ความสมเหตุสมผลและเหตุผลเชิงวัฒนธรรมในการใช้ยารักษาตนเองของผู้ป่วยยากจนสูงอายุที่เจ็บป่วยด้วยโรคเรื้อรังในชุมชนแออัดแห่งหนึ่งในกรุงเทพมหานคร

นาง รวงทิพย์ ตันติปิฎก

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาวิทยาศาสตรดุษฎีบัณฑิต
สาขาวิชาเภสัชศาสตร์สังคมและบริหาร
คณะเภสัชศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
ปีการศึกษา 2549

RATIONALITY AND CULTURAL REASONING IN SELF-MEDICATION AMONG THE CHRONICALLY ILL POOR ELDERLY IN A CONGESTED COMMUNITY IN BANGKOK

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A Dissertation Submitted in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy Program in Social and Administrative Pharmacy
Faculty of Pharmaceutical Sciences
Chulalongkorn University
Academic year 2006

Thesis Title	RATIONALITY AND CULTURAL REASONING IN SELF-MEDICATION AMONG THE CHRONICALLY ILL POOR ELDERLY IN A CONGESTED COMMUNITY IN BANGKOK
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รวงทิพย์ ตันติปิฎก: ความสมเหตุสมผลและเหตุผลเชิงวัฒนธรรมในการใช้ยารักษาตนเองของผู้ป่วยยาก่จนสูงอายุที่เจ็บป่วยด้วยโรคเรื้อรังในชุมชนแออัดแห่งหนึ่งในกรุงเทพมหานคร (RATIONALITY AND CULTURAL REASONING IN SELF-MEDICATION AMONG THE CHRONICALLY ILL POOR ELDERLY IN A CONGESTED COMMUNITY IN BANGKOK) อ.ที่ปรึกษา: ผศ.ดร.รุ่งเพ็ชร สกุลบำรุงศิลป์, อ.ที่ปรึกษาร่วม: ดร.นพ.โกมาตร จึงเสถียรทรัพย์, 130 หน้า

การศึกษานี้ต้องการทำความเข้าใจถึงเหตุผลเชิงวัฒนธรรมและความสมเหตุสมผลในการใช้ยารักษาตนเองของผู้ป่วยสูงอายุที่เจ็บป่วยด้วยโรคเรื้อรังในชุมชนแออัดแห่งหนึ่งในกรุงเทพมหานคร โดยทำการศึกษาระหว่างเดือนพฤศจิกายน 2548 - เดือนเมษายน 2549 ใช้วิธีการเก็บข้อมูลหลัก 2 วิธีคือ การสังเกตอย่างมีส่วนร่วมและการสัมภาษณ์เชิงลึก เรื่องราวชีวิตของผู้ป่วยสูงอายุที่ป่วยด้วยโรคเรื้อรังจำนวน 20 คนเผยให้เห็นถึงอิทธิพลของสภาพสังคมและเศรษฐกิจที่บีบคั้นในสถานการณ์ชีวิตหนึ่งๆ และความสลับซับซ้อน ความยากลำบากในการใช้บริการจากโรงพยาบาลตลอดจนการส่งมอบยาที่คุณภาพต่ำของร้านขายยา ที่มีต่อการตัดสินใจเลือกวิธีการรักษาด้วยการซื้อยารักษาตนเอง การศึกษาพบว่าการใช้เหตุผลเชิงวัฒนธรรมของชาวบ้านที่ยากจนเหล่านี้เกี่ยวข้องกับความจำเป็น สามด้าน ได้แก่ การดำรงรักษาความสัมพันธ์ทางสังคมที่ดีของครอบครัวและของเพื่อนบ้าน การมีอาชีพการงานที่มั่นคง และความพยายามที่จะรักษาสถานะของตนให้เป็นที่ยอมรับมากที่สุดภายใต้ความสัมพันธ์เชิงอำนาจที่ไม่เท่าเทียมกันระหว่างตนเองกับเครือข่ายทางสังคม นอกจากนี้ยังพบว่าการใช้เหตุผลในลักษณะข้างต้นนั้นเป็นไปเพื่อจุดมุ่งหมายอย่างใดอย่างหนึ่งในสองประการต่อไปนี้ (1) เพื่อรับผิดชอบต่อความเป็นอยู่ของบุคคลในครอบครัวตามบทบาทหรือสถานะที่ตนมีต่อครอบครัว หรือ (2) เพื่อให้ตนได้รับความช่วยเหลือในระยะยาวโดยเฉพาะอย่างยิ่งในยามที่เกิดวิกฤตในชีวิต จุดมุ่งหมายเหล่านี้มีความสมเหตุสมผล เนื่องจากเป็นจุดหมายปลายทางที่มีความเหมาะสม และความชอบธรรม และเป็นสิ่งที่มีความสำคัญและมีคุณค่าในมุมมองของคนจนเหล่านี้ การเลือกวิธีรักษาที่คำนึงถึงจุดมุ่งหมายเหล่านี้จึงสมเหตุสมผลในมุมมองของชาวบ้าน ดังนั้นการศึกษานี้จึงเสนอแนะว่า ก่อนที่จะประเมินหรือตีความเหตุผลที่แตกต่างหลากหลาย ว่ามีความสมเหตุสมผลหรือไม่นั้น จะต้องทำความเข้าใจแนวคิดที่ซ่อนอยู่เบื้องหลังเหตุผลที่ปรากฏให้เห็นเหล่านั้น ซึ่งแนวคิดที่อยู่เบื้องหลังของชาวบ้านที่ยากจนเหล่านี้อาจแตกต่างไปจากแนวคิดในมุมมองของผู้ประเมินหรือผู้ตีความ ดังนั้นผู้ประเมินหรือผู้ตีความ จึงไม่ควรใช้มุมมองของตนเป็นฐานในการประเมินหรือตีความ การศึกษานี้ได้เสนอแบบจำลองการใช้เหตุผลในการใช้ยารักษาตนเองในชีวิตประจำวันของชาวบ้านในชุมชนแห่งนี้

สาขาวิชามานุษยศาสตร์สังคมและบริหาร (นานาชาติ) ลายมือชื่อนิสิต.....

ปีการศึกษา 2549 ลายมือชื่ออาจารย์ที่ปรึกษา.....

ลายมือชื่ออาจารย์ที่ปรึกษาร่วม.....

4676958533 : MAJOR SOCIAL AND ADMINISTRATIVE PHARMACY
KEY WORD : RATIONALITY / SELF-MEDICATION / CULTURAL REASONING

RUANGTHIP TANTIPIDOKE: (RATIONALITY AND CULTURAL REASONING IN SELF-MEDICATION AMONG THE CHRONICALLY ILL POOR ELDERLY IN A CONGESTED COMMUNITY IN BANGKOK). THESIS ADVISOR: ASST.PROF. RUNGPETCH SAKULBUMRUNGSIL, PH.D. THESIS COADVISOR: KOMATRA CHUENGSATIANSUP, M.D., PH.D. 130 pp.

This ethnographic study seeks to understand cultural reasoning in self-medication and its rationality among the chronically ill poor people in a congested community in Bangkok. Participatory observation was the chief method for collecting data during 6 months (November 2005-April 2006) in the community. The biographical accounts of chronically ill patients and their neighbors reveal how socio-economic constraints in different life situations, including the quality and complexity of hospital service utilizing and poor quality drug dispensing, shape decision-making of treatment choices in everyday illness experience of the poor, elder people. I argue that lay cultural reasoning with regard to self-medication was greatly influenced by their own three concerns: the need to maintain social relationship within the family and community; occupational security; and keeping good status in asymmetrical power relation with networks of social support or working party. In addition, reasoning based on these considerations is the means to achieve two aims: (1) to fulfill responsibilities in one's capacity and role for the well-being of other family members and (2) to invest for long-term advantages which would be useful in the future as when one faces crises in life. These ends could be considered rational since they are appropriate and legitimate and are of great value to the poor people. Therefore, before assessing or interpreting the rationality of different actions, one needs to find out the inner logic, which could differ from that held by the assessor. This study also proposes a cultural model of everyday reasoning on self-medication.

Field of study Social and Administrative Pharmacy. Student's signature.....
Academic year 2006 Advisor's signature.....
Co-advisor's signature.....

ACKNOWLEDGEMENTS

This thesis is the result of four years of work whereby I have been accompanied and supported by many people. It is a pleasant aspect that I have now the opportunity to express my gratitude for all those who gave me the possibility to complete this thesis.

I would like to express my deep appreciation to my advisors, Asst.Prof. Dr. Rungpetch Sakulbumrungsil, whose help, stimulating suggestions and encouragement helped me in all the time of research for and writing of this thesis. A special thank goes to my co-advisor, Dr. Komatra Chuengsatiansup who is my teacher in medical anthropology and guided me the way to conduct this research. My appreciation is also extended to my thesis committee, who gave constructive suggestion.

My many thanks are expressed to Ph.D. students in my class: Ms Sumalee Pornkitprasarn, Ms Nunthaluxna Sthapornnanon, Nong Ponn (Sanita), Karnt Wongsuphasawat, and Nong Pom (Jittrakul) who facilitated learning environment both in and out of classroom, and also shared empathy among us.

I would like to thank my dear friends, Nong Tao (Malee), Nong Wao, Dr. Vibul, Nong Daeng and all in Journal Club organized by Society and Health Institue.

A special thank go to Asst.Prof. Sathitpong and Dr. Suntharee and all of my colleagues at Social Pharmacy Unit, Faculty of Pharmaceutical Science, Chulalongkorn University for taking care of the course while I was away.

I wish to thank Ministry of Education for granting the study and Health Promotion Support Fund and Chulalongkorn University for granting the research project.

Finally, I feel a deep sense of gratitude for my parents and my family who nurtured me and gave me the good things in life, and my husband who had been on my side during this study, with warmly assisting in my fieldwork as well as in computerized document work

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CHAPTER I

INTRODUCTION

Rational and Statement of the Problem

Over the past two decades, the problem of drug use in self-medication is increasingly recognized. In developing countries, including Thailand, the majority of illnesses are treated with western medicines - both non-prescription and prescription drugs -without any professional consultation. Research findings had shown that drug use in self-medication were frequently in irrational fashion. Even prescription drugs and dangerous items which have been withdrawn in developed countries (e.g. Dipyrone (Metamizole), Phenylbutazone, Oxyphenbutazone, high dose Estrogen-Progesterone) were commonly used in the communities. The uses of poly-pharmacy (or "yachud" in Thai), antibiotics, steroid drug and injections were frequently reported in various studies (Ross-Degnan et al, 1992; Hardon, 1991; Haak 1988; Kamat and Nitcher, 1988; van der Geest, 1987; and Greenhalgh, 1987). Harmful drugs were available both at pharmacies and groceries in most rural and urban communities (Chuengsatiansup et al, 2000; Ratanawijitrasin et al, 2000), particularly in the poor neighborhood (Suttajit et al, 2003).

Worldwide attempts have been made to implement the various strategies in order to encourage saver drug use including intervention studies and action programs (Ross-Degnan et al, 1997; Le Grand et al, 1999; Chalker et al, 2005). Promoting 'rational use of drug' has become an international agenda when, in November 1985, WHO held a 'Conference of Experts on Rational Use of Drugs' in Nairobi. Subsequent collaboration among various organizations known to involve in improving drug use led to the establishment of the International Network for Rational Use of Drugs (INRUD)[1] in 1989. The Strategies and its perspective to promote

[1] INRUD was established in 1989 to serve as a catalyst for the promotion of well-designed research into drug utilization problems, and to identify interventions that are the most promising for promoting rational drug use.

'rational use of drug' had been recommended from various international conferences, organizations and research scholars (van der Geest, 1987; Ross-Degnan et al, 1992). While Sjaak van der Geest (1987) called for more attention to the local conditions of distribution and use of pharmaceuticals in developing countries, Ross-Degnan et al (1992) suggested that an understanding of the reason why people decide to use medicines in their particular social environments is crucial in formulating effective working strategies. Ross-Degnan et al also pointed out the fundamental problem of defining 'rationality' in the contexts where drugs play different culturally-determined roles (Ross-Degnan et al, 1992). Understanding 'rationality' of lay persons from their points of views should be a prerequisite for any effective solution for drug use problems in self-medication.

Reviews of drug use studies revealed that most researches in this field were quantitative in nature exploring patterns of drug uses and mostly conducted by health professional using biomedical framework of analysis (Hardon, 1991; Chuengsatiansup et al, 2000). Such studies described how often people self-medicated and identified the drugs they chose and their methods of use. The results of such studies often described or assessed community drug use as 'irrational' or 'inappropriate', two terms which were often found to be used interchangeably. There seemed to be little awareness on how rationality could be defined and contextually specific.

As one the reviews (Chuengsatiansup et al, 2000) suggested, judging from a professional view, the term 'irrational' was used in the sense of clinically and economically 'inappropriate' use of drug. It means that, from a professional point of view, there was no 'good reason' for such drug use practices, since it's harmful and the cost of drugs would increase in a long run. The case of antibiotic resistance was often used as an example of how irrational use of drug could be damaging not only to individual user but also to the national drug system. Such an explanation was strongly influenced by medical professional perspective; it thus downplayed the importance of cultural contextual circumstances within which drug use decision was made.

The limitation of medical professional perspective could be seen from the proposed strategies to improve quality drug use. They focused on knowledge gap between lay users and professional practitioners and tried to promote further

education on saver drug use. For instance, an expert conference convened by WHO in Nirobi in 1985, brought together academics, health planners, representatives of the pharmaceutical industry, and consumer activists. Participants agreed on the importance of rational use of drug and recommended better drug information dissemination as well as further proper training and continuing education. Similar recommendations could be frequently found in many other studies (Ross-Degnan et al, 1992). However, little concrete information was available with regard to how the filling of knowledge gap could improve drug use quality in the communities.

In addition, at a conceptual level, evidence to support the correlation between knowledge or health belief and the practice of health related behavior is questioned. In Health Belief Model (HBM) theory, Calnan and Rutter (1986) pointed out a serious problem at the conceptual level which led to its limitation to explain and predict health related-behavior. Their study found that a set of belief in HBM (perceived susceptibility, perceived severity and perceived benefits /barriers) were poor predictors. The author found that 'previous behavior' could be a better predictor which they called 'value of belief.' They suggested that the 'value of belief' or 'normative belief' in the 'Theory of Reasoned Action' should be added to the equation to better predict behavioral changes (Calnan and Rutter, 1986).

Different perspectives on rational use of drug lead to different perception and explanation on what is the essence of the problems and how to solve them (Chuengsatiansup et al, 2000). In order to gain a balanced perspective on the problem of drug use, more understanding on psychological and social dimensions is needed. In this regard, more researches are considered necessary particularly those applying social science and qualitative method. As Ross-Degnan et al put it:

> … formative behavioral research is needed to discover and explore the motivations, expectations, and incentives which underline the drug use behaviors of providers and consumers. This research needs to draw heavily on the broad array of methodologies that have been developed in the social sciences, which are only now beginning to be applied to the study of clinical problems in drug use. These formative studies must include application in different environments of some of more promising qualitatively - oriented techniques.

However, it should be emphasized that balance between macroscopic and microscopic approach is also important. Certain approach such as "Knowledge

Attitude and Behavior model" or KAP model ignores social and cultural constraint in the model of decision making. As Chuengsatiansup et al, (2000) put it:

> … such a conceptual framework precludes any intervention at the macro-structural level… Current behavioral approach presupposes a 'freedom of choice' model of decision making. It assumes that villagers are free to choose whatever good for them… Such a view is based on middle-class' perspective, which are relatively free to choose the products according to their desire."

Emphasizing on the individual decision-making, such a perspective precludes the intervention at the macro-structural level. Moreover, instead of viewing local people as having a freedom of choice in their decision-making process, it is important to understand how exactly people make up their mind when they self-medicate. In this regard, anthropological research could be particularly effective in providing an understanding of a "native point of view" (Geertz, 2000) as well as socio-cultural factors influencing people's self-medication pattern.

Recent development in the anthropology of the pharmaceuticals provided interesting analytical framework to understand drug use behavior in various contexts. For instance, van der Geest et al (1996) proposed the idea of 'the cultural reinterpretation[2] of modern pharmaceuticals' in which they argued that the meanings of modern pharmaceuticals, when introduced into other cultural settings, were reinterpreted according to local cultural framework. Drug in self-medication was often taken in accordance with reinvented meaning (see also Bledsoe and Goubaud, 1985; Nitcher, 1980). Medicines were also seen as 'the commodities' affected by pharmaceutical advertising. Drug has become the social representation of medical intervention partly because of the 'concreteness' of drugs' (van der Geest et al, 1996; Hardon, 1991).

These studies, in socio-cultural approach, can provide a better understanding of social and cultural influences on people's selection and use of drug under particular contexts, however, they do not focus on the reason in lay decision making process. As such, they provide little understanding of 'rationality' or logical reasoning of drug use in the illness experience of poor people. These may be a weakness of most studies

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[2] The authors refer to Logan (1973) the first scholar who talk about the concept of cultural reinterpretation

focusing on socio-cultural influence often provided little understanding in the cognitive or psychological elements. Conversely, cognitive studies in cognitive medical anthropology[3], largely provided cultural models for emotions and psychological functioning in various societies, were criticized that have little attention to lay pragmatic and formative dimensions in their *particular social and cultural constraint.* Most cognitive studies, even in particular cultural analysis "often tell us remarkably little about the societies being studied" (Good, 1984:52). Moreover, Keesing criticized cognitive anthropology as "*curiously innocent of social theory"* (Keesing, 1987, cited in Good, 1984:52).

However, recent cognitive studies of illness representations provided a way to investigate 'rationality' or logical reasoning among local people. Patel, Eisemon, and Arocha (1988), for instance, constructed a cognitive model of 'everyday reasoning' among lay person. They suggested that the way lay persons thought and made decision could be viewed as having a causal logic in relation to the cause of illness. Similarly, Blaxter (1983), in his sociological study of the cause of disease in working-class woman, found that working class women explained their illness with 'a causation logic' and 'coherence' with their life situation. Although, these two studies provided an understanding of people's causal thinking, and the latter also provided the influences of women life situations over their reasons. However, there is a gap of knowledge in understanding the dynamics interplay of individual, socio-cultural and political factors in decision-making process, which was a situated in particular social contextual circumstance.

In addition, review of studies about 'reasoning' and 'rationality' in the illness experience and self-medication found that those studies often ignore to investigate the notion of rationality in terms of 'cultural reasoning' and 'philosophical aspect of rationality' of local people points of view. Review of previous studies and action programs on rational use of drugs reveal that there are three different viewpoints to define and investigate 'rational use of drugs' or 'rationality'—i.e. (1) Economic perspective; (2) Medical professional perspective; and (3) Legal

[3] The early studies in cognitive medical anthropology provided broader understanding of folk knowledge, psychological theories of common sense reasoning of illness and care-seeking narratives.

perspective (Chuengsatiansup et al, 2000). These perspectives are informed by different disciplines, which affect to different understandings of 'rationality' of people point of view and how to solve the problem of 'rational use of drugs'. This dissertation project interest in investigation of 'cultural reasoning' under an assumption that "the factors which are taken into account when making a rational decision are not only physical and material needs and satisfaction, but also psychological and symbolic[4] ones" particular study of rationality in pre-capitalist societies (Seymour-Smith, 1988: 239; Good 1994: 68). Modern capitalist society privileges economic rationality while pre-capitalist society privileges other domains such as kinship or religion. Thus in making a decision which place priority on the demand of kinship system, strong patronage system or the religious system, the poor community members may act rationally in terms of dominant mode of social organization in their community (Seymour-Smith, 1988).

Summary of the above studies including its critiques indicates the need of a perspective and approach to understand the logical reasoning or rationality from people's point of view within its socio-cultural contexts. In this respect, this study will use ethnographic approach in order to study local people's system of thought. It will seek to explore the notion of "rationality" and "rational use of drug" from local people's point of view. By viewing "self-medication" as a social and cultural phenomenon, this study will help to explain the cultural reasoning of self-medication practice among poor people and propose a new way of thinking to formulate proper strategy for promoting rational use of drug in our society.

Objectives:

1) To seek to understand "rationality" from local people's point of view.
2) To understand the dynamics interplay of individual, socio-cultural and political factors in self-medication decision-making process within its contextual circumstances.

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[4] Good illustrated symbolic ones as: "Symbolic forms" and "culture" are similar meaning as Cassirer, idealist philosopher of culture, proposes his idea that, for instances, (1) culture was conceived as thoroughly historicized, as embodied in this distinctive symbolic forms and mode of human activity; (2) culture or symbolic forms mediate and organize distinctive forms of reality.

Research Questions:

1) What are the various sets of cultural reasons used in process of decision making and action of people's self-medications practice?
2) How do such self-medication practices become a routine practice in everyday life of poor people? What is the cultural reasoning of everyday life that influences the practice of self-medication?
3) Within the context of the poor communities, how is their cultural reasoning generated? How is it socially constructed, internalized and sustained in everyday life?

Expected Contributions

1) Understanding the system of thought of poor lay persons, or "the hidden logic" of self-medication practice will be useful in formulating the proper strategy for promoting appropriate use of drug. Such an understanding and strategy can be valuable for rethinking the problem of irrational use of drug in other areas of poor people and in other developing countries.
2) There has been evidently a bias in professional perspective with respect to how the notion of "rationality" is defined. This "professional ethnocentrism" needs to be balanced with a better understanding of how local people's decision-making could be viewed as logical a reasoning process when take into account their circumstantial context. Finding from this study will provide an understanding on how the nature of rationality conception is 'context-sensitive. This will help to reduce the tendency of 'blaming the victims' and encourage a more humanistic approach in solving health problems particularly among the poor or marginal people.

CHAPTER II

REVIEW OF LITERATURES

The main focus of this study is to seek to understand 'rationality' and "rational use of drug" in self-medication from local perspective. It will explore logical reasoning of self-medication practice in its social and cultural aspects. Review of related literatures will be divided into three parts. Firstly, the notion of rationality as a philosophical problem will be reviewed since it is crucial to understand how 'rationality' could be differently interpreted in various systems of thought. Secondly, to provide a background understanding of the pragmatic and strategizing role of poor people to cope with their life constraints, the 'theory of practice', proposed by Pierre Bourdieu—a French sociologist, will be used to explain the self-medication behavior in social and cultural aspect. A review of Bourdieu's related concepts will be provided. Thirdly, a summary review of literatures on self-medication and community drug use will be presented.

'Rationality': Philosophical Background and Theoretical Understanding

'Rationality' has long been the problem in philosophy and social theory. In this study, the concept of rationality will be used to discuss and interpret logical reasoning of lay poor people in their justification of self-medication practice. Review of related literatures suggested four major points of the nature of rationality which could be applied to this study.

First, rationality as deliberative conduct

Nicholas Rescher (1988), in his writing 'Rationality: A Philosophical Inquiry into the Nature and Rationale of Reason', describes 'rationality' as a human resource. As he puts it:

> Rationality consists in the appropriate use of reason to resolve choices in the best possible way. Rationality is a matter of deliberately doing the best one can with the means at one's disposal—of striving for the best results that one can expect to achieve within the range of one's resources—specifically including one's intellectual resources. Optimization in what one thinks, does, and values is the crux of rationality. (1988: 1-2)

Defining rationality as deliberative conduct, Rescher proposes that there are 3 spheres of cognitive, practical, and evaluative reason, which compose rational deliberation. Although, according to Rescher, rational agency seems to require deliberative thinking and doing, he also points out that rational agency does not always require deliberation. In some situations, deliberation is a luxury or not necessary such as: (1) a drowning man can not deliberately 'clutch a branch' and (2) a driver puts the seat belt on automatically. Therefore, doing rational thing may be in tacit way or unconscious if there was a good reason for what one did. As Rescher (1988: 13) puts it:

> There must always be good reasons why a genuinely rational act was done as it was, and indeed the agent must have such reasons in an at least tacit or implicit way. But this recognition of reasons can be unconscious.

Secondly, rationality is a holistic or systematic character, and demands the practicality of reason

Rationality is as wide-ranging and complex as the domain of intelligence at large. It is many-sided or many characteristics in which all are inseparable—a holistic. Its two sides that are not dispensable are valued appropriate ends and the efficient means to achieve that appropriate ends. Furthermore, in the rational procedure, it requires many key characteristics of reason. The 'coherence' in rational procedure is one of key characteristics. As Rescher (1988: 16) puts it:

> Rationality calls for proceeding on the basis of good reasons for whatever we do… It consists in one's being in the position to provide, in principle, a cogent account of one's proceedings… This demand for an account that is both cogent and coherent endows reason with a certain holistic and systematic character… Rationality is governed by certain pervasive 'desiderata of reason' that bind together the proceedings of different rational agents—and the proceedings of different occasions of a single agent.

For a better understanding on the demand for 'coherence' in rational procedure, Rescher provides its meaning as "make sure that your commitment is hang together". Furthermore, he gives an example of 'coherence' in rational procedure of single agent as:

> For a rational being deliberately to (1) accept a contention; (2) adopt an end; or (3) make an evaluation, is also commit himself to (1) accepting those thing he deems to be consequences of this contention, (2) accept those things he deems to be means to

> this end, or (3) make like evaluations of those things he deems to be analogous with this valued item. (1988: 16)

In addition, rational procedure also demands other characteristics such as:

> consistency (avoid self-contradiction),
> uniformity (treat like case alike),
> simplicity (avoid needless complications),
> economy (be efficient). (1988: 16)

These systematic characteristics are served to make sure that everything is fit together in an effective and mutually supportive way. Rescher (1988:16-7) describes the advantage of such characteristics in term of the instrumentality of mind thus:

> Reason is the organizing force in the mental life of an intelligent creature—the orderer of chaotic events into coherent experience. It is instrumentality by which mind secures its grasp upon the difficult and unstable world.

All of these characteristics are required for rational procedure, but another characteristic in the function of its instrumentality is the practicality of reason. As Rescher (1988: 17) puts it:

> The rules of reason are 'regulative principles'—instructions that keep the conduct of our various affairs on an efficient, effective, and thus intelligent basis. Reason is eminently practical—it wants what works (its efficient and effective). But it pre-eminently also wants what makes sense.

Thirdly, rationality is universal, but circumstantially universal

Rationality is universal in the sense that "what is rational for one person to do, to believe, or to value is also of necessity equally rational for anyone else in the same circumstances.[1] Rationality is universal, but circumstantially universal." (Rescher 1988: 158) It means that the fundamental principles of reason are the same or universal. Whilst, what it is rational for someone to do or to think "hinges on the particular details of how he is circumstanced—and prevailing circumstances of course differ from person to person and group to group." (Rescher, 1988: 159) In order to more understanding in differentiation between what is principle of reason being

[1] Rescher notes that: we here construe 'circumstances' very broadly, including not only the outer and situational, but also the inner conditions that relate to a person's physical and psychological make-up.

universal and what is the variability between rationality in particular circumstances. Rescher provided an instance of "cognitive rationality to medicine" by proposing the "stratification levels of the principles of rationality", presented briefly as in the following table. (Rescher, 1988: 164-5)

Stratification levels of the principles of rationality*

Step	Principles of rationality	Cognitive rationality to medicine
1.	*Defining principles of rationality*: The basic principles that determine the nature of the enterprise and specify what rationality is all about.	'Maintaining health', 'curing illness and disease', 'restoring and maintaining normal bodily functioning', 'removing painful symptoms'
2.	*Governing norms, standards, and criteria*: For cognitive rationality, these norms are afforded by desiderata such as coherence, consistency, simplicity, and the like. (These norms provide our criteria for assessing the acceptability and adequacy of our rules of rational procedure.)	'How is one to assess 'health'? 'How is one to construe "normality"?' 'How is one to identify a "symptom"?' 'Just what constitutes an "illness"?' (Note that …At this level there is some room for variation)
3.	*Rules of rational procedure*: Rules for the rational resolution of choices. (These rules constitute our criteria for assessing the rational acceptability and adequacy of particular resolutions.)	The modus operandi of medical practices—surgery or chiropractic treatment, drugs or psychotherapy, and the like. (These of course differ from age to age and culture to culture)
4.	*Rationally warranted rulings*: Resolutions with respect to particular issues arising in particular concrete cases.	The specific interventions, prescriptions, and medical measures adopted in particular cases.

** Modified from "Display of Stratification levels of the principles of rationality" (Rescher, 1988:164)*

Fourthly, many-sided rationality and the practical application

As mentioned above, rationality is many-sided. Many characteristics of its rational procedure are inseparable. There are some other sides of rationality that can be seen from particular perspective or discipline as being at the threshold of rationality For instance, a logician may see "the avoidance of inconsistency is as

rationality's be-all and end-all"; the economist, "it is efficiency in the pursuit of chosen objectives" and the scientist requires "evidential cogency" (1988: 8). These perspectives are easy to lose sight of how complex and many-sided rationality is. In this study, it is realized that one has to take into consideration the complexity and the many sides of rationality in order to apply its key characteristics to explain the phenomenon of self-medication.

It should be noted that 'rationality' is not equal to the *reasonableness* of practice. Rationality is better compared to politics: It is an art of *possible*. It means that rationality is a matter of doing the best that is possible in the over all circumstances, included cognitive circumstances, in which the agent functions (Rescher, 1988: 23).

Finally, applying the notion of rationality to explain the social phenomena of illness experience and self-medication behavior, especially when consider its logical consistency, we need to understand rationality as being *context-sensitive*. Changing in the perception of a situation which led to the change of the decision making should not criticized as irrational or inconsistency. As Tambiah (1990: 120) puts it: "Rationalization is a kind of adaptive mechanism that by contrast shapes of the perception of a situation itself rather than its evaluation." Furthermore, interpreting socio-cultural phenomena should be done carefully not only attending to the action that we can easily see but also the logic behind such action that may be situated in the larger contexts of life. Tambiah (1990: 136) suggests that:

> …the socio-cultural phenomena that anthropologists (and all social scientists) have to cope with are totalities in which instrumental and performative symbols and actions, causal logic and communicative logic, are intertwined and fused.

All of these points concerned with 'rationality' conception and its application will be used to discuss of the logical and cultural reasoning of self-medication according to the research questions of this study.

Theory of Practice

In his 'theory of practice,' Pierre Bourdieu proposed the conception of **'logic of practice'** and **'habitus'** in order to explain the social 'practice' and its logic. By habitus Bourdieu means the disposition of the agent which was programmed to act

and react to social circumstances. His theoretical model of social practice is not losing sight of the wider structures and patterns of social life (William, 1995). His analysis of 'practice' is characterised by a number of key features, which contain important implication for analysis logical and cultural reasoning. Bourdieu particularly interests in the cultural logic of practice in every day life rather than viewing human action as a result of conscious 'rational' reasoning. Let us look at each of his theoretical formulations in turn.

Logic of Practice

First, Bourdieu stresses the fact that 'practice', particularly in everyday life, *is not consciously, or at least not wholly consciously organized* (Jenkin, 1992). As Bourdieu succinctly puts it:

> Each agent, wittingly or unwittingly, willy nilly, is a producer and reproducer of objective meaning…it is because subjects do not, strictly speaking, know what they are doing that what they know has more meaning than they know. (Bourdieu, 1977:79)

As William (1995), in his "Theorising class, health and lifestyle: can Bourdieu help us?" building on Jenkin's (1992) observation, thus.

> That is to say, most of us, most of the time, take our selves and the social world around us for granted; we do not think about what we do because, quite simply, we do not have to. Indeed, the business of social life would be impossible if it were not taken for granted most of the time: imagine the absurdity of having to keep an active file in our heads of each and every social rule and regulation! (Jenkins, 1992) (William, 1995: 582)

Bourdieu refers to this taken for granted feature of practice as *'doxic experience'*: namely that *'coincidence of objective structures and internalized structures'* (Bourdieu 1990: 20). He also points out, social life, in all its richness and complexity, is not simply accomplished on a rule-governed basis. Rather, practice has an essentially improvisory nature and a 'fuzzy logic'. As such, lines of action engaged in according to the logic of practice, do not, indeed cannot, have the neat and tidy regularity of conduct deduced from normative or juridical principles (Wacquant, 1992: 22)

Secondly, building on this point, another feature of Bourdieu's account of practice is that practice is not without its practical intent. As quoted from William (1995):

> Bourdieu's account of practice concerns the fact that whilst it is organized in a manner largely devoid of conscious deliberation or reflexive control, it is not without its purpose or practical intent. Here the aim is not only to emphasize the fact that individuals do have goals and interests, but also to locate the source of their practice in their own experience of reality (i.e. their practical logic), rather than the second-order analytical models which social scientists construct in order to predict and explain that practice (e.g. Rational Action Theory or RAT for short! (Jenkins, 1992)

In the respect of the practice with the agents' purpose, Bourdieu's description of his theoretical move from 'rules to strategies'. His use of the notion of 'strategies' is quite different from that of recent sociological debates concerning this concept. As it is meant to capture that subtle interplay of freedom and constraint which characterizes social interaction, and enables individuals to 'know without knowing' the right thing to do (Jenkins, 1992, cited in William, 1995). In the other words, the strategizing agency has no such thing as an individual's free will. In Bourdieu's hands therefore, the notion of 'strategy' is not quite as fluid and open as it might first appear (William, 1995).

Habitus

In his description, Bourdieu proposed his term 'habitus' to be a self-regulative device of an individual's free will. 'Habitus' may be conceptualised as an 'acquired system of generative dispositions', which is objectively adjusted to the particular conditions in which it is constituted (1977: 95). It is through the habitus that:

> …the structure which has produced it governs practice, not by the processes of a mechanical determinism, but through the mediation of the orientations and limits it assigns to the habitus's operations in invention. As an acquired system of generative schemes objectively adjusted to the particular conditions in which it is constituted, the habitus engenders all the thoughts, all the perceptions, and all the actions consistent with those conditions, and no others. (1977: 95)

In the other words, 'habitus' is the disposition of agents through which the agents apprehend the social world, essentially the product of the internalization of these vision and division of that world. Habitus is meant to function as an 'open

system of disposition', there is a 'relative irreversibility' to the process: the 'unchosen principle of all choices', which in turn is largely determined by the social and economic conditions of its constitution (Bourdieu and Wacquant, 1992: 133, 136).

These two concepts, 'the logic of practice' and 'habitus', will be used for explaining the self-medication practice or behavior and its logic in terms of cultural reasoning of lay decision making among poor people.

Finally, another point of Bourdieu's theoretical description, which will be useful in this study, is the transition from *'doxa' to 'heterodoxy'* of the agent. According to his description, the taken for granted feature of practice is referred to as *'doxic experience'*. It means that the agents who are in the doxa state apprehend and accept the existing social world or social order as natural and legitimate. It is only when the sense of naturalness ceases to obscure an individual, or the passage from doxa to heterodoxy (Bourdieu, 1977: 169), that an individual becomes conscious of him/herself as a social actor. Once such a transformation occurs, an individual desists the passivity and subsumes a more strategizing role. The agent will use all of their resources (4 forms of capital: economic capital, cultural capital (legitimate knowledge of various sorts), social capital (involving various kinds of relations with significant social others) and symbolic capital (prestige and social honour)) in the transformation. In this light, this study wants to explore the conditions that reproduce the naturalness of the social world or their practice or habitus, and the conditions that transform doxa to heterodoxy.

Self-Medication and Community Drug Use

The investigations of self-medication have been increasing since 1980s (Hardon, 1991). Most studies point out to the quality of care and drug use problems. Summary review of the existing studies will be divided into three aspects of self-medications—practice of self-medication together with drug distribution and used, factors effecting the use of drugs, and action or intervention studies of promoting appropriate use. The review is summarized as following.

Practice of Self-Medication and Drug Used

Self-medication is seen as most popular form of symptom management in most society. A review of household survey and other community-based studies from Africa, Asia and Latin America estimated that 80 percent of illness episodes are self-treated with modern medicines in these developing countries (Helling-Borda and Quick, 1996). In addition, study of childhood illnesses done in Philippine, a rural village, also found that 80 percent of childhood diseases were treated without consulting a doctor using modern medicines (Hardon, 1987).

Studies in widely scattered third word location have similar findings that modern medicines are broadly pervaded in the rural area (van der Geest, 1982; Hardon, 1991). Most studies found unsuitable drug for people common illnesses. A study in Ecuador found that registered health practitioner prescribed only 34 percent of prescription drug sold in this country (Price, 1989). It means that about 66 percent of such drugs were used without direct medical advice nearly similar as another study in India (Krishnasmay et al, 1985, cited in Helling-Borda and Quick, 1996). In the same way, finding of the study in Philippine was shown that only one-third of antibiotics were prescribed by health personnel.

Moreover, many studies found that many drug items available in the communities are unsafe even drugs for childhood illnesses such as all of anti-diarrheas and half of cough syrup (Hardon, 1987). Hilbrand Haak (1988), studied in two rural communities in Brazil, found that almost one third of cases studied, 30 families in each village were selected at random, are potentially dangerous. The researchers also considered that between half and two thirds of self-medication on modern drugs ought to be regarded as irrational from strictly biomedical viewpoint. They reported the use of restricted medicines in the study villages such as Dipyrone, Piperazine, Oxyphenbutazone, Chloramphenicol, Barbiturates as antiasmatics, Neomycin as antidiarrhoetic, and combined of one or more antibiotics and corticosteroids. All these drugs were those in warning list compiled by the UN in cooperation with the WHO and seemed to be ‘withdrawn’ and ‘severely restricted by governments anywhere in the world (Haak, 1988). Studies in Cameroon (van der Geest, 1982), India (Greenhalgh, 1987), Phillipines (Hardon, 1987), including

Thailand (Cunningham, 1970; Jaidee et al, 1980; Chuengsatiansup et al, 2000) reported similar to those above findings.

Channels of those unsafe drug distributions were revealed by many studies, including a study in Thailand (van der Geest, 1982; Sringernyuang et al, 1994). The results showed that most of drugs are sold at pharmacy—both licensed and non-licensed pharmacy, groceries, market trader and drug peddlers in the communities.

Factors Affecting the Use of Drugs

Studies in this approach, can be said that, are divided into two different orientations. First orientation is looking for "factors" that determine community drug uses with an expectation that drug use pattern "could be modified once we know enough about factors influencing villagers' decision" (Chuengsatiansup et al, 2000). The second orientation is to seek understanding of self-medication from local perspective and within local contexts. The latter concerns socio-economic and cultural circumstances influencing or constructing those inappropriate practices. In this respect, the researcher belief that understanding of contextual circumstances is essential to design the effective way of solving such problem.

In the first approach, many studies have shown similar findings that many factors influence decision-making process of villagers. These factors are peer opinions (friends, relatives, and neighbors), advertisement, and past experience both the medical visited and lay advice (van der Geest et al, 1996; Chuengsatiansup et al, 2000). Some researches focus on the socio-economic status or the demographic characteristics (i.e. age, sex, education, occupation, income, etc.) of the populations studied, mostly done by quantitative method (Hardon, 1991; Chuengsatiansup et al, 2000).

In the second approach, some studies, mostly cross-cultural studying, have shown that cultural background of villagers affects their perception and decision to self-medicate (Bledsoe and Goubaud, 1985; Nitcher, 1980; van der Geest et al, 1996). A review of studies in Thailand shows that "the decision-making in self-medication is in fact a complex process". The information for making a decision comes from many sources such as relatives, neighbors, and commercial advertisement. Such

information is distributed and exchanged in the community's social life as "public pool of drug distribution" (Chuengsatiansup et al, 2000).

Action or Intervention Studies for Promoting Appropriate Use

During the past decade there is global interest in programmes to improve use of drugs especially in developed countries. Most effective action programmes, such as established standard treatment guidelines, essential drug list, promote responsibility of pharmacy and therapeutic committee of each health setting, and training and continuing education of health professionals, require both policy direction and institutional support (Laing et al, 2001). A few studies emerge in developing countries both approaches to medical professionals and consumers. However, some studies in developing countries reveal the effective approaches particular in public sector (Laing et al, 2001; Thamlikitkul and Apisitwittaya, 2004). In Indonesia, the interactive group discussion (group process) among doctors and paramedics result in sudden sustained decrease in injection use (Hadiyono et al, 1996). Another study using group discussion among mothers about package inserts and necessary information results in incline of their monthly purchase of brand-name drugs and duplicative products (Laing et al, 2001).

Studies aimed to improve dispensing practice of drug sellers in Nepal, Kenya, and Indonesia, have shown that it was possible to improve the practicing through a combination of focused small-group training and building up their image as health professionals (Laing et al, 2001). The authors also point out that these approach would not recommended yet for wide spread implementation, it is important to look for unintended consequences (Laing et al, 2001).

A situational review of community drug use in Thailand pointed that most of study approaches are mostly concern with local intervention—i.e. education for consumers and drug sellers, encouragement for improving service, and promoting substitutes of safe drugs (Chuengsatiansup et al, 2000). Although there are some legal measures used to control distribution of unsafe drugs, but some local authorities do the, ineffective, enforcement and inspection. In addition, a few recommendations in policy level aimed at solving problem of drug distribution are seen, but not implemented. For instance, policy recommendations from a study in Songkhla

Province conducted in 1995, using interview and focus group of drugstore owners, pharmacists, representative from drugstore association, FDA staffs, and provincial public health pharmacists are proposed. They suggest that there should be only one type of drug store with pharmacists providing practice during service hours and certain kinds of pre-packaged registered drugs should be permitted to be dispensed in groceries. These recommendations are similar to what Jaidee and colleagues had proposed over a decade before (Hutangkabodee et al, 1995; Jaidee et al, 1980, cited in Chuengsatiansup et al, 2000).

Lack of implementation of such, national, recommendations may be operated on the assumption that "the status quo drug system is a given and thus is left out of consideration" (Chuengsatiansup et al, 2000). In this respect, the majority of researchers, mostly health personnel, expect to modify self-medication behavior to fit the existing drug system rather than changing drug system.

In the light of such perspective, "the question is how much can we achieve in promoting rational use of drug without taking the structure of drug system administration into account" (Chuengsatiansup et al, 2000). For this study, in the same line of concept, its objective is to seek an understanding about the effects of drug system that strongly involve self-medication pattern of poor people as well as those of socio-economic and cultural circumstances.

CHAPTER III

METHODOLOGY

Methodological Framework: Ethnographic approach

This dissertation project used the anthropological approach to examine illness experience and self-medication among the poor in Bangkok shantytown. The main aims of the study are to seek understanding on "rationality" and "rational use of drug" from local people's point of view and to explore the dynamics interplay of individuals, as well as socio-cultural and political factors influencing their self-medication decision-making process within its contextual circumstances. The studied objectives mainly require the understanding of contextual circumstances in order to explore the system of thought situated in the larger context of life in term of its 'rationality' and cultural reasoning. The investigation was emphasized on what conditions reproduce the sense of naturalness and legitimacy of the objective world that made lay persons sustained their habitual practice on self-medication and what conditions quicken their strategizing role to be the social actors who could deliberately take an appropriate action.

To answer these questions, it requires deep understanding of lay realities, their meanings, their system of thought or logical reasoning situated in the contextual circumstance. It needs the interpretive approach of anthropological study called 'ethnography study'. This approach needs the researcher to use an 'emic view' or looking from the 'insider' in conducting the field research. The goal of ethnography was concisely written by Malinowski, in his work in 1922, as: "This goal is, briefly, to grasp the native's point of view, his relation to life, to realise his vision of his world" (Malinowski, 1984: 25). In addition, Clifford Geertz, one of influential proponents of interpretive ethnography in anthropology, gave his illustration that ethnography was not defined by the technique it employed, such as participant observation, interview, establishing rapport, selecting informants, keeping diary and so on. But it was a particular kind of intellectual effort as, his term, "thick

description" (Geertz, 1973: 6). He described this term as quoted by Liamputtong and Ezzy (2005:16):

Thick description focuses on detail and background information. It aims to explain people pattern of life by describing the pattern of meaning that inform theirs actions, so as to render them accessible and 'logical'.

> 'Thick description' was also described as, in the other words, 'holistic' approach in which it is concerned the influence of contextual and historical factors (Podhisita, 2004).

It should be emphasized that this interpretive method provides not only the needed contextually sensitive understanding of human thought and action, but also the understanding influenced from interpretation of interpreters. In the other words, it cannot avoid the effect of interpreters as to say 'knowledge and people who know cannot be separated'. Research finding or the report writing can effect easily with bias of the ethnographer or non-rigorous technique of doing the field study. Thus, this interpretive approach should be conducted under its 'rigorous methodology' that will be mentioned in the following parts.

Research Design

This project requires ethnographic approach. The ethnography is composed of several qualitative methodological techniques: participant observation, in-dept interview, focus-groups interview, and so on. Participant observation will be the main method that leads the researcher to be able to interpret the finding as an "insider". It requires an ethnographer to become close to the everyday experience and activities of people whom the researcher wants to study. As, Boyle (1991) and Goffman (1989), cited in Liamputtong and Ezzy (2005:169), have suggested the term 'participant observation':

> The researcher is directly involved in the informant's life, observing and talking with people as he or she learns their view of reality. The end result is that participant observation allows the researcher to take a particular slice of behaviour and interpret it by putting it into context (Boyle, 1991: 227).

Participant observation involves subjecting yourself, your own body and your own personality, and your own situation, to set of contingencies that play upon a set of individuals, so that you can physically and ecologically penetrate their circle of

response to their social situation, or their work situation, or their ethnic situation (Goffman, 1989: 125).

The main concept of this participant observation method that makes researcher to achieve the insider is the interaction between the researcher and the informants which has to be much more sufficient to gain trust and rapport that requires time and occurring in natural life situation of informants. That is to say, this study requires the researcher to study in the field for many months.

Field Site and Sampling Method

This dissertation project using the ethnographic method aims to study the poor people in congested slum community situated in an urban area. The field site started at the community level in Slum Klongtoey, the biggest slum, located in Klongtoey district, Bangkok, Thailand. Out of 42 communities in the district, 25 were defined by Bangkok Metropolis Administration (BMA) as the congested community (more than 15 households per Rai). Total households in these 25 slum communities are 52,092 with 138,803 populations (report of BMA district office in Jan. 2000). These congested communities are different in the congestion and size of the population, ranging from 400 to 1500 households and different in its history and confronting problems. Some communities have been formed for nearly 10 years but some have been for 30 years. Some are faced with house security problems but some are not. One community with small population size was purposively selected according to the purposes of study.

As part of an intervention research in 20 congested communities in slum Klongtoey for the last three years[1], I, as a researcher, am familiar with some community leaders, community health volunteers, two major NGOs—Duang Prateap and Mercy Foundation, and local Health Center of BMA staffs. The community to be studied was intentionally chosen from 20 communities of the researcher's previous

[1] Title of my intervention research is 'Involvement of Civil Society in a Strategy to reduce the Use of Antibiotics in the Treatment for Adults with Upper Respiratory Infections (URIs) from Viral Origins at the Household and Community Levels: A comparison Study in Congested Community, Bangkok, Thailand'.

study area to gain the benefit of some previous baseline data and minimal time for establishing the relationship with the community members.

The two important criteria for selecting the studied community are the good relationship of the community leaders with outside researchers and the low violence of drug addiction to ensure the security and the smooth operation of the researcher. Although, I have been familiar with some people there, this study requires close investigation and has limited time, which is inadequate to initiate new trusting relationship with any group of people, especially drug addicts and dealers. I could not assure, within the time period of this research, a trust would be assumed from a person who may be related with drug addicts and/or dealers. In general, they do not want outsiders to get close to the community members. Another criterion is the appropriate population size, which should be practical for the researcher to thoroughly explore and observe during the study period. This estimated size of 450 households in the selected community would be manageable.

Purposive sampling had been used to select the participants or the key informants in the selected community. Criteria for selecting key informants are (1) people who are vulnerable considering from variety of these rendered characteristics such as: minor ethnic, disability, and economic migrant; and (2) two main extremes of inappropriate and appropriate self-medication. These extreme or deviant cases should provide an insight into the effects of their life constrains, and the variation of these cases may provide wide variation in the experience or process of rationalization. However, I focus my attention on the apparently irrational self-medicating practice in order to gain insights into their reasoning. Exclusion criteria are (1) new residents who are not socialized by community culture; and (2) ethnic migrants whom researchers are unable to communicate in the limited data collecting duration of this study.

The sample size for key informants is 20 cases who suffered from chronic diseases including hypertension, paralysis, epilepsy and diabetes. The concept of saturation to terminate sampling had been used.

Data Collection Method

The data and information for this dissertation project had been acquired mainly through participant observation approach using in-depth interview, open-ended structured interview, and focus group interview. Quantitative data collected are socio-economic status—distribution of wealth, debt, property, etc. These had been done in an informal manner from community leaders and through some previous survey data from BMA.

Qualitative data collecting techniques particularly anthropological tools in ethnography had been used to collect both the contextual data and the individual data such as: geographic mapping; genogram (kinship mapping); social and cultural organization structure; local pluralistic health system; community calendar; community history and biography.

Participant observation is the main method of this study. I participated in many activities of the informants both in individual and community activities such as the cremation rite; ordination ceremony; Children Day fair; Elderly Day fair and New Year festivity.

In order to gain the reality of lays' life-world while minimizing the bias, I, as a researcher is an important tool for data collection in this method. I concerned to behave under the methodology rigor. Some basic principles of the participant observation technique, including some parts of triangulation concept, are proposed (Podhisita, 2004: 307-8) and it was the guidance in conducting this study.

Observe and record in detail or as Geertz puts it: 'thick description'. The researcher recorded detail of the context in which the event, the action or the behavior occurs such as time, place, or setting.

Concern the dynamic of all social action being observed. I also focused on its process of changing.

In addition, I learned and concerned in doing balance between two roles, the insider and the outsider, being as 'a part of and apart from' people/ informants in the field at the right time and place (Podhisita 2004: 307). I used the flexibility concept in order to adjust the appropriate level of participation. For instance, role of health

professional position of the researcher which should be used when the situation is needed (i.e., help to solve lay health problem) and do not forget the role of the researcher as to answer the research questions.

For interviewing, usually combined with other methods, both in-depth interview and open ended structure interview had been used. The interviews had been done by using informal manner and had had to be conducted several times. The interview was with general social life and health problems and along with doing biography, and then investigating their illness and health seeking behavior, its reason, its evaluation, its consequence with relation to their living in social, mental and physical health aspects.

For focus group interview, usually conducting informally, it had been used after collection of some data in community level such as historical community data and local folk or popular health system. Aims of doing this interview are: (1) to get efficient historical and collective community data, which have to come from the recalled memory or the integration of a variety of each individual view, and (2) to get benefit under the concept of triangulation. The triangulation method in this technique provided me to confirm and recheck the information from other key informants.

Beside of the above data collection tools, taking field-note is an important and essential instrument in gathering people illness experiences. I took all four separated types of field-note. The first one was for recording the appointment and the passive event in each day. The second one was for recording of interview in each moment combined with the audio recording. The third one was a journal record combining the information from two former records and adding more details of such events or activities and including non-data such as: my opinions, feelings, and understanding of such data. Non-data part had been done separately by a salient marker. The fourth one was for recording the important issues with more systematic details and intention to do more investigations.

Data collection activities had been conducted completely in approximately six months, from November 2005 to April 2006. The brief data collection activities include as follows:

- Introduction of myself and researchers' team and the objective and nature of the study.
- Observation of general social life and health problems in selected slum community.
- Observation of the communication facilities, socio-economic situation and start of mapping out its household geography.
- Identification of initial key informants and starting to find the social structure of community both formal and informal group and its history.
- Starting to take genealogies of influential families.
- Participation with the community activities (the researcher had had the experience that there were many activities in each month organized or provided by the outsiders, official organizations or non-government organizations (NGOs), and the community groups).
- Charting the structure of social relationship.
- Observations and interview on people health problems and their healing activities to define the pluralistic health system and looking for people who have chronic illness and vulnerable people.
- Charting kinship mapping of the informants.
- Observing and interviewing key informants.
- Participating with the informants' activities and the community activities.

Data Analysis

The process of analysis method started with data coding according to its concept of each theoretical approach, then linked the related salient and look for a feasible theme or an imaginary concept to fit the explanation and find the point that the data could be supported or against. If the explanation concept is not a good fit to explain the data, then re-categorizing or finding a new relationship and new theme to fit the data or reinvestigation will be tried to find and collect more data.

Ethics

Ethical issues of this ethnographic study are composed of five points of concerning. The first issue is not to do deception. Self-introduction as an academician who conducts the research in the doctoral program had been done, as

some people in the field have known the researcher before. The community members had been told about the general objectives and the nature of the ethnographic study. The second issue is voluntary participation. Asking for the permission from the community leader to do the research and careful observation of the community members' response had been done meanwhile walking around community to introduce myself and doing the geographic map. The key informants would be asked for the permission after they were told about the nature of the study. Their willingness to participate had been observed. They were told that they might refuse to participate in this study any time, which would not affect our relationship or their life security. The informed consent was not used because the research experienced that the poor people in Thai culture do not like to sign their signature. Thus, the researcher had used implied or the passive consent indicated by the participant taking the time to complete the interview. Another concern within this ethical issue is a small incentive that the researcher had offered because of their time consumption. The researcher had adjusted the amount as appropriate so that the amount paid was not too few or too much to affect the voluntary of participation.

The third issue is 'no harm to the participant'. The researcher told them about the process and the result of my study or any piece of information, which would do no harm or increase any risk to the participant and the community. Some privacy or sensitive issues would be kept anonymously and confidentially, which bring into the fourth of ethical issue as anonymity and confidentiality. In addition, the researcher asked permission before audio tape recording and provided them a chance that they might cancel it or delete any part of it after finish recording.

The last ethical issue is about the report writing. The researcher use the concept of reflexive rigor as Altheide and Johnson (1994: 494) wrote 'Good ethnographies show the hand of ethnographer'. Reflexive research acknowledges that the researcher is part and parcel of the setting, context, and culture he or she is trying to understand and analyze. The researcher try to put much more details of the researcher's role and the context into the writing for being the own consideration of reader to interpret it.

CHAPTER IV

THE CONTEXT OF A CONGESTED COMMUNITY

General Description of the Community: Location

The community for this study is a medium-sized one with 750 families in 450 households living on a ten-rai plot of land – a population density of 45 households per rai. Built on land owned by Port Authority of Thailand, it and other 24 communities are situated in conjoined areas which form Bangkok's largest congested community. A few local elder persons told me they came to settle more than 40 years ago and erected makeshift houses on the site, near to a large swamp which was connected with the Chao Phya through a canal. There were then plenty of fish to be caught and wild vegetables to be harvested. Such abundance has gone, and today all foods have to be bought.

That swamp was filled up to make room for new settlers, but the ground is one meter lower than the roads that surround it. The community area is rectangular in shape – its width approximately one-third of its length. To the North it is bordered by a small road under an elevated expressway which runs parallel to railroads for transporting cargo from the port. To travel on foot to the nearest health center under Bangkok Metropolitan Administration (BMA) where a few general medical practitioners offer their service, one has to cross the railroad and a road before entering a lane for a distance of 400 meters.

A big road which crosses the small road under the expressway almost at the right angle forms the community's eastern boundaries. A dozen of other congested communities nestled behind commercial buildings lining on both sides of this road, which serves as the main street for them. Also located on this road are the offices of two private volunteer organizations (PVOs) which have been working to support poor people in the areas for more than two decades. There is a school near the organizations' offices where most children from the community attend because the distance to the place is just over one kilometer, making it convenient for them to walk to school.

To the South, there are an adjacent community consisting of more than 10 flats, a sports ground and an area which was once the site of PAT warehouses which stored toxic chemicals until they were destroyed by a fire over a decade ago. Many residents of the community were affected by harmful fumes from that blaze. The empty space between the flats and the sports ground is used to hold a market selling foods, clothes and utensils twice a week. To the west, there is another community where another fire destroyed all the dwellings nearly 20 years ago, and its residents rebuilt their homes from scratch.

Entry to the Community

Before I started gathering information for my field study, I had known this community for more than three years through my participation in an intervention research targeting 20 communities on promoting appropriate drug use in upper respiratory infection. I became acquainted with the community's committee members, health volunteers and staff of the local health center through our collaboration in activities to raise the residents' awareness of problems of drug use from household surveys and educate them on appropriate self-medication by using educational media and training workshops. I had opportunities to visit this community several times since its committee was enthusiastic in participating in these activities.

That project offered me a few glimpses of local housing conditions, but I was then assisted by committee members who coordinated work to support the activities and was too preoccupied with the specific issues of my study to have time to study its residents' livelihood. Returning to the community this time, I aimed to learn about the livelihood of disadvantaged people – a group which might not have close ties with the community's committee. I intended to avoid asking for help from these leaders to prevent suspicions among other residents who might harbor some grudge against some of them. Consequently, I asked an acquaintance who used to work for one of the PVOs and a resident of a neighboring community to be my guide and take me around the community during the first two weeks. Sometimes I went there by myself since the guide could not afford time to help me every day or full days.

However, after a few weeks, I realized that I needed assistance from the committee members or health volunteers whom I knew for introducing me to key

informants since their status were recognized by local residents. My concern that my association with them may affect my access to information proved groundless. On the contrary, being introduced by someone locally known helped me gain trust and caused no suspicions about my motives other than those stated.

The local residents were not used to the presence of non-locals paying them regular visits. Even though officials from concerned agencies or PVO workers sometimes came over to gather information for surveys, their visits were brief and sporadic. In most cases, people were reluctant to cooperate as they see no benefits to be gained. “They came and asked questions. But nothing happened. Our people gained nothing. They never returned to inform us about the results of the surveys whatsoever,” a committee member told me.

Nevertheless, my presence in the community without a local as guide or companion triggered doubts among some residents who suspected hidden motives. A group of teenage boys hanging out at one place must have seen me coming and going several times in the evening or after dark shouted to me one evening. “Sister…sister, are you from s*ueb hok*, aren’t you?” They thought I might be an informant gathering information on drugs for the police.

During the first few weeks, I focused on drawing maps of the community and making general observation of the residents’ activities outside their homes such as chatting, trading and shopping. I talked and greeted with members of around 4-5 families who showed no hesitation to converse with a stranger while they were relaxing or chatting in front of their houses. Others whom I talked with were the owners of local food shops and their customers.

Physical Maps of the Community

The community’s main road is a concrete path, 3 m. wide, running through the middle along the length of its rectangular shape and dividing it into two parts. The path, called *soi klang* (central lane) by locals, leads to a group of flat blocks at one end. At the other end it joins the road under the expressway where the local health center and the community committee’s office, housed in large cargo containers, are located. This is where local residents enter and exit if they come to buy things from

stores along *soi klang* or want to get to the market place or the sports ground at the other end.

There are 4-6 smaller concrete lanes off from each side of the central lane. All these paths were raised 1 m. above the ground to make their height level with the roads surrounding the community area. The lanes are so narrow that when two people walk past each other in the opposite directions one has to keep close to the edge or turn aside to make room for the other.

The central lane are teemed with stores ranging from groceries; food stalls selling rice and curries, fried foods, roasted chicken, *som tam* (papaya salad), etc.; beauty salons to computer game shops. These trades take up the path's edge on both sides and reduced the space for traffic to only 2 m. wide. The road is thick with traffic for people also use the route to reach the market place or the sports ground. The sight of people swarming to groceries to buy freshly cooked rice after work before going home made me realize that dozens of local families did not even cook their own rice. Groceries selling liquor are other favorite places where some people stop to buy themselves drinks on their ways home or just hang out in front of them. Most people buy one *peg* – a quantity of less than 20 cc. – of liquor at a time just to quench their thirst for spirits. But some return for more, making the spots in front of these places crowded. The path is off limit for motorcycles for the safety of children who play and run about in the areas.

Along both sides of the central lane and smaller lanes, houses were built densely and so close to each other or to the paths that there is almost no space left for yards or entrances. Except a lawn sitting next to the flat blocks, a few empty spaces with some trees, either cultivated or naturally grown, can be found on some lanes. Together these 4-5 spots, each 80-160 m^2 in size, serve as the lung for the community. The vacant places still bear remnants of the houses once stood there until a few years ago before they were dismantled and their occupants were relocated in flats provided by PAT or National Housing Authority.

The relocation program was undertaken under PAT's policy for reduction of the communities' population. The agency and the local communities' committees made an agreement under which the former would provide land for residents agreeing

to be relocated while the latter have responsibility to ensure that after the houses are removed, the places would not be resettled by new occupants. The committee of this community in particular has been cooperative in fulfilling this obligation. The agreement resulted from negotiations between community residents and PAT, which made offers regarding the sizes of living spaces to be provided as incentives for relocation in Nongchok and Minburi areas.

Danger from Drug Problems and Access to Key Informants

Although I obtained useful information for learning about people's way of life and their livelihoods in the community during the first month of field study, I could sense my own fear that this probing could put me in risky situations and bring harms to myself. I had concerns about my information-gathering methods as well as the information that came to my knowledge. Consequently, I made adjustments to the techniques I used and took precautions when I collected information. Before I approached any families for interviews, I would check out their backgrounds with committee members and health volunteers or ask someone to introduce me to them.

There were incidents which stirred fear for my safety. Walking around to survey the community or visit some families, I often came across teenagers gathering at several places. I also saw middle-aged men sitting and drinking together at liquor stores scattered throughout the community. On each of 4-5 lanes I frequented, I always found at least one person drinking in front of his or her house. On another occasion I ran into 3-4 drunken women, some of them were obviously alcoholics. Later I learned that these women had lost either their children or husbands and found solace in cheap spirits.

What could be frightening for visitors to the community were two madmen. One of them was a large-built man with dark skin, wearing long hair and bearing tattoos on his body. Bare-chested and with only a dark red towel on, the man wandered around or just sat staring into empty space on a light near the spot where I usually parked my car by the side of the road along the railroad. I heard that from time to time people found him removed his loincloth and bared all. Once I got off my car and found him sitting very near to it. Gathering my courage, I offered him some foods to eat. Being afraid that the man could harm me, some people advised me not to be

too friendly and to stay away from him. Community leaders, fearing the man could cause harm to their children, consulted with me on ways to solve the problem. They agreed with my suggestion that the man should be sent for treatment at a hospital but his relatives were not receptive to the idea and refused to give approval.

I heard about fights between local youths in which a teenager from the community was stabbed and critically injured by their rivals from a neighboring one. Though surviving, the boy was crippled for life. In view of the undercurrents of violence, I became more cautious when I was walking in the community. Given its narrow walkways, one can easily be trapped in a tight spot in case a fight erupts. My worry intensified as I heard about people being killed in revenge. There were two incidents in which blood was shed in fights while I conducted my research in the community. The first, taking place half an hour after I left the community one evening, involved a man being slashed on his hand by a knife-wielding attacker. The injured man ran to the health center to ask for referral to be treated at a hospital where he needed more than twenty stitches for his wound. In the second incident, a man was stabbed and in critical conditions but he was hospitalized in time for doctors to save his life.

Drugs is another cause of my concern for safety. I was informed that after a crackdown over the last year dealt a heavy blow to drug dealing, it resurfaced and became widespread again. There was real danger from those involved in drug dealing or from accidentally being in the middle of a police raid or arrest. A 50-year-old woman confided to me: “The news is two persons will be caught dead soon.” The information could be from an insider because the woman’s daughter was recently sentenced to 22 years in prison for peddling drugs. She left her three children in her parents’ care. The woman showed me her daughter’s ID card while asking me to help with her house repairs. Having seen me talking with PVO workers who handed out things to elderly people at the annual Social Welfare Day event, she mistook me for one of them. The organization has a program which supports residents if they want to have their homes fixed.

Initially, I was shocked to learn that there might be extrajudicial killings in the community as happened frequently two years ago. When I checked it out with several people including some committee members, no one confirmed the news about

imminent arrests. They said, however, that big drug dealers were still at large and went into hiding elsewhere. These people hardly returned home, or if they did, they would come at irregular hours. Those arrested were mostly small peddlers. I was told that those suspected of selling drugs tends to live in large houses like those of the rich. I saw several houses in the community which matched this description and avoided talking to their owners.

This precaution alone seemed inadequate for me to discern troublesome families though. As mentioned earlier, without checking the background of the families I intended to establish contacts with, I could not tell if they were possibly involved in some shady businesses. Auntie Suay is a case in point. I visited her house twice and each time talked with her and other family members for hours. I took her son and daughter-in-law to see doctors at the local health center. When the son, who was released one week ago after serving his time for five months for drug charges, wanted to ride a motorcycle for hire, I lent him a hand facilitating his request for support in obtaining a used motorbike for the purpose. I offered my help in the hope that the young man would be able cut himself loose from the vicious cycle of drugs without the knowledge that Auntie Suay's family was involved in drug peddling.

My encounter with Auntie Suay happened by chance and unprepared. After finishing my lunch at a small eating place at the far end of the community, I found a few people gathering for a chat next to it. I introduced myself and joined in the conversation, from which I learned about a skinny girl, aged around four or five, who was seen playing nearby and coming over to buy omelet. I was told that the girl was a slow learner and did not like to go to school. Since both of her parents were in jail, she was now cared by her grandmother, who was a drunkard. Having my husband as my companion on that day I felt safer than usual and decided to visit the woman at her place less than 10 m. away.

Following the direction given to me, I walked into a dirt path too narrow for two people to walk past each other and just over 20 m. in distance before reaching a dead end. All the few two-storey houses on both sides were run-down.

Auntie Suay's was the second of the only two houses whose fronts facing the path. It was a shaded area where big trees nearly blocked out sunlight. I did not

have a clear view of the house's dimly lit exterior. The ceiling above the ground floor was very low, and we could not stand upright. On the floor I found Auntie Suay lying under a blanket inside a mosquito net. She got up to greet us. The space was so small that it could hardly accommodate three people sitting together. Aunt Suay had to retreat to the inner wall to make room for us. She told us she had a flu and was resting.

Auntie Suay's life interested me because this 56-year-old woman raised her five children single-handedly after breaking up with her husband more than 30 years ago. She had to rent a house since her own house was burnt down in a fire nearly 20 years ago for which she was paid less than 20,000 baht in compensation. With one child dead and another living in her home province of Nakhon Ratchasima, Auntie Suay had other three children, all allegedly involved with drugs in one way or another. She was raising her six grandchildren. Some of them were in secondary school and in adolescence, making them vulnerable to bad influences which could veer them to drugs just like their parents.

Trying to find help for her son and grandchildren, I brought up her story when I talked with some committee members. They advised me not to get involved with her because it was an open secret that she still peddled drugs. That knowledge put an end to my visits and my attempt to help her family. One month later I heard that the woman was arrested in a set-up by police and her house searched for drugs. I did not know how severely she would be punished for her crime.

The episode led me to improve my techniques in approaching people for interviews. I would ask for basic information from committee members or health volunteers about the persons who were prospective informants. This information helped me gain access to my key informants more quickly. Additionally, I used triangulation techniques to crosscheck information from different sources.

In addition to Auntie Suay, I paid visits to another elderly woman who suffered from paralysis and diabetes. Despite knowing beforehand about allegations of drug dealing against her children, I wanted to visit the patient after learning that she had stopped visiting hospitals for more than one year. My guide took me to her house and introduces me to the family. Her daughter was not so friendly toward a stranger.

Still I expressed my concern over the fact that she had stopped giving her mother insulin for over a year. When I offered to coordinate with the health center to send someone to take tests on the patient to check the level of sugar in her blood, she did object. I found out later that the daughter did not cooperate with health officials who paid a visit, and there was no improvement on the patient's conditions. I myself called on the old woman only twice.

While drugs make a handful of people rich, they inflict great suffering on a large number of families. In making charts of family relations, I found that a majority of the families I checked out their background and was certain that they were not drug-dealing households had at least one of its members – a son, a son-in-law or a daughter-in-law – who have problems with drugs either as a user or a user-cum-petty dealer. Many of them are in jail for their offenses, being separated from their children and parents. Others lost their lives prematurely because of overdose or AIDS. Given the loss of their loved ones, I was hardly surprised to see people of middle and old age who were fearful and abhorrent of dangers from drugs.

Overcrowded Dwellings

Houses in the community can be classified into 2 groups. Those in the first tend to be two-storey ones which are strongly built and fully equipped with doors and windows, reflecting the financial status of their owners who can afford to hire workers and buy materials for construction.

The second group comprises those which are one-room houses whose average sizes are 3-4. m by 3-6 m. They are built with cheap or recycled materials which are not durable. Typically, sheets of old plywood are used for roofs, and parts of wooden crates for floors. The only new materials for these makeshift houses are sheets of corrugated iron which are used for either roofs or walls.

Most of them have only one door and are without windows. Because of poor ventilation and low corrugated roofs, the houses are extremely hot in the dry season – the chief reason for their dwellers' habit of drinking iced water. I was not surprised to find that most families like to buy and store soft drinks at their homes and drink them everyday. I found a baby just over one year old being fed with soft drinks contained in

his milk bottle. His parents said the child asking for sodas after seeing some adults drink them.

Having a toilet or toilet bowl is a key criterion which qualifies these one-room sheds for house registration under PAT's regulations. From my observation, probably half of them contain only a room and a toilet. Without a kitchen, food is prepared at one corner of the room. Most do not have bathrooms. Hence bathing and laundry are done on the side of concrete walkways in front of the houses.

Statistics and observation attest to the fact that these houses are overcrowded. Official figures on house registration show an average household has 8 persons. I was told that houses with two families are in the majority. In many cases kin of three generations cram into the same houses. An extended family like Sri's exemplifies the overcrowding in the community.

In her 3.5 x 4.5 m. hole, walled with corrugated iron and with no windows, live two families with seven members – three in her father's, three in her own and an orphan. The grownups were Sri, her father and her stepmother, who was 35, a comparable age with Sri's. The teenagers were Sri's two sons, 18 and 15; and her 17-year-old stepsister – all in secondary school. The seventh member is a three-year-old girl Sri adopted when she was an infant when her parents and grandmother were all sentenced to 20 years in jail for drug offenses.

Sri has a younger brother, who moved out more than 10 years ago to live near his workplace. Working and studying for a bachelor degree, he is her father's hope and pride. Her father always takes heed of the son's words. He hated going to see doctors when ill, and would yield only to his son's urge or wait until he is available to accompany him on a hospital visit.

Sri's and her father's families are not large, but overcrowding forced some of their members to leave for other places. Problems are even greater for bigger families, whose members scatter as children have to leave when they grow up due to limited living spaces and financial resources.

Overcrowding pushes newlyweds or those starting their own families to move out of their parents' and live in rented houses nearby. Children who decide to leave are often those with abilities to provide for their own and earn enough to pay for

the rents. The ones who stay are often poorer or dependent on their parents. This pressing economic situation further reduces chances that parents could rely on their children when they need someone to take them to the health center or hospitals.

Livelihood

The first wave of migrants came to settle in the areas and work as construction workers when the port was under construction. The opening of the port created great demand for labor for unloading goods from cargo ships and justified the presence of the early migrant workers and newcomers who dwelled on the land around the port. These settlements have grown into congested communities over decades. However, as machines were increasingly replacing manual labor in the port's operation and the demand for workers were in decline, the dwellers in these communities faced PAT's attempts to evict them. The ensuing struggles to retain their rights to dwell on the land have become a legend which is still told to this day.

As a result of mechanization of the port's discharge systems, jobs available for the dwellers changed to ones which involve loading goods from warehouses onto trucks and then delivering them to stores or companies ordering the purchases. The numbers of jobs, however, are reduced to one-tenth or even one-hundredth of what previously available. Moreover, these opportunities are limited to male workers.

A similar kind of jobs is transporting and installing industrial machines or equipment. These jobs carry high risks of damage to the goods and thus call for the service of physically strong male workers highly skilled at transporting goods. Some residents in the community and its neighbors developed skills in this trade and organized among themselves to hire out their service to customers. There are two such groups operating under team leaders who are residents of other communities.

Grandma Awn's younger son told me he liked this *khon khrueng* (machine moving) job. It is a challenging, risky task which needs to be performed with great care because mishaps could happen when ones are moving heavy machines with only human labor and a few basic tools. The jobs are highly paid though. The man said he would be paid 500 baht a day if the job was difficult or required the workers to work non-stop day and night. This kind of jobs often take the workers to distant places – sometimes to the northernmost or the southern most parts of the country – or to our

neighboring countries like when his brother traveled to Laos. There are no fixed schedules for this kind of work. It is contingent on assignments which their leaders accept, but members of the team must be well prepared and ready to take off to work or travel. This is the chief reason he cited for not being able to take his mother to hospitals.

Office movers or cleaners are other occasional jobs, but unlike machine transporting, workers do not need high skills even though they must be careful not to break or damage things. Turnover rates are high for these jobs for which a worker is paid up to 200 baht a day. Another job which earn a worker comparable wages is distributing advertisement leaflets. A worker can be hired individually. He or she needs not to be supervised or to work as part of a team.

All these manual labor jobs are not permanent or regular. When a team leader accepts an assignment he would come to recruit workers from people waiting at home in anticipation of jobs. It is common for residents to land jobs via connections with their neighbors. Irregular incomes or work schedules are disadvantages which prevent them from making appointments or planning their activities in advance. This is a major obstacle for them to fulfill their duties to their parents or elder persons by taking the patients to see doctors as appointed.

One type of regular employment available mostly for women is being employed by contractors as maids in offices of PAT or the Customs Department. At work 10-12 hours a day, they leave home at five and arrive at the workplace at 5.30 am. and get off work around 3.30 or 4.30 pm. They are paid a daily wage of 181 baht in compliance with the minimum rate or an average monthly income of less than 4,000 baht, part of which is deducted for contributing to the Social Security Fund. There are no bonuses or other benefits. A majority of people working on these jobs are women in the 30-40 age group. Some younger people got more physically demanding jobs in squid factories. Some young men from the community earn regular incomes from being security guards for various companies.

Self-employment such as driving taxis and riding motorcycles for hire is popular among men. Selling foods in the community or vegetables at markets in the neighborhood are women’s choices. To my surprise, a few people still earn their

living by harvesting wild vegetables from nature and swamps. The number of the gathers is down from a dozen to two though. It is hardly a big earner as vegetables prices are low. However, vegetables used to grow in abundance in nature. They need no investment and are free to take any day off if need be. Lee, 65, told me when her three children were small, she took them along on her round to gather vegetables. The youngest one was cared by the elder two. Then by the time she reached Phrakhanong she would get enough vegetables for the day. In the course of time canals, swamps and other natural water sources were either filled up or polluted, and most vegetables disappeared. Today the two gatherers have to travel on foot as far as Khlong Hua Takhe in the proximity of Suvarnabhumi Airport to find vegetables. They leave home at five, and it takes two hours to reach the place. The return trip takes almost half a day because they have to ride buses or *song thaew* in congested traffic and make 3-4 connections before reaching home. Their incomes may be small, but, unlike most residents, both have no debts.

Debts and Non-institutional Loans

To start a business or an occupation, one needs money for investment on certain things: cooking utensils, a cart, fresh food for food sellers; hire-purchase of a motorcycle and *kha win* (protection money) for a motorcycle taxi operator, etc. To obtain funds for investment, these people have to borrow money and incur debts. Most of the returns from investment are usually spent on daily living necessities and on interest charged on a daily basis, and little money was left to repay the capital. Thus despite a small loan, it would take them several years – if they can at all – to pay back. Several people told me it was good enough if they can keep the capital from building up.

In addition to investment to make a living, they could borrow money for other purposes: repairing their houses or making additions to them; school fees; or medical treatment in emergency. The advent of the Universal Health Insurance Program relieves these poor people's financial burdens to some extent as it cover part of the last item's expenses.

The shortage of cash is also reflected in arrangements in which families having too little money to afford public utilities can get extensions of these services

from their neighbors by paying the providers monthly rates of 200 baht and 500 baht for water supply and electricity respectively. These are standard flat rates which have been in use for several years and apply to all, regardless of relationships between users and providers or amounts of usage.

The practice, however, could make utility expenses considerably high for, say, a family of three which does not cook or do its own laundry. Many houses which get electricity through this arrangement have only a TV, a fan and a couple of light bulbs. Many families said they agreed to pay at these rates because they did not have cash in amounts large enough for deposits and installation fees for the utilities.

When some families cannot earn enough to cover their expenses, they have to borrow money from loan sharks. In such cases, the amounts borrowed are often small. For instance, Ta sometimes needs to take a loan of 1,000 baht from a money lender to pay for household expenses while her husband was away for his *khon khrueng* job. She is occasionally hired to distribute leaflets, but normally she works as a hand at a shop at the lane's entrance. She earns up to 100 baht a day, which is not enough to feed her family of three.

There are a few types of non-institutional loans for which interest is charged at high rates, but they are often the last resort for people in the community.

1) *Dok loi* (floating interest) is a sort of emergency loans taken in amounts ranging from 1,000 to 5,000 baht. They carry the highest interest rates among all types of loans, but need no requirements other than assurance that the debtors could be found at their residences or certain places. Interest is collected daily at a rate of 2% or 60% per month. The debtor can pay back the capital or part of it at any time on condition that the repayment exceeds the minimum set by the lender – for example, 1,000 baht each time.
2) General loans are taken at 20% interest per month. Repayment is made daily or in installments. For example, a loan of 5,000 baht would be repaid in 200-baht installments for 30 days.
3) Money can be borrowed from friends or acquaintances at 10% interest per month. Repayment conditions are similar to those of general loans, but the debtor can opt to pay only interest on a monthly basis.

4) Money is lent by relatives at 5% interest per month.

The first two types of loans are offered by Sikh money lenders who live in rented houses in the community. Many people prefer to borrow from them because they never embarrass the borrowers in the public and are flexible when they cannot pay the amounts due.

Fast Feeding Families

Although those who hold regular jobs outside home can be reassured that they would have regular incomes to support their families, the jobs requires them to leave home at five in the morning. Talking with these families, I found none of them have time to prepare breakfast for their kids before they go off to school. The children seldom have breakfast at home; they are given money to buy foods at their schools. I saw them scamper off after school to buy snacks to eat before going home to eat the foods their mothers bought for dinner.

Small children in the community can buy sweets and foods on their own even before they can speak clearly. They cannot tell which foods are nutritious which are just filling. With five baht – a typical amount given by parents – they end up buying a pack of snacks rather than nutritious Thai snacks like sweet sticky rice, boiled bananas or steamed peanuts. A food shop owner told me she needed more than 100 eggs each day for making omelet cooked in *khnom khrok* earthern tray and earned several hundreds baht from selling them to children. “Kids come running to buy it 5 baht at a time. They are hungry, but their parents not home yet. I used to use quails’ eggs, but now they are expensive. Chicken’s eggs are better. At least the children can have something to eat. I cannot sell for more since they have only five baht each,” she said.

Many families rely on *kab khao thung*, ready cooked side dishes sold in plastic bags, which they buy from outside or locally. Some do not even cook rice; they buy cooked rice at 9 baht per kg. Sweets or fruits are seldom found on their diet at home. Diet heavily dependent on ready cooked foods increase food costs, and people have to pay for the convenience that comes with these eating patterns.

Family and Kinship

The information obtained from my interviews with several local elderly women shows that most of them are natives of other provinces, especially those in the Northeast, who came to find jobs in Bangkok as young women and have lived in the community since. Some have relatives who migrated and settled nearby. Many middle-aged dwellers were born locally. While the families have grown with new members of the second, third and even fourth generation, the community, enclosed by roads and railroads on all sides, has no room for expansion. There are few families in which all the siblings live in the same community; pressure from limited dwelling and living spaces drives some of them to live in other places.

There are quite a few marriages between young people living in the same community. But ties between in-laws are not as strong as those in rural communities partly due to the fact several of these marriages are short-lived. When a couple goes their separated ways, their children – if they have ones – are usually taken care by the parent of either sides.

A majority of local dwellers are long-time residents. They live either in the houses owned by their parents or in rented houses if they start their own families. There are a few families which moved from neighboring communities and live in rented houses. A handful of job seekers and peddlers selling steamed peanuts or sweet potatoes rent houses for their short stays in the community. Because of the community's proximity to main roads, houses are rented at monthly rates of 1,000-1,500 baht, compared to 700-1,200 for those in communities farther away.

Community Committee

With a majority of its members being of middle age and active, the community committee provides strong leadership in contrast to the inertia of some of their counterparts who hold on to positions for nearly 20 years. The current leaders give older community leaders opportunities to play roles by seeking their help and appointing them as advisors. By strictly adhering to the policy against nepotism, the committee earned wide recognition among the residents. When items are donated to the community, they do not give them to their families or relatives but distribute among elderly and poor people. They see to it that these needy people get assistance

from government agencies and PVOs. They donated their own money for installing electric lamps at the main entrance into the community and for paying electricity bills.

The committee shows concern for children and takes measures to protect them from bad influences by prohibiting computer game machines and gambling, which can be found in other communities. It organized a Rakbankerd youth group which involves more than twenty local youths in useful activities.

The committee has a project to promote exercise among locals. Led by committee members who were trained to lead an aerobic dance, about twenty people join the exercise held every day at five in the afternoon. Another group of people and teenagers join an aerobic dance at a stage at sports ground adjacent to the community.

Another achievement is the setting up of the community health center, which opened six months ago. Supervised and funded by the local BMA health center, this sub-center is located on the community's central lane and housed in a cargo container. It has four volunteers on duty for treating minor ailments and dispensing basic or common household drugs. The sub-center already achieved its target in terms of the number of users and should be qualified for permanent operation.

Health Service Systems

The Universal Health Insurance Program has provided comfort and financial relief for a large number of people in the community. But after 4 years of its implementation, most of them have been complaining about poor medical service they received from the designated private hospital under the program. They feel powerless about the situation except discussing the matter among themselves. They are afraid to lodge complaints lest that would pit them against the hospital, on which they depend for medical care. They are left with no other choices. The nearest BMA hospital under the scheme is too far to be a practical alternative. Other two hospitals – one with a medical school and the other under the Interior Ministry – that they used to visit for treatment opted not to take part in the scheme.

Distance is an important issue for hospital choices since people expect to get medical help at a hospital mostly in emergency. For treatment of illnesses or conditions not severe or critical, they can visit the local health center, which has 3-4

general medical practitioners and specialists offer their service every day. The center is 600-900 m. from the community, but to get there a visitor has to cross two big roads and heavy traffic, which is not convenient for small children and patients.

There are private health service providers in the neighborhood. One of them is a private clinic which has offered its service for almost 20 years. Local residents would rush to the clinic for treatment in case of injuries or sudden illnesses. In this way, many lives were saved.

Five pharmacies – all selling modern medicines with no licensed pharmacists on duty – can be found in the areas. One of them is located in the community where it adjoins the big road. Others are in surrounding areas and less than 1 km. in distance from the community.

In addition to health service in modern medicine systems, some residents still rely on traditional healing practices. I found in the community an elder person specialized in swabbing children's throats for 10-20 baht, two traditional masseurs and a medium by whom some people ask to have their fortune told. A few people boil herbs and drink the concoction for diabetes or stiff and pain. Many families use commercial herbal products or take herbal medicine pellets.

CHAPTER V

CULTURAL REASONING AND ECONOMIC RATIONALITY OF SELF-MEDICATION: A CULTURAL DIMENSION OF ECONOMIC RATIONALITY AND THERAPY MANAGEMENT STRATEGY

Introduction

Many studies in medical anthropology found that self-medication is prevalent in poor communities in rural and urban areas alike (Hardon 1991; Haak 1988; Kamat and Nitcher 1988; van der Geest 1987; and Greenhalgh 1987). Given the prevalence of medicines – some with harmful effects – which are readily available at outlets where people can purchase them with ease, the practice puts the users' health at risk and poses the problem of cost-effectiveness (Wibulpolprasert 2002). Thus it has attracted attention from concerned parties including practitioners in the health professions, health policy makers and academics for more than two decades (Ross-Degnan et al 1992).

Questions regarding economic rationality of self-medication have been raised on two issues. First, it has led to unnecessary and wasteful use of drugs ranging from overuse of antibiotics, abuse of pain killers by laborers for an energy boost, to unwarranted use of medications for minor ailments or self-limited diseases. Second, when people administer themselves medications for severe conditions instead of receiving treatment from doctors, it could aggravate the illnesses and develop complications in the long term (Chuengsatiansup et al 2000).

In spite of doubts from economic viewpoint, there have been so far no studies focusing on self-medication in terms of economic rationality of the behavior at village level or reasoning on which these decisions are based.

Studies on how local people rationalize their decisions on treatment options have varied in their focuses, depending on determinants to which different conceptual and theoretical frameworks attach importance in each field of study. Social psychology, sociology of illness, and medical anthropology are among the disciplines

which draw from social sciences for their multidisciplinary approach to health studies and share interest in socio-cultural factors which influence people's reasoning in choosing methods of treatment for their illnesses – an aspect long neglected by the health professions in Thailand.

These fields, however, have applied concepts and theories in social sciences, particularly cultural analysis, in different manners. Key studies in the first two areas, for instance, have given scant attention to cultural factors (Good, 1994), and yet these works have had an important influence on studies on health behaviors. On the other hand, the role of culture is prominent in medical anthropology. This study intends to draw attention to cultural factors and their influence on the reasoning and rationality of poor people in making health-related decisions.

In this chapter, I explore cultural reasoning in self-medication, its economic rationality, and the role of culture in therapy management strategies of poor people. In doing so I seek to answer these questions: What are cultural reasons of therapy management and self-medication? How their cultural reasoning is generated? How it is socially constructed, internalized and sustained in everyday life? How do such practices become a routine practice of everyday life of poor people? How do the reasoning in everyday life influences therapy management? To what extent are such practices economically rational? What can we actually learn from poor people's management experiences?

In addressing these questions, I gathered experiences on health seeking and self-medication practices from more than twenty elderly poor people in an old crowded community in Bangkok. I focus my attention on self-medicating practices in severe or chronic diseases to gain insights into these apparently irrational behaviors and to understand cultural reasoning of the poor from their own perspective. Their life stories reveal that most patients need some kinds of assistance from relatives and neighbors in order to get access to hospital care. Good social relationship is, therefore, a requisite in making requests for such help. Patients who could not maintain social relationship are usually unable to visit physicians and thus tend to buy medicines from drug stores nearby. Maintaining social ties entails costs, e.g. time, labor and money. Although the economic costs of self-medication or even, in some situations, hospital care are lower than the expenses incurred in maintaining relationship, poor people

generally decide to keep and sustain such costly social ties. I argue that in the life world of poor people who have economic scarcity, this social relationship is crucial to their survival. In order to elaborate and posit this argument for further propositions, I will first briefly review theoretical discussion in three related areas: 1) cultural analysis in lay practical reasoning, 2) human agency and decision making strategies and 3) the concept of economic rationality.

Cultural Analysis in Lay Practical Reasoning: "Utilitarianism" in Medical Behavioral Sciences

Studies by medical anthropologists on health seeking behaviors for more than two decades have produced counter-arguments and empirical findings to the opposite of those suggested in major studies in social psychology and sociology of illness (Good, 1994).

In his critique of studies in applied medical behavioral sciences on care seeking and referral network, Good (1994:42) argues that these works have narrow conceptions of culture and human action, based on cultural theories which follow classic utilitarianism. This opinion is also reflected in Sahlins' critique of the analysis of culture in some theories of anthropological studies (Sahlins, 1976: 101-102).

Good also suggests that utilitarianism has been influential not only in the two fields mentioned above but also in medical anthropology[1]. To understand the role of culture from the utilitarian perspective – an important argument I intend to make in this chapter – I will review the origin and characteristics of this concept, which Sahlins analyzes in Culture as A Practical Reason and later will discuss two studies – Health Belief Model (HBM) and A Basic Model of Illness Behavior – which exemplify works in the utilitarian tradition in social psychology and sociology of illness respectively.

Utilitarianism in Anthropological Studies on Culture and Human Action

Sahlins traces conflicting theoretical concepts on pragmatism in anthropology between utilitarianism and what is, in his view, a truly anthropological

[1] As a form of common-sense reasoning, this type of analysis can be still be found being used by anthropologists, according to Good

account of culture and human action back to the 19th century (Good, 1994: 46). He argues that cultural order is not to be "conceived as the codification of man's actual purposeful and pragmatic action." An analysis of culture in this tradition amounts to manipulation of human and impoverish "human symboling" or "human essence". Sahlins proposes that "human action in the world is to be understood as mediated by the cultural design, which gives order at once to practical experience, customary practice, and the relationship between the two" (Sahlins, 1976: 55).

Sahlins explains the logic of utilitarianism as follows:

> "The general line of force of the argument, the orientation of logical effect, is from natural constraint to behavioral practice, and from behavioral practice to cultural: circumstance → practice → organization and codification (institution)" (Sahlins 1976: 60-61).

Criticizing Lewis Henry Morgan's analysis of culture, which exemplifies this line of thought, Sahlins suggests:

> "Morgan's theory is appropriate to a nonhuman culture – or else to a noncultural humanity. For just as thought is the recognition of an external significance, so the words of men are not the concept external realities but the sign. Consisting merely of the capacity to act rationally upon experience, the intelligence Morgan understands as human is not different in kind from that of other mammalian species…" (Sahlins, 1976: 61).

Utilitarian theories, according to him, can be divided into two main types: naturalistic or ecological and subjective.

> Naturalism understands culture as the human mode of adaptation. Culture in this view conceived as engaged in reproducing itself as culture or in maintaining the human population within limits of biological viability… the praxology is "objective" in the sense that explanation consists of determining the material or biological virtues of given cultural traits.." (Sahlins, 1976: 101).

Subjective utilitarianism, on the other hand, is "concerned with the purposeful activity of individuals in pursuit of their own interests and their own satisfactions." It presupposes actor as "a universal Economic Man". Man acts "rationally towards goals, which, however, vary from society to society." Sahlins illustrates culture in this praxology as:

> …culture is taken as an environment or means at the disposition of the 'manipulating individual,' and also as a sedimented resultant of his self-interested machinations. The characteristic resolution of culture is thus solipsistic in form. Only the actors (and their interests taken a priority as theirs) are real; culture is the epiphenomenon of their intentions. (Sahlins, 1976: 102).

However, both types of utilitarianism, Sahlins claims, play out the same end – that is "the elimination of culture as the distinctive object of the discipline."

Good gives an instance of his critique on an ecological perspective of medical anthropology[2] as follows (Good, 1994: 46).

> Diseases provoke individual and social responses, and these are codified as ethnomedical systems. In the ecological paradigm, a variant of "naturalistic or ecological" utilitarianism, culture is conceived as "the human mode of adaptation," and "explanation consists of determining the material or biological virtues of given cultural traits" (Sahlins, 1976: 101).

Although Good's critique indicates the influence of these paradigms on the ecological perspective of medical anthropology, he does not suggest that they are reflected in most medical anthropological studies and study of care-seeking behaviors in particular (Good, 1994:46). In his opinion, "the critique of subjective utilitarianism is more appropriate to many studies of illness behavior in health psychology and medical sociology." To make his point, Good critically examines two major theories: Health Belief Model (HBM) and a basic model of 'illness behavior and referral system.'

HBM, one of important studies in social psychology, was developed by a group of social psychologists in 1950s with an aim to find out about factors which would promote greater use of health service among people for prevention against highly dangerous communicable diseases such as tuberculosis, rheumatic fever, polio and influenza. Good comments:

> HBM theories are explicit versions of what Sahlins (Sahlins 1976: 101-102) called "Subjective Utilitarianism." Its actor is a universal Economic Man, proceeding rationally toward the goal of positive health, a preference only slightly modified by health beliefs. Actors weigh the costs and benefits of particular behaviors, engaging in a kind of "threat-benefit analysis," then act freely on the perceptions to maximize their capital (Good, 1994: 42).

The model, he argues, reduces the meaning of culture to "a set of propositions held by individual" or "instrumental belief of individual".

Good also discerns the influence of subjective utilitarianism on a basic model of illness behavior proposed by Mechanic (1982, 1986, cited in Good 1994).

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[2] Medical Anthropology in Ecological Perspective in his sense is an ethno-medical system

His comment on this point is not dissimilar to those being studied in medical anthropology.

> Illness behavior…describes the manner in which persons monitor their bodies, define and interpret their symptoms, take remedial actions, and utilize the health care system. People differentially perceive, evaluate, and respond to illness, and such behaviors have enormous influence on the extent in which illness interferes with usual life routines, the chronicity of the condition, the attainment of appropriate care, and the co-operation of the patient in the treatment of condition.

According to this model, individual experiences illnesses, appraises them, uses available illness representations and then makes treatment choices in consultation with members of a lay referral network. Good points out that the decision making process in the model is devoid of values and thus has limited use for explanation beyond health-seeking behaviors of middle-class Americans who are generally covered by health insurance. These people, usually seeking health care service for minor ailments, can freely make their treatment choices without any constraints. However, management of illnesses varies among other racial groups varies due to cultural influence (Lin et al., 1978).

In their study of care-seeking pathways to mental health service and referral systems among members of three racial groups – Anglo-Saxon and middle European, Chinese, and American Indian – residing in Vancouver, Lin et al. found that patients of the Chinese group were usually cared by their families, and that they tried to deal with illnesses early on after being discovered and continued for lengthy periods without consultations with doctors. Homeless members of the American Indian group, on the other hand, were referred between social service agencies and police.

In these cases, it is evident that patients are incapable of managing treatment by themselves as portrayed in the model. Patients are influenced by their cultural conditions in their decisions to seek health care service which vary among racial groups.

In this chapter, I examine the role of culture in contributing to the decisions on treatment choices and on self-medication. As the manifestation of human life, culture functions in ways which rationalize their behaviors and design their actions. The role of culture is articulated through meanings and values assigned by human. This definition of culture, as Sahlins suggests, reflects human role in creating symbols

as well as culture. This concept of human role agrees with structure-agency theories, which recognize human as actors in determining social behaviors as well as being socialized by external forces – the roles which are interrelated and mutually conditioned. Regarding this role of culture, my further argument will focus on the agency approach to the care seeking process.

Strategies for Management of Capitals: Limited Choices under Structural Conditions

The concept of capital management strategy is part of Pierre Boudieu's theory of practice, which explains social behaviors through structure-agency approach, which posits that the actors and structural determiners are interrelated and mutually conditioned (Smith, 2004). Thus the concept of strategy proposed by Bourdieu departs from those commonly found in management sciences in that the actor cannot devise strategies with total freedom. In fact, his choices of strategies are structured by shared cultural rules and influence which shapes his social experiences. However, the actor has a room to utilize capitals – the process encompassing accumulating, convertinging and using them – and social status to design or adjust the strategies to suit real situations he confronts.[3]

Bourdieu divides capitals into 4 categories: economic, cultural, social and symbolic. He proposes that everyday life activities are the expression of the process of capital utilization and social exchange. This exchange is not confined to commercial transactions or economic capital but involves non-economic capital. More important, the exchange of capital between two persons would lead to the adjustment of their social relations and status.

Bourdieu explains the differences between types of capital and their specific benefits. Cultural capital is defined as the qualities – knowledge, taste, manners, etc. a person acquires through the socialization process – he could use to enhance his value. To generate cultural capital, it needs long-term investment of economic and social capitals at family level. The value of cultural capital depends on the nature of

[3] These strategies are not based on conscious calculation but rather the result of unconscious dispositions towards practice even though the actor is usually aware of the goals and the benefits to be gained.

scarcity through which social values are generated (Bourdieu, 1983 cited in Richard Nice).

Social capital means relationship networks among people, which can generate value and turn into benefits – the most evident is to give those who possess it access to goods and service which cannot be gained or purchased immediately by economic capital. This relationship is cultivated over lengthy periods. (It is my understanding that one of its specific benefits is the sense of security from being cared by relatives and friends.) Moreover, social capital enables people to have access to or benefit from capital of other kinds which they might lack, but which is possessed by persons whom they maintain ties with.

Although social capital has specific qualities and helps people gain access to other forms of capital, its drawback lies in risk on return of investment for those who invest in building relationship even at family level.

Symbolic capital is defined as certain qualities – physical strength, wealth, or honors – which could be converted into benefits and values only through interpretations by actors based on a set of perception and evaluation processes. Legitimacy is the key element from which the value and hegemony of this form of capital derive. Symbolic capital is associated with cultural capital for the acquisition of the latter could lead to the former. For instance, having good taste and high education could enhance a person's prestige and honor. In this respect, cultural capital often works as symbolic one as well.

In this chapter, I explore the strategies employed by poor people in crowded communities to amass, convert and use different forms of capital in their social exchange as described by Bourdieu. Spending most of their life struggling to get by in cities, these needy people are definitely lacking in economic capital and natural resources, and hardly have cultural and symbolic capital at their disposal. Under these socio-economic structural conditions, they have developed strategies to accumulate social capital more than any other kinds in order to use it in their daily life as well as when matters of urgency arise – as in sickness and need of treatment. I will present the life stories of patients who resort to their social capital by asking their neighbors to accompany them to receive treatment at hospitals. The stories reveal the strategies

the patients devise to generate and use social capital to solve their health problems – an instance of specific use of its benefits and a form of social exchange in crowded communities.

Nevertheless, the strategies for accumulating and making use of social capital in their decisions on treatment choices are not developed without constraints or free from structural influence, as reflected in the scarcity of all other forms of capital. Their life stories demonstrate how the strategies are shaped under structural influence, which restricts their treatment choices. Structural influence, on the other hand, could be viewed as collective rule or reasoning for their actions in everyday life. In this respect, the stories reflect the people's role as actors who adjust their strategies within limited choices and in the process develop a pattern of social exchange which suits their livelihood and is distinct from that of the middle class or well-off people. Moreover, the process of social exchange developing in each life phase amidst changes in social status and relationship reveals distinctive strategies each person has toward others. His strategies might be different from other community members due to differences in life experiences. From this perspective, the distinctiveness of an individual's social exchange process indicates his role as actor. Learning about the people's life stories and decisions on treatment choices would better our understanding of rationality from the viewpoint of poor people which could differ from others.

Economic Rationality: Utilitarianism in Rationality Conception

Lay people's rationality in making decisions on treatment choices is one of the key questions this study aims to address. What is rational from their perspective could be different from the views held by others, especially those in the health professions and policy makers, who often question economic rationality of their decisions. A review of the meaning and the basic premise of economic rationality would be useful in evaluating the differences between the two perspectives and understanding lay people's conception of rationality.

Definition of Economic Rationality

The definitions of rationality vary from discipline to discipline. Economic rationality is a tool used by economists or policy makers to assess the rationality of any given choice. The basic principle of economic rationality is cost-effectiveness – a concept deriving from utilitarian philosophy. Hence choices which are economically rational are those which maximize ends with minimum expenses on means – in other words, they have most efficient means.

Economic Rationality: Problem of Rationality of Ends

This definition of economic rationality, however, has been disputed by those who do not accept any efficient means as being truly rational unless they have appropriateness and legitimacy.

Rescher, a philosopher who wrote about rationality, observes that rationality must not be justified by individuals' liking, desire or self-interest, and that a rational action must have appropriate ends. Appropriateness can be determined by whether any given action meets the principle of universality of fulfilling one's duty or meeting one's needs as human being – for instance, the need for good health and having sound mind and body or peaceful coexistence among humanity (Rescher, 1988). "Desire may be enough to explain an action, but it is not thereby enough to quantify it as rational." (Rescher, 1988: 102).

This observation points out the importance of scrutinizing the appropriateness of ends, which cannot be quantified in terms of money or economic values as favored by mainstream economic reasoning (Rescher, 1988: 107-110). In many cases it involves non-measurable qualities or values such as virtues, mutual help, sharing or exchange of benefits in kind.

Cultural Perspective on Economic Rationality

In evaluating the appropriateness of ends and efficient means which a person use for making decisions, it is important to have clear understanding of what is to be measured before it can be defined in measurable ways – directly or indirectly. In other words, the meanings and values of ends must be understood in comparison with those attached by that society's or universal norms.

These meanings or values are usually influenced by culture and the way of life in given societies or communities. Culture guides people on matters to be valued, how they should be done, in what order and when. Therefore, before assessing any decision for its economic rationality, it is essential to understand the cultural aspects of that decision in order to evaluate the appropriateness of its ends' meanings and benefits.

In this chapter I demonstrate why, through cultural reasoning, patients view as a rational action their decision to discontinue requesting their neighbors to accompany them to hospitals, and turn to self-medication instead. This reasoning, which is to prevent the deterioration of social ties, represents cultural meanings which value social relationship more than material benefits to be gained or loss of investment on social capital investment.

Chronic Illness and Life among the Poor

Apparent Reasons of Refusal to Hospital Visit

As mentioned earlier, this study aims to understand cultural reasoning of poor people who are afflicted with serious diseases and treat themselves with self-medication – the practice viewed by practitioners in health professions as economically irrational for the prospect of higher expenses on treatment in the long term due to the aggravation of their conditions. I would like to understand how lay people's reasoning differs from that of the health practitioners.

From my interviewing of more than 20 people who suffered from chronic diseases including hypertension, paralysis, epilepsy and diabetes, I found that most of them previously received treatment at hospitals, the local health center or private clinics.

Despite being entitled to free treatment accorded to elderly or poor people, these patients do not make regular visits to the hospitals. (There were others who never went to see doctors for treatment since they were not registered in the universal health care coverage program.) The cost of health service, therefore, is not the reason that prevents them from visiting the hospitals since they are not higher than those of medicines they purchase from drug stores in their neighborhood. A typical answer to

my inquiry into their reasons is: “The condition has improved.” Or “it’s not as bad as when I was admitted to the hospital or the first time it was diagnosed.” Initially I believed that was the real reason and concluded that the problem lied in their ignorance of the nature of their illnesses for which they probably need to take medications for all the rest of their life and should see doctors regularly. I saw no other plausible explanation. After becoming acquainted with them for a few months, I began to suspect there were other hidden reasons for this behavior which were often overlooked by outsiders like me.

Several patients whom I talked with agreed that the main reason they turn to self-medication was because it was more convenient and cheaper than the overall expenses of visiting health centers or hospitals, which include the so-called indirect medical costs such as transportation and lost income. Although the distance from the community to the nearest health center is 600-900 m., the road and sidewalks are difficult for old people or patients to walk there. A patient strong enough to visit the center by himself can ride a motorcycle taxi which would cost him 40 baht for a visit. To get there by taxi, a patient needs someone, probably a relative, to hail a taxi from the main road to pick him or her up inside the community areas. It would cost 80 baht – 40 baht for each trip to and from the center. This amount is more than half of one worker’s daily wage.[4] A taxi to and from the nearest private hospital cost 120-160 baht and the nearest public one cost 160-200 baht.[5]

I found that, apart from indirect medical costs, most elderly people have social expenses – the cost of strengthening bonds in their relationship with relatives, neighbors or even their own children or grandchildren. Good relationship is useful when they ask these people to be their companion on a hospital visit. When compared to the minimum wage their children earn, social expenses are quite a financial burden

[4] Some residents secure a job for which they are paid a minimum daily wage of 181 baht. However, they work five days a week and a percentage of their wages is deducted for the Social Security Fund.

[5] Since Police Hospital and another medical school hospital, two state hospitals near Klongtoey areas, do not take part in the Universal Health Insurance Program, patients in the areas cannot claim the benefits of the coverage except in case of emergency or visiting after office hours. These exceptions became known after the program had been implemented for more than five years, and yet few people in the community are aware of them. Charoenkrung Pracharak Hospital, a participating hospital, is far from the community, and traffic congestion poses a big hurdle for those who want to go there. Thus the choices are too few for residents who want to visit a hospital for treatment.

which explains why some patients like Grandma Tew, who has lived in this community for more than 30 years, rarely makes such request.

Grandma Tew has trouble walking for she had several wounds on her feet and is almost blind because of cataract. She has a grandson taking her to the health center to receive treatment for hypertension. However, she had thought of asking a teenage girl – a granddaughter of one of her neighbors – to replace him for the task. The girl is good at school and responsible at home where she helps with house chores. She has a strong built like adult even though she was only in the second grade of a secondary school. Grandma Tew has good relationship with her and thought she could do the job better than her own grandson, who does not care her properly. “He let me go up the stair by myself. I almost fell off it. My hand slipped off the rail. Luckily, I collapsed on the spot,” she recalled the last time she went to see a doctor with him.

While I understood Grandma Tew’s intention and knew she would be treated better, I saw no point in her asking for help from the girl if she could not afford to return her favor. I have learnt – from a story of Grandma Duen, another elderly resident, which I will relate later – about the practice of paying *sin namjai* or a-token-of-appreciation money to helpers for such favor. Grandma Tew did not have enough money for transportation, but the money I gave her for taxi and miscellaneous expenses enabled her to visit the health center 4-5 times in over two months. After listening to her, I did not give her additional money or offer any comment, implying that I did not agree with the idea. I believed that Grandma Tew herself knew that she could not afford for the girl’s service, judging from the fact that she was frugal with the money I had given. Following up with her health seeking behavior a few months afterward, I found Grandma Tew still stuck with her grandson, who was alternately relieved by his sister.

Grandma Tew’s case differs from others because she has several grandchildren, who can rotate the responsibility of taking her to see doctors, never mind that sometimes she has to wait for several months. For those whose children or grandchildren are few or too busy and whose conditions do not allow them to travel alone, they opt to buy medicines from pharmacies to treat themselves instead of visiting hospitals. A handful of them are in the position to seek help from their

neighbors but cannot afford to do it regularly and eventually turned to self-medication as well.

What are the reasons for these people to stop asking for help from acquaintances? Why is the practice difficult to get started and sustained? To answer these questions, I present here a story of another patient, who got help from her neighbor in managing her illnesses and other matters by using social capital that she accumulated. And yet the patient faced problems in sustaining the help she received.

Grandma Duen's Life Story: Interdependence of Social Relation and Therapy Management Options

The story of Grandma Duen, a 62-year-old diabetic, illustrates how much relationship with neighbor means for poor people in crowded communities; why the maintaining of this relationship is the basis of cultural reasoning for the patients' decision to discontinue their treatment at hospitals and switch to self-medication; how – to build and preserve social relations – the patients need to convert the capitals in their possession; how social expenses become a burden for poor people; how the conversion and use of capital could be viewed as social exchange process or as actor's strategies; how changes in life situation and environment effect adjustments of their strategies in management of capitals; how these people deal with risks in their use of social capital; why they view as rational their decision to stop asking for the company of their neighbors on hospital visits; whether it is economically rational.

Illness Experiences and Self-Medication Practice in Everyday Life

Troubled by chronic wounds on her feet and muscle aches as a result of diabetes, Grandma Duen, a plump woman with light skin, had difficulty in walking even a short distance. Still almost every day she labored to walk from her house to the entrance of the lane 50-60 m. away – hands groping for support against the walls of the houses along the way to buy some foods and chat with some neighbors there.

Four years ago Grandma Duen learned she had diabetes. She went to receive treatment at hospitals over the past two years. Now she bought medicines for herself from a drug store nearby. She was one of the patients who were not aware that they

also had hypertension [6] and consequently did not buy medications for high blood pressure. She also did not know that because of diabetes the wounds on her feet were difficult to heal but mistakenly believed that was because they were wet most of the time. She treated them with Chloramphenicol ointment bought from a pharmacy nearby.

Grandma Duen was given two kinds of medications when she still visited the hospital. But when she stopped doing so, she bought herself only one of the two. I learned from other residents that this medicine was Glibenclamide-5 mg. She did not buy the other, Metformin-500 mg, for she was not sure whether it was for diabetes even though she recognized it as one of the medications the hospital prescribed to her. Lee, one of her neighbors and also a diabetic, sometimes shared this medicine with her, but she did not know exactly what it was for. [7]

For almost two years Grandma Duen did not go to hospitals for tests on her blood sugar levels. She first went to get treatment at the local health center, but later asked to be referred to a hospital reputed for its expertise on orthopedics because she had nagging back pain and bad knees. “Someone told me I’d get better treatment at the hospital. So I asked to be referred to it,” Grandma Duen told me. She regularly visited that hospital for almost a year. It had been over a year since her last visit there. She now took one Glibenclamide 5 mg a day. Any time she experienced frequent leaks during the night – a sign of a rise in the levels of sugar in the blood – the next day she would increase the dose to two pills, one in the morning the other in the evening.

Grandma Duen also had problems of back pain and aches on her body. After having her X-rayed, a doctor at the hospital told her she had “contracting bones” which could not be cured, and prescribed her some medicines, which helped relieve her pain somewhat. The pains and aches have troubled her so much that she now depended on sets of medications she have bought for herself for a few years.

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[6] There are other community residents who were prescribed medications for hypertension without their knowledge. Grandma Duen’s blood pressure was 160/90 mm.Hg. when I took it one month before she had a stroke

[7] Lee occasionally visited the health center and sometimes bought medicines for herself. She got Metformin-500 mg pills from another neighbor who – though visiting the center regularly – underused the medicine she was prescribed.

Recently she had to take at least one set every day, some days twice. When she did not take them, she could hardly pull herself up even on all fours. Worse still was severe pain which kept her sleepless. The lack of rest and inability to do daily activities worried her as well as other elderly people who face similar problems and could be a reason for their dependency on these set medications. I found that the set of medications [8] Grandma Duen usually bought consisted of Dipyrone or Paracetamol 500 mg, Dexamethasone 5 mg (steroid), Indomethacin, Phenylbutazone, and Aspirin 300 mg. Controlled drugs such as steroid, Dipyrone and Phenylbutazone are usually included in these sets. [9] There are variations of combinations of drugs in medication sets for stiff and pain. For example, Ibuprofen or Piroxicam may be in place of Indomethacin, or Cimetidine 200 mg included. The sets are priced at 5-7 baht depending on the combinations. A regular customer for over 10 years would get a discount – buy 10 and get one free. These sets of medications are almost like common household remedies for any families with elderly people or members working as laborers.

I was particularly concerned about the wounds on Grandma Duen's feet, which could get infected and spread without being detected because steroid usually suppresses infection, which is the reaction of the body's immune system. I then made a request to the local health center for paying visits to Grandma Duen and educating her on the harmful effects of these medications so that she could gradually cut down their use.

While her wounds worried me, Grandma was much less concerned. She told me with a steady calm voice about the problem, pointing out that the biggest one, on one of her right foot toes, showed signs of improvement. "The wound is closing quite a bit," she said, seeming satisfied that the medicine she bought and applied to the sore apparently kept it in check. She had had the wounds for more than two years, and was not troubled by them anymore. Besides, their conditions appeared stable.

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[8] This information was obtained from my inquiry with pharmacists at the drug stores.

[9] I have pictures taken as part of my previous research showing medication sets for common cold sold by drug stores in the neighborhood. The three medicines were included in those sets.

Grandma did not want her wounds to get wet but she needed to do house chores from laundry, cooking, washing the toilet to cleaning the floor. It was her daily routine. “Can’t stay still, need to work.” she said. I noticed that though the floor was covered with worn out mat sheets, it looked spotless with no items left on the floor. A few of her belongings were put aside in plastic bags hung on the wall.

The layout of the house, which is actually a room, made it almost impossible for her not to get her feet wet when doing her laundry because the only water tap it had was at the spot outside the house near the right corner of its front, where she bathed and washed everything. [10] As a result, she had to walk or step on the wet floor most of the time. [11]

Because of her declining strength, it took Grandma Duen longer to finish her chores, especially laundry. With her fingers getting stiffer, she had to clean the floor with dripping wet rags and by pouring water to wash away dirty spots. To wash her mechanic son’s oil-smeared clothes, she needed to cleanse them with detergents and bleachers and rinse a few times using gallons of water. I noticed that the clothes and even the rags she washed were very clean. “When she prepares fish, she uses big jarfuls of water.” one of her neighbors told me about her way of using water profusely.

Under the circumstances, it was very difficult for Grandma Duen to keep her feet dry. To avoid using the toilet during night time, she used a spittoon instead. But in general she had got used to the pain and inconvenience brought by the wounds – a distress pale in comparison to the suffering inflicted on her one month before our first encounter.

The Predicament of Elderly People in Single Families

When I first met Grandma Duen, she was at the lowest point of her life. From a family of four – herself, husband and two sons – she then lived by herself.

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[10] It is common for many families in the neighborhood to take a bath at the water tap outside their houses

[11] Grandma Duen connected a hose with the tap outside through a hole at the bottom of the wall for refilling water in a container in her squatting-style toilet. The water dripping from the hose and her frequent use and flushing also made the toilet’s floor wet.

With little money left, she was thinking about pawning her TV and radio, but a few days ago her younger sister gave her 1,000 baht. The sister traveled all the way from Khon Kaen to visit her after receiving the news that Grandma Duen's younger son was arrested by police. "I don't know how he is doing. How long he will be serving time?" Grandma Duen said, looking downcast. "I forbade him to go out to see friends at late hours at night. But he didn't heed my warnings. I told him not to take drugs or mix up with bad friends. But he kept quiet, not arguing or talking but not listening." she said, Later I learned from the young man himself that he was behind bars for 50 days for charges of having 2 amphetamine pills in his possession. If he had had money to pay for a 1,000-baht fine, the sentence would be reduced to 30 days.

Grandma Duen showed the ID card of her elder son to me. "This son was a good-hearted man He didn't drink or smoke. He earned money to support and cared for me. But he died of tuberculosis." His death left a big void in her life. "The good son was gone, and I'm left with the bad one." It was the only time she showed her disappointment with the younger son because his release from jail two weeks later seemed to brighten her life.

Grandma Duen's family is not alone in its loss of members at young ages. It happens to many other families in the communities. There are few families in which both husband and wife are still alive together after reaching the age of 60 or older. Grandma Duen's husband died of lung disease almost twenty years ago. He was approaching 60 then. Similarly, most of the women I talked with lost their spouses who were around 50-60 when they died. And nearly all the families have at least one of their sons died at young or middle ages – the causes of death ranging from accidents, fights (as a result of drinking), drugs (overdose or extrajudicial killings [12]), AIDS to suicide.

I learned from one of Grandma Duen's neighbors that her eldest son had AIDS and probably died of lung infection. According to Grandma Duen, her son developed a lung condition resembling her husband's. The loss of two bread winners had plunged the family into a crisis since all of their relatives lived elsewhere.

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[12] More 2,000 people were reportedly killed in this manner in a campaign by police against people suspected of dealing amphetamine pills.

A housewife until her husband's death and in her 40s then, Grandma Duen started getting herself a job to ease the pressure of earning income on her elder son, who was 21 then (the younger son was 13). She started harvesting wild vegetables and selling them to the market. It was the job she learned from La, one of her neighbors and also a widow, who had been doing it since she was a young woman. It was a demanding work requiring her to brave all kinds of weather conditions, sun or rain, but she persevered for almost two years without taking days off. She felt proud in accomplishing something difficult and vindicated after having been disparaged by some neighbors – "She gives it up in a few days." After that job, she was hired a lawn keeper for 6-7 years before her elder son asked her to quit.

With two members having jobs and only the younger son in school, the family fared better than many families living on the same lane in terms of economic situation. Grandma Duen could afford to pay for the ordination of her other son, fulfilling her wish that he became a novice monk and stayed away from their community, which was rife with drug addiction among youths.

After Grandma Duen quitted her job, her elder son took the sole responsibility of supporting the family financially, but it posed no problems for the young man since he, unlike others of comparable age who usually had wife and children, was still single. Besides, he was a hard-working man, hiring out his service of transporting machines and riding a motorcycle for hire. The latter job earned him handsomely at that time when drug dealing and gambling dens were flourishing in the neighborhood, and gamblers called for his service at late hours. Since he spent frugally and did not drink or smoke, he was able to save some money in the bank and soon purchased his own motorcycle.

Nobody knew for sure how he got infected with HIV. His neighbors said he did not like going out for fun. But it was not unusual for a man in his 30s and not married to use the service of prostitutes. One of his colleagues believed he contracted the deadly disease while he was in Laos to deliver some machines. [13] After falling ill,

[13] I learned about his contracting HIV from some of his close friends and colleagues who used to go out with him and from a few neighbors. Grandma Duen told me the first time we met that her son died of a lung disease, which is partially true. I did not know if she was really not aware of the fact or chose to reveal only part of it.

he spent his savings of 20,000 -30,000 baht for treatment. After visiting the health center a few times, he was hospitalized and died at the age of 34.

Unlike the time after her husband's death, the family never recovered from the loss of the elder son. Grandma Duen's hope to give her younger son good education and keep him away from drugs was shattered when he left the temple after three months and returned to Bangkok without her knowledge. He later returned to live with her and resumed his study in Mathayom 3, but it was not long before he dropped out to find work. [14] In our conversation shortly after he was released, he told me he chose to attend the school at his friends' suggestion and because he learned that its teaching standard was better than that of another school located in the center of the community center. But after a while, he began to dislike the atmosphere in the class and wanted to get a job so that he would not be a burden for his family. He got himself hired for delivery job just like his brother. There was a time when he had good self-control and stopped drinking, he could save as much as tens of thousand baht. According to Grandma Duen, he earned enough to take care of himself, but it was his brother, who bore all other expenses of the family. After his brother died, he paid for those expenses and bought foods home. But at times when he was away for several days, he never gave his mother any money. He had no idea how much she had in her savings. He knew she sold his brother's motorcycle for 12,000 baht. [15] He disagreed with her but did not object because he did not want to upset her.

In her old age, Grandma Duen now had only her younger son, a close friend and neighbors. The friend lived in a flat nearby and dropped in regularly to give encouragement and urge her to accept the situation and go on with her life. She recalled her friend's words: "Life was easy on you when you're young, but it's hard when you got old. For me life was difficult when young, but gets better when old." Some years ago when Grandma Duen still had a good life with her family, she always helped her needy friend and share things with her. When the woman got married to a

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[14] It is typical for local youths in the neighborhood to drop out before completing Mathayom 3, when they become physically strong enough for manual labor. They reason that they should get jobs and take care of themselves so that they would not be a burden for their families.

[15] She sold the bike for only half of the market price because she expected difficulties in transfer of ownership due to her son's house registration and wanted to get rid of it, fearing that her younger son would use it in wrong ways.

Westerner, her life took a better turn. Now she lived on the fortune her husband left after his death while Grandma Duen's life descended into the lowest. But these changes of fortunes did not weaken their friendship. The friend frequently called on her and bought foods and other things – new mat sheets, herbal medicine for diabetes, etc. – for her. Grandma Duen also had neighbors who made her feel less lonely, especially Ta who helped buy foods medicines and a few other things for her almost every day.

Network of Social Support for Treatment of Illnesses

The Role of Family Relations in Treatment of Illnesses

I presumed that the loss of her elder son was the cause of financial problems which forced Grandma Duen to stop going to the hospital for treatment. To prove this assumption I asked her several times to relate how and when she started buying medicines for herself, but I always got the same answer: it started when her elder son was still alive and healthy. In fact he was the one who bought them the first time by bringing the prescribed medicines to show to a drug store near their house and asked for the same kinds of medicines. Explaining why she did not get all the medications for diabetes, she said she did not know exactly what kinds of medicines she needed. "I'm afraid to ask why he only got some of them. I don't want to bother him. Maybe those were the only medicines that the drug store got."

Gradually I began to grasp what she meant when she said she did not want to bother (kreng chai is the exact Thai word she used) her son. Almost every elder person whom I talked with expressed this feeling of kreng chai – the reluctance to impose on others – toward their children who worked to support the families. [16] Even with her younger son who had disappointed her, Grandma Duen hardly said harsh words or scolded him. Several times I found them looking happy in each other's company while eating or watching TV together. She liked to tell me what kinds of food or things her son brought home. I was not the only one who noticed her tenderness toward her son. Ta, a neighbor who helped buy foods or medicines for Grandma Duen, said the son, unlike his deceased brother, hardly took good care of

[16] These include Grandma Lee, who still works to support herself. She treated her grandson kindly, never said anything to hurt his feeling or asked him for money.

her. Yet “Grandma Duen loves her younger son more than the elder one. She indulges him, never complains or criticizes.” She washed all of his clothes even underwear, socks and shoes. It was not only an act of a mother’s love but to maintain good relationship with her son – the attitude common among other elderly people in the community.

Buying Medicines for Mother, Yes

Accompanying Her to a Hospital, No

While her younger son dutifully bought the medicines for his mother just like his brother did before his death, both of them never took their mother to the hospital. Apart from the inconvenience of their working hours, they simply disliked visiting hospitals or even the health center. The younger son recalled his frustration when he visited them:

> When we ask the officials where we’re supposed to queue up, they reluctantly point to some directions showing no interest in us as if they only want to get rid of us. So we couldn’t go to the right places. Sometimes they angrily shouted at us as if we offended them before. Their answers to our questions are hard to understand. I’m quick at understanding. If I can’t make them out, how you can expect the elders or ordinary people to understand.

In his mother’s presence, when I asked him whether he could accompany her to the hospital. “Of course, I could. But it depends on whether I’m not too busy,” he replied.

The man is like most sons in other families who do not know much about their mothers’ illnesses. To them, it is good enough of them to work and earn money for their mothers to spend on medicines or visiting doctors. The task of accompanying parents on hospital visits usually belongs to their wives or female cousins. In families which have only sons or nephews aging mother would find it difficult to go seeing doctors by themselves. Consequently they would stop visiting hospitals or, if they have to, request help from their neighbors from time to time. There are few families, as in Grandma Duen’s case, which can find such help regularly at least for a period of time.

Relationship with Neighbors: Requesting Help for Buying Medicines or Accompanying to Hospitals

After being diagnosed as having diabetes when she was 59, Grandma Duen regularly visited the health center near her home by asking a neighbor next door to help take her to the place. The neighbor continued to offer her help after she asked to go to another hospital well-known for its orthopedic treatment. But in less than a year Grandma Duen stopped visiting the hospital altogether and uses self-medication instead.

In the first few months that I started paying her a visit 3-4 times a week, she simply told me that the reason she discontinued visiting the hospital was that that neighbor had moved to somewhere else. A few questions came to my mind. Why only this neighbor? Why not others? How about, say, Ta who now helped her buy medicines and foods?

Requesting Help from Neighbors: A Form of Illness Management

It took me nearly two months to gain deeper understanding of the practice of requesting help from neighbors. The activity is not simple or spontaneous as it may seem. Help cannot be sought from anybody or repetitiously. In fact requesting help from neighbors is a way of managing illnesses when needs arise. There are certain requisites for the practice: existing good relationship, ability to cover the ensuing expenses, and a suitable person to offer help if requested.

Jib was the neighbor who used to help out Grandma Duen. They had known each other for ten years. Jib and her husband separated, and her children were put into care of her husband's relatives, which left her with few financial obligations. Jib had no permanent jobs. "Jib was good at pleasing people. She often bought things for Grandma Duen. She used nice words. Grandma Duen liked her very much," Ta told me. Jib was also different from other neighbors as Grandma Duen recalled:

> The person who took me to the place was deft. She knew how to talk with people or ask questions. She knew everything – what to do or where to contact. I just sat waiting while she handled all the talking. Without her, I wouldn't know what to do.

Grandma Duen shared with other people in the community the same fear that they would make mistakes when visiting hospitals. Most of them are afraid even to approach someone to ask. Other residents told me that while doctors did not scold

them, other officials often talked with them harshly. The fact that Grandma Duen used her claims for free medical service at a hospital other than the one she was assigned to and that she needed a wheel chair, had to be x-rayed on the first few visits and to take blood tests every time made her visits complicated activities. One needs to know the ways around the hospital, steps to do, how to communicate with officials who tend to rebuke patients when they do something not right. Having a caregiver who can coordinate with the hospital was crucial to Grandma Duen's hospital visits.

Jib did not only handle the contacting but looked after Grandma Duen as if she were her relative. She went to buy food and water for her after taking blood tests and asked if she needed anything else. In addition to Jib's personality and her coordinating skills, what accounted for this attention was good relationship between the two. How did this relationship start and develop? I tried to find answers to this question by talking with Grandma Duen herself and Ta, the neighbor whom she asked to buy food and medicines but never sought her company for hospital visits.

The Building, Maintaining and Costs of Social Relations

After I learned that having Jib as her caretaker was the only way that Grandma Duen could have access to treatment at the hospital, I focused my attention on the practice of requesting help in different aspects. I was somewhat surprised to find that a person whose help was requested for even an insignificant errand would be paid in an amount higher than the wage he or she normally gets.

I saw this practice at a small eating place selling food to orders and pork leg with rice in the community. I often dropped in to talk with the woman who ran the place, and we got acquainted. I learned that she was in financial trouble and could not earn enough money to pay back the loans and their exorbitant interest. In this situation, she should have been careful with her money and had her adopted daughter run errands for her. Instead I witnessed her asking a boy next door to go and buy rice from a grocery 100 m. away. When he returned with it, she handed him five baht, saying: "Thanks. Take this and buy sweets for yourself." I couldn't help wondering why she did not send him for her daughter in the house 30 m away instead.

She also asked another woman, an alcoholic, to empty her trash bin at a dump site 20 m. away and for that reward her five baht. In this case, she probably took pity on the woman.

Grandma Duen was another person who rewarded others for their assistance in amounts larger than normal wages. Almost every day she asked her neighbor Ta to buy foods or medicines. To get them Ta had to go out to the main lane, about 100 m. from her house, or walk for another 100 m. to the community's outer areas close to the main road. Occasionally she would go to buy medicines from a pharmacy at a market near the flat houses 300 m. away.

When I asked Grandma Duen about the way she rewarded Ta for the errands, she reluctantly told me but insisted that I must keep it to my self since she did not want the word to be out and reach Ta's ears.

> Don't tell Ta that you learn from me about my paying her. That would upset her because people would say she helps me for the money. She is helpful and easy to use. It's her good will toward me. She doesn't have much money herself. I need to give her some. Otherwise, who would help me in the future?

Grandma Duen said she rewarded Ta for her favor once or twice a week.

> Sometimes fifty, sometimes one hundred. Sometimes buying spirits for her. She likes them. When she drinks, she doesn't speak much or complain, and still work as well as when sober.

One day as I was approaching Grandma Duen's place, I heard her calling out: "Ta come on in and get your favorite." When she knew it was me, she stopped shouting and greeted me instead. While we talked that day, I noticed that Ta' favorite thing was put on a spot against the wall. Although I did not see she give it to Ta, the spirit must be a token of appreciation for her service.

I learned that Ta accompanied her when she recently went to have her ID card renewed at the District Office, two kilometers away. They went there and returned by taxi. The trip took one hour. For her assistance – from hailing the taxi, helping to get on and off it,. Grandma Duen gave her 100 baht.

The amount seems small to an outsider like me but to people like Ta its value, when compared with daily wages, was much different.

Talking to her a few times, I learned that she had no permanent jobs. Sometimes with her neighbor asking, she hired out her labor distributing advertising leaflets for 200 baht a day – a wage higher than the minimum wage. But the job was demanding as she had to walk several kilometers a day and weather the sun all day long. Besides, she needed to spend 40-50 baht on food and water.

Although asking for help from neighbors is based on good relationship but the expenses of the practice are even higher than normal wages. This also applies when Grandma Duen needed assistance from neighbors other than Ta. When she asked another neighbor to fix a wooden plank on her floor – the job that took him less than half an hour – she bought him a bottle of spirit for the service.

Rewards for Resourceful Persons

When asked about the reward for Jib's service, Grandma Duen said: "I gave her 200 baht for each visit. We left early in the morning, and it took more than half a day before we returned." She felt that Jib deserved to be paid with that amount because she could not do it without her assistance.

> She took care of everything. Without her I'd have been lost.

Apart from rewarding Jib for her service, Grandma Duen's family used to help her out financially.

> She was on very friendly terms with Din (her elder son). Din was generous and liked to help people. I saw she borrowed money from Din a few times. The last time was 3,000 baht.

She was quite certain that her helper had not paid back this amount to her deceased son even though she did not know the total sum her son lent Jib. The money Jib borrowed and never returned should be considered as part of the expenses on requesting her help.

Grandma Duen never demanded for payment of that money and continued to pay Jib every time for help. While she felt that these expenses of maintaining relationship and requesting assistance were high, she deemed them necessary for her reliance on Jib on hospital visits.

Rewarding Money as Reciprocity and Social Relationship

The questions which kept coming back to my mind are what is the reasoning behind this practice of giving money for help requested on even trivial matters and why the amounts are so generous. Both the owner of the eating place and Grandma similarly explained to me that the money was an act of "returning the goodwill" to those who were kind to answer their needs, and it was not like giving wages when you hired people. What distinguishes this act from hiring is that the rates of returning the goodwill are decided after the tasks are completed and up to those who pay.

The nature of the practice of requesting help and returning the goodwill with money resembles what Sahlins called generalized reciprocity [17]— the act of giving without expecting repay or return, which is usually found among relatives or closely-knit social groups. (Seymour-Smith 1988)

The "goodwill" money can be considered as non-return or non-repay payment since its payment or the amount of it is decided after the task is completed and hence has no bearing on it. On the other hand, persons who help as requested could not expect to be paid or know how much they would be rewarded. In this respect, their generosity can be described as non-repay as well.

This characteristic distinguishes generalized reciprocity from balanced reciprocity, in which the exchange is made on equal terms. More important, generalized reciprocity, as Marcel Mauss describes, enables the giver to develop the bonds of giving because it makes the receiver feel grateful as when receiving gifts and wish to return the generosity whereas giving in the latter type of exchange generates no social bonding.

In Grandma Duen's view, by giving money in return for the goodwill, she fulfils her obligation as the receiver of assistance. Moreover, the act of returning the favor with money or in kind whose value is even higher than the help requested has an implicit meaning which turns her around from the receiver into the giver and makes the persons who received the goodwill money feel thankful to her. In this respect

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[17] Sahlins divides the acts of giving into three types: generalized reciprocity, balanced reciprocity and negative reciprocity.

Grandma Duen furthered social bonding which would be useful for her in making future requests.

It should be noted that the meaning of social bonding conveyed through the goodwill money is suggested indirectly. According to Bourdieu, this meaning is made implicit in order to conceal the benefits its giver would receive from the exchange, which could be done by two strategies: using disguising remarks and delay of returning (Bourdieu, 1977: 5-7).

To avoid the impression that repaying the goodwill is a form of wage, people who requested help would equate the money as a token of gratitude. I found that they often avoid giving money directly but chose to reward their helpers with their "favorites" such as spirits instead. And if they have to give cash, they would use expressions like 'Take the money and buy your favorite thing', Take the money and get yourself a spirit, or "Take it and buy sweets for yourself." Moreover, they prefer not to divulge the facts about goodwill money to outsiders as Grandma Duen told me: "Don't tell Ta that you learn from me about me paying her."

Delay of returning the favor is a tactic to make repaying not being seen as disregard for the helpers' goodwill or rejection of their social bonding. This tactic allows the helpers to complete requested tasks for some time before being rewarded. I found that Grandma Duen usually gave money to Ta once or twice a week, some time after the latter went on the errands.

Bourdieu explains that these practices by either disguising or delaying follow social norms to hide the benefits to be gained from gift exchange even though both parties – giver and receiver – are aware of the advantages from giving help and returning the favor (Bourdieu, 1977: 5-7).

Requesting Help: A Pattern of Social Exchange Found Exclusively Among Poor People

Although, as Bourdieu suggests, Grandma Duen and others in the community preferred to disguise the fact that they repaid someone whom they requested help, the manners in which they practiced it reflects their efforts to be more candid in their reciprocating acts. For example, Grandma Duen repaid her helper's

goodwill with money rather than gifts or things that she liked. [18] Moreover, the given amounts were usually higher than normal wages and paid immediately after the task were finished, instead of following a grace as found in gift offering or social exchange among members of social groups which are not needy. Yet Grandma still observed social norms which require the practice be made obscure and hidden from outsiders to preserve the dignity of the other party.

While the practice of asking for help constitutes a form of social exchange with distinctive patterns in which people in accordance with Thai society's norms, members of needy communities like Grandma Duen and her neighbors have altered it in ways which suit their social status and the capital they can afford. Because the scarcity of economic capital, the payment of money – usually at above-average rates and immediately after the completion of the task – is considered one of the most useful form of reciprocating others' help, as I witnessed in most cases. It is also a strategy for those who can afford to gain access to medical service at hospitals.

Financial Constraints of Requesting Help

Compared to the minimum wages—181 baht/day and 5 days/week—earned by their children, the high costs of requesting help place a financial burden on income-earning members of the families. In addition, social expenses are not incurred only at the time of request. People often bear other costs of preserving social ties with various forms of help offered including lending money at low interest rates; permission for connection of water work or electricity for monthly flat rates which are cheaper or more flexible with payment periods; joining a drinking party as investment to obtain information about job openings (Rabhibhattana 1998).

I found that most investment for social bonding in the community needs economic capital or money. Some elders recalled the old days when they could catch fish and harvest wild vegetables from ponds, swamps or canals nearby and share them with each other. These days people harvesting and selling wild vegetables for a living have to go as far as the areas in the vicinity of Suvannabhumi Airport. Almost everything has to be purchased. The practice of mutual help and pooling efforts has

[18] Many would say what they like most is money. Thus giving money would be the most direct means to satisfy the receivers and meet their needs.

become things of the past, with only a few exceptions such as the organization of Children's Day, Songkran Festival, or Eldery's Day. Even in these events labor has to be hired for tasks such as washing dishes, cleaning, etc.

In Grandma Duen's case, I found that financial difficulties restricted her ability to afford neighbors' help, making her postpone actions on matters which she deemed not important. For instance, her room was poorly lit by a fluorescent lamp constantly flickering through the ceiling fan rotating underneath it. I found its dizzying effect disturbing and asked Grandma Duen if she was bothered as well. But she said she got used to it. Similarly, she did not bother to ask anyone to replace batteries for a wall clock which had stopped for months. Obviously, she could not afford asking others for help unless they were matters of necessity.

Adequate Social Capital: A Requisite of Requesting Help

No less important than economic capital in the practice of requesting help and social bonding is social capital – for instance, good relations, long-time friendship or mutual trust. These qualities enable one to request help from another especially on delicate matters which require the helper to give special care and attend to the person's health in a holistic sense, encompassing physical, mental and emotional well-being. For Grandma Duen, Jib and Ta accorded such attention to her – the former when she visited the hospital and the latter when she needed medicines and foods. This kind of capital cannot be purchased but have to be cultivated with physical and mental efforts over time based on personal ties and goodwill.

I did not have a chance to observe the relationship between Grandma Duen and Jib but witnessed her ties with Ta. Not only was she caring toward her helpful neighbor but considerate in making requests since she did not want to cause problems for the woman.

> I've to be careful, trying not to ask for her help too often because recently her man has had problem finding work and complained her for allowing her son to stay with them. So she drinks quite a bit, and the spirit loosens her tongue. She doesn't talk much when sober though. She lets out her frustration when she's drunk. I pity Ta because her son has nowhere else to go.

The simplest thing a caring neighbor can do for others is to lend an ear to the problems they are facing. Better, one could offer assistance or do within his or her

capacity to help them solve the problems. In her case, Grandma Duen could only give moral support and offer her sympathy for Ta. I also learned the same story about Ta's problems from herself, which shows that Grandma Duen was really concerned and aware of her neighbor's problems.

Ta told me about the reasons she drank. "I'm worried, and drinking helps me to sleep. If I don't drink, my worrying would keep me awake." Ta said her son was in trouble after losing his job. He had no money to pay rents for his place. So she offered her place for him to stay. His 6-year-old daughter had been in Ta's care since her birth. With everyone crammed into a one-room house which belongs to a relative of her husband, he was frustrated by the lack of privacy.

Being aware of the situation of Ta's family, Grandma Duen would use her discretion in making requests. When the neighbor's husband got rough, she would not ask for her help or, if necessary, avoid requesting her to buy things from distant places such as a pharmacy in another community. The elder woman was afraid that it could become an issue and land herself in the husband-and-wife conflict. If that happened, it could damage her relationship with Ta, which she had taken great care to preserve.

Reasons One Stops Asking for a Neighbor's Help

With enough economic and social capital, Grandma Duen's family could afford to sustain Jib's help for her hospital visits. However, the relationship was discontinued when changes occurred to her helper; Grandma Duen judged that her neighbor was not in a position to continue her service. More important, to perpetuate the arrangement in spite of these changes would further erode their relationship in the future.

It took me more than two months to learn about what happened to Jib. Initially Grandma Duen told me that her former helper had moved to another place but did not mention about her getting married again. It had not been until we became more acquainted with each other that she revealed about Jib's new husband.

> Actually her new place isn't far from here at all. She moved to live on the next lane. The reason I don't want to bother her because I don't know her new husband well. He isn't a friendly guy. If I ask her to help, it could upset him and get her into trouble.

Ta, who also knew Jib and her spouse, told me that Jib's new place was on the next lane, about less than 100 m. from Grandma Duen's. Her new husband, a non-local, was a sort of a thug but had enough money to support Jib. He did not want her to get involved with others in the neighborhood. Thus she had kept her distance from Grandma Duen and other neighbors whom she had known for almost ten years.

This change of Jib's status from a widow to a married woman made Grandma Duen rethink about her relationship with her former helper. What would happen if she continued to ask Jib to accompany her to the hospital? Would Jib be in trouble if she complied with her request? I think Grandma Duen decided to end her reliance on Jib, knowing that that would displease Jib's husband, who forbade her to keep relations with other neighbors.

The possibility of causing problems to a neighbor is an important consideration Grandma Duen weighed in her decision to request help from others as well. During 3-4 months I had known her, I found she applied this kind of reasoning when she approached others for help.

Grandma Duen's Reasoning in Asking for Help from Thong

Thong was a taxi driver and a close friend of Grandma Duen's elder son. Both men were single and seen in each other's company so often that they were mistaken for homosexual partners. Their parents were close friends, and that friendship extended to the younger generation. Thong's parents moved back to Prachinburi, their hometown, to do orchard farming. Every time the man visited his parents he would bring something back for his close friend's mother. "When he visits them, he always brings fruits back and gives them to me," Grandma Duen said.

However, she never used his taxi for once because she knew that he would give her a free ride. "He wouldn't charge me. The car runs on gas, and he needs to refill it. So why bother him."

This reluctance for fear of causing inconvenience to others which could affect existing relations is a negative aspect of social relation and could be a reason for the decision not to request help or to end it.

I asked Grandma Duen about the situation after her elder son died, knowing that financially she could not afford to sustain social bonding needed for continuing the practice of requesting help. She was also concerned that her requests could be interpreted by either Jib or Thong as demands for return of favors they owed her family or for the sake of long-time relationship. When I asked her the reasons she did not ask Thong to take her to the hospital. “I was afraid that he misunderstood and thought I was bothering him,” she replied.

The same reasoning applies to Jib whom she had made substantial investment in building good relations with. “After Din died, I didn’t dare to ask her anymore for help. I was afraid she might think I wanted her to pay back. I didn’t ask her to return the money she borrowed from Din.”

Whether inconvenience or suspicions her requests may cause, they represent negative signs of deterioration in good relations which Grandma Duen wanted to avoid and thus decided against asking for their help.

Sense of Powerlessness

Grandma Duen’s dependence on her neighbors can be seen from her efforts to preserve her relationships with Jib and Thong as she feared that her approach for help would be misinterpret as demands for return of favors or imposing on them. That fear testifies to her sense of powerlessness which prevents her from demanding or negotiating for help from her neighbor despite the fact that her family used to help Jib and lend her money.

Conclusions and Recommendations:

Grandma Duen’s Strategies and Unavoidable Risks for Poor People

Grandma Duen’s story demonstrates the strategies used by poor people in a nuclear family in managing different forms of capital for care-seeking behaviors. When her elder son was alive, Grandma Duen’s family could earn enough income to sustain social bonding with her neighbors, which gave her access to medical service at a hospital which she thought offered better treatment for her health problems. Her case illustrates the point made by Bourdieu (1983, cited in Richard Nice) that to generate social capital one needs to make investment with other forms of capital.

The dependence of Grandma Duen and others in the community on economic capital, particularly money, to accumulate social capital resulted from the scarcity of natural resources which could provide them with food and dwelling. Unlike their counterparts in urban settings, rural people can convert resources available in the environment into social capital. Therefore, economic capital is the deciding factor for the success of social bonding for poor people in crowded communities even though it also requires time, energy and care for neighbors.

Because of their high rates compared to normal or minimum wages poor people earn, the so-called social expenses usually place financial burden on them and restrict their use of social capital for health care only to necessary cases.

The dynamic nature of poor people's lives which experience changes in social relations and status poses another hurdle to the building and use of social capital besides social expenses.

Changes in Jib's life put a distance between her and Grandma Duen whom she used to have close relations and readily help when requested. Her marriage to a man who was not eager to see her maintain good relations with neighbors convinced Grandma Duen that Jib was no longer a suitable person from whom she could request help. The situation rendered the social capital Grandma Duen had invested in her relationship with Jib unproductive. This supports the proposition that investment on social capital carries risks (Bourdieu 1983, cited in Richard Nice). As Bourdieu suggests, this could happen even at family level, this risk, in my opinion, is even greater in cases of poor families because they have inadequate economic capital to maintain close ties. In Jib's case, it means Grandma Duen would have had to spend a large amount of money to give her former helper the convenience and comfort she now enjoyed through her marriage.

Furthermore, changes in relationship on the part of those making investment can also heighten risks on social capital. The loss of her elder son directly affected Grandma Duen's reserve of economic capital needed for requesting help. It also affected the confidence of those from whom she used to requested help. Consequently, she delayed the use of social capital and reserved it for matters of greater importance in the future. In fact, she never had a chance to make use of this

capital again. The last chance Jib repaid Grandma Duen's generosity was when she helped organized her funeral when the elderly woman passed away and carried her photograph in her funeral procession.

Many would express doubts if poor people's decisions to stop asking for help from their neighbors and thus deprive themselves of access to medical service at hospitals are economically rational. The life stories of some of these people reveal their lack of capital of all types other than social capital, but even that seems to carry unavoidable risks. Given this situation, their stories contribute to our understanding of rationality from their perspective, which may disagree with others.

Rationality of Treatment Choices

Decision to End Requesting Help and Economic Rationality

Grandma Duen's decision to stop asking for help from her neighbor Jib indicates that she valued their good relationship more than the benefits of having the woman accompanying her to the hospital as before. Holding this reasoning against the principles of economic rationality to answer the question as to whether her decision is rational, I found that Grandma Duen did not aim for the maximum benefit but opted to accept risks on her use of social capital despite the fact that her family had made considerable investment in its bonding with Jib by returning her help with handsome amounts of goodwill money and giving other support including lending her money.

Grandma Duen's Rationality

While Grandma Duen did not calculate for the maximum material gain, her decision was based on the value shared by community residents – that is, the preservation of social relations for mutual help in the future – as she often said that it is important to reciprocate the generosity of those who helped.

I also found that social relations are crucial for Grandma Duen and other poor people in the community in helping them to get work or jobs especially when urgent needs arise.

Although social capital carries risks of bad return as a result of changes in personal life, social status or economic situation in either the receiver of help or the helper, it could be the last resort for those affected by these same changes. For

example, after her husband died, Grandma Duen was able to earn her livelihood by getting help from a neighbor who taught her how to harvest and sell wild vegetables. She also asked a friend elsewhere to take care of her younger son when he was a novice monk. Other old friends of the family offered them assistance at those difficult times.

Grandma Duen told me that while her elder son spent his last days in the hospital, his friends regularly paid him visits and kept watch on him until his untimely end. Because of her inconvenient conditions, she could not go to the hospital to see or keep watch on her son. When he died, Grandma Duen's neighbors lent their hand to arrange for his funeral, just like his father's. "I got all the help from his friends. The funeral's expenses were costly. Fortunately, he left some savings," she recalled.

When Grandma Duen decided to stop asking for help rather than risked her relationship with her former helper, she replaced hospital medical service with self-medication as her treatment choice. She would have considered other options such as asking help from another neighbor to take her to the hospital if she had known the drawbacks of self-medication. She was not aware that she did not get all the medicines she needed. Or if she had known that the quality of medications available at the pharmacies in the vicinity of her community were not appropriate for health condition, she would have had someone buy them from other drug stores. In fact, from her experience, she knew that pain killers which worked better could be more expensive than those of low quality and only available at drug stores not very near to her place. But without other candidates as resourceful as Jib or with whom she had good ties, Grandma Duen had no other choices but self-medication, which seemed the most practical and to some extent satisfactory even though it was not cheap.

From the viewpoint of economic rationality, Grandma Duen's decision appears irrational, but it reflects appropriate ends for poor people like Grandma, for whom the preservation of social relations is meaningful and crucial. From their perspective, her decision on treatment choices has rational ends.

Self-medication for Chronic Diseases: Problems of Irrationality or of Health and Drug Systems

The life story of Grandma Duen could help practitioners in the health professions gain better understanding of poor people's reasoning and rationality. This knowledge would be useful for efforts to address systemic problems inherent in the country's health care and drug systems.

As a treatment choice among poor people with diabetes, self-medication has posed problems of cost-effectiveness for the overall health investment since improper and ineffective use of medicines could lead to the aggravation of the diseases or complications which could be harmful to patients' well-being or even fatal as in Grandma Duen's case. What happened to her is instructive in explaining why the population's average life span remains problematic despite the country's per capita investment on health care. The failure of the health care and drug systems in addressing the urban poor's health problems has contributed to this problem.

From the medical viewpoint, self-medication poses many problems ranging from incomplete sets of medications; lack of proper instructions on treatment, the kinds of medicines needed or their dosage; the absence of tests on sugar levels in the blood. These services are not available at a large number of drug stores, even those in Bangkok areas, not to mention that many of them have no pharmacist on duty. The existing drug system offers no recourse to people having problems in getting secondary health service at hospitals. The local pharmacies, which were the nearest and most convenient providers of medical help for Grandma Duen, could have done more to address her immediate problems or persuaded her to occasionally seek primary health care service at the local heal center as I did.[19]

Even though the secondary health system offered Grandma Duen treatment of better quality, the procedures involved in hospital visits were too complicated for her, and the inconvenience eventually denied her access to the service. The problems she confronted reflect the system's lack of sensitivity and failure to reform its service to become more patient-oriented. Low-income users and the urban poor, who are at

[19] I coordinated with the center and requested house visits for Grandma Duen by a pharmacist and a nurse who took blood tests for sugar levels and brought her the prescribed medicines.

disadvantage in social, educational and economic status, deserve greater attention from the hospitals. Improvements particularly in information, attention and hospitality from hospital staff towards patients in these groups would do great service and enable people like Grandma Duen to benefit from the secondary health service with less need for the company of resourceful helpers.

In addition to complications from diabetes, the omission of hypertension medications might partially contribute to the stroke that killed Grandma Duen. This omission resulted from inattention or ignorance on the part of the pharmacies, which failed to ascertain the kinds of medications she was prescribed by the hospital or simply lacked the knowledge about them. Moreover, her body reaction to steroid intake from Dexamethasone (5-10 mg), which she took every day for more than 2 years, could also aggravate her condition since its administering abruptly ended when she was hospitalized. When I visited Grandma Duen, she had already been in the hospital for five days. The doctor in charge of her case informed me that the neurosurgeon had an opinion that an operation on the areas where her blood vessels ruptured did not pose high risk. But it never took place because the doctors decided against it citing her old age as reason, and her relatives agreed with the decision. Her sister from Khon Kaen told Grandma Duen's younger son it was better to let his mother depart peacefully. Even if she survived the operation, she would probably be paralyzed or comatose. It would only prolong her suffering and burden the family, her sister reasoned.

It is not possible to tell to what extent Grandma Duen regular intake of steroid has contributed to the worsening of her condition following the stroke or obstructed her recovery. But the availability of drugs which are of inferior quality and potentially harmful but can be readily purchased at prices as cheap as children's sweets has made them attractive choices for those facing problems in getting access to medical treatment by doctors even though they could endanger the lives of people like Grandma Duen and other patients with chronic diseases. The result of this study points out an urgent need to redress the flaws of the country's existing system of delivery and distribution of drugs. It demonstrates that the reasoning and strategies on which poor people's health-seeking decisions are based agree with their economic and

social conditions and thus rational from their perspective. Yet those strategies are limited by options available to them, and thus are not independently determined.

CHAPTER VI

CULTURAL REASONING OF SELF-MEDICATION AMONG POOR PEOPLE: A CONTEXT-SENSITIVE AND RELATIONAL RATIONALITY

Introduction

The difference between ordinary people's reasoning about illnesses and scientific explanation in modern medicine has been generally recognized in medical behavioral sciences as a major cause of problems in health behaviors in three areas: 1) adoption of preventive health practices 2) selection of treatment choices including self-medication 3) adherence to treatment recommendations (Rosenstock, 1974; Lieban, 1976; Dressler, 1980). This assertion, shaped partly under the influence of science on modern medicine, has become the basis of many studies in this field which hold that lay people's thinking and beliefs are incorrect, irrational or unreliable because they are not based on empirical evidence or unable to be verified with scientific methods (Good, 1994).

This scientific thinking not only rejects lay people's thinking and beliefs as realities with their own distinctive epistemology which does not necessarily agree with scientific knowledge but excludes conceptions of rationality other than those which can be scientifically proven.

The reliance on scientifically or empirically proven facts has narrowed the definitions of rationality to those which are understood exclusively among scientists themselves. Rescher, who points out the concept's complexity and its multiple connotations in view of philosophical principles, objects to the narrow definitive interpretations by academics in each specialty or discipline as he puts it:

> For the logician, the avoidance of inconsistency is seen as rationality's be-all and end-all. For the economist, it is efficiency in the pursuit of chosen objective. For the decision theorist, it is cost-benefit. …In fact, rationality is something far-reaching and much-inclusive… (Rescher 1988: preface).

Also inherent in these definitions is the superiority of science over other forms of reasoning which are generally regarded as lesser rationality unless they can

be scientifically validated. This view is rejected by philosophically oriented sociologists and anthropologists whom Tambiah calls relativizers or splitters and sumps up their thinking on rationality as follows:

> There can be multiple "rationalities", different "language games," "forms of life" (Wittgenstein) or "styles of reason"… and some of these can be incommensurable activities. It is therefore necessary to postpone, and to hold back as long as possible, from a too hasty application of rationality criteria that may not be appropriate. (Tambiah 1990: 115-6)

Tambiah, however, does not rule out the possibility of comparing two reasoning systems. Although a comparative study could be made on people's reasoning in two different socio-cultural systems, it must be done with great care under "ground rules" which facilitate the comparison. A study as such could possibly reveal that they are "truly relative rationality" and that the issue of superiority or inferiority is irrelevant. And, as the relativizers suggest, "they are best treated as incommensurable." On the other hand, the result could be the opposite – one reasoning system either superior or inferior to the other. Hence Tambiah proposes that before an assessment can be made on whether one reasoning system is inferior to or less rational than another, it is crucial for someone who makes the interpretation to conduct a relativity test on their own views in relation to each of the two types of rationality.

In this chapter, I will examine cultural reasoning of self-medication, its rationality from the viewpoint of poor people and its relativity with those of other social classes or perspectives.

In looking at cultural reasoning, I focus my attention on macro-structural factors or the so-called objective culture, which has been overlooked in cultural studies as they have taken greater interest in subjective culture – people's beliefs and knowledge. This emphasis has drawn criticism from academics that are of the opinion that the definitions of culture used in cultural studies on illnesses are too narrow[1] (Good, 1994) and that research in medical behavioral sciences has opted to focus attention on analysis of micro-cultural factors at the expense of macro structure.

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[1] This criticism also applies to medical anthropology, which favor the use of cultural theories more than any other discipline in applied social sciences.

The tendency to ignore objective structure has led to a dominant view in behavioral analysis that blames the victims rather than sympathizes with them or acknowledges that social behaviors including subjective culture are the products of the victims' reaction to structural problems. (Carlson, 1996; Janzen, 1978; and Morsy, 1990) I gathered the information on experiences in illness management from more than 20 elderly people. By focusing on people who frequently suffered from illnesses, especially severe or chronic diseases, as they reached or entered old age and who opted for self-medication instead of visiting physicians, I intend to find out about their reasoning for these behaviors, which are often considered irrational from the health professionals' point of view.

The life stories of these poor elderly people reveal that their decisions to buy medications for themselves are based on the preservation of social relationship at family level, which constitutes the same reasoning that they apply as a guiding principle for their everyday life activities. During my investigation and interpretation, I found that this reasoning, however, differs from the set of reasons they previously used to justify their practice of self-medication when they were still of working age. Thus I gathered illness experience of more than 10 people of working age presented in one of significant finding.

In this chapter, I argue that in considering the rationality of poor people's decisions, it is imperative to understand the relativity of rationality from their viewpoint and from the interpreter's or those of other social groups which the interpreter want to compare with. Additionally, this relativity test should be done with great care as Tambiah suggests. It is important to make sure that the interpreter does not apply his or her own perspective as the basis of the interpretation as in the case of scientific research which relies on empirical studies in determining rationality. In other words, any pattern of reasoning represents rationality for a particular group due to its socio-cultural context and life situation even though it may differ or deviate from what is generally accepted.

Before getting into the biographical account of a chronically ill elder people, I will present the ground rules proposed by Tambiah for comparison of rationality of one belief system or mode of action with another in order to use his concept for

further discussion of how to interpret rationality and test its relativity. Tambiah (1990: 131) states the ground rules of comparison as follows:

1. No comparison between two phenomena is possible, without "a base of agreement" between them, from which meaningful disagreements or differences can be projected.
2. The most straightforward case of comparison is where S1 and S2 (the systems to be compared) exclude each other by virtue of proposing conflicting consequences or implications to the same issue or question, which constitutes their baser of agreement.
3. If there is some straightforward decision procedure by which the efficacy or truth of the positions of S1 and S2 can be decided, then relativism will have been banished, and either S1 and S2 can be declared to be superior or rational, and the other inferior and irrational.
4. A truly relativistic outcome is one in which the formulations of both S1 and S2 are alternatives to the same problem, in that their formulations, untenable or implausible or inefficacious, such that neither side sees a necessity to abandon its position as inferior.
5. When two phenomena should not be compared at all because their presuppositions are different, and they constitute two different "forms of life," then there is no basis for setting up the relativism at all.

The life Story of Grandma Tew and Her Extended Family

My first encounter with Grandma Tew is still vivid in my memory. The 65-year-old woman was the first key informant whom I met and developed close relationship with during the period of six months of my field study. I came to know her at the introduction of my escort, who is a close friend of one of her granddaughters. It was already dark when I set out from the escort's house, which was 100 m from Grandma Tew's place.

I walked on a curvy concrete road lined with houses densely built on both sides. When I made a right turn into a narrow lane, the sight of the surrounding houses indicated that they belonged to close relatives even though there was no gate at the entrance. The path, just over 3 m. long, ended in front of the two houses sitting next to

each other. The one on my right hand was two-storey, and the other was one-storey, with the sizes of 4x4 m. and 3x4 respectively. The owner of the larger house was Nan, who was one of the daughters of Grandma Tew's elder sister and a principal member of this large family. The other belonged to Nan's sister. Immediately on my left was another house which faced the walkway and looked more like a shed because it was only 3x2 m. and walled with corrugated iron on all sides. Grandma Tew lived in this house, which was owned by another of her nieces. There was the fourth and last house, but it belonged to a neighbor and looked out to the concrete road.

Grandma Tew was on the floor trying to stow away a few large pots she just finished washing when I walked in. After our introduction and greeting, I squatted on the ground to avoid towering over her – a gesture considered impolite in the presence of someone your senior. She told me the family just finished a merit-making ceremony to mark 100 days of the death of her niece who died of heart failure.

While we were talking under the dim light, I spotted 3-4 rodents scurrying to collect food scraps left on the ground in front of the house. Hardly deterred by us, they took the food in their mouths and hurried back under the floors of the next two larger houses, which were elevated more than 1 m above the ground. During my visits to this house during the next 6 months, I got acquainted with these mice especially the ones that came very close to the elderly woman to get their food.

In the first month of our relationship I found that Grandma Tew's shabby house belies her status as the head of this clan. Everyone gives her respect and takes good care of her. When her five grandchildren of the age between 7 and 10 get too naughty playing together in the walkway, Grandma Tew's scolding commands their obedience even though none of them are the offspring of her own child. They were born to the children of her elder sister, whose family moved from Sena District of Ayutthaya province to settle in Bangkok more than 30 years ago before Grandma Tew and her only son joined them later. When her elder sister passed away several years ago, she became the family's eldest member. Her son lives with his wife's family two lanes away in the same community. He needs not to provide any care or support for her even though he and his children drop in on her frequently. The house Grandma Tew is now living in belongs to one of her nieces.

Despite going 65 and her white hair, Grandma Tew looks younger than many women of her age. With her light skin, a smile always flashing on her powder-stained face, and a clearly articulated, loud voice, Grandma Tew appears in almost every bit physically and mentally healthy. Hearing her commanding voice ordering children running around in the walkway to keep their noise down, to come to greet me, or to bend low when approaching adults, one would not know that she has been afflicted with several illnesses.

Illness and Treatment Experiences

It took me nearly three months – duration twice the time I usually spent in other cases – to discover all the illnesses from which Grandma Tew suffers, their severity, the treatments she has had. Most of the information was given in her response to my inquiry about her conditions or what I observed – for instance, when I spotted Chinese medicinal plasters on her temples – rather than volunteered by her. Always asking to see the medicines she was taking when I paid her a visit, I often found either changes of medications in the set or the addition of new ones. I also followed up with the chronic wounds she had on her feet. The only health problem that she volunteered the information and asked for my advice was about her sight.

Seeking Advice on Eye Treatment

On our fist meet, she told me about her sight problems. “Recently, my sight’s got bad,” she said, adding that one of her nieces would take her to see doctors. However, she did not say how severe the problems were but asked for my advice on the choices of treatment regarding their costs and safety, which were her major concerns. She was informed that if she went to her designated hospital – a private one – for an eye operation she needed, the Universal Health Insurance Program would not cover all the expenses of such treatment, and she would have to pay for the amount exceeding the coverage’s limit plus for the lenses. This happened to one of her nieces when she used her benefits under the Social Security Fund, another heath insurance scheme. Another of her nieces, who also registered under the Universal Health Insurance coverage, died less than four months ago while receiving treatment at this

same hospital. That experience has shaken Grandma Tew's confidence in the quality of service provided by the hospital under both health care schemes.

Later I learned that Grandma Tew went through a lot of trouble over the past year to prepare herself to get treatment for her vision problems. She applied for a new ID card after having lost one many years ago. She hired a car to go to Ayutthaya to fetch her only sister alive to Bangkok to verify her identity at Klong Toey District Office. She needed the card for her registration for the benefits from medical care for the elderly under the Universal Health Insurance Program. With the help from her nieces during the past six or seven months, she completed the process of her registration. Though now equipped with both cards, Grandma Tew still wanted more information while she was waiting for one of her nieces to be available so that she can accompany her to receive treatment at the hospital.

I mistook her delaying of the visit to see an ophthalmologist at the hospital and her wait for her niece as indications that her eyes' conditions were moderate and in no need of immediate medical attention. Perhaps I was more concerned with her feet wounds and thus not earnest in asking about her sight. Three weeks after we met, I learned that her blood pressure was 230 mm.Hg. When I urged her to go to the local health center for treatment of hypertension, she showed more interest in seeing oculists for her eye problems.

The severity of her sight problems came to my attention when I learned that she had difficulty in differentiating between the medicines that doctors prescribed for her high blood pressure if they were not clearly distinct in size or color. She put these medications in boxes of various shapes and sizes – some with labels others without – from which she could tell one medicine from another by touching.

As for 4-5 medications she was given by the health center, she kept them in separate containers of the same shape. The label of each one was removed from its original bag and stuck on the side of the respective container. By touching the labels Grandma Tew could tell that they were the medicines from the center. She showed these containers to me with such deftness that I was mistaken that her vision was still good enough to tell one from another, and that she needed no help when taking the medicines.

What I did not know was she took one pill from each container once a day without knowing the differences between them and their uses. When I urged her to double the dosage of medicines for hypertension as her doctor instructed, she simply took the medications from all the containers – including diuretic which she needed only once in the morning – twice a day. Only when I discovered about the gravity of her impaired vision and deformed hands and informed her family of it that Grandma Tew accepted that her sight worsened to the point that she needed help and agreed to let her nieces arrange the medicines for her to take. She admitted for the first time that she could not even recognize the face of her 7-year-old granddaughter whom she had raised since her birth or distinguish the child from other children of comparable age.

Deformity of Grandma Tew's Hands

Although I knew that Grandma Tew's had problems using her hands, I was not aware that her fingers were actually deformed. She still bore marks left by leprosy, which mutilated part of her right toes. She had a large chronic wound on her right sole. The disease contorted the fingers on both of her hands, bending them towards the palms with such stiffness that made her right hand not usable. I hardly had a chance to take a good look at that hand because she mostly used the left one to touch, hold things such as medicine bottles which she kept in a basket, or show them to me. I began to realize the problem of her hands when I brought boxes of unusual shapes for her to store her medicines so as to tell the distinction between those to be taken in the morning and the evening and those to be administered once a day. When I saw that Grandma Tew could not hold the containers when I handed them to her or open an oval-shaped plastic pillbox, it dawned on me that she had great difficulty in using her hands. When I asked her to demonstrate how she took the medicines, I found she struggled to open each box, using her body to help her impaired hands. She then tapped the box gently until it dropped 1-2 pills into the lid placed upside down. To take each pill, she touched it with the tip of her tongue and rolled it into her mouth. She did all these things with great efforts.

Earlier, when I found dirt in her pill boxes, I wondered how they got there in the first place and thought the specks could be leftover from her herbal medicines.

Tuk[2], one of her grandchildren and caregiver, thought otherwise, suspecting that some of them might fall off from the broom. In light of her handicap, when she dropped some pills on the floor, she would probably sweep them and everything else and put back to the boxes. It explains why I often found pills or food scraps left on the floor, which attracted mice to her house to collect food or eat the leftover from bowls which were not well-covered.

All this time Grandma Tew had hidden the severity of her sight and hand problems from her nieces and nephews. She tried to get by on her own – caring for herself, walking to take a bath, cleaning the house, washing her own and grandchild's clothes. She did not even tell them about the high blood pressure she had had for many years.

Self-medication for High Blood Pressure

Her family and I discovered that she had hypertension when she received a medical check-up provided as part of the celebration of the anniversary of His Majesty the King's birthday on December 5, 2005. Her granddaughter Tuk, with Grandma Tew sitting next to her, told me:

> A few days ago I took Grandma for a check-up. The doctor said her blood pressure was 230 mm.Hg. The doctor insisted Grandma should get treatment at the health center right away.

The news startled me. When I tried to press for details about her condition, she seemed not disturbed saying that she had had high blood pressure for years

> Long ago, twenty years back maybe, Father Myer[3] had a doctor coming with him to check me up. The doctor told me to get treatment but I never did. I just bought medicines from a drug store in Khlong Toey market for myself. Veera, that's its name. I stopped to buy medicines on my way back from work. Four sets of medications, five baht each. Four sets would last for quite a few days. I didn't take them every day. I used them only when I got a very bad headache.

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[2] One of Nan's nieces and Grandma Tew's grandchildren, Tuk does not work and stays home to raise her one-year-old daughter. Nan assigned her the responsibility of receiving me on my visit. If she was present, she often added information on the topic of my conversation with Grandma Tew.

[3] A German missionary, Father Myer founded Mercy Center to provide assistance in various aspects for needy people in these congested communities for more than 30 years. Programs to help children and people with AIDs are currently among the center's main activities.

Grandma Tew used to mention about her headache and a cracking pain around her eyes, which she treated with Chinese medicinal plasters stuck on her temples, but I never made the connection between that and high blood pressure. The elderly woman thought the headache and pain were major symptoms of high blood pressure and opted for self-medication for more than 20 years. For the past ten years, she has bought sets of medications for her headache from a nearby pharmacy. She told me about this drug store.

> The couple at that store, both husband and wife are doctors. The woman is a midwife. The delivery room is on the second floor. Many people visit the place. A lot of women are waiting there for their deliveries.

When I checked out at the drug store, I found no pharmacist on duty for the entire day. Grandma Tew must be mistaken that the keeper was a health personnel.

Grandma Tew told me more about her high blood pressure.

> When I still worked as a bricklayer, my headache could be very painful and my noses would bleed profusely. After a while the pain would subside, and I would feel okay again. The last time it struck me was when I was do plastering work, my noses bled so bad that I needed two handkerchiefs to soak up all the blood and several bowls of water to wash it off the spot on the site. That made me quit being a bricklayer for good.

Grandma Tew must be well aware of how severe her problem of bleeding noses was, which was why she decided to stop working away from home for almost 20 years. I could not help but wonder why, in spite of her condition, she did not seek treatment at hospitals or go to see doctors as recommended by the doctor who came with Father Myer. I did not press for the answer in forthright manner lest she felt that she was to blame or she made a mistake in buying the medicines for herself. In the second and third month, I tried to find the reasons for her self-medication in addition to what she already told me and urged her to visit a doctor as soon as possible.

In the meantime, I came to know by chance that Grandma Tew was also on heart medications she bought for herself.

Buying Cardiac Medications for Chest Pains

In a period of more than two months during which I visited and looked after Grandma Tew's medications for her high blood pressure, I learned about her sight problems, hand deformity, and difficulty in going about her daily activities. For that

reason, I had mistakenly believed that I was well-informed about her illnesses and treatment until I found other two medications, 5-6 pills each, in her medicine boxes. It prompted the following exchange:

I: "What are these medicines for?"
Grandma: "For heart condition and chest pains."

Dumb struck by her answer, I tried not to show my surprise or concern in my voice

I: "Grandma, where did you get them?"
Grandma: "From a drug store near here. I bought 10 pills at a time, twenty baht each. The red pills are heart medications, the white ones for chest pains."
I: "How long have you taken them?"
Grandma: "I have bought them several times already."

When I took a closer look at the pills, I was almost certain that the red ones were Propanolol 10 mg. The white ones looked similar to Digoxin 0.25 mg, a potent drug for heart condition which is to be administered with care and prescribed by doctors only. I explained this and asked her to stop taking this particular medicine until the information on its uses was checked out – the request which Grandma Tew readily complied.

I paid a visit to the drug store and asked the keeper to show me the container of this medication. It turned out to be Oxyphencyclimine 10 mg, an antispasmodic – a medication for relieving the contraction of ulcer or intestine muscles. The keeper was told to sell this drug to customers with knowing the differences between chest pains caused by digestive disorder and those from a heart condition. I felt relieved it was not the medication I suspected but saddened by the way the drug store dispensed its medicines carelessly. Fortunately, the store, which was a branch of a larger pharmacy one kilometer away, carried a rather small inventory of medicines, compared to most pharmacies selling modern medicine since it catered to slum residents and those living in more than 10 blocks of National Housing Authority flats in the neighborhood.

Grandma Tew recounted how listening to a night radio program led her to conclude that she had a heart condition. The monk who hosted the program suffered from hypertension and a heart disease. Talking about the balloon operation he underwent, the host urged his audience to have regular check-ups on their heart

conditions. “The heart beats strongly and loudly. Tuk, tuk, tuk…” Grandma Tew quoted the monk’s description which she found resembling to the symptoms she frequently had. Her self-diagnosis prompted her to buy medicines to keep what she believed to be a heart condition in check.

Additionally, she heard about what happened to two of her neighbors who were around her age and had high blood pressure. The first elderly man fell into unconsciousness and was hospitalized before recovering in a few days. The second one failed to make it to the hospital soon enough for doctors to save his life. “That scared me a bit,” she said with a chuckle.

I was not sure if Grandma Tew knew the differences, similarities or connections between the symptoms and complications of heart diseases and those of high blood pressure. It was quite clear, though, that she believed both types of illnesses were severe and life-threatening even though she chose to buy the medicines for herself instead of seeking treatment by doctors as recommended by the monk. Grandma Tew’s case offers a reminder that the decisions made by patients who are aware of the seriousness of their illnesses but still opt for self-medication do not necessarily result from their ignorance, neglect or fearlessness. There must be other reasons which compel the patients to adopt this practice.

Difficulties in Visiting Physicians: Chief Reason for Grandma Tew’s Decision on Self-medicated Treatment of Hypertension

I came to realize the difficulties Grandma Tew would have faced if she followed my advice that she go to see physicians for treatment of her high blood pressure. For a starter, a taxi would cost her 80 baht for a visit – an insignificant amount for a middle-class family but a substantial sum for a person with no income like her. Nan gives her aunt a daily allowance of 25 baht for food - an amount from which she saves some money to buy her medications. Nan sets aside 200 baht each day, which is enough to provide two and a half meals – breakfast, lunch and part of dinner – for 7-8 people in her care. Her elder sister brings back some food from her workplace, where she works as a cook, to complement the dinner.

Traveling expenses is a major hurdle for more than 10 out of 20 elderly patients whom I interviewed. Although the local health center is less than one kilometer from the community, the patients invariably need to hire a car or take a taxi to get there and paid for such service in an amount larger than half of the average wage. Even for families with no sick people to care for, they barely make ends meet with income based on this rate. When an elderly member with no income or savings gets ill, he or she would become a heavy burden to their children.

In addition to traveling expenses, most elderly patients failed to get treatment because their children cannot afford time to accompany them to visit the health center. But that would not be a problem in Grandma Tew's case since she has nieces and grandchildren who look after her well. Her granddaughter Tuk, who quitted her job to raise her child, is available and suited to the task. Given these advantages, Grandma Tew was in a better position than many elderly people in the community who lack money to pay for travel costs as well as children who can take care of them.

With no hesitation I gave Grandma Tew money for taxi and other expenses in an amount sufficient for her to visit the health center at least twice. I could not help wondering had I not covered the expenses for her whether she would have gone to see doctors immediately as I advised. What was more important than my curiosity was that further delays for treatment could endanger her life. My major concern was that her blood pressure was in the so-called hypertensive crisis, which put her at risk of fatal stroke.

Apart from offering to cover her expenses, I pointed out that by visiting the health center she would be able to consult physicians about treatment of her eye problems. She showed reluctance to accept my offer, saying she did not want to bother me. When I told her that I was willing to help her and that it caused me no problem at all for that amount of money, she agreed to the offer. I could not discern any signs that she dreaded the prospect of seeing doctors, which indicates that at present travel expenses was a reason for her to decide against it. But what could be other reasons that made her give up the idea previously. Could it be that she had the stigma of having leprosy once?

I used to give some thought about that possibility because one can recognize the marks left on her body – a slight dent on the bridge of her nose, the fingers on her right hand folding fast, her right toe missing. This appearance could deter her from meeting people or going to see doctors. But when I saw she was enthusiastic about a visit to the health center, I doubted if embarrassment was the real reason for her not seeking treatment by physicians. Besides, she told me that she hardly cared if people gossiped about her and that she knew that people may feel revulsion out of their fear of contracting the disease.

Whether the history of being a leper had any bearing on her decision or not, having slightly disfigured appearance and chronic wounds on her feet apparently made her avoid meeting people and socialize only with close neighbors. After quitting a bricklaying job, she hardly attempted to get work outside. Rather, she stayed home and did odd work mostly not to earn herself income but to help out her family. She had raised several of her grandchildren since they were small. For the last few years, she has helped Nan and her sister cook and sell foods on weekends. She hardly ventured beyond a short distance of 30-40 m between her house and the concrete road except on every Saturday, Sunday and Buddhist Sabbath on which she went as far as the community's main road, some 100 m. away, to offer foods to monks. Asking long-time elderly residents living on other lanes in the community, I found almost none of them knew about her.

The stigma of being a leprosy patient could be considered a cultural reason as, in Grandma Tew's case, it has influenced her way of life and daily activities, making her a reclusive person with regard to her relationships with neighbor. However, what I want to examine is cultural reasoning of poor people in Thai societal context. Thus my task is to look for hidden reasons, particularly cultural reasoning for the practice of self-medication among needy people like Grandma Tew.

Cultural Reasoning of Self-medication for Treatment of Headache Caused by Hypertension

One of my research questions is to find out about cultural reasoning for decisions by poor people who seek treatment through self-medication. In Grandma

Tew's case, I focus my attention on the treatment of her hypertension and chronic headache. Grandma Tew herself is aware that they are serious illnesses and the causes of the bleeding of her noses, which led her to quit her job. Her acknowledgement that the medications she bought had temporary effects in relieving her headache indicates that she also realized that self-medication might not be the best solution in the long term.

Through my observation of the pattern of her daily routine and her attitude toward illnesses I found an underlying principle on which she based her conduct in living her twilight years as part of an extended family, as expressed in her own words: "I don't want myself to be a burden to my children."

She had kept the severity of the problems of her sight and deformed hands from the knowledge of her nieces. In spite of physical difficulties, she tried to go on with her daily routine – house cleaning, doing laundry for herself and a grandchild, tidying up the place, taking medicines – as normal. She refused to let her nieces or grandchildren to help with tidying up. One of her grandchildren told me:

> Grandma always tells us not to mess up her things otherwise she cannot find what she looks for. Anyone tried to meddle would earn himself scolding for a few days.

This reminded me of the impression I had in the first few weeks during which I started paying her visits and found her room in a messy condition as if she was neglected by her children. In fact, it was her who did not want to ask for their help.

Food was another matter which she did not want to "burden her children."

> The children always worry about me and buy some foods for me. When they asked me, I would say 'I ate already. I'm fine.' I don't eat so much, only a little. I don't want them to worry or waste their money on that.

It explains why she left her foods in the tray for most of the day. Sometimes I saw rats came to feed themselves from leftover in dishes which were not well covered. It is evident that Grandma Tew saved the foods from one meal and carried them over to the next ones for herself or for her grandchildren when they come back from school.

Grandma Tew went about managing everything from her food, living condition, and daily activities to her sight problems in the same direction – that is, not to add trouble to her family. Her deteriorating vision, however, could be more troublesome than other matters since it requires medical treatment in addition to care and help from other family members.

She was afraid that if her family had known about her difficulties, they would have gone to a lot of trouble to make sure that she received proper treatment as soon as possible. There are grounds for her concern though. I recognized in her nieces their real concern and willingness to intervene and look after her health and illnesses despite their financial situation and debts.

Their caring was most evident in their efforts to find medicines to relieve her headache. I found that Nan bought her aunt several kinds of medications. Even though some were quite expensive, the woman did not hesitate to purchase medicines which her employer or friends recommended. One of these medicines was Ponstan, a commercial name of pain-killing Mefenamic acid 500 mg. One pack (10 tablets) of it cost almost 100 baht since it was an original drug, whose price usually is many times higher than a generic one.

Nan also bought Vitamin B 1-6-12 in addition to other food supplements for her aunt to take to improve her sight and headache.

Importance of Not Burdening Family

The financial situation and debts were the issues of great worry for Grandma Tew and other grownups in the family. She and her grandchild Tuk said Nan had to shoulder most of the family's expenses on raising her own child, nieces and nephews and giving them education. Tuk herself was supported by her aunt until she completed Matthayom 3 education. Grandma Tew spoke about Nan with admiration: "She put everything on her shoulders. She is the pillar of the family."

Having only one son, Man lost her husband who died of AIDS over a year ago. She works as a maid at the office of an architecture company. Because of her long experience, her trustworthiness and working overtime, she got paid higher than an average office maid. For a person who never completed Prathom 4, Nan earned

quite a good income compared to those with the same level of schooling. Yet she still had to borrow from some neighbors to support her family. This borrowing was known to and discussed among all adult members of the family[4]

Younger Generation's Support

Nan devoted herself to supporting everyone in her family and took great pride in helping out her brothers and sisters by taking some of their children under her wing. She said to me:

> I'll never let my children starve. I'll do my best to give them education even if it means I have to borrow from others.

This tradition of mutual assistance among brothers and sisters runs in their family. Grandma Tew recalled the days when she was a young woman, and that atmosphere prevailed in her family too. Now the younger generation, under Nan's leadership, follows in their footsteps, and seems to pass that tradition on to their children. Nan's nieces and nephews are pooling their money to build a new house for their grandmother. Their contributions depend on their financial resources. Those who have less in terms of money put in their labors. Tuk, for example, takes care of house chores and look after other family members like Grandma Tew or Nan's husband when they fell ill and needed to stay home or at a hospital.

Mutual Help and Support among Grandma Tew's Siblings

Grandma Tew recounted how her siblings cared and supported each other. A native of Ayutthaya province, she was the youngest of her parent's five children. When her father died, the rice land which was supposed to be given to him was taken away by her uncle. As everyone in the family faced hardship, her two brothers and a brother-in-law came to Bangkok and found work as bricklayers. One of her sisters got married and left the family to live with her husband. Then young Tew lived with her mother, a cousin who was in school and her brother's children. She earned herself a living by raising pigs and had a responsibility of caring her mother.

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[4] Recently, Nan's elder sister lost the possession of her the one-storey house to a creditor due to her failure to repay a 50,000-baht loan. She claimed that the creditor unfairly seized her property since she already paid back more than half of the loan capital. The current value of the right of possession is at least 200,000 baht.

When she was seventeen, she suffered from *kluen nam tao*, a skin disease which is a sort of ringworm. Her brother took her to receive treatment at various places in different provinces. One of the healers prescribed herbal medicine for her to boil and drink the concoction. After taking the medicine, sores broke out all over her body. Since then she developed symptoms similar to those of leprosy. The quest for her treatment continued for more than ten years until her brother heard about a place in Phra Khanong in Bangkok where the doctors had expertise in curing this disease. For the next 4-5 years, she had to travel by boat from Ayutthaya to Bangkok to receive the treatment twice a month.

Following her mother's death, Tew moved to Bangkok and stayed with her sister. She kept visiting the doctors as appointed and continued to do so even after they told her she was cured. Tew stopped visiting the place only when the agency running the place moved its office to somewhere else. The sights of other patients who were disfigured or suffered severely from their diseases made Tew felt she was fortunate to have a caring brother who took her on a search for treatment in the early stage of her disease.

While Tew was at the receiving end of care and attention from her elder siblings, she did her utmost in taking care of their mother, tending to all her needs from food to other living necessities. Grandma Tew believed that because of those good deeds, she herself was cared well by her siblings, nieces, nephews and grandchildren.

In Bangok Tew lived with her sister and worked as a bricklayer. She improved and perfected her skills until she excelled at the job. She could work so fast that at one time she soundly beaten another bricklayer in a contest, finishing two and a half walls whereas the other could manage only one. She was employed by a large building contractor which undertook projects constructing large buildings or high rises in all parts of the country. She was paid well for the job, earning a wage three times higher than that of a laborer.

With that income, she was able to financially support her sister, who barely made ends meet raising her five children with her own meager income. Grandma Tew did not say for how long her support lasted and how much the total sum was. She

simply said: “I did not want my sister to borrow from other people because they would charge her for interest at steep rates. I could save quite a lot of money then, bundles of notes actually. I never regretted that; I knew how much she needed it. I always helped her out because she was really in need.” She offer all this help without being asked.

This spirit of giving and caring for each other which prevails among siblings and members of different generations – whether related by direct blood line or not – has cemented the bonds and unity among Grandma Tew’s kin. I saw happiness in her smiles, laughter and the way she talked light-heartedly about her illnesses and problems while she was telling her story. It is a testimony of her mental well-being, nurtured by being part of a happy family which she has played a great part to build.

Powerlessness as Reflected in Elderly is People’s Reasoning

I am moved by Grandma Tew’s willingness to live her life to give more to others and take even less from them. I have sympathy for many elderly people in the community who willingly live in austerity to avoid being a burden to their children. Their sense of powerlessness is reflected in the fact that most of them never ask to be cared by their children even when they are ill. No bargaining, no demand to be repaid for what they have done for their children. They would speak with joy just for the fact that their children could find time to take them to hospitals. Yet some semi-paralyzed patients cried with hurt feelings when I asked about how they were cared by their children. It saddens me to witness their living conditions, the lack of proper care and attention, and above all powerlessness that they feel.

Cultural Reasoning Relates to Different Life Situation in Working and Old Age

While I can understand cultural reasons on which Grandma Tew grounded her decision on self-medication in old age, I doubt if that was the case when she first learned about her illness – at the time when she was in her prime of working life, able to earn herself a living, to save some money and even to offer her sister financial support.

My inquiry into this point led to our conversation as follows:

I: "Why did Grandma not go to see a doctor as Father Myer suggested?"
Grandma: "Didn't do it because I didn't want to give an impression that I was weak."
I: "If they thought you're weak, so what?"
Grandma: "My co-workers wouldn't want to work with me. My employer wouldn't like that either."
I: "Did it affect your work that much?"
Grandma: "Yes, ours were laboring jobs If I'm on one day and off another, who would like to hire me. Their work would be compromised."

Grandma Tew did not want her illness or sick leaves to affect her work. Even when her nose bled, she rushed to wash the blood off the spot for fear that if other workers had seen it; they would have thought she was sick or too weak for the job. Grandma Tew cherished her job, feeling it was worth her efforts and hard work. The job gave her pride and allowed her to show off her skills in addition to providing her with good income. More importantly, she needed to hold on to the job. "I had many responsibilities and many children to feed," she said. The job sometimes requires the workers to leave Bangkok to work in other provinces for weeks or even months. In that case it was more convenient for her to buy medicines for herself.

Similarities between Grandma Tew's Reasons and Those of Other People of Working Age: Family Breadwinner and Asymmetrical Power Relation

Role of Family's Breadwinner

When I reviewed the reasons she gave, I found few differences between her and more than 10 people of working age with whom I discussed about self-medication. Basically, they center on their jobs knowing that they are their families' breadwinners, having children or parents to feed and care for. To manage their own illnesses, they need to find treatment choices which are not in conflict with their jobs. It means the choices must be convenient and time-saving even if they were costly or not covered by their medical care benefits. It is not unusual that these people refuse to go to see doctors if such visit takes half a day or a whole day even though many of

them were entitled to such medical service almost free of charge under the Social Security Fund or the Universal Health Insurance Program.

I would like to present a case of illness management and reasoning of a taxi driver – a job which appears to be independent and have the benefit of time flexibility which allows the drivers to take time off from their work with little difficulty.

Somphob, a taxi driver aged 43, worked a night shift. He arrived at the garage to check out his car at 4 pm. His shift started at five in the afternoon and ended twelve hours later. For over a year, he developed a swelling on one of his soles. The swelling had increased in its size and got more painful in recent months particularly when he was driving. He walked with difficulty because he could not drop his full weight on his feet. Although he was entitled to medical care benefits at a private hospital of his choice, he delayed his visit for treatment for reason that he did not want to take time off from his work. He was also afraid that if he had to undergo an operation to remove the tumor, he would need to stop working for a while. In that case, he would not be able to retain his right to rent the taxi unless he continues to pay for the rent and left the car idle while he was in the hospital.

His wife said Somphob liked the night shift because the air was cooler, and the traffic was less stressful. Her husband was a hot-tempered man and could easily get into a fight with other drivers if he changed to the day shift. Somphob was mulling over his choices. He was not sure he could find another garage from which he could rent a taxi if he lost the right to the car he now drove. He was stalling for time while he still found the pains bearable. If he suffered from severe pains, he would take one set of pain-killers his wife bought for their household to ease them.

Asymmetrical Power Relation

Grandma Tew and other poor working people realize their lower social status as cheap or unskilled labor. Although Grandma Tew have improved the skill in her job at excellent level but it is not much sufficient for bargain on taking her day off in order to visit a physician. Somphob is afraid that he could not find a new garage for renting a taxi if he lost the right to rent this taxi. In this respect, it reflects the asymmetrical power relation between the poor working persons and their employers.

However, in the agency approach, I found their strategies for making and keeping their being good status as much as they could do it.

Similarities between Grandma Tew's Reasons and Those of Working Elderly People

Grandma Tew's reasons for her self-medication were also similar to those cited by other elderly people in the community who still worked to provide for their families. Their worry revolves around work as in Grandma Lee's case.

In spite of her advanced age, Grandma Lee, 65, still needs to work to earn herself a living. She harvests wild *phak bung* (morning glory) and *phak krached* (neptunia) from swamps and other natural places and sell them at the market. She had three children. Her husband died for more than 20 years ago. Her eldest son, suffering from diabetes which has impaired his vision, needs to be supported by his wife, who has children from her previous marriage. Grandma Lee's second child, a daughter, lives with her third husband. She has four children from her first two marriages. At the age of 16, she gave birth to a son with her first husband before they separated. Grandma Lee has raised the grandson since his birth while her daughter went on to marry another man and had three children together. They broke up when their youngest daughter was 8 months old. The baby girl was put into Grandma Lee's care since. Grandma Lee's youngest son died of overdose while giving himself a shot of heroine. The elderly woman lives with the grandson, who is now in his twenties. He has a teenage wife who has yet to complete a high school and a one-year-old baby girl to support.

Grandma Lee learned that she had diabetes and hypertension three years ago, when she attended a medical check-up program for the elderly offered by the local health center. She did not receive treatment regularly. At one time she suspended her visits to the center for 6-8 months. The main reason that prevented her from seeking treatment regularly was her worry that she would lose income from her job. Although a visit for blood tests and waiting for prescribed medicines would take half a day, it means she could not make her vegetable-gathering round which takes her as far as Nong-Nguhao in the vicinity of Suvannabphumi Airport. On her usual

day, she leaves home around four or five in the morning and returns around four in the afternoon – a twelve-hour period during which she divides time between walking and gathering wild vegetables. Back home she spent a few more hours to trim and bundle the vegetables in order to sell them the next morning. When she was younger and the daily trip was shorter in distance, she went on her round everyday. I asked her why she did not take some days off to see doctors. She replied: “If I stop, how can I earn the money for our food?” Instead she purchases a medication to treat herself. “I buy this medicine, paying one baht for each pill. I buy twenty baht at a time, and they last several days,” she said. She takes this medication – Glibenclamide 5 mg (called “rice grain medicine” by her and others) – two pills a day as opposed to four recommended by doctors. The center also prescribed her Metformin 500 mg which is administered one pill at a time, three times a day. She did not buy this medication however because she was not sure if it was for diabetes. To manage her limited financial resources, she purchases the medicine by small amounts each time.

No sooner had Grandma Lee’s responsibilities in raising her grandchildren been relieved somewhat as they were big enough to get themselves jobs; her grandson added another load to the family. He dropped out from Matthayom 5 to find jobs and save money for a down payment on a motorcycle. He got himself involved with a teenage girl, and they have a one-year-old baby girl together. The baby was put into Grandma Lee’s care for her mother is not ready to take up the responsibility. More than two years ago Grandma Lee’s granddaughter left home when she was 15 to work as a cook assistant in Sriracha District of Chonburi province. She sent back 5,000 baht to her grandmother, who spent 3,000 baht out of this remittance to build a new bathroom and toilet. But the girl has not returned home or sent any news since.

Grandma Lee came to find work in Bangkok when she was 18 and since then has worked to earn a living for everyone in her family and raised her children and grandchildren. She has applied to this task with joy and willingness. She said:

> I raised them like a mother bird nurtures her babies so they’ll grow up to be on their own and to earn themselves a living. I hope that they would have enough to eat or spend and that they would have easier lives than ours.

While her job as a wild vegetable gatherer is independent, the responsibility of supporting and feeding her grandchildren is her top priority. Thus she does not

want to take even a single day off. Grandma Lee has very few personal belongings – an old rice cooker and a couple of bowls and dishes. She has no savings and no money for house repairs. Repaired with funds supported by Duangpratheep Foundation 6-7 years ago, the corrugated iron shed she is living in has fallen into decay and could possibly collapse as termites eat away its wooden poles. Her work means a great deal for Grandma Lee and her family as it is their only hope to sustain their livelihood as expressed in her own words: “If I stop, how can I earn the money for our food?”

Cultural Reasoning Relates to Differences in Economic Standing and Social Status in Family

Although Grandma Tew’s reasoning for her self-medication apparently evolved as she advances in age, it has been in fact influenced by changes in her economic standing and social status in family indicated a change in family responsibilities from one life situation to another. Grandma Tew embodies a life situation of an elderly person who lacks means of living for old age or illnesses and needs to rely on his of her children whereas Grandma Lee, despite her age, and Somphob, the taxi driver, represent the case in which a person is the family’s principal income earner who have responsibilities to support and provide for their parents, children or grandchildren.

Rationality of Self-Medication among Poor People

Comparison of Rationality in Two Life Situations

To consider rationality of the two life situations, I rely on anthropological approach to understanding of concepts, valuations and ideologies prevailing among people who are the subjects of my study. Peter Winch, a thinker in the relativizer school, sums up this approach when he proposes that social scientists not apply culture’s standard of their own societies, namely Western cultures, in studying others (Winch, 1979).

Winch’s proposition is consistent with Donald Davidson’s working rules on translation of culture and Tambiah’s first ground rule for test on relativity of rationality between two groups of people or comparison of rationality of two different

actions. Tambiah suggests that one find “a base of agreement” or assume general agreement on beliefs in order “to make meaningful disagreement possible…”

In examining similarities and differences between rationality of the two life situations, I found the same reasoning at work for both even though the reasons given may be different.

The basis of this reasoning is a concept which attaches great value to fulfilling the responsibility of providing care and livelihood for everyone in the family. Towards this goal, each family member makes contribution by means which are within his or her capacity. When physically strong and able to work, they would be main providers for their siblings and children in the family. But when they become dependent on their children because of their deteriorating health or advanced age, they would manage their livelihood in ways which will not add burden to their family or weigh down their children’s living condition.

In other words, both sets of reasons attached greater importance to collectivity in family level than to individualism.

In this case since the two life situations share the same reasoning, there is no point to investigate the relativity of rationalities of poor people for their self-medication.

Rationality of Treatment Choices from Lay People’s Perspective

Understanding of the concept behind cultural reasoning in the two life situations helps me realize the benefits of appropriate ends of the poor people’s decisions on treatment choices. Grandma Tew opted for self-medication to treat her high blood pressure despite knowing that it could not cure her headache. Yet the treatment choice allowed her to continue working on a well-paid job which enabled her to financially provide for her elder sister’s family and children – the gratitude which her nieces and grandchildren repay by taking good care of her when she was in old age. In spite of suffering from headache for more than 20 years, Grandma Tew appreciated the benefits and value of her treatment choice. On the other hand, visiting physicians would have been beneficial to her health but would have had detrimental effects on the livelihood of her siblings, nieces and nephews. Therefore, from

Grandma Tew's perspective, her decision to treat herself through self-medication is rational because it takes into account maximized valued ends—rational ends is apropriate and ligitimate—as suggested by Rescher (Rescher, 1988: 100-103).

Comparison of Rationality from the Perspective of the Middle Class and Health Professionals

In his ground rules for comparison of rationality of two modes of action, or that of interpretations of rationality by the subjects, the researcher or others, Tambiah stipulates that the base of agreement must exist if any comparison is to be made. This can be ascertained by determining if the systems to be compared address the same issue or question. There are three possibilities for the outcome of a comparison. First, it can be a comparison in which the efficacy of the truth of the consequences proposed by two systems can be decided in a straightforward fashion. Secondly, it can be a truly relativistic outcome if the consequences of each of two systems offer an alternative to the same problem in a way which neither of them generates negative impact which makes one alternative inferior to the other. Finally, two phenomena which have different presuppositions should not be compared at all.

I apply these rules to the comparison of rationality of self-medication as treatment choice for hypertension from the perspectives of poor people, the middle class and health professionals. In making this comparison, I would like to highlight the gaps between the viewpoints of concerned parties – for instance, academics like me and health professionals – on the one hand, and that of lay people on the other toward the issue of lay people's health and use of medicines. The former are mostly members of the middle class or health professions. To start with, I try to determine whether these people's reasoning for treatment choices for their illnesses address the same question as that of lay people.

For the middle class and health professionals, their decisions on treatment options tend to deal with the issue of health through individuality. Better off in terms of economic status, the middle class highly value individuality as shown in their preference to live in a nuclear family of their own rather than being part of an extended family in which relatives and kin of more than two generations live together. Middle-class elderly people need not depend on their children after retirement

because they usually have savings large enough to support themselves and, unlike their counterparts in crowded communities, have no responsibilities in raising their grandchildren. Therefore, the middle class can afford to address their health problems directly in choosing methods of treatment with little concern for negative effects on their children.

Under contemporary western medicine influenced by scientific—Newtonian physics and the Cartesian—world view, human being becomes viewed mechanistically; diseases are examined reductionistically as abnormality of certain organs which need specific procedure or medication to repair or change parts like a machine (Capra, 1983). This mechanistic and reductionistic views cause health professionals to mainly focus on biological or physical health rather than other aspects of health. Moreover, majority of health professionals have social and economic status characteristic of the middle class. Because of their social and economic background, members of the health professions do not understand why poor people fail to choose treatment methods which are most beneficial for their health.

However, from the poor people's perspective, the choices which give maximum benefits for their health could be detrimental to the livelihood of other family members. Consequently, they take into consideration the consequences of the choices when they have to make health-related decisions. Thus the issues concerning treatment choices from the viewpoints of the middle class and health professionals, who are mainly interested in the patient's physical wellbeing as the end result, are different from the problems which concern poor people, who look beyond their own health and consider the livelihood of other family members whom they provide for or rely on.

The above analysis shows that the two systems or reasoning for treatment choices address different questions. Thus it lacks the requisite condition for any meaningful comparison, as stated by Tambiah. An attempt to compare rationality of the two modes in order to determine which one is superior to the other would be pointless.

Such comparison would not be only futile but degrade actions which are held in comparison. For example, most studies on self-medication among lay people

come to conclude that the practice is irrational without investigating or understanding their cultural reasoning and thinking which drives this behavior. This lack of understanding could lead to incorrect translation or misinterpretation which could be ethnocentric or disregard for human dignity of the poor people whose livelihood represents a set of meanings and values different from the interpreter. It is therefore vital for concerned parties, particularly those who by their professions have responsibility to contribute to all aspects of the patients' health from physical, mental social and spiritual well-being, to recognize their own perspectives and take great care not to impose to them on others.

Conclusion: Careful Application of Rationality Concept to Social and Cultural Phenomena

I propose that assessment or comparison of rationality of actions taken by people who have socio-cultural conditions or contexts different from the interpreter's must be undertaken with thoughtfulness and care. Any assessment should not be made before one gains true understanding of differences in reasoning among groups of people. The results of this study indicate that even though reasons for actions may appear different, they could share the same basis of reasoning. This finding suggest that the interpreters have to concern any kinds of logic behind those socio-cultural phenomena as Tambiah describe his concerning on logic behind such action situated in the larger contexts of life such as "*causal logic and communicative logic"*. (Tambiah, 1990: 136)

While self-medication and seeking treatment by physicians seem to be conflicting treatment choices, both could be rational in different socio-economic contexts. Rationality, as Rescher states, is circumstantially universal (Rescher, 1988: 159), and in applying the concept to study social and cultural actions, we need to understand rationality as being context-sensitive (Tambiah, 1990: 120).

CHAPTER VII

CONCLUSION AND RECOMMENDATIONS

This study is concerned with poor people who seek health care for their illnesses and the reasoning on which they base their decisions on self-medication. Specifically, it aims to understand the cultural reasoning and rationality of such practices from their own point of view. Moreover, the results of study are expected to be consistent with a cultural model of 'everyday reasoning' proposed at the conclusion of the findings of this study.

This study is an ethnographic work in which participatory observation is the chief method that enables the researcher to interpret the findings and understand illness experiences from insiders' points of view. To achieve this, I, as a researcher, spent 3-5 days a week for 6 months from November 2005 to April 2006 working and observing closely everyday life and day-to-day activities of people in the community for this study. Although overnight stays in the community were not arranged due to safety reasons, I often spent time late into the night there to build rapport and acquaintance.

To gain insight into what appear to be irrational and harmful behaviors, I focus my attention on self-medicating practices in severe or chronic diseases of the poor from their own perspectives. From my interviews with 20 people suffering from chronic diseases ranging from hypertension, paralysis, epilepsy to diabetes, I found most of them previously received treatment either at hospitals or the local health center. Despite being entitled to free state-sponsored medical treatment accorded to elderly or poor people, these patients hardly make regular visits to the hospitals.

Informed by socio-cultural approach and the structure and agency concept in particular, the biographical accounts of key informants who are chronically ill elderly patients – Grandma Duen, Grandma Tew and her neighbors – demonstrate poor people's reasoning for their decisions on self-medication and their refusal to visit physicians.

Cultural reasoning can be divided into 3 groups: 1) reasoning based on three considerations concerning the poor people's strategies; 2) reasons related to life situation with an emphasis on its dynamic quality; 3) reasons related to macro-structural circumstances and existing health care systems. In addition, the findings illustrate the rationality of lay reasoning from their own viewpoints and address two issues: 1) to what extent lay reasoning is economically and relatively rational 2) the way to interpret rationality of those self-medication practice as socio-cultural phenomena.

This chapter is divided into four parts: 1) cultural reasoning; 2) rationality of lay reasoning; 3) a cultural model of 'everyday reasoning'; and 4) recommendations.

Part One: Cultural Reasoning of Self-Medication

1. Reasoning based on three considerations concerning the poor people's strategies

The ethnographic accounts of the poor people indicate that their cultural reasoning with regard to self-medication or their refusal to visit physicians is based on three issues.

Firstly, they are concerned with preserving and maintaining good social relationship with their social network support at two levels: the neighbors from whom the patients seek assistance and their own family members. Grandma Duen's life story reveals that good social relationship is a requisite for making requests for any kinds of help especially in emergency. She has cultivated social ties and taken great care in preserving her relationship with neighbors. Even if the patient can afford to pay for medical bills, she still needs "someone" to accompany her on a visit to the hospital and help her deal with a not-so-friendly health service system. The story of Grandma Tew shows that she manages her livelihood including illness treatment in ways which will not place a burden to her family. In this respect, I argue that social relationship is crucial to the survival of poor people who have economic scarcity.

Secondly, occupational security is another consideration which exerts influence on decisions on treatment choices. Life stories of poor people who continue

to work into old age or even when they are ill to provide for their families show that they give priority to job security over treatment of their illnesses. Thus they do not want to take a leave off their work to see doctors even when they are aware that it would worsen their illnesses and that their treatment choices are not the best options for their health.

Thirdly, keeping good status in asymmetrical power relation with networks of social support or working party is another concern of poor people that I have found. The fact that the patients go at great length to preserve social relations with the neighbors on whom they rely when they need to go to see doctors or with their children by whom they expect to be cared in old age reflect the resignation of their own powerlessness and dependence on those people. They feel they cannot afford to stir suspicions in their networks of social support, fearing that their requests for help could be misinterpreted as demands for return of favors or being inconsiderate. The nature of these social relations implies asymmetrical power relations in which the powerless accepts their powerlessness and try to gain recognition from the powerful. For instance, Grandma Tew tried to compensate her frailty by improving her skills to prove her worth to her employer and co-workers.

2. Reasons related to life situations

This study found that poor people's reasoning for treatment choices is dynamic and contingent upon life situations. When Grandma Tew was young and the main provider for her family, her priority was to retain her jobs. Thus in deciding on treatment choices, she made sure they would not compromise her work. When her livelihood in old age depends on her nieces, Grandma Tew put great value on a way of living that does not burden her family, and this has influenced her decision on treatment choices.

3. Reasons related to socio-economic structure and existing health care systems

Because of their poverty, lack of job security, low income, and child support, most elderly people in the community were unable to save money when they were in their prime of their working life. When they grew old, their lack of savings makes them dependent on their children. This dependence compels them to weigh the

impact of each treatment choice on the livelihood of their children. This situation is in contrast to the middle-class elderly, who have enough savings to be on their own. They can choose the best option for their health using their own money and not worrying about their children. Their savings also allow them to take advantage of social relationship by asking their children or neighbors to take them to hospitals. These differences in socio-economic conditions affect reasoning for treatment choices.

Apart from socio-economic factors, the poor quality of health service systems and drug systems could make them less accessible to poor people and thus influence their choices of treatment.

This study found that the problems of the health care systems lie in the complexity of hospital service and the lack of hospitable information service which can guide patients and their caretakers through the labyrinth of procedures. Hospital staff often reacts to inquires from patients or their relatives on how to proceed with their visits as if they are intrusion upon their business. In response to their questions, the visitors could be admonished for their “ignorance”, or receive scant attention or information. Although staff hospitality and information are not principally medical services, their substandard quality could limit or even deny patients, especially those who are needy and poorly educated, access to health service. The situation would only aggravate the patients’ predicament and hardship and compel them to seek and rely on their neighbors’ help for hospital visits. For those who are ill afford to secure such help, they would resort to buying medications from local pharmacies.

Major problems in the drug system are concerned with distribution systems and the quality of dispensing medications which is handled by store keepers who lack adequate training in knowledge on drugs. The practice has led to widespread wasteful and unnecessary use of drugs, and the consequences could be fatally harmful to patients. The prevalence of strictly controlled drugs such as steroid drugs, dipyrone and phenylbutazone is an indication of the drug system’s failure to regulate the dispensing of drugs with harmful effects. In addition, it is not unusual that patients are given incomplete sets of medications for their conditions by sellers who are not properly trained. For instance, many patients in the community for this study received only one of two medications needed for their diabetes. Some of them were never

administered drugs for their high blood pressure again after giving up hospital visits. Neither did they receive blood tests from physicians before the drugs were dispensed

At local pharmacies, patients often buy medicines without being informed about their doses and usage. As the front line in dealing with people's immediate health problems, these outlets have failed to offer safe and reliable health service. Possible harms from the poor quality of this drug dispensing system are probably beyond the awareness of most poor patients. These poor patients, without other alternatives, must depend on this easily accessible but unreliable system.

Part Two: Rationality of Lay Reasoning on Self-Medication

1. Rationality from their own perspective

It was found that when poor people in the community are considering treatment choices for their illnesses, they are most concerned with the impact of their decisions on other family members or their relationship with social networks on which they rely for support and help in crisis or when they need to visit hospitals. This consideration has become the guiding principle for their living and daily activities as illustrated by the stories of elderly women like Grandma Tew, Grandma Lee and Grandma Duen.

Considering the end results self-medication in terms of health, it may not be the best way to treat illnesses, but the choice allowed young Tew to keep her job which provided for her sister's family and would not create more problems for Grandma Tew's family. To opt for self-medication, Grandma Tew has achieved the ends she values most and thus it was a rational decision from her perspective. Her case exemplifies rationality as maximized valued ends suggested by Rescher (1988).

Likewise, Grandma Duen decided to end her request for Jib's help to preserve their relationship which the old woman highly values even though it means for the time being she could not reap the benefits of social relationship which she cultivated with considerable economic resources. While her decision appears economically rational, it achieved what Grandma Duen considered long-term benefits and more meaningful than health advantages.

2. The way to interpret "rationality" of self-medication practice as socio-cultural phenomena

Although Grandma Tew applied two different sets or reasons to explain her decision to buy medicines to treat her hypertension at the time when she was young and able to work and when she was old. They share the same underlying concern for the livelihood of her children and other family members. Whether this decision can be judged rational depends on the answers to two questions: Does the underlying reasoning and the decision deriving from it represent a case of maximized valued ends? What is the rationality of those ends?

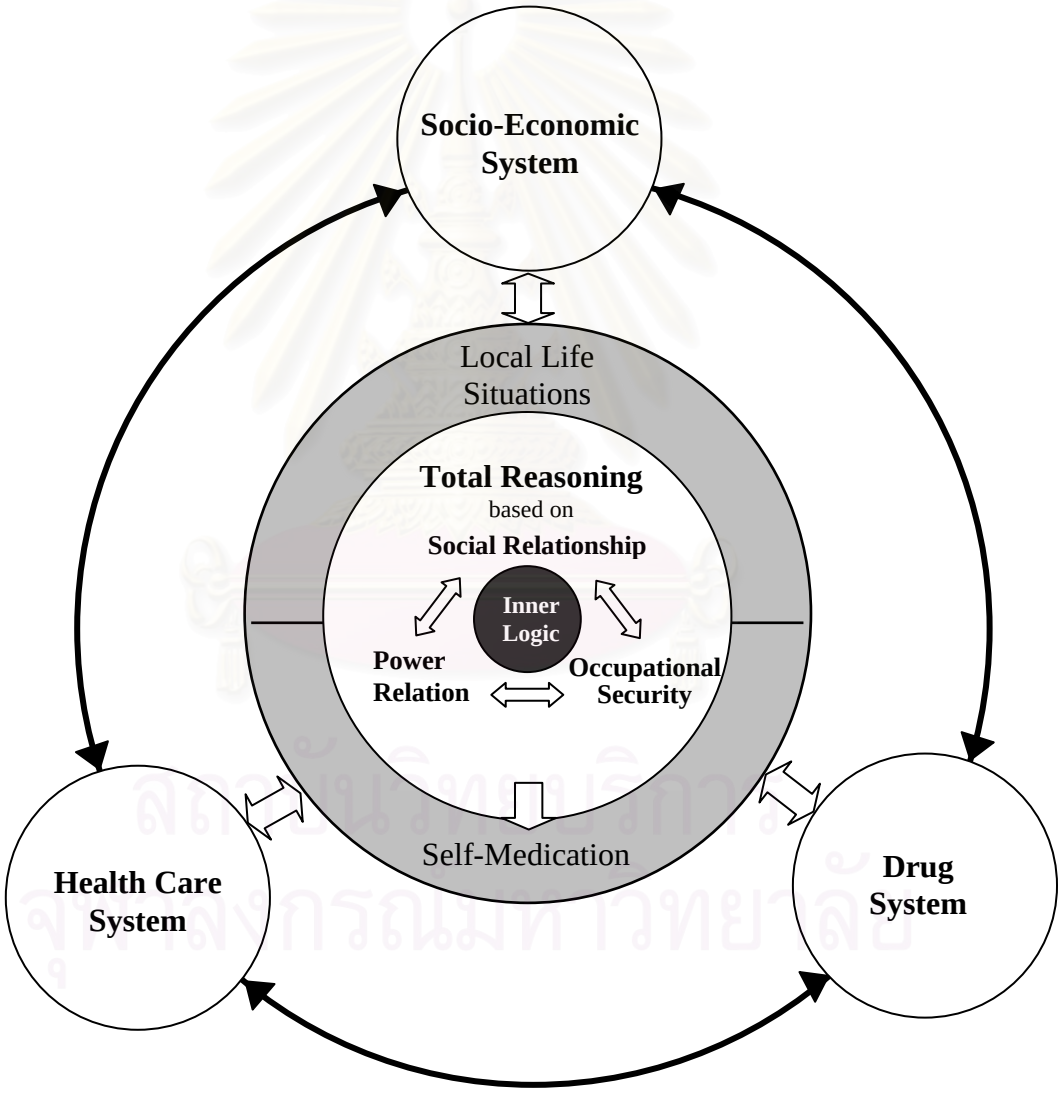
To the first question, Grandma Tew's life story affirms the importance which she attaches to the underlying reasoning, and to that end she is repaid her with good care she receives from her nieces and grandnieces, making her an elderly person with good mental health. To the second question, the rationality of Grandma Tew's ends are based on the principle of performing duty appropriate to one's role in the family such as a mother has duty to care and raise her children (Rescher 1988).

The findings do not only show that understanding of underlying reasoning is crucial to interpretation of rationality but also point out the differences in reasoning for health-seeking behaviors between poor people on one hand and the middle class and health professionals on the other. The latter tend to assess the end of treatment choices in terms of the maximum benefits for physical health whereas the former are concerned with the consequences of their choices on their family's well-being. Against the ground rules proposed by Tambiah, the disparity make the decisions, though on the same issue, not fit for comparison of rationality since they are meant for different ends or address different problems. The findings should also serve to make health professionals, academics and concerned parties be aware of this disparity and to remind them that they are likely to obtain inaccurate results if they impose their own views as the basis for comparison in assessing health or social behaviors. Moreover, by doing that they would disparage lay people's reasoning and show insensitivity towards those who have already suffered a great deal from their plight.

Part Three: A Cultural Model of 'Everyday Reasoning' on Self-Medication

From the findings summarized above, a model was formulated to present the conclusion of the study as follows**:**

Cultural Model of Everyday Reasoning on Self-Medication



The model above represents an analysis of lay people's reasoning systems at macro-level and micro-level. The structural influence of the former is represented by three components – socio-economic system, health care system and drug system – which circle the rings. The three systems are interrelated and together form social structure which shapes treatment choices and gives rise to self-medication. Their combined influence on the practice is mediated by life situations – represented by the outer ring – at different stages.

In the macro analysis, the influence of health care system and drug system are distinguished from that of socio-economic system due to the findings which pinpoint the two systems as being problematic. Moreover, the researcher aims to highlight for policy makers' consideration the importance of resolving the existing problems of health care system and drug system – a suggestion which is in line with recommendations made by previous studies. Chuengsatiansup et al. 2000 propose that efforts to solve the problems of inappropriate drug use should focus on "redesigning the drug system that would make self-medication safe." Young and Garro (1982) and Foster (1977) argue that social structure and health care systems are greater obstacles to access to medical services and treatment choices than incompatibility between lay people's beliefs and knowledge of modern medicine.

The formulation of the model at macro level is informed by the conceptual framework on community drug use proposed by Chuengsatiansup et al. 2000.

At micro level, the analysis of reasoning for self-medication is shown as the inner ring of total reasoning to signify the agency of these poor patients who act upon three interrelated considerations: 1) social relationships based on reciprocity and mutual help 2) power relation to persons on whom they depend 3) occupation security which seeks and sustains employment.

With the three considerations at work and the dynamic of reasoning, reasons cited for certain behaviors may vary. Yet they derive from the same set of values, principles and goals, represented here at the center of the model as inner logic to signify thoughts which are deeper than manifested reasons.

However, the agency as shown above is not free from structural forces of socio-economic-cultural systems which are exerted through life situations at different ages or phases which in turn result in variations of reasons given for treatment choices and self-medication.

The attention given to structural influence in this study centers on structural constraints—objective social factors or macro-level structure of inequality. More specifically, these constraints include poverty, the lack of natural resources in urban livelihood, and insecure and low-wage jobs. Until recently the factors were overlooked in studies which tended to focus on subjective culture or system of belief (Morsy 1990; Young and Garro 1982) Therefore, one could find that this study's findings on poor people's reasoning could depart from those of studies such as Lieban 1976, which showed that knowledge or beliefs on illnesses are is key factors in determining treatment choices.

In sum, the model is based on the findings on reasoning for health-seeking behaviors of a group of the urban poor. These people have been struggling to make a living for the most part of their lives in the capital city. Because of their low incomes, very few manage to save enough money to support themselves when they retire in old age, especially to cover the expenses needed for medical services which exist in multitude but are too complex and too expensive for them. The model is intended to illuminate the reasoning of poor people for this study and those in similar contexts. It has no purpose for use in predicting behaviors from determinants as decision-making models based on quantitative research.

Part Four: Recommendations

Some recommendations were already made in Chapter 5 and 6. Recommendations in this chapter emphasize the application of knowledge and understanding of cultural reasoning in poor people's self-medication to improve drug systems and health care systems to make them more responsive to poor people's problems. The starting point should be to revamp the current conceptual framework for solving problems of health systems.

The realization of socio-economic constraints of the poor people should convince health personnel to shift their strategies to promote appropriate use of medicines, as one reviewer suggested, “from an institution-oriented or a system-centered view to people-centered drug system” (Chuengsatiansup et al. 2000). The former view seeks to identify the “irrational use of drugs” as incorrect behavior that need to be modified in order to fit the existing drug system. The latter perspective takes people’s life situation as center of analysis that needs modifying the drug system to make it suitable for ordinary people’s way of life.

In addition, the quality and complexity of hospital service utilizing also need to be considered. One of the most important findings of this study is that difficulties and poor service behavior in healthcare system were the major constraint of accessing care particularly for the poor elderly people. When healthcare system was complex and needed a sophisticated person to assist, these poor elderly people have to rely on helpers from their social networks. This further necessitated the need to maintain their social relationship which, as the finding of this study shows, was oftentimes relatively costly. Therefore, the whole health care service system, both hospital care and proper drug distribution, have to be target of solving the problem of harmful self-medication and accessibility of hospital care.

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