	To address the gaps by exploring the perceptions that Bedouin women have of reproductive health services	In-depth interviews IW IC	Facilitators Barriers Cultural influences
Munro, J., and McIntyre, L.	2016	Indonesia	To shed light on the interrelated consequences of Indonesian anti-politics and donor-led interventions through an exploration of Papuan women's experiences of services intended to prevent mother-to-child transmission of HIV	Semi-structured, in-depth interviews IW, HCP Local Papuan-run healthcare association	Barriers Cultural influences
Nguyen et al.	2015	Vietnam	To develop a pilot study and learn about feasibility of a low cost mHealth behavior-change communication (BCC) model in order to improve maternal and child health in mountain areas	Survey IW, HCP DH, CHC	Barriers

Authors	**Year**	**Country**	**Purpose**	**Study design (method, participants, setting)**	**Findings**
Norsa'adah, B., and Wnorlida, W.I.	2014	Malaysia	To identify the preventive health practices among women living in rural areas, including blood pressure, blood sugar levels, blood cholesterol levels, pap smear, and breast self-examination	A cross-sectional survey IW IC	Facilitators Barriers Cultural influences
Pati et al.	2014	India	To measure perinatal and antennal practices by women in tribal communities	Interviews IW, TBA IC	Barriers Cultural influences
Ratzon, Sheiner, and Shoham-Vardi	2011	Israel	To assess the independent role of prenatal care in preventing recurrent preterm delivery and in reducing adverse pregnancy outcomes	A population-based retrospective cohort study IW DH	Barriers Cultural influences
Sharma et al.	2013	India	To understand the choices made as well as practices and perceptions related to childbirth amongst tribal women and how these have been influenced by modernity in general and modernity brought in through maternal health policies	In-depth interviews, focus groups, participant observation IW, TBA, HCP DH, IC	Facilitators Barriers Cultural influences
Shoham-Vardi et al.	2004	Israel	To examine attitudes towards and practice of pregnancy termination, following an unfavorable prenatal diagnosis	A mixed-methods IW DH	Barriers Cultural influences
Sidney et al.	2016	India	To advance the state of knowledge on the Chiranjeevi Yojana (CY) program—a large public-private partner program that provides childbirth services to poor and tribal women	A survey IW DH	Facilitators Barriers
Towle, M. S.	2009	India	To examine how healthcare providers were defining implementation failing, challenges, successes, and improvement needs of the Prevention of Parent-to-Child HIV/AIDs transmission (PPTCT) program	Semi-structured interviews, focus group discussions and participant observation HCP Four states in southern India	Facilitators Barriers Cultural influences
Wongwatcharanukul et al.	2014	Thailand	To examine factors associated with cervical cancer screening uptake by Hmong Hill tribe women in a northern province of Thailand (Phetchabun province)	A survey IW IC	Barriers Cultural influences

and Vietnam (Binder-Finnema et al., 2015; Nguyen et al., 2015); in general most countries are still lagging behind.

A recurring challenge reported among Indigenous women was the absence of, or limited access to, health services (Binder-Finnema et al., 2015; Carrion et al., 2015; Gipson et al., 2015; Kottegoda, Samuel, & Emmanuel, 2008; Norsa'adah & Wnorlida, 2014; Sharma et al., 2013). This lack of access to health services was frequently attributed to geographic restrictions, poverty, limited availability of services, lack of healthcare providers, lack of public transportation, and distance to health services. In addition to these, language barriers (Binder-Finnema et al., 2015; Kottegoda, Samuel, & Emmanuel, 2008; Shoham-Vardi et al., 2004), unaffordable healthcare (Binder-Finnema et al., 2015; Mansour, 2010), and lack of Indigenous persons in the health workforce (Munro & McIntyre, 2016) were identified as barriers to access, making it even more difficult for Indigenous women to obtain what is required to maintain or achieve the best possible health.

Healthcare providers also reported that inadequate access to health services is the major reason for undesirable health outcomes of Indigenous women (Binder-Finnema et al., 2015; Lama & Krishna, 2014; Sharma et al., 2013; Towle, 2009). Additionally, the exclusion or lack of local Indigenous people working in the health sector was a challenge reported by service providers. This contributes to the failure of services to effectively address Indigenous practices and concerns (Munro & McIntyre 2016). The women's lack of knowledge or awareness of available services was reported as an additional challenge to providing services and support (Lama & Krishna, 2014; Pati et al., 2014; Towle, 2009).

Facilitators to Accessing Health Services

Just under half (7) of the included studies reported facilitators to accessing health services for Indigenous women. Indigenous women reported the following factors that positively influence the use of health services and adherence to treatments: a subsidy for maternity and delivery services (Gipson et al., 2015; Sharma et al., 2013; Sidney et al., 2016), ability of family to be around during delivery (Gipson et al., 2015; Mansour, 2010; Gyaltsen et al., 2015), free or better forms of transportation (Gipson et al., 2015; Sharma et al., 2013), and the presence of female doctors or healthcare providers who were culturally sensitive (Gyaltsen et al., 2015; Mansour, 2010).

Among the studies that reported facilitators to accessing health services, only two studies described the perspectives of healthcare providers. The facilitators identified by service providers are similar to those identified by Indigenous women, like a subsidy for maternity and delivery services. Interestingly, the service providers also identified repeated contacts with healthcare providers (Sharma et al., 2013) and integration of health services (Towle, 2009) as facilitating access to health services. Sharma et al. (2013) noted that repeated contacts were perceived by healthcare providers to have a positive impact on the use of services. In a study conducted by Towle (2009), it was reported that healthcare providers recognized the necessity for service integration to increase uptake of the programs and enhance Indigenous women's access to health services.

Barriers to Accessing Health Services

All of the studies in this scoping review reported barriers to accessing healthcare among Indigenous women. All but one reported from the perspectives of Indigenous women, with five of the studies reporting the perspectives of women and healthcare providers and one study only representing the views of healthcare providers. The most reported barriers identified by Indigenous women included distance to healthcare facilities and costs of transportation, poverty or low income, lack of knowledge and awareness about the available services, distrust of the healthcare system, traditional gender roles, and language barriers. Other barriers faced by Indigenous women included low or limited education level, insufficient human resources, long waiting times, and shyness or shame.

Studies that focused on Indigenous women's access to maternal and child health services found that women tended not to attend antenatal care and were more likely to birth at home without assistance from skilled birth attendants (Binder-Finnema et al., 2015; Gipson et al., 2015; Gyaltsen et al., 2015; Kottegoda, Samuel, & Emmanuel 2008; Lama & Krishna, 2014; Nguyen et al., 2015; Pati et al., 2014; Sharma et al., 2013; Ratzon, Sheiner, & Shoham-Vardi, 2011). A study by Sharma et al. (2013) revealed reasons for preferring home birthing assisted by traditional birth attendants as: easily accessible and managed within the community; and affordable and pragmatic. Indigenous women who gave birth at home were more likely to have limited or no education and their decisions and choices of maternal services were greatly influenced by their family members (Gipson et al., 2015; Gyaltsen et al., 2015; Kottegoda, Samuel, & Emmanuel, 2008; Lama & Krishna, 2014; Mansour, 2010; Pati et al., 2014).

One study investigated Indigenous women's perspectives on counseling and services intended to prevent the transmission of HIV from an infected woman to her child (Munro & McIntyre, 2016). The authors noted that women often experienced poor-quality HIV education and counselling, and that their concerns were largely overlooked (Munro & McIntyre, 2016). In addition, there was a lack of Indigenous health professionals working in HIV services, contributing to uncomfortable feelings and fears of asking questions or raising concerns.

Two studies focused specifically on preventive health practices of Indigenous women (Norsa'adah & Wnorlida, 2014; Wongwatcharanukul et al., 2014). Indigenous women tended to have poor adherence to preventive healthcare and cancer screening due to a range of influences, such as lack of awareness and knowledge about diseases, risk factors, and the screening guidelines (Norsa'adah & Wnorlida, 2014). In a study by Wongwatcharanukul et al. (2014), a lack of time was cited as the most significant barrier to obtaining cervical screening. Among these two studies, low education level had been positively associated with poor screening uptake. A study done by Carrion et al. (2015) identified additional barriers to preventive cancer screening. Though the primary focus of this study was not on the preventive screening behaviors, study participants reported distance to healthcare facilities, insufficient human resources, and cultural beliefs as factors influencing their use of cancer preventive screening.

The six studies that reported the views of healthcare providers identified the following access barriers for Indigenous women: the lack of knowledge and awareness, distrust in the healthcare system or providers, geographical restrictions, and limited availability of services. Three studies found that lack of trust in health services and providers affected access to health services, and recognized previous negative healthcare experiences as significant influences on women's decisions to seek health services (Binder-Finnema et al., 2015; Munro & McIntyre, 2016; Sharma et al., 2013). Healthcare providers perceived lack of awareness of available services as the most significant barrier to the use of services (Lama & Krishna, 2014; Nguyen et al., 2015; Sidney et al., 2016; Towle, 2009). Interestingly, healthcare providers in Lama and Krishna's (2014) study reported that low economic status was not a barrier, as many health services were available free of charge or at minimal cost.

Among the included studies, three focused on the effectiveness of maternal and child health programs (Nguyen et al., 2015; Sidney et al., 2016; Towle, 2009). While the programs were valuable for improving maternal and child health outcomes, studies showed that there was a lack of awareness of program availability and women’s involvement in the programs was still low (Sidney et al., 2016; Towle, 2009). Sidney et al. (2016) found that the women involved in the program were more likely to have had prior knowledge of the maternal and child health program and were more educated. Healthcare providers involved in maternal and child health programs reported that the programs reduced their workload (Nguyen et al., 2015).

Cultural Contexts Impacting Health and Access

The majority of studies (16) discussed the influence of culture on health services accessibility for Indigenous women. Cultural beliefs and practices were noted to play a critical role in women’s health practices, as well as their ability to seek medical attention. Culture affects perceptions of health and illness, beliefs about causes of illness or disease, health practices, and health seeking-behaviours (Binder-Finnema et al., 2015; Gipson et al., 2015; Gyaltsen et al., 2015; Kottegoda, Samuel, & Emmanuel, 2008; Lama & Krishna, 2014; Norsa’adah & Wnorlida, 2014; Pati et al., 2014; Sharma et al., 2013; Wongwatcharanukul et al., 2014), as well as attitudes towards healthcare providers (Mansour, 2010; Shoham-Vardi et al., 2004; Towle, 2009). For example, a study of Tibetan pregnant women in China (Gipson et al., 2015) found that the women continued working hard throughout their pregnancy because of a Tibetan cultural belief that working hard leads to an easier labour and a smaller baby. In the same study, the women shared another belief that for the pregnancy to be successful and less painful, the pregnancy should be kept secret. Likewise, Munro and McIntyre (2016) found that Papuan women, who are considered in their culture incapable of making decisions, chose to keep their HIV positive status secret from their families for fear of family disruptions, abandonment, and discrimination.

Indigenous women rely heavily on traditional and cultural practices as their primary source of healthcare, particularly in relation to pregnancy and birth. This reliance leads to reduced access to Western health services. Indigenous women interviewed by Lama and Krishna (2014) felt that it was important to follow their culture and tradition regarding home delivery, especially for the first baby. Several other studies showed similar results in Vietnam (Binder-Finnema et al., 2015), Sri Lanka (Kottegoda, Samuel, & Emmanuel, 2008) and India (Pati et al., 2014; Sharma et al., 2013). Healthcare providers reported cultural practices as a barrier to Indigenous women's participation in Western health services and tended to feel Indigenous women did not always heed their advice (Binder-Finnema et al., 2015; Lama & Krishna, 2014).

Eight studies reported on the importance of the family's influence on women's health choices. Family support and influence on women's choice of birth location was described by both Indigenous women and healthcare providers as a significant factor hindering women from choosing to access needed care and treatment in Western hospitals (Gipson et al., 2015; Gyaltsen et al., 2015; Lama & Krishna, 2014; Munro & McIntyre, 2016; Pati et al., 2014; Shoham-Vardi et al., 2004; Towle, 2009). Chen et al. (2008) reported on the experiences of suicidal elderly Taiwanese women and found that the influence of family and friends was the most significant influencing factor in preventing suicide.

Indigenous women were considered inferior to men and often excluded from participation in the decision-making process (Binder-Finnema et al., 2015; Kottegoda, Samuel, & Emmanuel, 2008; Norsa'adah & Wnorlida, 2014; Munro & McIntyre, 2016; Wongwatcharanukul et al., 2014). The exclusion of women from participating in decision making within the family and community created difficulties for Indigenous women. For example, they were silenced from voicing their concerns and needs. Among these studies, traditional gender roles were also identified as critical in limiting the ability of Indigenous women to access and seek care and treatment when they are ill.

Discussion

This scoping review provides a step toward a better understanding of issues surrounding health and access to health services among Indigenous women in Asia. The findings demonstrate that Indigenous women across Asia have unique characteristics that reflect their current situation. In terms of health and access to health services, Indigenous women in many parts of Asia perceived difficulties when accessing health services and providers. In other words, Indigenous women in Asia are more vulnerable to poor health in comparison to non-Indigenous women in Asia, and continue to face challenges and barriers in accessing quality and equitable health services. There are significant barriers that are potentially common across Indigenous groups and some particular influences that are specific to certain groups. The barriers identified in this review are useful in explaining why inequities in health and access to healthcare for Indigenous women living in Asia continue to exist. The perceived facilitating factors were discussed in a few studies. The reason for less consideration of facilitators in the literature remains unclear, but may be related to perceived research needs, funding priorities, and time constraints. The facilitators identified in this review are essentially useful for service providers and policy makers to ensure health services are being effectively and appropriately used.

The findings of this review elucidate previous results illustrating barriers and cultural differences affecting access to health services among Indigenous women within and outside of an Asian context. The findings that geographical restrictions create obstacles for Indigenous women living in mountainous and remote areas is highly consistent with the extensive literature that has explored this issue among Indigenous women (Jose et al., 2014; Browne, 2010; Morgan & Wabie, 2012; UN, 2015). Jose et al. (2014) found that distance to healthcare facilities and limited access to public transportation was the main reason among Indigenous women living in

Kerala for not using services. In addition to transportation difficulties, Browne (2010) noted that Indigenous women and their families living in northern Canada encountered a significant burden in terms of financial, childcare, and related stresses when reaching and using services that were not available in the rural areas. This distance creates additional challenges for both Indigenous women and healthcare providers, such as the need for emergency care and the inability to respond quickly, which in turn leads to undesirable outcomes.

Furthermore, findings from this study revealed that the degree to which Indigenous women were denied access to basic education and excluded from decision-making in their families or communities affected their knowledge about health problems, use of health services, and preventive health behaviours. The studies included in this review noted that lower educated Indigenous women were not aware of the potential benefits of attending antenatal care (Binder-Finnema et al., 2015; Shoham-Vardi et al., 2004) and did not see the value of seeking routine preventive care (Carrion et al., 2015; Norsa'adah & Wnorlida, 2014; Wongwatcharanukul et al., 2014). A recent study by Jose et al. (2014) has some parallels to the findings of our review. These authors found that Indigenous women residing in Kerala with low literacy skills were more likely to not access available health services. As a result of providing outreach to this group by healthcare professionals, they arrived at an understanding of the women's priorities and created education strategies that the women perceived as optimal.

This scoping review revealed that cultural beliefs and practices, including family restrictions, affect Indigenous women's decisions to obtain healthcare. This conclusion is supported by other research found outside of an Asian context. In Kenya, the cultural beliefs and practices related to pregnancy and birth are still strongly adhered to, where, for example, birthing occurs mainly at home (Nyambedha, 2013). Indigenous women in northern Canada often experience lack of familiarity with the mainstream health system and discrimination in the provision of healthcare, creating further barriers to accessing health services (Browne, 2010). If the experiences of Indigenous women regarding access to health services are to be improved, it is essential that cultural beliefs and practices are recognized and taken into consideration when planning and developing health services.

The perspectives of healthcare providers on healthcare access for Indigenous women appeared to reflect the sentiments of Indigenous women. However, no studies compared and contrasted perspectives of healthcare providers and Indigenous women using a systematic approach. A comprehensive comparison and contrast of healthcare access barriers from the viewpoints of service providers and users would add to the developing literature in this area. Adding to the challenges and barriers discussed, some included studies (Binder-Finnema et al., 2015; Munro & McIntyre, 2016) reported Indigenous healthcare providers' feelings of working in the mainstream healthcare sectors, such as frustration, loss of autonomy, dissatisfaction, and limited professional development. Indigenous healthcare professionals working in the health sector in Indonesia reported tension and discrimination from mainstream healthcare workers (Munro & McIntyre, 2016). Similar findings were revealed in a study conducted in Vietnam by Binder-Finnema et al. (2015), as there was marked dissatisfaction with the work environment for care providers in small and remote communities. The recruitment and retention of Indigenous care providers was viewed as a high priority issue because it resulted in a lack of consistency within provider-patient relationships, preventing the development of culturally appropriate health services. Efforts to increase diversity in the healthcare workforce are necessary in order to promote consistency and overcome possible blockages to accessing health services, leading to decreased health disparities (Phillips & Malone 2014). This includes allowing Indigenous care providers to work to their full scope of practice, providing greater professional and leadership development opportunities.

This scoping review has highlighted the dearth of literature relating to Indigenous women's postpartum health and access to postnatal supports and services, despite the fact that complications following pregnancy and childbirth are a leading cause of maternal deaths in developing countries, particularly in Asia (WHO, 2016). The current research on Indigenous women's perspectives of maternal health was exclusively studied in the context of antenatal and perinatal health. This suggests a clear need for further research to consider the health consequences of Indigenous women after childbirth from a holistic perspective: physical, psychological, social, emotional, and spiritual aspects.

Promotion of Gender Equality and Women's Fundamental Human Rights under the Sustainable Development Goal (SDG) 5

According to the United Nations Sustainable Development Goals (2015), more specifically Goal 5: Achieve gender equality and empower all women and girls, gender equality is "not only a fundamental human right, but a necessary foundation for a peaceful, prosperous and sustainable world". Although research to date has shown that targeting gender equality and women's rights contributes to reducing poverty and improving health outcomes, gender equality remains a distant dream in Asia. The findings of this review indicate that economically and socially marginalized Indigenous women living in Asia continue to suffer discrimination and face greater barriers to accessing education, essential health services, and participation in decision-making processes in comparison to non-Indigenous women. These are violations of women's fundamental human rights. Efforts to ensure that Indigenous women have equal access to and attainment of non-discriminatory education, and are encouraged to reach their full potential, might be effective in achieving gender equality.

Taking steps to eliminate discrimination against Indigenous women and tackling specific healthcare access barriers might reduce health disparities and enable women to achieve their full enjoyment of life through the rights to health. This includes integrating gender perspectives into the design and implementation of health policies and programs. Enhancing the full and meaningful involvement of Indigenous women in the planning and the provision of health services will lead to a reduction in health disparities. All services provided must be culturally sensitive and responsive to the priorities and unique health needs of Indigenous women. In addition, providing education (including on gender issues and the rights to health) and culturally competent training for healthcare providers, and recruiting local Indigenous providers to serve Indigenous patients, might help tear down the barriers to accessing health services. Healthcare providers, who provide services to Indigenous peoples, should also be encouraged to engage more with reflective practice, particularly in relation to the impact of their attitudes and behaviors on patients' health status and adherence, satisfaction with care, and care seeking. These will reduce disparities in accessing health services and, ultimately, improve the lives and health outcomes of Indigenous women, contributing to the attainment of the SDGs.

Limitation

This review is subject to certain limitations. As per our inclusion and exclusion criteria, several studies were excluded because they included children or family members among participants. This limited the scope of the review to the perspectives of Indigenous women and/or healthcare providers regarding health service accessibility. The search strategy used to identify potentially relevant studies was limited to specific search terms and databases. This review used the definition of Asian countries as identified by the 2015 United Nations' report on the State of the World’s Indigenous Peoples. This does not include the Middle East and Arabian Peninsula, which could be a limitation for this work. The literature search was limited to English and Thai languages. This may have affected the studies identified.

Conclusion

This scoping review of the literature on views and perspectives of Indigenous women and care providers reveals emerging data on factors influencing use of health services. While there has been a growing concern about basic human rights, particularly in relation to gender equality and women’s empowerment under the SDG 5, achievements are still low in Asia. Indigenous women in Asia continue to experience compounding forms of discrimination and face greater challenges than non-Indigenous women, particularly in their quest for achieving optimal health that is exacerbated by unequal access to health services.

Findings of this study stress the need for improved access to equitable and appropriate healthcare through the elimination of barriers and the integration of cultural considerations into practice and policy. The results of this review provide a basis for a new approach to the design and delivery of health services for Indigenous women that take sociocultural aspects and the diversity of local beliefs and values into account. This will ensure that health services meet the healthcare needs of diverse groups, providing respectful and culturally appropriate care, and in turn, facilitating access and improved health outcomes.

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Disclosure Statement

No potential conflict of interest was reported by the authors.

Key Messages

(1) Indigenous women living in Asia continue to experience health services inaccessibility that result in health disparities.

(2) This scoping review supports the need for future research that focuses specifically on issues related to health and access to healthcare services in this region and across the lifespan.

(3) Consideration of health services access barriers and associated contextual influences can reveal culturally-specific strategies that will improve equitable access to, and the delivery of, culturally appropriate services of higher quality.

(4) Efforts to ensure that healthcare providers are aware of cultural beliefs and practices, and are given relevant cultural skill training and education, will contribute to the development of best practices and policies that results in improved health services accessibility and health outcomes for Indigenous women in Asia.

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Chapter 3: Paper 2: Healthcare Access Experiences among Indigenous Women in Northern Rural Thailand: A Focused Ethnography Study

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Abstract

Introduction: Persistent inequities in health and access to healthcare services for Indigenous women in Thailand remain a significant challenge. This study provides narrative accounts of Indigenous women's experiences accessing healthcare in northern rural Thailand, and explores the complexity of culture and its interaction with multiple intersecting influences.

Methods: A focused ethnography study was conducted by following Knoblauch's (2005) applied research methodology to understanding and describing culture and cultural phenomenon. We recruited 21 women participants aged 20-41 years between March and April of 2017. In-depth semi-structured interviews conducted in Thai were used to explore the experiences of the participants living in a northern rural village. Data analysis was conducted using Roper and Shapira's (2000) framework for ethnographic analysis.

Results: Seven themes presented across three phases of experience (pre-access, making choices, and encountering challenges and difficulties) revealed an in-depth understating of the Indigenous women's lives, the broader sociocultural context in which they lived, and the challenges they faced when accessing healthcare. Analysis of data showed that the participants did not benefit from equal access to healthcare and often experienced disproportionately, discriminatory practices and negative attitudes of mainstream healthcare providers.

Conclusions: This is the only study to date to discuss healthcare access challenges experienced by Indigenous women living in a northern rural Thai village. This study found an urgent need exists to enhance non-discriminatory access to, and quality delivery of, healthcare services to Indigenous women in northern rural Thailand. Future responses to equitable healthcare access and disease burden reduction should focus on these findings in the development of the most effective strategies, programs, and policies.

Keywords: Indigenous women; Northern Rural Thailand; Ethnic minorities; Healthcare services, Access to healthcare; Gender equality; Human rights

Introduction

The truth about stories is that's all we are.

--Thomas King, *The truth about stories: A native narrative, 2003*

Access to healthcare is complex and multidimensional. Culturally diverse populations experience intersecting layers of complexity when accessing healthcare. Although access to quality healthcare is internationally recognized as a fundamental human right, inequities in health and healthcare access persist for many ethnic groups, posing serious public health threats (UN, 2015; WHO, 2015). Asian Indigenous women are more likely than non-Indigenous women to bear a greater burden of disease and rates of ill health (UN, 2015). They are less likely to receive appropriate healthcare services and face a myriad of obstacles in their quest for achieving optimal health (Thummapol et al., 2018; UN, 2015). In Asia, there exist some studies that provide evidence of the significant inequities for Indigenous and non-Indigenous populations. However, few studies have been published to understand healthcare access among Indigenous groups in Asia; thus Asian Indigenous health research remains largely overlooked (Dhir, 2015; UN, 2010, 2015). The existing literature shows that there are significant differences in Asian Indigenous women's access and use of health services in comparison to the rest of the population (Dang, 2012; Jose et al., 2014; Shah & Belanger, 2011; Thummapol et al., 2018). Specifically, Indigenous women in Asia are excluded from sexual and reproductive health services and are less likely to seek care when they are ill (Dang, 2012; Dhir, 2015; UN, 2015). Specifically and more importantly, the health status of Asian Indigenous women remains a low priority and is often ignored by their governments (UN, 2015).

Seventy percent of the world's Indigenous peoples are residing in Asia (AIPP, 2014; UN, 2015). Thailand is a country in Southeast Asia, with 3,429 Indigenous villages and an Indigenous population of approximately 923,257 (Dhir, 2015; UN, 2015). Indigenous peoples of Asia, including Thailand, as defined by the UN (2015), are those who have a long connection with the lands and an experience of marginalization or discrimination; largely because they have a distinct and different cultural tradition and history compared to other groups within a state. While 'Indigenous' is a commonly used international term, its use in Asia, in particular Thailand, is limited (AIPP, 2014; Dhir 2015). In recognition of the right to self-identification declared in the Declaration on the Rights of Indigenous Peoples (UN, 2015), this paper primarily uses the term 'Indigenous women' throughout.

In Thailand, many different Indigenous groups reside in northern rural highland areas. The government legally recognizes ten Indigenous groups, leaving almost half of Indigenous peoples in Thailand stateless (Dhir, 2015). These stateless people are subject to discrimination and the denial of basic human rights (Dhir, 2015). Thailand has the largest number of stateless people in the world, approximately half a million people with many belonging to ethnic minorities living in northern and rural areas near the Thai-Myanmar border (Cadchumsang, 2011; Spindler, 2015).

Thailand is a country where health inequities exist for Indigenous groups (Lutvey, 2014). Indigenous peoples often live in northern and rural areas, where access to healthcare is limited or not available and they are less likely to access public health services (Dhir, 2015; UNHCR, 2010). This healthcare access inequity between Indigenous and non-Indigenous groups in Thailand can lead to negative health consequences. Indigenous women are in the upper percentile of diseases that are preventable, such as cervical cancer (Kritpetcharat et al., 2012) and HIV/AIDS (Apidechkul, 2016). Indigenous women experience multiple forms of discrimination and often have difficulties in obtaining healthcare (Apidechkul, 2016; Cadchumsang, 2011). This is attributed to a ‘double burden’ of Indigenous identity and gender (Lutvey, 2014).

Globally, literature on Indigenous peoples’ healthcare access is available; however, it is not gender specific (UN, 2015). The current literature on healthcare access for Indigenous women is from countries such as Bangladesh (Chowdhury, 2017), Canada (Denison, Varcoe, & Browne, 2014; Van Herk, Smith, & Andrew, 2010; Morgan & Wabie, 2012), Guatemala (Schooley et al., 2009), India (Jose et al., 2014; Shah & Belanger, 2011), and Vietnam (Dang, 2012). These few studies report on inequitable healthcare access and high disease burden; however, there is no Thai specific literature. Furthermore, an understanding of healthcare access experiences among Indigenous women in Thailand has not yet been explored. The purpose of this study was to understand the healthcare access experiences among Indigenous women in northern and rural Thailand and to explore within these experiences the complexity of culture.

Methods

The study design was a focused ethnography conducted using purposive sampling and snowball strategies by following Knoblauch’s (2005) applied research methodology to understanding and describing culture and cultural phenomenon. This study was guided by the following research questions:

1. What are the experiences of Indigenous women accessing healthcare services in northern Thailand?
2. What do Indigenous women living in northern Thailand believe are the facilitators and the impediments to accessing quality healthcare?
3. How do cultural beliefs and practices influence access to healthcare for Indigenous women living in northern Thailand?

4. How do Indigenous women experience efforts to engage with healthcare providers and system?

The study site was a village located in the rural highland areas of Mae Hong Son province, one of the northern and mountainous provinces of Thailand that borders Myanmar. This province is approximately 924 kilometers (574 miles) away from the national capital city of Bangkok. The village has a population of 457 Indigenous people, is located 55 kilometers (34.17 miles) from the closest hospital, has poor road conditions, and offers no access to public transportation. (Figure 3.1).

Figure 3.1. The study setting

Institutional Review Board human ethics approval of the study protocol was received in both Canada and Thailand. Informed consent was obtained prior to conducting all of the interviews, which included a request to audio-record the interview and to return after the interview had been transcribed to check that the participants' responses are reflective of their experiences (member checking). When obtaining informed consent, the researcher ensured that participants fully understand the purpose of the research, procedures, potential risks and benefits associated with research participation, and that they can make a voluntary decision to participate in this study or withdraw at any time and to choose not to answer any questions. All study participants provided written informed consents.

Data Collection

Twenty-one women aged 20-41 years participated in interviews between March and April of 2017. Demographic data was collected from each participant at the beginning of the interview. Multiple recruitment strategies guided by the literature were used (Bonevski et al., 2014; Liamputtong, 2007; Roper & Shapira, 2000; Sixsmith et al., 2003; Higginbottom et al., 2013). The researcher identified and recruited participants using purposive and snowball samplings, as well as through the researcher's personal networks, an Indigenous mentor (approached during a study feasibility trip), face-to-face, and study posters. The author of Thai ancestry collected data in Thai from participants. In this study, data saturation dictated the sample size (Cruz & Higginbottom, 2013; Guest et al., 2006) and occurred after 21 interviews. Field notes (e.g., observations and information recorded during the interviews) and a reflexive journal (e.g., the researcher' thoughts, reactions to people and the setting, or personal feelings and emotions) were maintained during the course of fieldwork and used for analysis (Ortlipp, 2008).

The first author of Thai ancestry conducted face to face, in-depth interviews with 21 women. The interviews focused on participants' past and current experiences with the healthcare system. The interviews were semi-structured, with some prepared open-ended questions (Spradley, 1979). Interview questions and probes included: Where do you usually go for healthcare? Can you tell me about your last (or last two) healthcare visits? What influenced your decision to seek healthcare? How was it for you to get the healthcare services you needed? The interviews were tape-recorded with consent, lasting around 45 minutes, and then transcribed verbatim to text in Thai and then translated and back translated (Al-Amer et al., 2015; Chen & Boore, 2010; Nurjannah et al., 2014). The translation and back-translation process is discussed in more detail in the following section.

Data Analysis

Data collection and analysis proceed concurrently from the very first interview. The first author transcribed and translated the first three interviews into English for review and analysis with the PhD supervisors. The rest of the transcripts were kept in the original language (Thai). Data analysis was guided by Roper and Shapira's (2000) framework for ethnographic analysis, which includes five strategies: a) coding for descriptive labels, (b) sorting for patterns, (c) identification of outliers or negative cases, (d) generalizing themes, and (e) noting included as reflective remarks (e.g., ideas or insights of the researchers when collecting data and reviewing interview or relevant documents). NVivo qualitative data analysis software (Version) was used as a tool to organize and code narrative data.

Written materials compiled from the field notes, a reflexive journal, and transcribed interviews were read and re-read prior to coding. Initial coding was discussed and refined within the research team, and then grouped into meaningful and descriptive categories and subcategories. These categories were then compared, contrasted, and sorted for patterns that reflect the similarities and differences between the interviews, as well as shed light on the cultural beliefs and practices of the participants and explain the phenomenon of interest (Roper & Shapira, 2000). Following the identification of patterns and through noting, the data was re-

read and seven themes that captured the nature of the women's experiences into a meaningful whole were abstracted. Finally, this iterative process of data analysis resulted in organizing the seven themes across three phases of the women's experiences, which was further discussed and refined by the research team, taking both emic and etic perspectives into account (Roper & Shapira, 2000).

Field notes and a reflexive journal enabled the reflective process within the project. The researcher was able to reflect on interviews and gain a deeper understanding of the women's stories and their experiences. This enabled the development of richer interpretation and themes to emerge, contributing to the iterative process of data analysis (Roper & Shapira, 2000).

Translation and back-translation. The interviews were conducted in Thai; however, English was the language used with the PhD supervisors and to report the findings. Therefore, translation of the interviews was required. All audiotapes were transcribed verbatim in Thai. The first author read the transcribed transcripts in conjunction with the audiotapes to verify the accuracy of the transcription and to correct any transcription errors. The process of translation and back-translation began after themes and categories had emerged and been identified (Al-Amer et al., 2015; Chen & Boore, 2010; Nurjannah et al., 2014). Three people were involved in the translation and back-translation process. The three people were: 1) the author, a PhD student who conducted all of the interviews in Thai; 2) a Thai nurse researcher who conducted research in English and Thai; and 3) another Thai nurse researcher who conducted research in English and Thai. The use of three translators is recommended given it can enhance the quality of translated data and minimize translation errors (Chen & Boore, 2010). The process of translation and back-translation that followed in this project is outlined in Figure 3.2 (Al-Amer et al., 2015; Chen & Boore, 2010; Nurjannah et al., 2014). Note that each process was conducted independently.

The translated documents were compared and any discrepancies were resolved through discussion between the first two translators (Al-Amer et al., 2015; Chen & Boore, 2010; Nurjannah et al., 2014). The final English version was reached by agreement of the first two translators (Chen & Boore, 2010). To ensure the accuracy of translation, the process of back-translation was conducted by the third translator (Al-Amer et al., 2015; Chen & Boore, 2010;

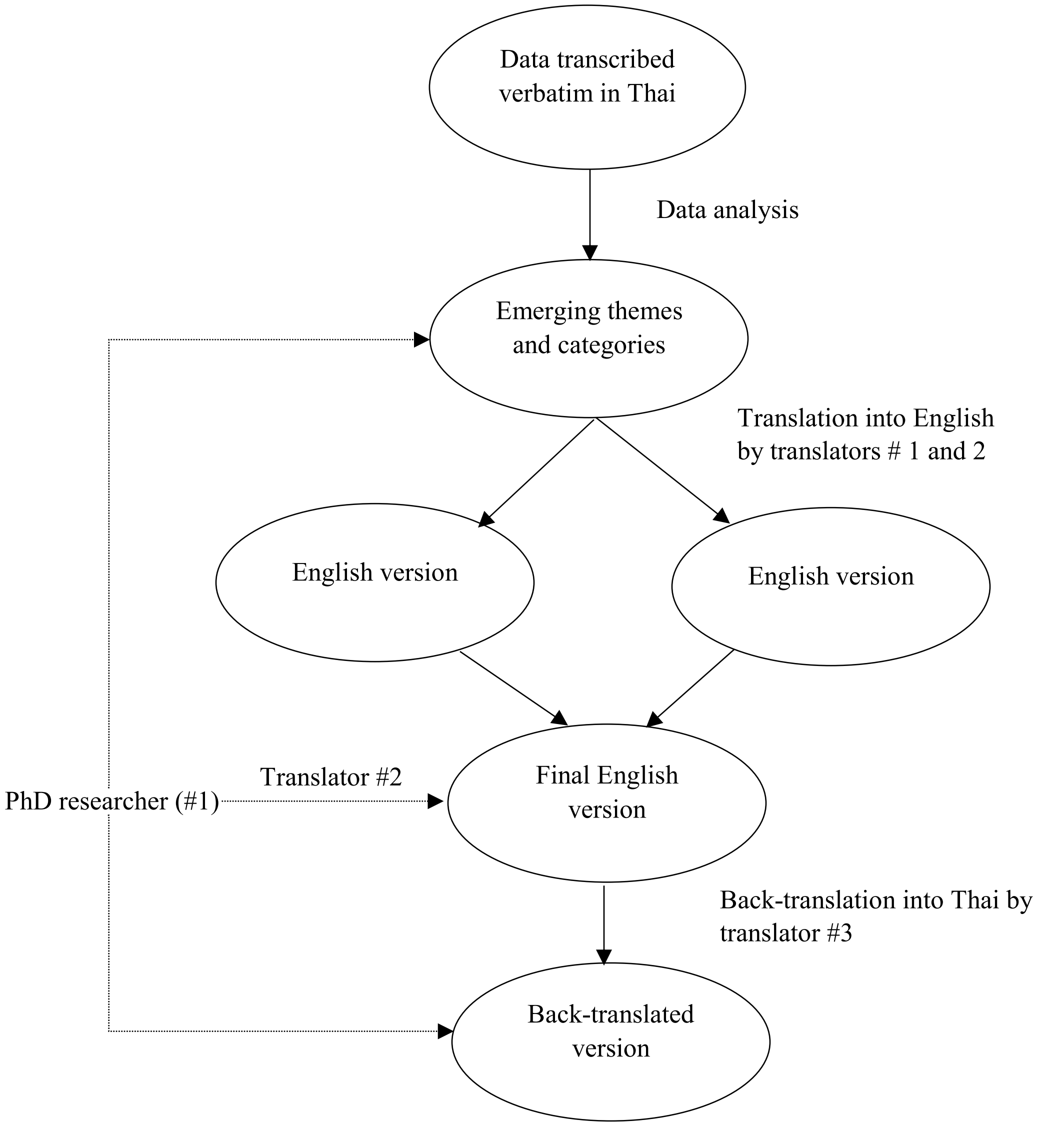

Figure 3.2. Translation and back-translation processes

Nurjannah et al., 2014). To achieve equivalence between original and targeted languages, and to avoid misrepresentation of participants' meaning, the first researcher compared the back-translated transcript with the original version (Chen & Boore, 2010; Nurjannah et al., 2014). The translation and back-translation processes were repeated multiple times and discussed throughout, in order to minimize any discrepancies in meaning (Maneesriwongkul & Dixon, 2004).

It has been well recognized that achieving equivalence between two languages is a challenge (Squires, 2008). Therefore, working with a bilingual translator who possesses an understanding and knowledge of participants' culture and language and is familiar with medical terminology and research is an optimal way to produce accurate and meaningful data (Chen & Boore, 2010; Nurjannah et al., 2014; Squires, 2008).

Results

Themes and sub-themes emerged that further exemplified participants 'experiences with access to healthcare including: (1) understanding the lives of the women; (2) women's roles in Thai society; (3) wellness and cultural practices; (4) seeking out health services; (5) engaging with healthcare providers; (6) navigating access to quality healthcare; and (7) understanding what facilitates healthcare access. Table 3.1 presents the demographic characteristics of the participants and Table 3.2 summarizes the thematic analysis of the participant's narrative accounts.

Understanding the Lives of the Women

Citizenship status. The majority of participants reported having Thai citizenship. Participants who had citizenship status generally reported that they were able to access basic education, healthcare and social services, freedom of movement, and employment opportunities.

Table 3.1

Demographic Characteristics of the Study Sample (n=21)

Characteristics	N	%
Age (mean = 34)		
≤ 20	2	10
21-30	7	33
31-40	5	24
≥ 41	7	33
Place of birth		
Home birth	18	86
Institutional birth	3	14
Citizenship status		
Thai citizenship	18	86
Non-citizenship status	3	14
Highest education level		
Some high school, no diploma	9	43
High school graduate	7	33
Some college credit	2	10
Bachelor’s degree	2	10
Master’s degree	1	4
Occupation		
Employed	20	96
Farmer	14	68
School teacher	3	14
Small shop owner	2	10
Cook at school	1	4
Unemployed (student)	1	4
Monthly Income (in Baht [34.40 Baht = 1 USD, Rates on April 30, 2017])		
< 5000	10	48
5000-10000	6	29
11000-15000	3	14
16000-20000	1	4
21000-25000	1	4
Health conditions		
Chronic (at least one)	9	43
Non-chronic	20	95

Notes: Chronic health conditions included high blood pressure, high cholesterol, diabetes, thyroid dysfunction, and ear, nose, and throat problems.

The non-chronic health conditions included accidents/injuries, dental issues, tropical disease (malaria), skin problems, drug allergies, headache, and anxiety.

Table 3.2

Summary of the Thematic Analysis of Participants' Narrative accounts

Understanding the lives of the women	Non-citizen women have restricted access to care Health-seeking behaviour is influenced by employment More disadvantaged and vulnerable to poor health outcomes
Women's roles in Thai society	The expected gender roles create 'double burden' Caregiving as a female responsibility Unequal distribution of responsibilities
Wellness and cultural practices	Reproduction, chronic conditions, and accidents are most common issues Traditional herbs/medicines, farm work, and religious rituals used to stay healthy Some cultural specific practices and beliefs influence health and decisions about care
Seeking out healthcare services	The provision of services not equally distributed Traditional and Western medicines are complementary Structural barriers and socioeconomic characteristics identified as reasons for avoidance or delayed access
Engaging with healthcare providers	Having familial connections is described as beneficial A sense of belonging and acceptance created by meaningful interactions A discriminatory and insensitive behaviours of providers influenced healthcare decisions and access to healthcare
Navigating access to quality healthcare	A desire to engage enhanced when feeling treated with respect Unequal treatment and discrimination based on different characteristics Long waiting time viewed as the most challenging
Facilitating healthcare access	The complexity of gender and its intersection between social categories Strong family and community relationships promoted care seeking and outcomes Need for reducing wait times; better healthcare environment; outreach services; and transport system

While participants who did not have Thai citizenship reported having difficulties in achieving the rights and benefits given to 'citizens'. The following excerpt illustrated challenges the undocumented participants[5] faced when attempting to obtain needed care, "I took my child to the community clinic early in the morning on a weekend because of fever and got yelled at by the health worker…she was not friendly and there was a lot of attitudes happening. The health worker refused to provide care and said, "Come back during the operating hours"--the tone of

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[5] Based on self-report of health status, the undocumented participants refer to those who did not have Thai citizenship status at the time of interviews. However, they were registered within a non-Thai category as being displaced people and were issued non-citizenship pink ID cards. Note that displaced people, issuing pink ID card, refer to those who are members of the following ethic groups: the Mon, the Karen, the Tai-Yai, and the Burmese, and resided in Thai border provinces, including Mae Hong Son (Cadchumsang, 2011).

her voice was rude and nasty. I did not want to go there again and would rather treat my son's symptoms myself" (Participant 17). Another participant discussed her experience with the lack of citizenship and restriction of movement, as she was unable to travel freely within the country, "I do not have citizenship… I am stuck here; I cannot go anywhere I want to" (Participant 16).

Employment. The majority of participants were self-employed (farmers, shop owners, and cooks), while some participants were government employed schoolteachers. The self-employed participants reported that they faced additional difficulties, such as fear of income loss when taking time away from work for doctor visits. One participant stated, "I was crying in pain at work because I could not afford to take my day off to go to see the doctor…The employer will only pay me 100-200 Baht [$ 3-6 USD] a day and if I take a day off work we will not have money to buy food…" (Participant 11).

Health conditions. Participants with chronic conditions reported facing increased difficulties getting to the many doctor visits due to time and associated travel costs. One participants reported, "I've been diagnosed with Thyroid and ever since, have had regular doctor appointments. I've got to take time off work to attend the scheduled appointments because it will take a day, and I could not afford to purchase the drugs [over-the-counter] because it's expensive and it is difficult sometimes to get to the hospital especially when it rains or when the scheduled appointment is not on the day that other people are going to town for 'gad nat' [grocery market]. The shared transportation with neighbors will cost you a 100 Baht [$ 3 USD]" (Participant 9).

Women's Roles in Thai Society

Gendered roles. Participants reported that they spent large amount of their time meeting gendered expectations of their domestic and reproductive roles. One participant stated, "…cooking, washing clothes, and caring for children are our responsibility…we work within and outside the home. So you know caring for the children and going to the hospital…it's hard for me" (Participant 3).

Familial roles. Participants also mentioned about substantial unpaid caregiving activities for the ill, elders, and young, as well as the impact it had on their decisions to seek care when they were ill. One participant explained, "I have 2 siblings but they are not here. I live with my mom and have to look after her and take care of everything…like going to town to fill my mom's prescriptions…I will not go to see the doctor unless I'm really sick because I don't want to leave my mom alone" (Participant 2).

Labor roles. In addition to unpaid work in the household, participants also engaged in paid work to supplement family income. Participants explained that they had a little time-out to think about their own health needs, let alone access to healthcare. One participant shared, "Besides cooking, doing household chores and looking after children and the family, I am also working in the farm…I have to do everything and have no time for myself" (Participant 4).

Wellness and Cultural Practices

Common health conditions. The three common health issues (past and current experiences) that participants sought healthcare for included: reproductive health (including childbirth, contraception, annual exams and pap smears; chronic health conditions; and accident/injury. One participant with chronic condition discussed her experiences and challenges when accessing the care she required, "I have high blood pressure and the last time that I was there [district hospital] for blood tests was extremely long. I was starving because I did not drink or eat anything at all before going to the hospital and the nurses kept me waiting 4 hours to have my blood drawn, just in the same line with other patients [who did not fast]." (Participant 14).

Staying healthy and well. When asked about what they do to stay heathy and well, these responses were most commonly heard: consuming foods and traditional herbs/medicines that were good for health and managing illnesses; engaging in the physical activity like farm work (farm work was seen as a form of exercise); and participating in religious activities/rituals. One participant described, "…drinking herbal water made from ginger root, galangal, and lemon grass is good to remain healthy especially during cold weather. Fah talai jon (andrographis paniculata) is a very effective solution to cure fever and sore throat, it's bitter but very powerful…" (Participant 6). Another participant reported, "Sarb sue (Siam weed) is used to help stop bleeding and cure wounds. Just crush some leaves and then put it on the affected area" (Participant 11).

Cultural and religious beliefs and practices. Across many of the interviews, traditional beliefs and practices mainly during the postpartum period like herbal steam baths, keeping the body covered from head to toe, and food beliefs were brought up copious times. One participant described, "Herbal steam baths made by the boiling a mixture of herbs such as roots and leaves will promote mother's perspiration which eliminate residual impurities, improve the skin, and stimulate breastmilk" (Participant 6). Another participant shared, "Keeping the body of both mother and baby covered from head to toe for at least a month after delivery is important to prevent further cooling. We believe that it will give strength and protect mother and baby from getting sick" (Participant 5).

Certain food beliefs that were commonly practiced by participants after giving birth to babies were identified. Several participants mentioned about certain food items that were restricted and recommended, "In our culture, there are specific kind of foods that should not be eaten at least one month following the delivery…like strong-smelling vegetables like cilantro and green onion…" (Participants 18). Several reasons were discussed as to why this may be, including a cause of sickness to mother. One participant explained, "Eating foods that are restricted by our culture can cause muscle soreness or aches to the mothers" (Participant 2).

All participants identified foods that were recommended during the postpartum phase. One participant shared, "We are only allowed to eat dry grilled pork dipped with salt during the first month after giving birth because they are not culturally restricted and believed to accelerate wound healing and recovery time" (Participant 7). However, the food provided at the hospital does not meet participants' cultural food needs, as this woman described, "I stayed in the [district] hospital after giving birth to my child, I could not eat the food provided there…ones with cilantro…it was restricted by our culture and believed to cause sickness like deafness to the mothers" (Participant 12).

Several participants noted the religious inclinations that were deemed important to women's way of life as going to the village temple when marking important events related to Buddha to make merit, practice meditation, or to listen to a sermon. One participant explained, "We will take our time off work to go to the temple on the Buddhist holidays to make merits especially on the major Buddhist holy days like the full moon and waning moon, we will not work." (Participant 9).

Seeking Out Healthcare Services

Geographical health service options. All participants discussed healthcare services that were accessed inside and outside the village in sub-district (including the traditional healer, traditional herbs/medicines, and community health center), district (including private clinics, drug stores, and the district hospital), and the hospitals within and outside the provincial areas. The majority of the participants primarily accessed the community health centre when experiencing symptoms of illness, while some participants bypassed the community health centre and directly accessed the hospitals at which they were registered or preferred, and often paying extra for this. The latter group was more educated, had a higher income, had experience of medical conditions, or know someone at healthcare. One participant discussed her personal experience with accessing healthcare and the preferences that influenced her healthcare choices, "I will go to [provincial] hospital when I'm sick because I like the quality of services there better even though I have to pay extra for it. I paid 800 baht [equivalent to $23 USD] for blood tests because it was not covered by the universal healthcare when you bypassed the community health center and district hospital" (Participant 19).

Traditional and Western medicine. All participants used a hybrid of traditional and Western practices. The combination and/or shift among using traditional and Western medicines was largely influenced by the perceived nature and severity of health conditions, as this participant explained, "If you were feeling not well and did not get better after visiting the doctor, you have 'lom nok' [physical symptoms for which doctor can find no cause, which believed to be caused by supernatural forces], I would go to see a traditional healer for some religious rituals and drink 'nam mon' [holy water] and then I would get better" (Participant 7). Several participants mentioned about some particular health conditions that were believed to be caused by demons or supernatural forces. As a result, a traditional healer was primarily consulted, "When my son was 3 months old, he cried inconsolably for several nights for no apparent reason. I took him to the village traditional healer at night for healing. The traditional healer got him to drink 'nam mon' [holy water] and put 'sai sin' [a white holy cord] around his neck. My son got better after treatments by the traditional healer" (Participant 17).

Delaying and avoiding healthcare services. Participants reported only attending a healthcare service when experiencing symptoms of illness that were quite serious and after using self-administered medication and/or traditional medicines without success. All participants reported reasons to delay or avoid accessing healthcare included long waits, experiences of discriminatory and insensitive communication or treatment, and concerns about family responsibilities and loss of income. One participant shared, “I took my child to the community health center early in the morning on a weekend because of fever. I got yelled at by healthcare staff. She [healthcare staff] said “come back during the operating hours”--the tone of her voice was rude and nasty…I did not want to go there again and would rather use the remaining medicines to treat my child’s symptoms” (Participant 17).

In addition, preventive healthcare was not common among participants, as this participant stated, “If I’m feeling a bit ill I will take the drugs [purchased over-the-counter or supermarkets] specific to my condition. I would get better after that…but I never get annual physical exams because I think I am okay. I do not believe that I have to see a doctor unless I am extremely sick…you know the [district] hospital is always busy and you will have to wait very long to see the doctor” (Participant 10). Several participants mentioned that they were aware of the available pap smear screening, yet they were less likely to receive them due to a lack of knowledge and understanding. One participant explained, “There is a pap smear screening at the community clinic once or twice a year. But I did not get checked because I’m under age 30” (Participant 12).

Engaging with Healthcare Providers

Connected relationships. Participants mentioned that knowing someone at the hospital gave a privilege in terms of the quality of services they received. They noted that these connections helped encourage participation in their care and adherence to treatment. Likewise, several participant discussed the meaningful and familiarity of connection they had with a village traditional healer made it easier for them to approach for traditional healing when needed. One participant explained, “Because my sister is a registered nurse and my husband is working in healthcare sector. I’ve always been received a good quality of care and not having to wait as long to see a doctor. But other women might not get the same treatment, you know the difference is there” (Participant 1).

Helpful interactions. Throughout the interviews, it became apparent that participants’ perceptions of the quality of the healthcare they received was highly dependent on the interactions with their healthcare providers. Participants reported feeling that they were respected, accepted, and cared for, particularly when a strong positive relationship/interaction was formed. The presence of Indigenous health providers, in particular, was perceived as crucial because of the shared cultural and linguistic heritage, creating the sense of belonging and acceptance, as this participant stated, “I really appreciate that I get to see an Indigenous nurse when I visited the district hospital, she was very friendly and understanding...making me feel at ease” (Participant 3).

Insensitive healthcare providers. Many participants reported a lack of trust of non-Indigenous healthcare providers, resulting from firsthand experience of discriminatory and insensitive behaviors by healthcare providers. They felt that providers were not friendly towards them or not paying significant attention to their needs because they were ‘Indigenous’, spoke with accent, appearing poor and uneducated. One participant shared, “The last time I was there [district hospital] was when I had an ankle sprain from a motorcycle accident. I was not okay with the way I was treated. I feel like the doctor did not respect me as a patient when he talked to me in that tone of voice. You know I wish he knew how to treat patients fairly and not based on how we look or how much money we have” (Participant 5).

Navigating Access to Quality Healthcare

Experiencing quality healthcare. Women who described being treated by healthcare providers who took the time to listen to and understand their unique needs and preferences, and explained information clearly, reported greater satisfaction and experience with healthcare services. One participant stated, “One of the things I like about this [provincial] hospital is I was treated with respect and felt cared for. They [providers] would take time to listen to my health concerns and perform comprehensive assessment” (Participant 19).

Experiencing discrimination and unfair treatment. The past negative experiences as experienced by participants seemed to predominate and were primarily of discriminatory and insensitive behaviors and attitudes of healthcare providers. Several participants stated feeling as though healthcare providers at times treated them inferior and talked down to them. Participants also believed that they were not treated fairly as they had to wait longer than others to receive care, as this participant explained, “I will not go to [district hospital] if not necessary. I got yelled at by healthcare providers, it is always crowded there and I had to wait longer than others who are not Indigenous for treatment. I would rather go to the private clinic for medication, it’s faster” (Participant 2).

Experiencing long waits. Long wait times in the hospital was brought up copious times as a significant factor to maintaining connections or engaging with healthcare services. All participants complaint about the length of time that they were required to wait before receiving any medical attention and felt that this wait-times situation discouraged continued use of healthcare services. One participant said, “I got lower back injuries caused by bending one time and I went to the [provincial] hospital at 4-5 am and got to see the doctor around 6 pm and got home around 9 pm. This is what we are facing by living up in the mountain. I did not want to go there because it costs me more time and money" (Participant 6).

Facilitating Healthcare Access

Intersectionality of multiple influences. Multiple intersecting influences regarding healthcare access facing participants were identified through interviews. These include rural geography, transportation, time away from work, long waits, financial constraints, family responsibilities, degree of un-wellness, cultural discrimination, and previous negative experiences with healthcare. One participants shared that, "…you are going to spend a day waiting to see a doctor…it's a waste of time. I would rather not go and wait for the suffering symptoms to go away on its own…it's difficult we are living very far from town and if we are not extremely sick we would not go. Many of us are poor and do not have a vehicle and asking others who have private vehicles to drive you will cost thousands Baht, not to mention about food, the transportation alone will cost you 1000 Baht [$ 29 USD]" (Participant 5).

Family/community support and networks. Positive social support from family, neighbors, and community was mentioned as an important factor contributing to participants' ability to make decisions about health and access to healthcare services. Several stories emerged regarding support system, for example during a crisis neighbors offering rides to the doctor. One woman stated, "I did not make it to the hospital for delivering my first child. The village vehicle at the community clinic was not available, but luckily, one of our neighbors drove me to the district hospital. The health worker at the community clinic tagged along and I was giving birth to my child in the car, on our way to hospital." (Participant 12).

Expectations of health services. Several suggestions were made regarding how to improve access to healthcare services or what would make it easier for participants to see a doctor. The most commonly heard responses include reduce wait times, making the waiting room/spaces more inviting and welcoming, the need for outreach services to the village, and the establishment of transport system especially during emergency. One participant shared that, "I would like them [healthcare providers] to come to the village…every once in a while if possible, services like pap smears or physical check-up for those who are ill. We are poor and many do not have money to go to the hospital so they would miss the appointment. If they [healthcare providers] take the services to us it will save us a lot" (Participant 7).

Discussion

The findings of this study highlight the significance of personal, socioeconomic, cultural and geographical contexts, and previous healthcare experiences that affect participants' access to and use of healthcare services. These contexts and experiences provide a window into understanding the lack of or unequal access to care resulting from differences in the determinants of health, such as those based on gender, racial/ethnic background, citizenship, socioeconomic status, and rural geography. The findings capture how multiple sources of influences intersect to shape women's decisions and opportunities to receive equitable healthcare, creating distinct patterns of experience. In light of the findings of this study, participants' experiences are discussed under the following phases: pre-access, making choices and accessing a location, and encountering challenges and difficulties.

Pre-Access

The process of obtaining care encompasses the demand and supply-side determinants (Levesque et al., 2013; O'Donnell, 2007). Although the two intersect, in essence, 'pre-access' represents the characteristics of participants (demand-side forces) that affect their decisions and ability to access healthcare. In addition, the implications of the findings for healthcare practice is discussed.

Cultural norms and values, including gender roles and family responsibilities play a vital role in women's healthcare decisions (Phonklieng, 1999; Munro & McIntyre, 2016). The participants gave accounts of life circumstances that were based in traditional and patriarchal norms of gendered domesticity, primary caregiving for the family, and work responsibilities. The expected gender roles create 'double burden' of work for women and adversely affect their health and well-being (Ferrant et al., 2014). The findings highlight the unequal distribution of responsibilities (within and outside of home) which translates into unequal opportunities in terms of time to seek health-related attention (Binder-Finnema et al., 2015; Norsa'adah & Wnorlida, 2014; Munro & McIntyre, 2016; Wongwatcharanukul et al., 2014), to invest in educational and vocational skills, and to equally participate in paid work, thereby aggravating poverty (Ferrant et al., 2014). This is consistent with previous studies suggesting that the multiple roles of Indigenous women limit their activities to domestic spheres, family and social obligations, affecting women's ability to nurturing their own health needs and seeking care during operating hours (Lama & Krishna, 2014; Munro and McIntyre 2016). Further, participants have been shown to underuse preventive and screening services and may be at risk for misdiagnosis and inappropriate treatment. These findings suggest a need to focus on health prevention and education, creating an awareness of preventable diseases and their sequelae. In addition, a consideration regarding location and hours of operation that reflects the needs and circumstances of Indigenous women is essential, in order to make health services accessible.

The abovementioned findings offer an important snapshot of how gender inequality affects women's health and well-being, decisions to seek care, and adherence to treatments, resulting in differences in health and access to healthcare. Gender equality and the right to health is part of the Sustainable Development Goals (SDGs) (UN SDGs, 2015). This poses a major challenge for society, healthcare providers and policy makers to not only recognize but also take steps to reduce gender inequality across and simultaneously within households and communities. I propose the following actions: recognition of women's roles and circumstances, implementation of strategies to change cultural and social norms that can form an unintended barrier to equal opportunity, better integration of gender perspectives into healthcare systems, and change harmful laws and practices that limit or violate the rights of women (Sen & Östlin, 2007; UN SDGs, 2015).

There are differences in employment (self-employed VS government employed) that give rise to a host of inequities that influence health, wellbeing, and access to healthcare services (Harris et al., 2010; Binder-Finnema et al., 2015; Lama & Krishna, 2014). Government employed women were better equipped to cope with financial costs associated with access, while several self-employed women delayed and/or had to pool their resources to get needed care. This negatively impacts the health of women, as well as raises concerns over long-lasting health implications. These findings are consistent with previous literature suggesting that women who belong to socioeconomically disadvantaged and marginalized groups are more vulnerable to poor health and have higher rates of chronic diseases, yet they are less likely to seek healthcare (Harris et al., 2010; Binder-Finnema et al. 2015; Lama & Krishna, 2014; Sen & Östlin, 2007). The UHC has been introduced in Thailand to reduce inequities in health and improve access to healthcare, particularly in terms of service affordability (National Health Security Office, 2002). This serves to reduce financial barriers to accessing health services. However, the findings of this study indicated that women in lower income levels faced greater difficulties in meeting indirect financial costs associated with accessing healthcare, including transportation and unpaid time off work for medical appointments. While these findings correlate with the fact that Indigenous women are disproportionately economically disadvantaged, the inequality in income is not uniformly experienced by all Thai women. There is a need for urgent actions to stop the perpetual cycle that places women at great disadvantage due to financial instability. Strategies that provide culturally diverse patients living in rural areas with transportation to appointments or subsidies for health and delivery services have seen some success (Canadian Medical Association [CMA], 2013; Gipson et al., 2015; Sharma et al., 2013; Sidney et al., 2016; Thummapol et al., 2018). Providing outreach or programs for rural residents, for instance, home visits from healthcare professionals has the potential to eliminate this barrier (Jose et al., 2014; Thummapol et al., 2018).

For Indigenous women, health is viewed from a holistic perspective—they take care of their health and wellness by attending to different aspects of their being such as physical, spiritual, and mental. The findings provide a good vantage point to understand the differing views of health and treatments of illnesses, which has important implications on women's access, adherence to treatment, health practices, and decision-making regarding when and whom to consult or when to switch between treatment alternatives. For example, the findings revealed that participants are more likely to self-treat or use alternatives when they are feeling unwell given the multiple source of influences such as their belief systems, shared family valued, multiple roles, socioeconomic status, geographic restrictions, past personal experiences, and structural barriers. These acts are evident in women's delayed access to Western medicine and use of traditional remedies for primary healthcare to manage some health conditions, including cold, flu, wounds, and postpartum care, which also has been found in previous studies (Krit et al., 2015; Srithi et al., 2012; Thomlinson, McDonagh, Crooks, & Lees, 2004). Research suggests that the use of traditional practice in Southeast Asia, including traditional medicines have made a fruitful, yet often unrecognized contribution, to the promotion and maintenance of health, as well as the prevention and treatment of illness (Srithi et al., 2012; WHO, 2010). In addition to the health benefits of traditional medicine, the most common reasons for using it are that it is easily prepared and quickly accessible health resource, more convenient and affordable, and closely aligned with peoples' values, beliefs, and practices (Srithi et al., 2012; Thomlinson, McDonagh, Crooks, & Lees, 2004; Wachtel-Galor & Benzie, 2011; WHO, 2010).

Given the extensive use of traditional medicine practice for primary healthcare among women in this current study, understanding more clearly the role of traditional medicines and practices in primary healthcare and healing process, as well as looking to improve and support integrative governance models for traditional approaches, could have a positive impact on health outcomes for Indigenous populations in Thailand (Oliver, 2013; WHO, 2010). With such an understanding, policy makers, district health authorities and healthcare professionals would be more apt to integrate cultural values and holistic approaches (e.g., traditional medicines and food) into healthcare delivery system in order to reduce Indigenous patient delay and facilitate participation in the provision of healthcare. This is closely aligned with the Beijing Declaration on the role of traditional medicine and its integration into mainstream healthcare system (WHO, 2008). This declaration encourages and calls actions from states to include traditional medicine in national health systems, ensure the safety, efficiency and appropriate use of traditional medicine practice, and to respect, protect, preserve and promote the traditional knowledge and natural resources essential for its sustainable development and application (WHO, 2008).

Making Choices and Accessing a Location

In the context of the present findings, many influences have been shown to impact women's healthcare decisions and options. Making choices and decisions about which health practice to use was attributed to a range of influences, including perceived causes of illness, social support, provision of health services and referral system, and previous experiences with health facilities and/or providers, including waiting times.

As the findings showed, traditional and Western medicines were complementary, allowing participants to maximize the effects of treatment without sacrificing traditional practices. The participants shifted or combined various options to manage specific situations, largely based on the perceived nature of the health condition (either taught by experience or passed from generation to generation) and influenced by family and/or older people (Li et al., 2017; Thomlinson, McDonagh, Crooks, & Lees, 2004). For example, the findings highlighted some particular health conditions and events like 'lom nok'[6], which were believed to be caused by demons or supernatural forces, and thus a traditional healer was primarily consulted. The coexistence of traditional forms of healing and Western medicines has been commonly practiced among Indigenous peoples living in rural areas both in developing and affluent countries (Li et al., 2017; Morgan & Wabie, 2012; Oliver, 2013; UN, 2015). Although many health-related practices and beliefs might not be consistent with Western biomedical practices or carry scientific basis, they are perceived to be a good fit in the context of women's lives, reflecting sociocultural norms and values (Li et al., 2017; O'Donnell, 2007). These findings will be useful for healthcare providers to better understand the influence of deeply rooted traditions on health and respect patients' knowledge of traditional treatments and practices. It also underlies the need

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[6] Medically unexplained physical symptoms or conditions for which the doctor cannot find a cause or participants do not get or feel better after doctor visits (this information is based on interview data and personal communication).

for policy initiatives and effective strategies that might contribute to improve Indigenous patients' health outcomes, access and adherence to treatment, and satisfaction with care.

Several inferences can be drawn from the findings to suggest how family and community resources influenced participants' decision and ability to seek care. The participants generally agreed that the enabling factor to using healthcare services was primarily related to social support, especially from spouses, other family members, and neighbours. This conclusion is supported by other research found outside of a Thai/Asian context. Previous studies conducted in Egypt (Ohashi et al., 2014) and Guatemala (Schooley et al., 2009) found that support from family and friends was a key factor in women's decisions to access healthcare, contributing to improvement of women's health. This is due to the ability to mobilize the resources necessary to obtain needed healthcare and achieve the best possible health outcomes (Ohashi et al., 2014; Schooley et al., 2009). Given that family plays a role in women's healthcare decisions and has potential to create or remove access impediments, it is important to take the role and influence of family into account when plaining and designing strategies and programs for women to encourage the seeking of treatment in healthcare facilities during illness (WHO, 2009).

Further, community resources such as the presence of health workers in the village was perceived to be beneficial, particularly during an emergency or crisis situation. However, the findings also indicated factors such as poor transport networks and the attitudes of health workers, which can potentially hinder access to existing health services. A previous study in low-income countries like Uganda showed that the use of community health workers in rural and underserved communities was central to the national healthcare delivery system, contributing to community development and improved access to basic health services (Musinguzi et al., 2017). Given community health workers play a vital role in providing essential health services to underserved people, leading to improved health outcomes, considerable investment and management should be made to ensure that they are effectively and efficiently selected, trained, and supported (Lehmann & Sanders, 2007).

In Thailand, there are a number of initiatives that are designed to improve access to health services in rural areas. The construction of community clinics (also known as community health centers), for example, has been shown to be effective (Tangcharoensathien et al., 2018). The findings of this study show that the majority of participants seeking health services at the community clinic given the referral system[7] and proximity highlighted the importance of this initiative in improving availability of healthcare. Nonetheless, lack of access to needed care remains in part explained by late entry to health services and/or financial burden of out-of-pocket expenses. This is highlighted in the findings where several participants bypassed care at the community clinic or nearest healthcare facility and seeking care at the private clinics or a higher-level hospital where they felt more comfortable voicing their needs and priorities even when they had to bear financial costs associated with access and health services. This is attributed to deficiency or low quality of health services, which is highly consistent with previous research conducted in developing countries (O'Donnell, 2007). As O'Donnell (2007) argues, poor quality of health services is a major impediment to the delivery of effective healthcare and has direct implications for equitable access to healthcare. A current initiative in Thailand (i.e., the construction of community clinics) tends to focus on geographic access or lowering the barriers of distance. While the availability of healthcare resources is important to the consideration of

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[7] According to Jongudomsuk et al., (2015), the community health centre is the first point of contact providing primary care (by a nurse and trained workers) and referring a patient to district and/or provincial hospitals when needed. Secondary and tertiary care are provided by the hospitals, often on referral up the system (from community health centre to district to provincial/regional).

access and prima fasciae rural concerns, it does not capture the complexity and interconnection of access influences. These findings parallel previous literature demonstrating that accessible health services are more than the physical presence of a health facility (MacKinney et al., 2014; Silal et al., 2012). Thus, it is essential that policy makers specifically consider multiple access influences and system characteristics when considering rural access to healthcare such as the characteristics of a rural population (e.g., personal, cultural, and belief systems), the appropriateness and quality of healthcare services, a person's experience with healthcare system, and the impact or consequences of current healthcare infrastructure and policies (e.g., facility hours of operation, provider cultural understanding/competence) on access to healthcare among Indigenous peoples.

The findings revealed that previous experiences with the healthcare system, including waiting times influenced participants' perspectives of access and healthcare decisions. Long wait times is a unique challenge to maintaining connections or engaging with healthcare services, especially when combined with contexts of domestic and family responsibilities, employment, low incomes, geographical restrictions and lack of transportation (Bierman et al., 2010; Kalich, Heinemann, & Ghahari, 2016). In this current study, women's responses to the barriers to accessing healthcare such as taking on financial strain and stress, traveling longer distances for faster or better care, substituting with informal care, and delays in accessing medical care raise concerns about equitable access to healthcare. For instance, many women reported using private clinics or over-the-counter medicines[8] (i.e., fees for services) to address the long waiting times in the local hospital. Clearly, women with lower income will have fewer options, placing them at even greater disadvantage and may result in inequitable access. Some previous studies have

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[8] In Thailand, prescriptions are not necessary for many medications. Therefore, pharmacy is often the first port of call for Thai people when they are feeling sick or unwell, given they can simply purchase over the counter.

found that the use of the drug kiosk is significantly associated with delayed access and decreased health facility utilization (Ebid & Abdel-Wahab, 2006; Petkova, 2008). Delay in seeking medical treatment can result in longer hospital stays, development of devastating complications, poorer health outcomes, and premature death (Blankart, 2012; Wachtel-Galor & Benzie, 2011). These actions may have a devastating impact on women's livelihoods and health. Attention is required to structural barriers that introduce financial difficulties and hamper women's access to healthcare.

Participants provided examples of both positive and negative experiences of care that affected their access, use, and satisfaction with healthcare services. Although stories with a negative sentiment seem to predominate, positive events are present in Indigenous women's accounts. The findings revealed that participants perceived being treated with respect and felt more welcomed particularly when interacting with healthcare providers whose background was Indigenous, enabling a sense of belonging and acceptance. These feeling of respect, cultural safety and security in which trusting relationships could be built contributed to women's desire to engage with healthcare services (Askew et al., 2014; Davy et al., 2016; Thummapol et al., 2018). This perspective is consistent with previous studies suggesting that increased diversity in the healthcare workforce can contribute to expand healthcare access, improve quality of patient-provider interactions, and reduce racial/ethnic health inequities among the underserved populations (Phillips & Malone 2014; Thummapol et al., 2018).

Encountering Challenges and Difficulties

The findings offered valuable insights into understanding the complexities of participants' lives, the broader sociocultural context in which women live, as well as how it relates to health inequities. Participants faced unique challenges and substantial barriers in accessing essential healthcare services both at individual and structural levels. Consistent with the claims made by UN (2015a), which indicated that female members of culturally and ethnically discriminated groups are associated with multiple characteristics that contribute to poor access. Barriers to access influence the use of health services, which in turn, lead to unmet healthcare needs, delays in receiving appropriate care, inability to benefit from preventive services, unacceptable financial burdens, and preventable hospitalizations (Carrillo et al., 2011; Jose et al., 204; Lama & Krishna, 2014; MacKinney et al., 2014; Norsa'adah & Wnorlida, 2014; Schooley et al., 2009; Thummapol et al, 2018; UN, 2015; Wongwatcharanukul et al., 2014).

The findings suggested that sociodemographic characteristics and resources, including legal status and geographical location, were important determinants of healthcare access and use among participants. For example, undocumented participants had been subject to restrictions on their rights to healthcare as well as freedom of movement based on such factors as a lack of nationality or citizenship. Issues concerning the rights to a nationality and how the lack of a nationality or citizenship have negative consequences in the lives and health of Thai Indigenous peoples have been identified in the literature (Cadchumsang, 2011; Dhir, 2015; UNHCR, 2010). Additionally, the UNHCR (2010)'s report on ending statelessness reveals that individuals who lack a nationality may have difficulty accessing basic rights to health and social services and are especially vulnerable to abuse of human rights. Although there are some of the impressive actions taken in Thailand to enhance greater access to a nationality through the enactment of legislative changes in 2008 [9](Dhir, 2015; UNHCR, 2010), the findings warrant further considerations and efforts. With a growing interest on issues related to prevention of human

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[9] Acknowledging the problem, the Thai authorities have attempted to address situations of statelessness by enacting legislative changes in 2008 to enhance greater access to nationality, ensuring that a child born in Thailand, regardless of the nationality or legal status of the parents, has access to birth registration (UNHCR, 2010).

rights abuses and reduction of health inequities, globally, the findings provide policymakers with important dimensions to reflect on and consider when assessing progress made to date, and what strategies they can implement to effectively address the issue. These may include facilitating naturalization as well as eliminating procedural and practical obstacles to ensure enjoyment of the full range of human rights for minority groups who are entitled to it under law (UNHCR, 2010).

Furthermore, health service provision was challenging due to geographical isolation. Transportation difficulties, in particular, was shown to be one important factor affecting participants' ability to access and use needed healthcare. These findings parallel previous research suggesting that personal characteristics and social resources, including travel burden can represent important barriers to access among socially and economically disadvantaged women, particularly those living in rural areas where there is limited access to a range of services, some of which (e.g., specialist services) may not be available at all (Binder-Finnema et al., 2015; CMA, 2013; Gipson et al., 2015; Gyaltsen et al., 2015; Kottegoda, Samuel, & Emmanuel, 2008; Lama & Krishna, 2014; Nguyen et al., 2015; Pati et al., 2014; Ratzon, Sheiner, & Shoham-Vardi, 2011; Schooley et al., 2009; Sharma et al., 2013; Tej Ram et al., 2015; Thummapol et al., 2018). While acknowledging that road building is expensive and is outside of the direct control of the healthcare system, a focus on interventions that target multiple determinants of health as well as dimensions of access can help to mitigate inequities and ensure equitable access to effective and appropriate healthcare services (MacKinney et al., 2014; Thummapol et al., 2018). Strategies such as providing credit to cover travel expenses or bringing health services to the community has been found to be effective in improving healthcare access for underserved populations (Davy et al., 2016; O'Donnell, 2007; Thummapol et al., 2018).

The findings revealed that several women perceived discrimination from some healthcare providers because they were Indigenous and poor. Many reported hostile encounters with healthcare staff and a lack of cultural sensitivity and understanding of cultural differences. In the stories described previously, the experiences of unequal treatment, discrimination, and insensitivity of healthcare providers affected the quality of interactions and participants' decisions to seek medical care for their own needs. This can further contribute to unequal burdens of morbidity and mortality because care is avoided or delayed in response to such negative experiences, thereby exacerbating inequities in health and access to healthcare. This finding is highly consistent with the extensive literature that has shown perceived discrimination as a major barrier to Indigenous populations accessing, utilizing, and being satisfied with mainstream healthcare services (Binder-Finnema et al., 2015; Browne et al., 2016; Munro & McIntyre, 2016; Rix et al., 2013; Sharma et al. 2013).

The reality and barriers of discrimination and racism facing Indigenous women living in rural and northern Thailand suggests that it is imperative for healthcare providers to understand factors that contribute to inequity in healthcare access for Indigenous populations, particularly through healthcare providers' attitudes and behaviors. It also sheds light on the need for increasing sensitivity, compassion, and reflective practice among healthcare providers. Studies have shown that the ability of mainstream healthcare systems and providers to understand and take account of cultural differences, beliefs, and values when providing care are integral to encourage care seeking and full participation in healthcare services for Indigenous peoples (CMA, 2013, 2013a; Davy et al., 2016; Durey & Thompson, 2012; Li, 2017; Thummapol et al., 2018). In addition, efforts to tailor care, programs, and services that are culturally sensitive and responsive to the unique health needs of diverse populations and address the intersecting forms of discrimination, are critical (Browne et al., 2016; Thummapol et al., 2018). These efforts can be facilitated through partnerships with Indigenous peoples and community members, training around health equity, cultural safety and anti-oppression for healthcare professionals at all levels, and increasing the recruitment, participation and retention of local Indigenous healthcare providers (Browne et al., 2016; Phillips & Malone, 2014; Thummapol et al., 2018).

Limitations

The limitations of this study are the small size and the homogeneity of the sample, and language barrier. The researcher interviewed a small and select sample of participants who had similar backgrounds and social levels (education, geographical, or occupation). In particular, the setting for this research was relatively homogeneous with respect to gender and ethnicity. As is essential in qualitative research, the participants were selected based on their ability to provide information, not on the basis of how they represented the general population. Given that this is a focused ethnographic inquiry, knowledge generated by this approach is not assumed to be generalizable. It is also acknowledged that participants who participated in this study may well not be representative of others who did not participate. In particular, given the lack of translation facilities, participants who did not speak Thai were excluded. This may have resulted in the study not capturing the healthcare challenges of non-Thai-speaking Indigenous participants who may have different experiences.

Conclusion

This is the only study to date to discuss healthcare access challenges experienced by Indigenous women living in a northern rural Thai village. This study found an urgent need exists to enhance non-discriminatory access to, and quality delivery of, healthcare services to Indigenous women in northern rural Thailand. Future responses to equitable healthcare access and disease burden reduction should focus on these findings in the development of the most effective strategies, programs, and policies.

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Chapter 4: Paper 3: Methodological Challenges Faced in Doing Research with Vulnerable Women: Reflections from Fieldwork Experiences

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Abstract

Methodological challenges of qualitative research involving people considered vulnerable are widely prevalent, for which many novice researchers are not well equipped or prepared for. This places great physical and emotional demands on the researchers. However, a discussion to bring to light the issues related to the researchers' experiences and practical concerns in the field remains largely invisible in the literature. This paper presents the reflective accounts of a doctoral researcher's fieldwork experience, particularly in relation to the methodological challenges encountered in carrying out research with vulnerable women in rural and northern Thailand. Four of these challenges pertain to selecting a field site and acquiring access, recruiting and building trust, maintaining privacy and confidentiality, and being vulnerable as a researcher. Suggestions from the literature and practical strategies the researcher employed to deal with such challenges and real dilemmas are discussed. This paper calls for more formal safeguards during the research process and suggests that researchers reflect upon their experiences and emotions in undertaking a field research, making the accounts of their research journey heard and beneficial to other novice and/or experienced researchers.

What is already known?

It has been widely acknowledged that researching vulnerable groups poses unique and sometimes difficult challenges, requiring careful consideration, planning, and continuing vigilance by the researchers. However, a question remains with regard to how novice researchers can be better prepared to anticipate and manage the challenges that arise in the field.

What this paper adds?

This paper contributes to the literature on the methodological challenges of undertaking qualitative research with vulnerable women in the field, including the emotional aspects generated during the research process, which often is less of a focus in the research endeavor. It also adds insights into the importance of reflection on qualitative research experiences, challenges and practical strategies, particularly in relation to qualitative enquiry. The researcher contends that this reflective piece was an invaluable learning experience and is beneficial for those planning and undertaking research with vulnerable populations.

Introduction

There has been a growing interest in the experiences of those whose voices have been absent from health research and policy discourse, such as vulnerable and disadvantaged groups (Bonevski et al., 2014; Derose, Gresenz, & Ringel, 2011; Liamputtong, 2007; Von Benzon & Van Blerk, 2017). This is because the burden of disease and rates of ill health fall more heavily and frequently on these groups in comparison to the general population (Derose, Gresenz, & Ringel, 2011; Liamputtong, 2007; Szczepura, 2005; Tang et al., 2015; WHO, 2015). Women from ethnic minority communities, in particular, are among the most disadvantaged and vulnerable members of society, and are more likely to bear a disproportionate burden of disease and social discrimination (Binder-Finnema et al. 2015; Browne, 2010; Defo, 1997; Joes et al., 2014; WHO, 2015). The need for the development of knowledge from the perspectives of these women has been part of a move towards an inclusive approach, and towards the use of research as a means for the elimination of poverty, marginalization, social exclusion, and social justice (Hankivsky, 2012; Hankivsky & Cormier, 2009).

Conducting research with people who are considered vulnerable presents unique challenges, and requires special attention from researchers (Liamputtong, 2007; Von Benzon & Van Blerk, 2017). Specifically, Research Ethics Boards (REBs) are more likely to put particular requirements on researchers intending to include participants from vulnerable groups. This may include the meaningful inclusion of key members of the groups being studied from the earliest stages of conception and planning, through to the generation of research findings, or a careful consideration of issues relating to weighing risks and benefits of a study, fairness, and power inequalities and inequities (Liamputtong, 2007; Medeiros, 2017;Von Benzon & Van Blerk, 2017).

While methodological challenges of qualitative research involving vulnerable populations are well recognized, many novice researchers are often not well equipped or prepared for the responsibilities (Liamputtong, 2007; McCosker, Barnard, & Gerber, 2001; Medeiros, 2017). Without adequately attending to a range of methodological and practical concerns associated with the conduct of research, novice researchers can be overwhelmed by the magnitude of the challenges, while simultaneously damaging their creditability and professional standing if released to the fields unprepared (Ballamingie & Johnson, 2011; Iphofen, 2015; Li, 2018). Li (2018), for example, bravely shared her embarrassing and unexpected circumstances while collecting data in the field, for which she was not prepared. In her naivety as a novice researcher, Li (2018) admittedly revealed, “I thought that once I had gained permission from the research ethics committee to use an audio recorder, I took it for granted that I had a passport for everything else” (p. 24). Yet, participants refusing to give consent for recording left her feeling downhearted and treated as an unwanted outsider (Li, 2018). The researcher later realized when writing her research diary that, consent required an ongoing process of discussion and re-negotiation of trust throughout the research process (Li, 2018).

It is important to acknowledge that many of the issues and challenges that arise when employing qualitative research methods are not sufficiently addressed or accounted for by existing REBs’ guidelines (Ballamingie & Johnson, 2011; Block et al., 2013; Woodgate, Tennent, & Zurba, 2017). Thus, this requires careful consideration, planning, skills, and continuing vigilance on the part of researchers. This can place great physical and emotional demands on researchers, and possibly be a daunting task for those who are novice researchers. I argue that it is important, therefore, to make explicit the potential experiences, the potential challenges faced, and the practical strategies and safeguards employed when carrying out research with people who are considered vulnerable. By doing so, it has great potential to address the unresolved or unexpected challenges, identify resources and support, and increase research capacity (Ballamingie & Johnson, 2011; Dickson-Swift, James, & Liamputtong, 2008; Liamputtong, 2007; McAreavey & Das, 2013).

Reflections on the experiences and practical concerns of researchers in the field, however, are often not standard practice and therefore remain largely invisible in the literature (Ballamingie & Johnson, 2011; Iphofen, 2015; Liamputtong, 2007). Drawing upon the fieldwork experiences of a doctoral researcher who conducted research with women who belong to ethnic minority groups in northern and rural Thai village, this paper attempts to address this gap. By explicitly outlining some of the methodological challenges (both anticipated and emerging), as well as those specifically encountered at the earliest stages of conception and planning through to the collection of data, practical strategies are identified that can be used to mitigate and/or resolve such challenges. These insightful considerations that maintain the integrity of the research process are discussed.

Defining Vulnerability and Vulnerable Groups

There is no single universal definition of the term ‘vulnerability’ as this notion is mostly socially constructed (Liamputtong, 2007). Vulnerability in general is related to ‘susceptibility’ and refers to ‘at risk for health problems’ when applied to healthcare in particular (De Chesnay & Anderson, 2016, p. 3). Within the context of health research, vulnerable people can cover individuals and groups who are “…susceptible to being harmed, wronged, exploited, mistreated, discriminated against or taken advantage of…” (Ganguli-Mitra & Biller-Andorno, 2011, p. 239). These individuals are more likely to experience discrimination, social exclusion, and limited access to resources and services (Ebert, Bellchambers, & Ferguson, 2011; Wilkinson & Marmot, 2003). It is important to note that the term ‘vulnerable’ is often used interchangeably with such terms as ‘disadvantage’ (Bonevski et al., 2014; Vinson, 2007) and the ‘hard-to-reach’ (Bonevski et al., 2014; Hancock & Flanagan, 2010), particularly in the discourse of health and social inequalities.

Vulnerable groups most commonly identified in the literature include but are not limited to children, Indigenous peoples, ethnic minorities, people experiencing disabilities, drug users, prisoners, and the homeless. There are other groups to which the description applies, including women (Adams et al., 2013), people living in rural areas (Ebert, Bellchambers, & Ferguson, 2011), refugees, and asylum seekers (Von Benzon & Van Blerk, 2017), as well as undocumented or illegal persons (Birman, 2005). Some vulnerable groups experience multiple influences that diminish their capabilities to ensure their rights, further marginalizing and rendering them ‘doubly vulnerable’ (Liamputtong, 2007). The doubly vulnerable populations, according to Liamputtong (2007), may include women of low socioeconomic status and ethno-cultural backgrounds. This applies to the research participants in my study who are female members of an ethnic minority group and at greater risk of economic hardship.

According to Ebert and colleagues (2011), women from vulnerable and disadvantaged groups have limited power to act freely, exercise their rights, and fulfill their potential as full and equal human beings. When these populations are involved in research, they are likely to be vulnerable to coercion or undue influences, and thus require special protections or appropriate additional safeguards (Liamputtong, 2007; Stone, 2003). Although conducting research with vulnerable populations can be a complex process and often requires extra thought and effort, knowledge produced from such research can be used by healthcare providers and government officials to develop programs and policies that reduce health inequities (Bonevski et al., 2014; Hancock & Flanagan, 2010).

The Study Context: A Focused Ethnography with Indigenous Women

As in other countries, Thailand is a nation where health inequities exist and continue to pose significant challenges, especially among ethnic minorities (Lutvey, 2014). This situation is of particular concern among Indigenous peoples, as they often live in rural and remote areas where access to healthcare is limited or simply not available (Dhir, 2015). Specifically, Indigenous women in northern Thailand tend to bear a greater burden of ill health, and experience compounding forms of discrimination and oppression, stemming both from their Indigenous identity and gender, a so-called 'double burden' (Lutvey, 2014) or 'double vulnerability' (Liamputtong, 2007); creating an even greater barrier that limits their ability to obtain the care they need. The health inequities and limited access experienced by Indigenous women in northern Thailand are often ignored; thus is an under researched topic (Dhir, 2015; IWNT, 2014; Lutvey, 2014), despite the fact that it is clearly a social concern that requires a national government response.

The purpose of the focused ethnographic study was to gain deeper insight into, and provide rich accounts of, the experiences of Indigenous women accessing healthcare services within their unique cultural context. As the aim of the study was to research cultural beliefs and practices, I determined a qualitative research method was the most suitable tool, particularly when undertaking research with Indigenous peoples, because it "provide[s] congruence and cultural safety for the tenets of Indigenous worldview" (Denzin & Lincoln, 2000, p. 14). Focused ethnography was considered a methodological fit, given it seeks to unveil a distinct inquiry within a particular cultural group (Roper & Shapira, 2000). Following a focused ethnographic approach (Roper & Shapira, 2000), study data was gathered through 21 in-depth interviews with women living in a mountainous, rural village of northern Thailand. The interviews were semi-structured, with some prepared open-ended questions that were developed based on the ethnographic interview (Spradley, 1979), which focused on participants' past and current experiences with the healthcare system.

Reflections on the Methodological Challenges

The methodological challenges that were experienced when undertaking this research with women in the field include issues related to: 1) selecting a field site and acquiring access, 2) recruiting and building trust, 3) maintaining privacy and confidentiality, and 4) being vulnerable as a researcher. The strategies used to mitigate and/or resolve these challenges are also understood through the discussion of first-hand fieldwork experiences and suggestions from existing literature. The excerpts from my research journal, which captured a record of my thoughts, emotions, questions, dilemmas, and interactions as I engaged with people, are used to provide a picture revealing some of the challenging moments of being in the field.

Selecting a Field Site and Acquiring Access

Choosing an appropriate study site and gaining access is a key part of the research process; yet is one of the greatest drawbacks to successfully conducting research (Johl & Renganathan, 2009; Kondowe & Booyens, 2014). It involves a combination of careful planning; academic knowledge; practical research experience; researcher knowledge, skills, and commitment; and luck (Kondowe & Booyens, 2014). Research has shown that negotiating access and gaining entry to the field can pose a challenge, and in some situations be quite problematic, particularly in groups who are often excluded or difficult to reach (Liamputtong, 2007; Siwal, 2015; Sixsmith, Boneham, & Goldring, 2003). This, in part, is due to the lack of trust in researchers and/or past abuses of research (Liamputtong, 2007; Suzanne, Vanessa, & Sara, 2008). The success of the research then, depends greatly on the researcher's ability to gain access to the setting, as well as build and maintain trusting relationships in the field (Johl & Renganathan, 2009; Kondowe & Booyens, 2014; Sixsmith, Boneham, & Goldring, 2003).

There are a range of factors that a researcher should take into account, especially when selecting a field site, such as gatekeeping obstacles, over-researched issues, and burden to the participants and community (e.g., need for resources) (Angrosino, 2011). I selected a northern and rural Thai village located in the second most northern and mountainous province of Thailand, bordering with Myanmar. This was because I had personal contacts in the village with a trusted member of the community (Angrosino, 2011). Specifically, the women residing in this northern and rural village had been identified as the most ignored and under researched group compared to other ethnic groups in Thailand (Cadchumsang, 2011).

Entry to the research field was established and negotiated through informal phone calls to familiar people (e.g., schoolteachers) in the village (Johl & Renganathan, 2009). After the initial contact, gatekeepers at various levels were identified and approached. A study feasibility trip was then conducted prior to the development of a research protocol and submission of ethics applications, in order to meet with the village leader—the 'formal gatekeeper' (Liamputtong, 2007; Roper & Shapira, 2000). This person held a position of authority and high respect, enabled community access, and introduced me to group members and potential participants (Caine, Davison, & Stewart, 2009; Liamputtong, 2007; Roper & Shapira, 2000). It is important to note that research access to the Indigenous women required gaining the trust of respected community leaders who were the gatekeepers (Liamputtong, 2007; Roper & Shapira, 2000). The study feasibility trip allowed me to: 1) engage with the village leader and key members of the group (e.g., schoolteachers), and 2) to share research questions and discuss the research project (including purposes, methods, intended use of the research, risks, and benefits) in a positive, clear, and respectful manner (Caine et al., 2009; Kelly, 2006; Roper & Shapira, 2000). This is reflected in my personal narrative and supervisor response below:

> Met the village head, key members, and some women. Felt immediately connected and welcomed. They agreed and were happy for me to start. I felt relieved. They would identify potential participants for me when I returned for data collection (Research journal, Thummapol, 2017)
>
> It sounds like you are making great progress in this regard. Thanks for sending along the pictures. It really brings it to life (Supervisor email).

Given that gaining trust and enlisting the help of gatekeepers is not an easy task, I volunteered at the village school, being visibly present among village members, and dressing in the manner of most Indigenous women during the time I spent in the field (Rodney, Colleen, & Barbara, 2016). Hammersley and Atkinson (2007) acknowledge the importance of being aware and sensitive to self-presentation and clothing choices, with consideration of the cultural norms, as it can positively or negatively influence relationships that develop during the research process.

After the study feasibility trip, the village leader happily granted access and agreed to introduce me to village members. One schoolteacher agreed to be my Indigenous mentor and assisted with recruitment (Bonevski et al., 2014; Liamputtong, 2008; Roper & Shapira, 2000; Wilson & Neville, 2009). By experiencing the study feasibility trip and spending considerable time (one month) in the setting, I was provided with greater opportunity to develop a deeper understanding of the social and cultural norms, become familiar with the setting and local people, and establish trust and rapport with potential participants (Caine et al., 2009; Liamputtong, 2008). Although I was given the green light to start my data collection, I felt that it was in knowing A [A is my friend, who is also a trusted community key member] who really gave me credibility in the community and assisted me to win their trust, as my journal below reveals:

> Permission granted by the village head. I wondered, though, would these lovely people be so receptive and eager to support me if I did not know my friend A, I don't think so. (Research journal Thummapol, 2017)

Recruiting and Building Trust

Recruiting and retaining participants can be challenging and time-consuming (Liamputtong, 2008). It is a gradual process that depends on the skill of the researcher in communicating, negotiating, and building a sense of trust and mutual respect with each participant (Roper & Shapira, 2000). This is particularly important when undertaking research with disadvantaged and vulnerable women. According to Smith (2008), there is a need for substantial and consistent support and encouragement for women to participate in studies. Therefore, the relationship with research participants must be carefully managed, as it can affect participation and retention (Liamputtong, 2007). This requires the researcher to thoroughly consider how participants are selected and encouraged to participate or remain in a research project, and are assisted to withdraw from participation if so desired (Iphofen, 2015).

During the study feasibility trip, I took the time to form trusting relationships with potential participants by maintaining visibility in the village, engaging in conversations, and listening to village members (Suzanne et al., 2008; Liamputtong, 2007). I was amazed at how quickly I established relationships and rapport with people. I became increasingly familiar with many women in the village, their language and local accent, and felt at ease with living in the village. Some of the women started to talk to me in a friendly and caring manner, and offered me food and beverage. I felt I was well received by the women and village members, as my journal below testifies:

> Making myself known and appreciated. Starting to make some friends and talk to a few women. They were very friendly and welcoming and offered me food and beverage whenever I went visiting! Did not realize until later how much I had been absorbed by people's lives - I was able to speak in their peculiar local accent and interact with women in their unique way! Or so it seemed to me at the time (Research journal, Thummapol, 2017)

Through personal networks and the study feasibility trip, I had been accepted and welcomed with open arms. I was confident that I could build on these relationships when I returned to the field for data collection. To create and maintain reciprocity and respect for participants, strategies used included: flexibility in scheduling interviews, member checking (allowing participants to read the transcription of their recorded interviews if desired), and acknowledgement of partner expertise (recognizing that they were the experts of their experience and of the elements that shape those experiences (Bonevski et al., 2014; Suzanne et al., 2008; Liamputtong, 2007).

It is widely acknowledged that the quality and quantity of the data shared with researchers depends in part on the relationship that develops between research parties. As Duncombe and Jessop (2012) point out, close rapport enables participants to disclose their experiences and speak more freely, enhancing the gathering of detailed and rich data. Yet, it also brings ethical dilemmas concerning the potential abuse of the researcher's power of persuasion, using what Duncombe and Jessop (2012) refer to as shared ‘womanhood’ or ‘friendship’ to facilitate access to information. As Duncombe and Jessop (2012) explained, qualitative (female) researchers are armed with skills of ‘doing rapport’ through their gendered subordination and socialization, in order to achieve disclosure with women participants.

On further reflection, while taking into account the power the researcher holds, I became aware that participants are not necessarily powerless. Participants hold some power, as they are in possession of the knowledge and lived experience of the phenomenon of interest; are in control of what, and to what extent, personal knowledge is shared; and are able to withhold their participation at any time with no further obligations (Duncombe & Jessop, 2012). However, I reflected upon the idea if participants actually recognized this shift in power or genuinely felt able to refuse participation in the research. To assess and ensure participants’ understanding regarding their rights and participation in the study, I asked the potential participant to briefly describe the purpose of the study; what the participant needed to do; the risks and benefits of participation; and how the participant may withdraw. Inconsistencies were discovered and corrected at this time. If the potential participant was able to relate this information back to me, then understanding of the project had been demonstrated, and they were invited to participate in the study. I also informed all of my participants prior to the interviews that they were free to refuse to answer any questions or withdraw from the study at any time without giving any reason. While there was no evidence of participant discomfort or withdrawal from the study, I was concerned that permission obtained from the village leader to conduct the research may have created obligations for participants. This resonates with a cross-cultural study conducted in rural districts of Lao PDR, suggesting that agreement to participate in research may be given as a means to show respect to the local leaders (Durham, 2014). The following narrative in my journal recorded this observation:

> Sensed there was tension of some sort amongst the women, especially when being introduced by the village head. Wondered if they were interested in participating or just felt obligated to do so? (Research journal, Thummapol, 2017)

Multiple recruitment strategies guided by the literature were used (Bonevski et al., 2014; Liamputtong, 2007; Roper & Shapira, 2000; Sixsmith, Boneham, & Goldring, 2003; Higginbottom, Pillay, & Boadu, 2013). Participants were identified and recruited using purposive sampling, the researcher's personal networks, an Indigenous mentor, face-to-face meetings, study posters, and snowballing. I initially described the research questions, purpose, the process of the study, and provided study flyers to my personal networks and Indigenous mentor. Potential participants identified through informal gatekeepers (i.e., personal networks and an Indigenous mentor) were contacted in person to provide further information about the study and ascertain their willingness to participate. Participants were also recruited face-to-face at the village's grocery shops where people commonly gathered. Study flyers were placed at various locations such as the village center, school, and grocery shops. Snowball sampling was used to enhance variety within the sample (Sixsmith, Boneham, & Goldring, 2003). At the end of the interview, all recruited participants were asked if they had friends or acquaintances who also met the inclusion criteria who could be referred to the study (Higginbottom, Pillay, & Boadu, 2013). A token gift (i.e., a scarf that was equivalent to CAD $2) was provided to all participants, in order to value their contribution, knowledge, and time. The provision of gifts or financial incentives is a controversial issue and can raise ethical problems. Many researchers argue that compensation for participating in research, particularly with vulnerable groups, is appropriate and should be seen as a way to honor and recognize participants' contributions (Beauchamp et al., 2002; Holt & McClure, 2006; Liamputtong, 2007; Umana-Taylor & Bámaca, 2004). With these efforts, twenty-one women agreed to participate in the study.

Among the different methods used to recruit participants, the use of personal networks and an Indigenous mentor, as well as snowball sampling, worked effectively and efficiently as a result of having established trust and rapport between parties. This reflects the importance of considering and integrating cultural values when recruiting culturally diverse populations. Research suggests that the use of gatekeepers in the recruitment process is particularly beneficial for research involving ethnic minorities or underserved groups (Bonevski et al., 2014; McAreavey & Das, 2013; Roper & Shapira, 2000; Wilson & Neville, 2009). However, this process is not straightforward and requires careful consideration of the researcher in order to maintain integrity and carry out their research successfully. In order to achieve these goals, researchers need to be upfront about expectations and intentions, highlight the benefits for participants and their communities, take into account the cultural nuances, and ensure confidentiality.

Maintaining Privacy and Confidentiality

Privacy and confidentiality are essential in research; however, it is extremely important when undertaking research with vulnerable groups who are at great risk of abuse and exploitation (Liamputtong, 2007; Wilson & Neville, 2009). Therefore, the researcher's commitment to honour the inherent rights of research participants as human beings, while protecting their privacy and confidentiality, is of particular importance (Liamputtong, 2007; Wilson & Neville, 2009). This can pose unique challenges, particularly for qualitative researchers working (in the field where they are identified as the 'researcher') with specific, small, and easily identified groups, to be able to ensure confidentiality and maintain anonymity (Dickson-Swift, James, & Liamputtong, 2008; Liamputtong, 2007).

There were two particular issues pertaining to privacy and confidentiality that I faced while working in the field. First, I encountered ethical questions about confidentiality because the village was small and participants knew each other. Some participants had a close relationship with healthcare staff (in the village) and/or had negative experiences of discrimination and unfair treatment, so their stories were easily identifiable. I chose not to provide quotations from some stories, although they were incredibly poignant, in the interests of ensuring confidentiality. Further, a number of identifying features had to be changed so that people would not be recognizable to healthcare professionals, the village leader, and participants who will read the research findings.

Second, although efforts were made to arrange the interviews in settings that afforded as much privacy as possible, the interview locations determined (as safe and most comfortable) by participants posed a particular challenge. The majority of the interviews took place in the afternoon and evening, and were held either in the living area or on the balcony of each dwelling. At times, uninvited people (e.g., family members, children, and neighbors) showed up or came along to listen, in addition to village distractions (e.g., noises from loud vehicles/mopeds and telephones). In the village context, it was common for uninvited people to be present or come onto the balcony of the interviewee’s house without obtaining permission. A challenge here was how to continue with the interview during interruptions and distractions, as my journal below testifies:

> Gosh, what a crowd! What on earth are they doing here? What I am going to do? Felt frustrated. But I could read from her [my participant] eyes that she did not mind (Research journal, Thummapol, 2017)

I am aware that the presence of others may affect a participant's ability to disclose information in an honest manner; however, asking people to leave would have been culturally inappropriate and offensive. It was difficult to determine an "ethical line" in this instance. Although the women did not seem concerned about talking in the presence of family members or neighbors, I found this particularly frustrating as I was concerned about potential breaches of privacy and confidentiality. I chose to pause the interviews and ask if the women wanted to carry on or reschedule the interviews to a date and time that worked for them. All participants agreed to carry on and I chose to respect their choice and continued with the interviews. Evidence of these concerns and the action I took is evident in my journal below:

> I felt awkward after five minutes of being distracted by uninvited people. Though she [my participant] carried on talking, I could not keep up with our conversation. I said to her: 'I don't know what the best way is, do you want me to come back later?' as I hinted that it would be easier if we could reschedule the interviews. She looked at me with a smile on her face and said: 'oh no we're good'. I learned then that I had to be more open and flexible to cultural values from the women's unique perspectives. (Research journal, Thummapol, 2017)

In light of these encounters, it seems fair to suggest that although ensuring confidentiality is essential, researchers need to take into account the context of the situation (e.g., the nature of research topics, the needs, and concerns of participants), make sound judgements, and choose responses that are considered ethically and culturally appropriate (Woodgate, Tennent, & Zurba, 2017). This resonates with a study conducted by Durham (2014) in rural villages, where the author faced ethical dilemmas regarding respecting the social and cultural norms, while also maintaining confidentiality. Research suggests that in cases where the research is deemed ‘sensitive’, special consideration and comprehensive strategies (e.g., development of a clear protocol or safety plan, sufficient support, and preparatory training) need to be put in place and be taken seriously to mitigate risks generated by undertaking such research (Durham, 2014; McCosker et al., 2001). According to Liamputtong (2007), sensitive research topics may include sexual preferences, the use of drugs and abuse, intimate partner violence, illegal activities, and death. While I was not asking questions about these issues, as a researcher I was still concerned about privacy and confidentiality. As a result of these experiences, I am left with questions about whether confidentiality and privacy can be assured alongside maintaining sensitivity to cultural norms. Ethical concerns surrounding practical solutions to real dilemmas when attending to confidentiality are rarely discussed, and need to be more fully addressed in the literature.

Being Vulnerable as a Researcher

Much of the discussion in the literature seems to concentrate on issues pertaining to risks, harm, and emotional experience of participants (Guelder et al., 2012; Liamputtong, 2007; Medeiros, 2017; Preethi, 2013; Seidman, 2013). Conducting research involving marginalized and vulnerable groups, however, can present a number of threats to the physical, psychological and emotional safety of researchers, particularly novice and/or student researchers (Liamputtong, 2007; McCosker et al., 2001; Medeiros, 2017). The need for support for researchers is evident in the literature, yet there is a paucity of research discussing challenges and issues related to researchers who may be in vulnerable positions; and even less information related to preventing or mitigating researcher vulnerability (Ballamingie & Johnson, 2011; Booth, 1999; McCosker et al., 2001; Medeiros, 2017; Sherry, 2013).

In reflecting on my experience carrying out this research, I was surprised by the degree of vulnerability encountered as a doctoral student during the research process. In this study, Institutional Review Board human ethics approval of the study proposal was received in both Canada and Thailand. I clearly explained how I was going to manage and minimize any potential physical or psychological risks and discomforts, mitigate harm, ensure confidentiality and anonymity; and how I would provide opportunity for a debriefing session after each interview and/or assist with a referral to counselling if necessary. Each aspect of the paperwork required detailed steps to ensure that the research did not harm the safety, dignity, or privacy of any vulnerable research participant. While I agree with the need for a thorough process and consideration to protect the participants as a primary focus, I felt what was missing was a section that asked me to consider any potential risks, discomfort, and harm to myself as a student researcher. I wondered if a researcher's safety and vulnerability is taken for granted. Few researchers have explored this issue or alerted researchers to prepare for physical and emotional dangers that may arise in the fields (Ballamingie & Johnson, 2011; Dickson-Swift, James, & Liamputtong, 2008; Liamputtong, 2007; McAreavey & Das, 2013).

The study site was located in a remote and mountainous area, bordering Thailand and Myanmar. Concerns for my safety prompted me to anticipate the dangers I could encounter and to discuss how I would respond to them with my supervisors prior to entering the field (Kondowe, & Booyens, 2014; Paterson, Gregory, & Thorne, 1999). One of the strategies used to maintain safety in the field was to always make sure someone (who I could trust and contact easily) knew where I was and the timing of my interviews (Jamieson, 2000; Paterson, Gregory,

& Thorne, 1999). Not only did I give them details, but I called them before and after each interview and instructed them to call me at a specified time if I had not called first. I also had a fully charged cellphone with me at all times (Boynton, 2002; Jamieson, 2000). There was one occasion when the interview went longer than expected and I could not make a call to my friend (a contact person) due to a power outage, disrupting the network for the phone service. As expected, he showed up at the interviewee's house to make sure I was safe, as my journal below testifies:

> I was not cautious about time nor did I know the power went off. To my utter embarrassment, however, I learned that no matter how careful I planned or prepared, things could still go wrong and that I had to be more aware of certain things and their consequences, and abandon any taken-for-granted thoughts/assumptions (e.g., that my friend would show up). A [my friend in the village] reiterated his full support for me. Felt safe and reassured. That is what I needed (Research journal, Thummapol, 2017)

Despite having adequate supervisors' guidance and support (through email, Skype, and telephone), my fieldwork in a rural and northern village (alone) was an emotionally challenging experience. Although I became familiar with the setting and participants, working in relative isolation with no fellow researchers to discuss at a given moment (due to the time difference between Canada and Thailand), and without breaching confidentiality was a lonely experience. My vulnerability became increasingly evident during the interviews in which I often struggled with emotional responses while listening to women's narratives (Liamputtong, 2007; Melrose, 2002; Sherry, 2013; Von Benzon & Van Blerk, 2017). I chose to document my emotional experiences in a research journal (e.g., my thoughts, reactions to people and the setting, dilemmas, personal feelings and emotions, setbacks, and challenges), describing how I was affected by the field relationships, some of which I shared in this paper (Liamputtong, 2007; Ortlipp, 2008; Roper & Shapira, 2000). The following excerpt reflects my emotional investment:

> Harbored mixed feelings. I felt anger at those stakeholders who seemed to be very insensitive, and at the same time, I felt very sorry for my participants that their concerns were falling on deaf ears. I wish I could do something to help now. Hope that when I take these findings back there, they are going to change how they serve and treat Indigenous women (Research journal, Thummapol, 2017).

This ‘debriefing’ process allowed me to express my emotions and release them in a timely and effective manner (Sherry, 2013). In addition, this journal was used as a means to create transparency and maintain integrity of the research, particularly when analyzing and writing the research text (Ortlipp, 2008; Roper & Shapira, 2000).

In addition to journaling, I found that regular meetings with my supervisors were effective in helping me cope with my emotions. Sherry (2013) proposes that quality supervision is essential, as it brings researchers’ emotions to center stage during the course of fieldwork and assists with professional development. The (Skype) meetings were done on a regular basis (bi-weekly) to discuss issues or concerns raised by the interviews, plans for subsequent interviews, any support needed, and to debrief (Jewkes et al., 2005; Meadows et al., 2003; Sherry, 2013). At times I was reluctant to acknowledge and express my true feelings and chose to pretend that I was not emotionally affected by the process for fear of being seen as vulnerable, unprofessional, or inappropriate (Melrose, 2002; Thomson & Walker, 2010). It was only later that I realized the stress of suppression of my emotions had effected my health, as manifested by headaches and occasional sleepless nights. A similar feeling of emotional denial or suppression was experienced by Thomson and Walker (2010), more so when they realized that acknowledging and expressing emotions enhanced the quality of the research and facilitated the research journey.

Despite the emotional challenges I experienced, there were some very positive aspects of undertaking research with women who are considered to be ‘doubly vulnerable’ (Liamputtong, 2007). I became increasingly aware of the inequality and oppression around me and learned to appreciate things that I previously took for granted. This included even little things, such as having a hot shower to being a legal Thai citizen (which allows access to a lot of resources). The support I received throughout the study and the certain privileges I have made me aware of the lack of support in the lives of my participants, many of whom were living in poverty and dealing with multiple disadvantages (Melrose, 2002; Sherry, 2013). Often times, I felt a sense of purpose, being able to help people who I have privilege over, and having their stories and voices heard. These feelings have been reported in previous studies (Dickson-Swift, 2005; Liamputtong, 2000; Sque, 2000), highlighting the positive experiences gained from doing research with vulnerable and underserved people.

Admittedly, early in the research, I found myself constantly thinking about how to make the best of my time in the field and successfully get the research done (Kondowe, & Booyens, 2014). However, as the process unfolded, I became more engrossed in it, appreciated some of the challenges, and committed to supporting and giving it my best. Were there times when I felt like giving up? Yes, as my journal below reveals:

> I felt lost and unsure about how far I should go with my data collection. It was so lonely and felt isolated here. I wanted to leave the field (Research journal, Thummapol, 2017)

> The stress of completing my PhD was boiling daily in my mind. Felt like coming to a dead end. Must turn around real quick! (Research journal Thummapol, 2017)

Yet, the emotional investment I had in the study acted as a positive force that motivated me and kept me going. Profoundly, I left the field with feelings of gratitude to these women who had opened up and shared with me, many intimate experiences of their lives (Liamputtong, 2007).

Conclusion

This reflective account of fieldwork experiences provides a glimpse into methodological issues central to any (doctoral and qualitative) research project, yet is often overlooked or taken for granted. The need for discussion centered on the challenges encountered in carrying out research with vulnerable Thai women through employment of key tenets of focused ethnography. Some of these challenges, such as researcher safety and vulnerability, are not sufficiently accounted for by the research ethics boards approved protocols; thus such considerations require researchers' broader competence, and moral and ethical judgments, as well as reflexivity. This paper also addressed the emotional aspects (good and ill) that surfaced during the research process, which often is not written and less spoken about in the literature.

This paper does not present the full spectrum of methodological challenges and practical strategies, but a few significant experiences for those undertaking qualitative research in similar fields. While I strived to discuss, candidly, the challenges and strategies used to successfully overcome them, it was important to acknowledge that they are contextual and based on personal experiences. I hope that this reflective account, alongside suggestions from the literature, might be used as a resource for novice or student researchers planning and conducting research, as well as for those responsible for supervising the studies, particularly among vulnerable people in the field.

There is an argument that one can never anticipate all the possible challenges and issues prior to undertaking fieldwork (Yu & Gatua, 2014). Although the authors fully agree with these statements, there are ways in which novice or student researchers may be better prepared to deal with both anticipated and emerging methodological challenges that may arise in the field. I propose that researchers should consider and reflect on their research journey, particularly in relation to difficult or challenging experiences and emotions generated by fieldwork. Writing a reflective account of research experience not only serves as a researcher's (final) self-debrief and therapeutic self-reflection, but may also help and urge other novice and experienced researchers working in similar circumstances to be more reflective and reflexive in their research practices, better prepared to anticipate and manage such phenomena, as well as to avoid unsuspecting pitfalls (Sherry, 2013; Thomson & Walker, 2010).

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Chapter 5: Conclusion, Recommendations, and Limitations

This chapter provides a discussion of the research findings with reference to the theoretical perspectives and the literature. Following this, recommendations for policy, practice, education, and research are discussed. The limitations of the study are discussed along with concluding remarks

Findings in Relationship to the Theoretical Perspectives and Literature

The theoretical underpinnings used in this study included: intersectionality, cultural safety, and the right to health and gender equality. Although each perspective focused on different aspects, particularly in relation to health, they are all closely related to and concerned with equity and diversity, including perceived discrimination. More specifically, these perspectives share major assumptions about the multifaceted influences affecting access to healthcare services, and its delivery and quality; thus contributing to an understanding of differences in health outcomes and experiences. These theoretical perspectives, in combination, provide a richer understanding of the phenomenon than either perspective would alone.

Intersectionality Perspective and Indigenous Women's Healthcare Access

The major tenets of intersectionality used for this study were multiple intersecting categories, attention to power, and multi-level analysis (Bowleg, 2012). In this study of Indigenous women in rural and northern Thailand, participants had to contend with a host of individual and structural forces when endeavoring to access healthcare services, which put them at elevated risk for adverse health outcomes, as well as persistent health inequities. These differences in health and access to healthcare were stemming from gender, racial/ethnic backgrounds, culture, health beliefs and practices, socio-economic status, citizenship status, and geographical restrictions. In addition to individual and place characteristics that disadvantaged women in receipt of healthcare services experience, structural forces, like discriminatory practices and long waiting times, played an important role in creating differences in access and quality of care for the women in this study. These influences were interacting with one another and being tied together in a complex web, at the intersections of systems of racism and discrimination, exposing historically oppressed and marginalized women to various health risks and barriers, and compromising their ability to obtain care and achieve good health (Guruge & Khanlou, 2004; Hankivsky et al., 2010; Van Herk et al., 2011). For instance, many women described in this study circumstances that affected their decision and ability to access healthcare. Social and cultural norms, including gender roles and responsibilities within and outside the household, for example, had hindered opportunities for Indigenous women to access healthcare, due to a hesitation to leave one's home or farm work unattended or fear of income loss. In addition to this, poor roads and limited transportation options made healthcare services inaccessible or hard to reach for many women. This situation was exacerbated by indirect costs associated with access and the long waiting times in the hospital, discouraging the use of services. For Indigenous women, these intersections were further compounded by their uniquely disadvantaged social positions and structural racism expressed through discriminatory attitudes and behavior of healthcare providers.

In this study, structural inequities, including unequal power and discriminatory attitudes of healthcare providers were one of the key factors in determining the place where women received diagnosis and treatment, and in determining the quality of health services, with many choosing to delay and not use the healthcare system unless absolutely necessary. Yet, until now, there was a paucity of research recognizing inequities in access to healthcare or attempting to engage Indigenous women in rural and northern Thailand to address, explicitly, the impact of multiple intersecting identities and social positions, as well as the role structures of power plays in medical interactions that impact Indigenous women’s ability to seek medical assistance.

The intersection of racism and discrimination based on gender, racial/ethnic backgrounds, and other determinants have been increasingly observed in previous studies, which indicate that it has profound negative effects on access to healthcare and health inequities, as well as limitation or denial of basic human rights (Hankivsky et al., 2010; Hankivsky, 2012; Narvaez et al., 2009; Thompson et al., 2016; Van Herk et al., 2011; Waldron, 2010). These interactions occur within particular social and cultural contexts created by the intersections of structural systems of power (e.g., laws, policies, systemic practices and barriers) (Hankivsky, 2014). The findings of this study support the tenets of an intersectionality perspective that give rise to complex issues of entrenched health inequities. This requires a critical analysis acknowledging multiple intersecting categories, power relations, and their effects between and across various levels, including structural, institutional, and individual; in order to determine health access and outcomes among women of marginalized and disadvantaged groups (Bowleg, 2012; Waldron, 2010). Given the focus on understanding the experiences of marginalized groups and diminishing systems of oppression, an intersectionality perspective has the potential to facilitate and inform the development of well-targeted and cost-effective strategies, interventions, and policies essential to understanding and addressing health inequities.

Cultural Safety and Its Implications for Healthcare

There is ample evidence showing that the experiences of accessing healthcare for Indigenous peoples across the globe is often negative (Cameron et al., 2014; CMA, 2013; Durey & Thompson, 2012; Marrone, 2007; Thummapol et al., 2018; UN, 2010, 2015). Indigenous peoples often lag behind the rest of the population when it comes to healthcare access services.

In this study, although stories with a positive sentiment were present in participants' accounts, the findings that the majority of participants reported experiencing individual and systemic racism and discrimination when seeking mainstream healthcare services, confirm what is already known in the literature. These included being ignored, disrespected, and discriminated against (Cameron et al., 2014; CMA, 2013; Durey & Thompson, 2012; Marrone, 2007; Thummapol et al., 2018; UN, 2015). The experiences of racism and discrimination felt by study participants created doubt, influencing the desire to utilize and access health services. Poorer health outcomes and inadequate access to healthcare among Indigenous women may be a reflection of these negative experiences within healthcare systems (CMA, 2013; Durey & Thompson, 2012; Marrone, 2007; Thummapol et al., 2018). These findings underline the need for healthcare provision to be culturally safe, responsive to cultural differences, and aware and sensitive to the negative impacts of race-based discrimination and bias, whether conscious or unconscious.

Cultural safety is identified as a leading approach to promote equitable access, improve health outcomes, and reduce health inequities for Indigenous peoples (Cameron et al., 2014; Greenwood, McGregor, & MacDonald, 2017; Indigenous Health, 2017). Its key principles work on protection against individual, structural, and institutional racism, as well as elimination of unequal power relations inherent in the healthcare system. Cultural safety spans multiple dimensions and is effective at individual, professional, and system levels, encouraging identification of the preconceptions and assumptions embedded in practice (Richardson & Williams, 2007). At the patient level, cultural safety recognizes the uniqueness and cultural identity of the individual, striving to ensure that Indigenous peoples feel respected, comfortable, and safe when interacting with the healthcare system (Indigenous Health, 2017; Richardson & Williams, 2007). At the healthcare provider level, cultural safety allows for a more reflective, critical understanding of the actions of providers and the impacts they have on health and ability of Indigenous peoples to access health services (Bourassa, Mckay-McNabb, & Hampton, 2004; Cameron et al., 2014; Richardson & Williams, 2007). At the system level, cultural safety involves a commitment to deliver high quality, equitable care that is free of racism and discrimination (Bourassa et al., 2004; Richardson & Williams, 2007).

The findings of this study support the fundamental premise of cultural safety that structural forces, including racism and discrimination against Indigenous populations in the healthcare system, are pervasive; and may be a significant contributor to substandard care and poor health status of Indigenous women in Thailand, specifically through healthcare providers' discriminatory attitudes and behaviors. This is also congruent with the findings of international research, which indicated that racism and discrimination is deeply and pervasively embedded in the institutional culture, structures, policies, and practices; causing damaging consequences on the health and well-being of Indigenous populations and resulting in disengagement from care, delay in care, or avoidance of care altogether (Allan & Smylie, 2015; Bourassa et al., 2004; Browne et al., 2016; Cameron et al., 2014; Loppie, Reading & Leeuw, 2014; McCue, 2015; National Collaborating Centre for Determinants of Health, 2017; Richardson & Williams, 2007). With this knowledge of growing diversity and increasing health inequities among disadvantaged and marginalized populations in Thailand, I recommend that culturally safe practices be used to operationalize and enact equity in health and social justice, and be integrated into nursing education, clinical practice, research, and policy. For example, culturally safe practices could be used to prompt critical reflexivity on issues, such as understanding how the historical, social, and cultural contexts of people's lives, as well as discriminatory policies and practices, are linked to inequities in health and access to healthcare.

Access to Healthcare and Gender Equality as Human Rights

From a human rights perspective, equitable access to healthcare, gender equality, and freedom from discrimination are central to any efforts to improve the health of Indigenous women (UN Inter-Agency Support Group on Indigenous Issues [UN IASGIS], 2014). These human rights principles, aligned with the UN Declaration on the Rights of Indigenous Peoples, serve as the foundation for the achievement of the SDGs, particularly Goal #5. More specifically, the rights to health, equality and non-discrimination, and the SDG 5 are interdependent and interrelated, committing to redoubling efforts to ensure universal access to sexual and reproductive health and the reduction of widespread health inequities. In order to achieve these goals, countries have the primary responsibility and legal obligation to ensure, promote, protect, and fulfil those rights (UN ICESCR, 2000; UN SDGs, 2015; UN Women, 2018; WHO, 2017). The UHC is one of the strategies that has gained importance and been adopted in many countries in recent years to achieve health-related SDGs[10] (Bowen, 2001; McKee et al., 2013; The Elders, 2016; WHO, 2018). Building on the foundation of equity and human rights, the UHC concept is about ensuring that everyone has access to quality, needed healthcare services, without falling into poverty due to healthcare expenditure (McKee et al., 2013; The Elders, 2016, WHO, 2018). However, despite some progress, too many people worldwide are still denied or do not enjoy its benefits, particularly among minorities and marginalized groups (McKee et al., 2013; The Elders, 2016; WHO, 2018).

This is also the case in Thailand. Despite a commitment by Thailand to human rights principles and the UHC through primary healthcare (Paek, Meemon, & Wan, 2016), the findings

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[10] Within the SDGs, universal health coverage includes not just healthcare but "financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all" (UN, 2015a).

from this current study highlighted the particular challenges and detrimental situations facing Indigenous women when accessing healthcare. While there are no doubts that a strong policy framework is in place, sadly the majority of participants were still struggling to get quality health services that they needed and/or were experiencing financial hardship as a result. For example, some women in the present study described situations in which they experienced and suffered widespread discrimination including the denial of citizenship, and freedom of movement and access to primary healthcare in the community. Further, many of the women in this study described distrust caused by healthcare providers' discriminatory attitudes and behavior, creating and perpetuating differences in healthcare decisions, access, and outcomes.

The data highlighted that there were difficulties in accessing emergency medical transport, and the costs of private transport were beyond the reach of many participants. For these reasons, a substantial proportion of women in this study used services or informal care outside their designated facilitates that were not covered by the UHC, a situation also found in previous studies (Kirdruang, 2011; Paek, Meemon, & Wan, 2016). The overreliance of informal care may be a reflection of the lack of universal access, as well as a failure of the government to respect the right to health and to ensure equitable access to quality, needed services for underserved populations, without discrimination and financial burden. The unequal access to care of equal quality, as could be seen in the lives of many of the women in this study, may be responsible for health inequities and lowered health status. The literature that has explored this issue among Thai Indigenous women living in underserved areas supports this view (Dhir, 2015; Lutvey, 2014; Thummapol et al., 2018; UN, 2015; UNHCR, 2010).

While the UHC, through focusing on primary healthcare, provided hope in terms of access for the women in this present study, this action alone, unfortunately, will not guarantee equity and universal access to a healthcare system or to sufficient services of quality. Changes are needed at all levels to improve the overall access to healthcare for Indigenous women, beyond the availability of provision of healthcare services. For example, by not paying sufficient attention to gender inequalities that remain deeply entrenched in society and the unintended consequences of some discriminatory practices and policies, it is widely believed that this will further exacerbate inequities in access to healthcare for disadvantaged and marginalized women (Allan & Smylie, 2015; Green, 2015; Magar, 2016). Through a human rights lens and understanding of gender-specific dimensions of the SDGs, the findings of this study support the ideas that, the integration of the right to health; gender equality; non-discrimination; and inclusion into the design, implementation, and evaluation of interventions, programmes, policies, and institutional mechanism, are vital. These will result in reducing inequities between and among population groups, achieving greater equality, advancing health, and promoting everyone's fundamental human rights (WHO, 2015).

Recommendations for Policy, Practice, Education, and Research

Policy

The findings from this study have important implications for current discussions on closing the gender policy-practice gaps across the world, particularly for disadvantaged and marginalized women. The realization of gender equality and women's rights, including the right to health and freedom from all forms of discrimination as a human right, is fundamental to accelerate progress towards the achievement of the 2030 Agenda for SDGs, 'leaving no one behind' (Green, 2015; Magar, 2016; UN, 2016; UN Women, 2018). Thailand has made significant effort toward eliminating gender-based discrimination by endorsing the Gender Equality Act of 2015 (Committee on Elimination of Discrimination against Women [CEDAW], 2017). However, a number of persistent constraints and challenges remain, and need to be addressed; particularly in the areas of lack of gender and ethnicity disaggregated data, abuse of rights, and discrimination against minority and marginalized women in healthcare, education, and political representation (UN Women Asia and the Pacific, 2017). According to the United Nations Development Programme (UNDP)'s Gender Inequality Index (GII)[11], Thailand ranked 87th out of 188 countries in 2015, with the GII value of 0.366[12]. This yields insights in the remaining gender gaps, reflecting the need for critical policy actions and strategies to overcome structural forces and practices that place women at a disadvantage. This may include: 1) taking steps towards the progressive realization of the rights to gender equality and to health, 2) prohibiting any discrimination in the provision of healthcare through anti-discrimination legislation, 3) making continuing efforts to implement and analyze human rights obligations, 4) mainstreaming gender perspectives in national health policies (including cultural attitudes, power dynamics, and excessive domestic duties), and 5) ensuring meaningful participation of disadvantaged subpopulations in the planning, design, and delivery of health services, in the interest of health equity (Fredman & Goldblatt, 2015; UN, 2014).

It is important to recognize that access to healthcare services for Indigenous peoples are affected and determined by multiple intersectional identities and their relationship to interlocking systems of oppression (UN, 2015; UN IASG, 2014). Women who belong to Indigenous communities, already marginalized, face further challenges based on their gender, cultural norms, socioeconomic status, citizenship status, geographical restriction, to name a few, which

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[11] The GII (its values range from 0 to 1, with 1 representing perfect inequality) reflects the disadvantages of women in three important aspects of human development—reproductive health, empowerment, and economic activity (UNDP, 2015).

[12] This index rating indicates differences in the distribution of achievements and the loss in potential human development due to gender inequality (UNDP, 2015).

manifest in many interconnected spheres, as could be seen in the lives of the women in this study (UN Women, 2018; WHO, 2015). These groups also suffer disproportionately from intersecting forms of discrimination that leave them especially vulnerable to abuse, exploitation, and other human rights violations, including unequal access to quality healthcare (UN Women, 2018; WHO, 2015). Achieving gender equality and securing women's human rights, therefore, requires a comprehensive understanding of how identities, social and cultural norms, and structural racism intersect to shape decision-making; as well as the ability of women to seek care, and create distinct patterns of experience. These historical and contemporary experiences can adversely influence whether healthcare is sought (NCCAH, 2014; Strasser, Kam, & Regalado, 2016).

The intersectional knowledge and understanding obtained from this study can be used to inform advocates, policy makers, and stakeholders; in order to understand and take into account, the multiple intersecting social identities (e.g., gender, race/ethnicity, culture, socioeconomic status, citizenship, or geographical context) and the unique ways in which women experience racism and discrimination within government policies and healthcare, as well as how this interconnectedness forms the basis of their health. All of which influences the way in which women access, or fail to access, healthcare systems. For example, one of the political actions or policies by which structural racism is expressed against Indigenous peoples in Thailand is through the Nationality Act. Enacted in 1965 and revised in 2008 by the Thai government (Cadchumsang, 2011; Park, Tanagho, & Gaudette, 2009; UNHCR, 2010), the Nationality Act was purported to protect the citizenship rights of Indigenous peoples. In reality, however, it created an enduring structure that could inform institutions (e.g., healthcare) that perpetuate and deepen discrimination against Indigenous groups (NIPT, 2016; Park, Tanagho, & Gaudette, 2009; UNHCR, 2010). A more complete discussion of structural forms of racism that are deeply rooted in political policies and its relationship to healthcare access is beyond the focus of this study; however, I draw attention to it here because of its relevance to healthcare access for women in this study. Understanding this form of intersectionality has the potential to contribute to the removal of barriers to access, and the development of appropriate and supportive services that are respectful and responsive to the rights and diverse needs of Thai Indigenous populations.

Practice and Education

In the context of the present results, it is clear that many of the women encountered difficulties and challenges in accessing equitable health services, as well as experienced healthcare that was culturally unsafe. For instance, participants spoke of both a reluctance and inability to access healthcare due to negative experiences of disrespectful treatment, discrimination, and longer wait times. While not explicitly stated, these experiences of racism and discrimination are clearly linked to feelings of being unsafe or disrespected, with implications for future access to healthcare services and the development of a trusting patient-provider relationship (Browne et al., 2002; McCall & Pauly, 2012). The findings suggest that women often delay treatment or avoid accessing healthcare services as a result of feeling culturally unsafe and disrespected. While there is no doubt that healthcare professionals in northern parts of Thailand often do their best to provide quality services, despite increasing demands and limited resources, the accumulated past negative experiences and struggles faced by Indigenous women in this study are important to consider. In other words, the findings have implications for nurses and other service providers regarding their cultural awareness and sensitivity; and how it influences healthcare interactions and affects the health of Indigenous women in their ability to access healthcare. All healthcare leaders and providers are wellpositioned to close the gap and address access concerns. This is essential in order to promote timely access to healthcare and to ensure that Indigenous women obtain all necessary, culturally appropriate treatment, contributing to positive health outcomes (Cameron et al., 2014; McCall & Pauly, 2012; Thummapol et al., 2018).

Research suggests that culturally safe practice is integral to healthcare involving Indigenous peoples, and has the potential to shape and transform healthcare practices, institutions, and policies (Browne et al., 2016; Cameron et al., 2014; Greenwood et al., 2017; McCall & Pauly, 2012; Pauly et al., 2013; Richardson & Williams, 2007; Wilson & Neville, 2009). Increasingly in Canada, the USA, Australia, and New Zealand, culturally safe practice is being applied in the delivery of healthcare and serves as health equity principles and guidelines for nursing and medical professional education, organizations, and policies (Browne et al., 2016; Churchill et al., 2017; Richardson & Williams, 2007; Stout & Downey, 2006). Given its focus on health inequities, power differentials within healthcare interactions, and structural and systemic forces like racism and discrimination, the awareness and application of cultural safety has moved to become a globally recognized essential practice (Churchill et al., 2017; Richardson & Williams, 2007).

Although culturally safe practice is not a new concept, it remains largely unknown or poorly understood within nursing education and healthcare in Thailand. This is evident in a study conducted in Thailand by Bunjitpimol and colleagues (2016), where they found that the levels of cultural awareness, knowledge, skills, and comfort of Thai nurses working with patients from diverse backgrounds and cultures were considerably low. In a similar vein, Songwathana and Siriphan (2015) examined cultural competence in Thai nurses and highlighted the need for cultural competency and cultural safety education/training. As a nurse educator who taught at the undergraduate level, I believe cultural awareness affects nurses personally and alters the ways care is provided. Therefore, the classroom is the best place to gain a firsthand view of cultural differences and to foster cultural competency and safety among nursing students (Racine, 2018). Nurses and future nurses must understand the complexity of culture and its relationship to health, toward improving patient experiences in relation to quality of care and addressing health inequities.

Consistent with previous studies both nationally and internationally (Browne et al., 2016; Bunjitpimol et al., 2016; Cameron et al., 2014; McCall & Pauly, 2012; Songwathana & Siriphan, 2015), the findings of this present study underline the need for cultural safety in the care of patients, including Indigenous peoples. The first step towards the provision of culturally safe practice is for nurses and allied healthcare professionals to reflect on their own assumptions and culture, including dominant values, beliefs, and biases (Cameron et al., 2014; McCall & Pauly, 2012; NMBA, 2018; Richardson & Williams, 2007). Understanding and becoming aware of one's own culture, with associated worldviews and preconceived notions and stereotypes, is essential in recognizing how this, in combination with their practice, has an impact on healthcare access and the health and wellbeing of their Indigenous patients (Cameron et al., 2014; McCall & Pauly, 2012; NMBA, 2018; Richardson & Williams, 2007). Another strategy suggested recently by nurse academics and/or researchers (Browne et al., 2016; McCall & Pauly, 2012) is to attend to power differentials that exist between providers and Indigenous peoples, as well as creating a welcoming healthcare environment that allows Indigenous peoples to safely communicate their needs and preferences. This way a number of issues can be addressed, such as unequal power relations, experiences of racism and discrimination, and the consequent lack of trust in healthcare systems (Browne et al., 2016).

Furthermore, access to recurring cultural safety education and anti-racist training programs for staff at all levels is an integral component for fostering culturally safe practice; as well as for combating racism expressed through disrespectful treatment and longer wait times (Browne et al., 2016; Cameron et al., 2014; Thummapol et al., 2018). In addition, efforts to improve the diversity in healthcare leadership and the workforce is important in addressing the needs and interests of increasingly diverse and underserved populations (Cameron et al., 2014; Phillips & Malone 2014; Thummapol et al., 2018; Valentine, Wynn, & McLean, 2016). Such a strategy has a role to play, not only in advancing culturally safe practice, but also in affecting organizational policy or decision-making processes; as well as in working towards eliminating inequities in access to healthcare for disadvantaged and marginalized groups, such as Indigenous women (Cameron et al., 2014; Phillips & Malone 2014; Thummapol et al., 2018; Valentine, Wynn, & McLean, 2016).

Research

As I have undertaken this study, I have become aware of a number of areas that may benefit from future research. For example, I recommend additional qualitative research related to specific phenomena of concern for Indigenous women living in rural and northern Thailand. In this study, I offer the first qualitative research study on the healthcare access experiences of Indigenous women living in northern and rural Thailand. When I looked at all the health research literature in this area, I was surprised to find only four studies (Apidechkul, 2016; Duangtep et al., 2010; Kritpetcharat et al., 2012; Krit et al., 2015), which have been largely quantitative in focus. While I am grateful to the scholars who have pioneered this topic, and added to the literature, more qualitative and interpretive inquiry related to the complex healthcare access experiences of ethnically and culturally diverse women is warranted. Future research may replicate the findings of this study within similar contexts, such as northern and rural communities across Thailand, supporting the urgent need to improve healthcare access for Indigenous women.

Another area for future research would be on exploring the experiences of healthcare providers working with Indigenous communities or caring for people from a wide range of cultural backgrounds, which may enhance the understanding of gaps and inform strategies to remove or minimize barriers to access (Alvarez et al., 2018; Browne & Varcoe, 2006; Wuerch et al., 2016). Inquiry into factors influencing nurses and other allied healthcare professionals' views of, and practices with, Indigenous peoples would be a significant addition to the discipline's body of literature.

Given the lack of disaggregated data on Indigenous peoples in Thailand and of culturally relevant indicators, research is warranted pertaining to Indigenous data collection on gender, race/ethnicity, culture, Indigenous identity, health status, socioeconomic status, or geography. Collecting and using this meaningful data is important, especially as the basis for working towards advancing human rights, achieving equal opportunities, redressing discriminatory disadvantage, and improving Indigenous health outcome, as well as for understanding the impacts of the underlying determinants of health and structural barriers (Grey, 2009; UN, 2015).

In consideration of healthcare, and looking at barriers to access more specifically, I would suggest that future research be conducted on the consequences of racism within healthcare settings on health, well-being, and access to healthcare services for Indigenous populations in Thailand across the life course. Last, in this dissertation, I identified the impacts of gendered and family roles on the cultural understandings and experiences in seeking care among Indigenous women. It would be interesting to examine in-depth, the impact of Indigenous women's illnesses or diseases on family functioning and relationships. Thus, ethnographic studies with this focus are recommended.

Limitations

All research has limitations and this dissertation is no different. I interviewed a small and selected sample of women from a rural and northern village in Mae Hong Son, Thailand. In particular, the setting for this research was relatively homogeneous with respect to gender, race, and ethnicity. All participants belonged to Indigenous communities (i.e., Tai-Yai group) and spent the majority of their lives in this rural and northern village. As is essential in qualitative research, the participants were selected based on their ability to provide information and not based on how they represented the general population. This may have resulted in a very homogeneous sample. Given that this is a focused ethnographic inquiry, knowledge generated by this approach is not assumed to be generalizable (Cruz & Higginbottom, 2013; Hammersley & Atkinson, 2007), but it is transferable.

I offer the findings from this dissertation as representations of experience with healthcare access but they are inherently limited. For example, women who participated in this study may not be representative of others who did not participate. In particular, women who did not speak Thai were excluded due to the lack of interpretation resources. This may have resulted in the study not capturing the healthcare challenges of non-Thai-speaking Indigenous women who may have different experiences. In addition, while striving as far as possible to portray richly detailed and comprehensive accounts of participants' experiences, it is important to acknowledge that the findings from this study are contextual, representing a partial reality that is both imperfect and selective (Fenton & Baxter, 2016).

In Chapter 3 and 4, translation was required because the target language (i.e., English) for dissertation and publication was different from the source of data (i.e., Thai). Issues related to the translation process and its impact on the quality of data have increasingly become an area of concern, particularly in qualitative research (Al-Amer et al., 2015; Chen & Boore, 2009; Nurjannah et al., 2014; Van Nes et al., 2010). While I strive to ensure equivalence in translation, it is important to recognize that there are multiple degrees to which "meaning may get lost in the translation process" (Van Nes et al., 2010, p. 313).

Concluding Remarks

Despite a commitment to address the health needs of the population it serves, and more importantly, to equal access to healthcare for Thais, there are differences in access and quality of care for disadvantaged and marginalized groups. The findings of this study reflect this dire situation and the persistent challenges faced by Indigenous women living in rural and northern areas. In this study, Indigenous women's limited access to equitable healthcare manifests itself at different levels and in multiple ways. For this reason, it is especially important that Indigenous women's access to, and experiences with, healthcare be seen within the personal, social, political, and cultural contexts of their lives. Understanding the simultaneous and interactional effects of the multiple identities and structural forces is essential to reducing inequities in health and access to healthcare services among this underserved group. While these findings reinforce the understanding that, though it is important to acknowledge the growing evidence that inequity in access to healthcare disproportionately affects Indigenous women, it is of equal importance not to assume all Indigenous women experience uneven access to healthcare services and resources, and/or inequitable treatment.

The difficulty in accessing equitable healthcare for many Indigenous women highlighted in this study is clearly compounded in relation to multiple intersectional identities. As the findings show, the characteristics of rural Indigenous women and cultural context in many ways make them vulnerable to healthcare access challenges. This further is exacerbated by discriminatory practices and policies within healthcare systems, contributing negatively to the health and well-being of Indigenous women; as many avoided or delayed seeking treatment, relied heavily on informal care, underused preventive health services, advocated and paid for needed services, and/or decreased compliance with treatment. In other words, the experience of racism and discrimination, whether subtle or overt, continued to shape Indigenous women's healthcare experiences and prevented equitable access even when services were available.

In spite of a vast array of barriers and challenges experienced by women in this study, many of the recommended responses in relation to access to healthcare are similar. While there is indication of need for the removal of barriers and additional health services, such as specialized and outreach services, what appears to be most important is a change in how services are delivered. Changes and strategies identified in this study are anticipated to result in the provision of more equitable, responsive, and respectful services; combating compounded disadvantages and embedded racism, mitigating inequities, and making gains in the health status of Indigenous women. This requires inter-sectoral commitment and coordinated efforts on several fronts, including the health ministries in all jurisdictions, non-governmental or private entities, policy or decision makers, healthcareleaders, providers, staff, and Indigenous communities. Any attempts to address inequities in health and access to healthcare requires greater recognition of, and attention towards, systemic norms, and structures and power dynamics constraining the social positionalities; as well as the circumstances and underlying determinants of health of Indigenous populations that lead to them. In light of the findings of this study, I would suggest that looking through an intersectional lens, and working towards greater health equity and increased culturally safe practice, is particularly essential to improving health and access to healthcare for Indigenous women in Thailand. This has the potential to make substantial contributions to the advancement of human rights and gender equality, securing progress towards the SDGs.

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Appendix A: Study Flyer[13]

STUDY
ACCESS TO HEALTHCARE AMONG TAI-YAI WOMEN
SHARE YOUR STORY!

If you are a Tai-Yai woman and have had at least three experiences with the healthcare system, I want to hear about your experience.

I am a PhD candidate at the University of Alberta, Faculty of Nursing. My research aims to bring a greater comprehension and awareness of Tai-Yai women's health issues, of access obstacles they face, and of specific healthcare services needed.

To be eligible to participate in this study, you must:

1. **Be a Tai-Yai woman;**
2. **Be over the age of 18 and have the capacity to consent to participate in the study;**
3. **Have had at least three experiences with the system;**
4. **Be willing and able to share their experiences about access to healthcare in Thailand;**
5. **Speak and understand Thai language**

Interviews will take place at your convenience. You will receive a small token of appreciation for your time.

To learn more, please contact: Onouma Thummapol, RN, MN
PhD Candidate, Faculty of Nursing, University of Alberta
Call: 081-3562774
Email: thummapo@ulberta.ca

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[13] The study flyer was translated into Thai language.

Appendix B: Demographic Information Form

1. How old are you? _____________
2. Where is your place of birth? _____________________
3. What is your citizenship?
    - Thai, by birth
    - Thai, by naturalization
    - Non-citizenship status, please specify______________________
    - Other country, please specify_______________________
4. What is your marital status?
    - Single, never married
    - Married or domestic partnership
    - Widowed
    - Divorced
    - Separated
5. What is the highest level of school you have completed?
    - No schooling completed
    - Some high school, no diploma
    - High school graduate, diploma or the equivalent
    - Some college credit, no degree
    - Trade/technical/vocational training
    - Bachelor's degree
    - Master's degree
    - Doctorate degree
6. Are you currently employed?
    - Yes
    - No
7. What is your occupation? ______________________________
8. What is your income range:
    - < 5000 Baht
    - 5000-10,000

- 11,000-15,000
- 16,000-20,000
- 21,000-25,000
- 26,000-30,000
- 31,000-35,000
- > 36,000

9. Are you insured?
    - Yes
    - No
10. What types of health insurance do you have
    - A universal coverage health card
    - Social security insurance
    - Private health insurance
    - Other, please specify________________
11. How many people live in your house? ______________________
12. What is their relationship to you?
    - Spouse or partners
    - Children
    - Parents
    - Siblings
    - In-law
    - Other ________________________

Appendix C: Interview Guide

Prior to data collection, the researcher will discuss and obtain consent from each participant.

Research question # 1 & 4: What are the experiences/perspectives of Tai-Yai (Indigenous) women accessing healthcare services in northern Thailand? And How do Indigenous women experience efforts to engage with healthcare providers and system?

Interview questions and probes:

- Where do you usually go for healthcare?
- Can you tell me about your last (or last two) healthcare visits.
    - What influenced your decision to seek healthcare?
    - How did you decide to go to the physician or health professional, and the place for healthcare?
    - How was it for you to get the healthcare services you needed?
        - Probe: As being Indigenous?
        - Probe: As being a women?
        - Probe: And as living in a rural area?
    - What was the quality of your experience with healthcare professionals (e.g., physicians, support staff) and facilities?
- Have you had any positive experiences with a healthcare professional? Please explain?
- Have you had any negative experiences with a healthcare professional? Please explain.
- How do you want a health professional to treat you?

Research question # 2: What do Tai-Yai (Indigenous) women living in northern Thailand believe are the facilitators and the impediments to accessing quality healthcare?

Interview questions and probes:

- What facilitators have you experienced when accessing healthcare?
    - Probes: Health insurance, Support from family and friends
- What barriers and challenges have you experienced when accessing healthcare?
    - Probes: Cultural, Gender, Discrimination
- What has been done to make it easier for you to access healthcare when needed?

- What more could be done to make it easier for you to access to healthcare when needed?
- How can healthcare professionals foster and promote the health and access to healthcare services for Indigenous women living in rural areas?
- How can policy makers foster and promote the health and access to healthcare services for Indigenous women living in rural areas?

<u>Research question # 3:</u> How do cultural beliefs and practices influence access to healthcare for Tai-Yai (Indigenous) women living in northern Thailand?

Interview questions and probes:

- What are your health beliefs and practices surrounding life events?
  - Probe: Birth, Childcare, Death and Dying
  - How does this health beliefs and practices influence:
    - What you do to remain healthy?
    - What you do when you are ill?
    - Who you seek healthcare from?
- What do you do to be healthy?
  - Probe: Meditation, Spiritual healers, Food, Herbs, Support Network
  - How helpful or useful are the different resources you rely on to remain healthy?
- What do you do when you are ill?
  - Who do you see or speak to in order to get better?
    - Probe: Spiritual healers, family members, friends, other support systems
  - What are your health beliefs and practices when you become ill?
  - What impact does the illness have on your family?
  - How does your role as a woman, a wife, or a mother influence your decision to seek healthcare?
    - Probe: Support of family
- How different is the perception of your health in your culture compared to the mainstream culture?

  - Because of your Tai-Yai culture, what has been difficult with the mainstream healthcare?
- What do you hope to get from your visit with a health professional?
- How can your cultural beliefs and practices be integrated into the healthcare that you receive?
- Do you have any other recommendations for healthcare professionals or policy makers on improving access to healthcare for women from Tai Yai culture?

Appendix D: Confidentiality Agreement

Project title - **A Focused Ethnography of Indigenous Women Accessing Healthcare Services in Northern Thailand**

I, ______________________________, the ____________________________________ (specific job description, e.g., transcriber) have been hired to ____________________________

I agree to -

1. keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts) with anyone other than the *Researcher(s)*.
2. keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.
3. return all research information in any form or format (e.g., disks, tapes, transcripts) to the *Researcher(s)* when I have completed the research tasks.
4. after consulting with the *Researcher(s),* erase or destroy all research information in any form or format regarding this research project that is not returnable to the *Researcher(s)* (e.g., information stored on computer hard drive).
5. other (specify).

______________________________	______________________________	______________________
(Print Name)	(Signature)	(Date)

Principal Investigator

______________________________	______________________________	______________________
(Print Name)	(Signature)	(Date)

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615.

Appendix E: Ethics Approval (University of Alberta)

Notification of Approval (Renewal)

(Transcribed from PDF)

Date: February 15, 2018

Amendment ID: Pro00070620_REN1

Principal Investigator: Onouma Thummapol Study ID: Pro00070620

Study Title: A Focused Ethnography of Indigenous Women Accessing Healthcare Services in Northern Thailand

Supervisor: Tanya Park

Approved Consent Form:	Approval Date	Approved Document
	2/27/2017	Information letter (Eng)
	2/27/2017	Informed consent (Eng)
	2/27/2017	Informed consent (Thai)
	2/27/2017	Information letter (Thai)

Approval Expiry Date: Thursday, February 14, 2019

Thank you for submitting this renewal application. Your application has been reviewed and approved.

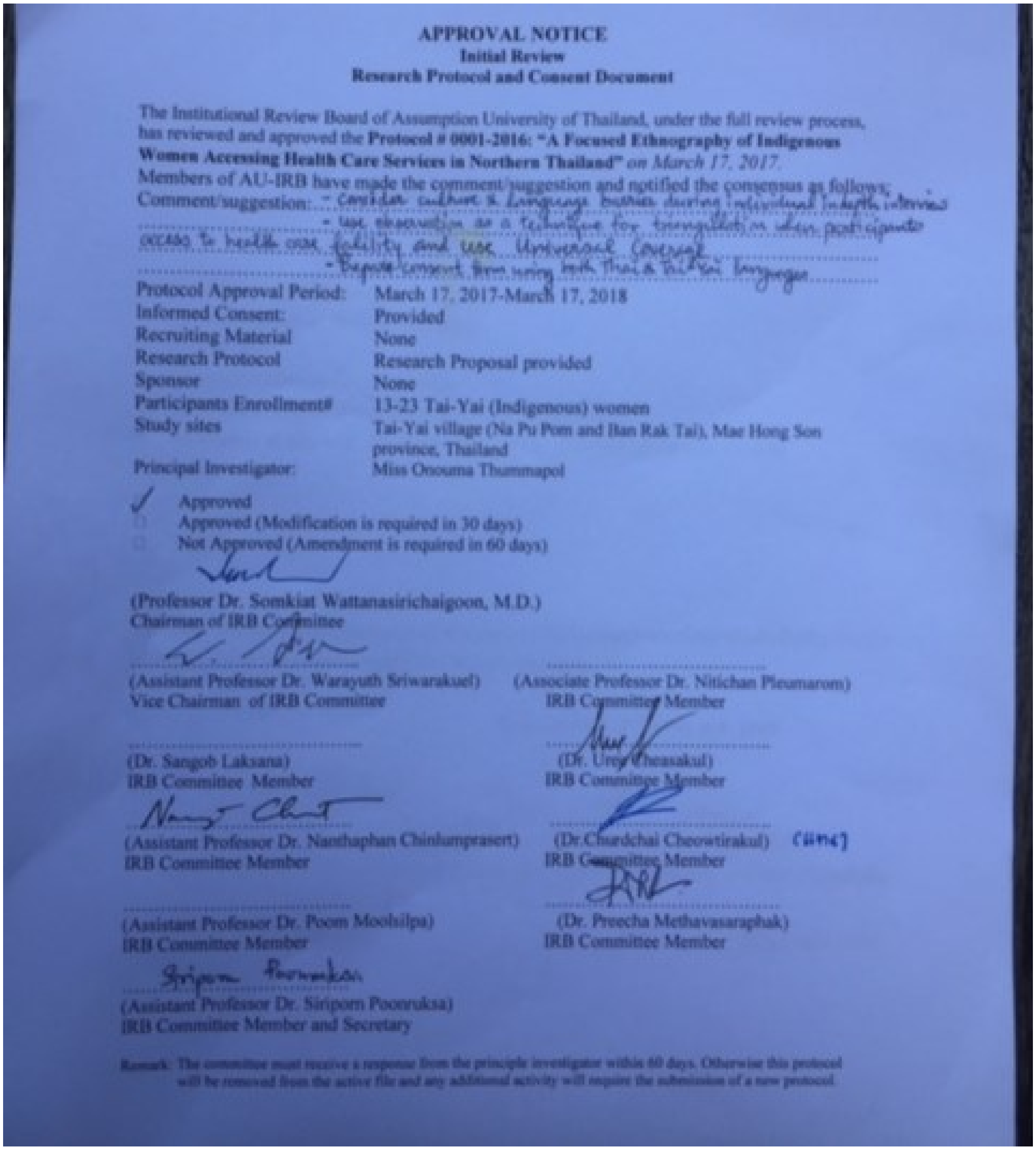
This re-approval is valid for one year. If your study continues past the expiration date as noted above, you will be required to complete another renewal request. Beginning at 30 days prior to the expiration date, you will receive notices that the study is about to expire. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Sincerely,

Anne Malena. PhD
Chair, Research Ethics Board 1

Note: This correspondence included an electronic signature (validation and approval via an online system

Appendix E: Ethics Approval (Assumption University of Thailand)



APPROVAL NOTICE
Initial Review
Research Protocol and Consent Document

The Institutional Review Board of Assumption University of Thailand, under the full review process, has reviewed and approved the **Protocol # 0001-2016: "A Focused Ethnography of Indigenous Women Accessing Health Care Services in Northern Thailand"** *on March 17, 2017.*
Members of AU-IRB have made the comment/suggestion and notified the consensus as follows:
Comment/suggestion: - consider culture & language barriers during individual indepth interview
- use observation as a technique for triangulation when participants access to health care facility and use Universal Coverage
- Prepare consent form using both Thai & Tai-Yai language

Protocol Approval Period:	March 17, 2017-March 17, 2018
Informed Consent:	Provided
Recruiting Material	None
Research Protocol	Research Proposal provided
Sponsor	None
Participants Enrollment#	13-23 Tai-Yai (Indigenous) women
Study sites	Tai-Yai village (Na Pu Pom and Ban Rak Tai), Mae Hong Son province, Thailand
Principal Investigator:	Miss Onouma Thummapol

✓ Approved
☐ Approved (Modification is required in 30 days)
☐ Not Approved (Amendment is required in 60 days)

(Professor Dr. Somkiat Wattanasirichaigoon, M.D.)
Chairman of IRB Committee

(Assistant Professor Dr. Warayuth Sriwarakuel)
Vice Chairman of IRB Committee

(Associate Professor Dr. Nitichan Pleumarom)
IRB Committee Member

(Dr. Sangob Laksana)
IRB Committee Member

(Dr. Urey Cheasakul)
IRB Committee Member

(Assistant Professor Dr. Nanthaphan Chinlumprasert)
IRB Committee Member

(Dr.Churdchai Cheowtirakul) (แทน)
IRB Committee Member

(Assistant Professor Dr. Poom Moolsilpa)
IRB Committee Member

(Dr. Preecha Methavasaraphak)
IRB Committee Member

Siriporn Poonruksa
(Assistant Professor Dr. Siriporn Poonruksa)
IRB Committee Member and Secretary

Remark: The committee must receive a response from the principle investigator within 60 days. Otherwise this protocol will be removed from the active file and any additional activity will require the submission of a new protocol.

Level 3 Edmonton Clinic health Academy
11405 – 87 Ave
Edmonton Alberta, Canada, T6G 1C9
Tel : 1-888-492-8089
Fax : 780=492- 2551
www.nursing.ualberta.ca

Appendix F: Consent Form[14]

TITLE OF RESEARCH STUDY:
A Focused Ethnography of Indigenous Women Accessing Healthcare Services in Northern Thailand

RESEARCH TEAM:

Principal Investigator:
Onouma Thummapol
PhD candidate, Faculty of Nursing
Level 5, ECHA, University of Alberta
081-356-2774
thummapo@ualberta.ca

Co-Supervisors:
Dr. Sylvia Barton
Associate Professor, Faculty of Nursing
University of Northern British Columbia
250-960-5000
sylvia.barton@unbc.ca

Dr. Tanya Park
Assistant Professor, Faculty of Nursing
Level 5 ECHA, University of Alberta
780-492-9109
tanya.park@ualberta.ca

Supervisory Committee member:
Dr. Bukola Oladunni Salami
Assistant Professor, Faculty of Nursing
Level 4 ECHA, University of Alberta
780-248-1801
Bukola.Salami@ualberta.ca

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[14] Consent form was translated into Thai language.

To be completed by the research subject:

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Letter?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the research study at any time, without having to give a reason and without risk and penalty?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you consent to be interviewed?	☐	☐
Do you consent to being audio-taped?	☐	☐
Do you consent to be contacted following the interview to review the transcription of your recorded interview?	☐	☐

Who explained this study to you? ____

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Subject ____

(Printed Name) ____

Date:______________________________

Signature of Witness ____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator ________________________________ Date __________

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Flesch-Kincaid Grade Level: 8.6

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Edmonton Alberta, Canada, T6G 1C9
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Appendix G: Information Letter[15]

TITLE OF RESEARCH STUDY:
A Focused Ethnography of Indigenous Women Accessing Healthcare Services in Northern Thailand

RESEARCH TEAM:

Principal Investigator:
Onouma Thummapol
PhD candidate, Faculty of Nursing
Level 5, ECHA, University of Alberta
081-356-2774
thummapo@ualberta.ca

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tanya.park@ualberta.ca

Supervisory Committee member:
Dr. Bukola Oladunni Salami
Assistant Professor, Faculty of Nursing
Level 4 ECHA, University of Alberta
780-248-1801
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[15] Information letter was translated into Thai language.

You are being asked to take part in a study. Before agreeing to participate, it is important that you read and understand this information and consent form. This form provides the information you need in order to make an informed decision about whether or not you wish to participate in this study. The following information describes the background, purpose, procedures, benefits and risks. It also describes your right to refuse to participate or withdraw from the study at any time. Should you have any questions while reading this form or after reading this form, please ask the researcher whose contact information is listed above. Make sure all your questions have been answered to your satisfaction before signing this document.

Background and Purpose

Indigenous women' access to holistic and culturally appropriate health services remains one of the most challenging and complex areas of healthcare. Indigenous women experience poorer health outcomes and face significant barriers to accessing appropriate and equitable healthcare. You are being asked to participate in this study because we need to gain insights into understanding the experience of Tai-Yai (Indigenous) women's access to healthcare services, the facilitators and barriers that exist, and the influence of cultural beliefs and practices on these experiences.

Procedure

You are invited to participate in one interview with the researcher (Onouma Thummapol). The interview will take approximately 30-90 minutes and will take place at a location and time that is convenient for you.

During the interview, you will be asked to discuss your experience with accessing healthcare services, the facilitators and barriers that you experienced when accessing healthcare, and the influence of cultural beliefs and practices on these experiences. The interview will be tape recorded (with your permission) and notes will be taken during the interview by the researcher. All tapes will be kept confidential and only be listened to by the research team and transcriber. Your name and anything you say that could identify you will be removed before sharing the transcription with other research team members for analysis. The transcription will not be shared with anyone outside of the research team.

Potential Benefits

There may be no direct benefits from participation in this study. However, by having an opportunity to share your circumstances - stories and situations - that in the process may empower you to understand your experiences, gain insightful knowledge into your human rights (especially the right to healthcare), and act on strategies to improve your health. Moreover, this research will lead to a better understanding of the complexities inherent in the lives of Indigenous women, the unique healthcare needs, and the obstacles faced in accessing needed healthcare services. This will help to: bring awareness to the ignored health inequities experienced by Thai Indigenous women, stimulate increased communication and action by between community members, healthcare providers, and policy makers in order to allocate healthcare resources, and inform nurses and allied healthcare professionals to develop culturally appropriate healthcare interventions and support services that are valued by Indigenous populations.

Potential Risks

There are no direct long or short-term risks anticipated as a result of participating in this study. The only potential risk may include emotional distress. In the unlikely situation where you become upset the researcher will ask you if you would prefer to stop your participation in this study. If needed, a debriefing session and assistance with referral to counselling will be provided.

Honorariums

You will receive a token gift (i.e., scarf) as compensation for your valuable information and time participating in this study.

Confidentiality

The information obtained during the interview will be kept confidential and will not be available to anyone except the researcher team members, and the transcriber. All information obtained in this study will be used for research purposes only. The information obtained during the interview (e.g. audio recordings, transcriptions, and field notes) will be stored in the Health Research Data Repository (HRDR) a secure and confidential online repository, housed in the Faculty of Nursing at the University of Alberta for a period of 5 years after the study is completed, and will then be erased/deleted. Consent forms will be kept in a locked filing cabinet for 5 years in the office of the co-supervisor (Dr. Tanya Park), Faculty of Nursing, University of Alberta, and will then also be destroyed. This office is locked and has limited access by master key.

The findings of this study will be used in presentations and publications. Direct quotes from the interview may be used in reports, presentations and/or publications, but no identifying information (including your name) will be provided with these quotes. Pseudonyms (i.e. fake names) will be used in research reports or publications.

Voluntary participation

Your participation in the study is voluntary. You are free to refuse to answer any questions, refuse to take part in the study or to withdraw from the study at any time without giving any reason. If you choose to withdraw from this study, your data will be removed and destroyed from the database. However, the last day to withdraw your interview once completed will be once analysis occurs as the answers will be integrated and impossible to remove after this point.

Future use of the study

The findings of the study shall be presented at the conferences and published in peer-reviewed journals. The executive summary reports will be given to the Mae Hong Son Provincial Public Health Office, Tai-Yai community leaders, and healthcare professionals responsible for the delivery of health services and the development of health interventions for Indigenous communities.

Further information

If you have any further questions regarding this study, please do not hesitate to contact Onouma Thummapol 081-3562774 or email thummapo@ualberta.ca. The plan for this study has been reviewed for its adherence to ethical guidelines by the Health Research Ethics Board at the University of Alberta and by the Institutional Review Board at Assumption University. For questions regarding participant rights and ethical conduct of research, contact the Research

Ethics Office at +1 (780) 492-2615 or at 02-300-4543. These offices have no direct involvement with this study.

Please keep a copy of this letter for reference