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The Community Innovation to Strengthening User- friendly Health Services Accessibility among Thai Ethnic Women in Chiang Mai, Chiang Rai, and Mae Hong Son

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ABSTRACT

Women's inequity problem was still a major problem around the world, especially among ethnic women. In Thailand, there were many ethnic groups settled in all parts of Thailand. However, previous research and surveys showed that they still had not the human rights to gain proper health services. Especially, Thai ethnic women were almost completely separated from society. These situations affected the quality of life and access to basic living life especially, health inequalities, so the social exclusion determinants needed to be studied.

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This solution will lead to the creation of development processes for the reduction of social barriers and adjusting health service accessibility. This study was qualitative. Data collection was conducted through in-depth interviews and focus-group interviews of 120 Thai ethnic women from 3 provinces in Thailand including Chiang Mai, Chiang Rai, and Mae Hong Son. The data were analyzed by using content analysis and data triangulation. The results showed that language restrictions, remoteness of their settlement, beliefs and perspectives of their womanhood, and unclear state registration status were the barrier determinants. From the social exclusion determinants, 1) Thai ethnic women should be promoted their health knowledge and health-self-care skills and increased their awareness about health based on correct knowledge. 2) The assignment of female leaders among Thai Ethic people will be an important way to drive the approach to human rights in many dimensions. 3) The creation of community interpreters was a strong basic need that will integrate the gap between Thai ethnic women and health personnel.

Introduction

The Thai ethnic women situation in Thailand is a major problem in the Thai public health system. Thailand has high women's violence statistics. Thai women were being abused for physical and mental violence by at least 7 people per day and the number of women undergoing treatment was reported at 30,000 cases per year. United Nations Office on Drugs and Crime (UNODC) found that more than 80 % of abuse cases had never been reported including Thai ethnic women (Thai Civil Rights and Investigative Journalism, 2022).

The information about Thai ethnic people from Ethnic Development Master Plan in Thailand 2015-2017 showed there were many ethnic groups distributed in Thailand in more than 67 provinces. The ethnic groups comprised 56 groups with a total population of approximately about 6,100,000 population or 9.68 percent of the population. The legal status was the main problem of the ethnic group in Thailand. Although Thailand had given status registration to this group, they were also classified as "Second class citizens" that had lower equal rights than others (Moss, 2002). Consequently, Thai ethnic women were a vulnerable group that was excluded from society (Redwood and Gill, 2013). Social exclusion referred to

the inability of people to participate fully in society including the economic, social, cultural, political dimensions of that society, rights, and access to facilities (Millar *et al.*, 2007). Social exclusion was one of the driving forces of health inequalities and it had been linked to poor health (WHO, 2010).

However, the Thai government tried to give status and fundamental rights to the ethnic groups; especially in health rights, but Many Thai ethnic women were also oppressive and excluded from fundamental rights due to many determinants such as the differences in origins, ethnicities, languages, social statuses, economies, religion, education levels, and political views especially, non- equivalence of socioeconomic status and ethnic health disparities (Ranganathan and Bhopal, 2006; Williams, 2002). Although the World Health Organization has supported national and various departments in addressing racial discrimination and solving the problem (WHO, 2022), this situation was continuing. It was obvious that Thai ethnic women were vulnerable to being healthy. Therefore, it was important to develop the processes to access health services and reduce social barriers to promote Thai ethnic women with personal status problems. The objectives of this study were to study the experience sets about social exclusion determinants in Thai ethnic women and develop the processes for accessing health services in Thai ethnic women.

Methodology

This study was qualitative. The format of this study was participatory action research (PAR) The participants participated in the processes of thinking, designing, implementing, and summarizing the results to create an effective guideline for accessing health services for Thai ethnic women. This study's settles were Chiang Mai, Chiang Rai, and Mae Hong Son because these areas had more than 5 ethnic groups in each area. The participants of this study were 120 Thai ethnic women from 3 provinces in Thailand included of Chiang Mai, Chiang Rai, and Mae Hong Son. The participant's groups were divided into 15 groups consisting of 5 Thai ethnic groups from Chiang Mai (8 people per group), 5 Thai ethnic groups from Chiang Rai (8 people per group), and 5 Thai ethnic groups from Mae Hong Son (8 people per group). The inclusion criteria of participants included Thai ethnic women who can communicate with their ethnic

languages and agree to participate in this study. The questionnaire reviewed by experts was used in this study. The data were collected through in-depth interviews and focus-group interview methods.

Throughout the data collection process, the communication between the researcher and the target groups is mediated by an interpreter (Village Health Volunteers and community leaders in each area). All participants who were invited to join this study accepted the invitation and continued their participation until the end of the study. After agreement and obtaining the consent of eligible participants, in an intimate and relaxing setting, before the interview, the researcher explained the study objectives and reasons why they had been selected to join this study, clarified the benefits of this study for them and how they could access final results, and requested the audio recording during the conversation. In the interview process, the researchers conversed and asked questions according to the questionnaire. The conversation time was flexible due to the smooth conversation. After the data collection process, interviews were transcribed immediately. The recorded interviews were typed verbatim in the computer program. Along with interviews, the participants' states and characteristics were noted. The data were analyzed with content analysis based on the conceptual framework of the study and checked by the data triangulation method.

This study was approved by Mahidol University -MUSSIRB No 2018/175.2607 (Date of Approval July 26. 2018). The researchers conducted this study over the research ethics by adhering to the participant's respect. Principles of ethics in research including informed consent, anonymity, confidentiality, and participants' rights to withdraw from the study were observed. Moreover, study objectives, the confidentiality of data, and the recording of interviews were explained to the participants before the interviews, and their verbal consent was obtained.

Results

Experience about social exclusion determinants in Thai ethnic women

The main barrier determinant between public health personnel and ethnic groups was the difference in language. Some of the ethnic populations in Chiang Mai, Chiang Rai, and Mae

Hong Son can't communicate with public health personnel which caused the important health service processes problem within some of these ethnic groups. For example, when they wanted to communicate with outsiders (the Thai population) or medical personnel, the communication would not be successful because both medical staff and ethnic groups didn't understand each other's language. The treatment of illness was difficult within ethnic groups, so they chose to go to find a medicine by themselves such as using population and folk medicine sectors instead of going to receive treatment from hospitals and healthcare centers. This gap between languages affected health-seeking behaviors as Thai ethnic women want to be healthy based on their social contexts. The opinion of Thai ethnic women, Thai ethnic women were afraid to be deceived and lacked the courage to go to the hospital because they were unable to communicate with medical staff. Although some of them can understand and talk with medical staff, the results of the conversation were often inaccurate or inconsistent understanding which caused a reduction in treatment efficacy. In the worst case, Some Thai ethnic women may be oppressed and excluded from human rights including being sexually harassed by ill-wishers. Creating an interpreter between Thai ethnic women and public health personnel or promoting communication skills among Thai ethnic women will be a good approach to reducing this gap in health.

Communication was an important social determinant of health service assessment which consisted of many supporting determinants, included of remoteness in the settlement, womanhood, state registration status, and culture and tradition.

Remoteness in the settlement

Some Thai ethnic women were settling in areas far away from basic infrastructure. Some groups lived in protected areas, islands, and border areas. Some groups were a migration. Remoteness was an obstacle to accessing the basic utilities of female ethnic groups. It was hard to certify the legal state from the Thai government. Social exclusion was often founded in the ethnic group that faced the health service problems such as slow services and complicated health service processes. Long-distance travel that took a long time was directly affected by troubled situations and environments. Thai ethnic women always lacked

opportunities in health service assessment. From the example case, when they had reproductive health problems, they often bought some medication by themselves and used the local treatments.

Womanhood

Women faced more complex and violent problems than men. Because of the basic reasons for womanhood, traditions, and beliefs that related to equity concealed with a great male ideology. Many times, women were enslaved through the form of culture and society overseen by males, especially the Thai ethnic women (e.g., Lahu, Hmong). In Thailand, ethnicities are still considered it difficult to access justice for their rights such as requesting Thai nationality requesting of ethnicities. It was very difficult because of the tribal culture that considered the female as a follower. The limitations of women were still unable to communicate in Thai.

In the case of Lahu; the ethnic group in Thailand, when they got treatment in the hospital, they were often oppressed by tribal culture. When they wanted to check for cervical cancer, they had been denied and prohibited by the community members especially the community leaders because the sex organs revealed to the doctor were a shame. From the experience of the Hmong; the ethnic group in Thailand, Hmong women had limitations in living such as they can't be the leaders and every right of Hmong women was controlled under the Hmong men included of divorce, marriage, and living in a family that depended on the men relative and family. The other problem of Hmong ethnicity was that Hmong men can have more than one wife. When a Hmong woman got married to be the second wife of a Hmong man, she had no wife rights. Afterward, Hmong women had to do much housework and were not allowed to have a meal with their husbands at the same time. Hmong women were barred from their families. They cannot consult the problem of married life with their family. If they broke these rules, they would be punished and relegated from the community. These reasons affected women's rights included of health service right.

State registration status

Although there were currently provisions of the civil registration Act that record "Stateless people" found in Thailand with civil registration records under the civil registration law, the unequal was still a problem for these people. These people would be called persons without registration status, and they were given the personal without status in the civil registration card to solve the unequal problems. Therefore, people without registration status were becoming a vulnerable group deprived of society and were discriminated against in many dimensions which affected health conditions and the quality of life.

However, there were organizations and funds to take care of the status of people's health called "unregistration status civil individual cards", this fund had fairly administrative problems. It was a cause of inequality in ethnic groups especially compared with the medical rights in the universal health insurance system. It was a fund taken care of by 4-5 hundred thousand people that caused a limited budget and management problems.

This action caused inequality in people's health management especially in the healthcare centers in rural areas which faced the inequality of basic health assessment and basic health service needs.

Culture and tradition

The differences in culture between the capitalist group and ethnic group in society were affected on many dimensions of ethnic groups. They had faced many problems such as poverty, lack of opportunity to receive basic services, and reduction of quality of life. The combination of ethnic, language, religious, beliefs, culture, and traditions is affected by a lack of legal endorsement from the Thai state. The important point of this study showed ethnic groups were not the same group. They were a single image but they were many complexities in multifarious races. For example, there were many races in Mae Hong Son included of Karens, Haw, Lahu, Hmong, Lisu, and Lua. In Chiang Mai, Karens, Hmong, Mien, Lahu, Akha, Lua, Khmu, Haw, and Palong were founded, while Bizu, Akha, Lua, Tongsu, Lisu, Lahu, Haw, Tailue, Taiyong, Karens, and Khmu were founded in Chiang Rai.

In the self-care of ethnic groups, the health care of the population was based on the culture of the family or each community. In Akha's case, Akha lived in cold and high places such as mountains in the north of Thailand. Akha did not like to shower. In 1 year, they took a shower only 1-2 times per year, and they just rubbed water on their face and head in daily life.

The development of processes for accessing health services in Thai ethnic women procedure for accessing health services in Thai ethnic women

Many Thai ethnic women lacked information about accessing health services and health promotion knowledge. It was very important to give this information to Thai ethnic women, how to access health centers, and what were the steps for accessing health services. These were the basic information that Thai ethnic women should be known. The development of knowledge in health promotion management in ethnic groups was an important priority to manage. From the data, some Thai ethnic women were unable to take care of and promote their health by themselves which may cause some problems with their health such as poor hygiene and malnutrition. The most worrisome was the female ethnic group health because there were many sensitive issues about female health such as reproductive health, body hygiene, and women's self-care.

The guidelines for the development of information about accessing health services and knowledge for Thai ethnic women included 1) Strengthening the promotion of health knowledge and preparation of information about accessing health services 2) Raising health awareness in Thai ethnic women and supporting the information and knowledge about accessing health services for Thai ethnic women and 3) Create appropriate communication and campaigning for Thai ethnic women. The challenge in the information and knowledge development was a modification of the inherited beliefs of the ethnic groups. We had to explain why they should do health promotion behaviours by themselves and choose to receive health services at hospitals. However, the important gap between ethnic groups and health personnel was the difference in language, the process of the knowledge development process can be accomplished through key factors, including local cooperation and

intermediary between ethnic groups and health personnel. The creation of women community interpreters and female leaders from the ethnic group was an important process to manage health services to the ethnic group that will explain below.

Woman community interpreter

At the present, there was an intermediary between the ethnic groups and health personnel called "Community interpreter". The community interpreter was the volunteer consisted of community health volunteers and volunteers or people who were interested in volunteering to participate in health activities. Community interpreters can solve the gap between ethnic groups and health personnel by linking the language between health personnel and ethnic groups.

Community interpreters should become from the ethnic people who saw the problems widely, stayed in the problem situation, and could speak in Thai because these people knew the problem situation clearly and can communicate with health personnel. Their familiarity will enable them to work more easily. On a sensitive issue such as womanhood and reproductive health in women, supporting the creation of the woman community interpreter to work in the health system was necessary to reduce social inequality. The woman community interpreter will help and support the Thai ethnic women to access health services. For example, the women community interpreter will be linked between female ethnic groups and health personnel in language translation that made health personnel and Thai ethnic women understand each other. In health action operations, a woman community interpreter can disseminate the correct and proper healthcare knowledge to the ethnic group especially Thai ethnic women that were health promotion way to this group.

The woman community interpreter was an important mechanism that made the same understanding between health personnel and ethnic groups and helped reduce the burdens of personnel in the health service system.

Female leader

Some societies were patriarchal, like many ethnic groups in Thailand. Many women were oppressed by men which caused inequality in the social included human rights access.

Most people still had the old belief that men were better than women in the leader role. If a problem aroused, who could solve this problem better? These ideas and beliefs made many women lack the opportunity to step up to work as a leader. At the same time, women who have been allowed to become a leader will encounter problems about the negative attitude when working with men because many men still unaccepted the female leader. Although many women can work as well as men or better than men, it was very difficult for women to be accepted as a leader, especially in our country where men were a leader and women was a follower. Making socially acceptable about female leaders was an important key to developing the social system.

From the result, there were few female leaders in all ethnic groups, so the inequality problem was still founded in many ethnic groups area. The female leader concept will solve this problem and manage human rights access. The important properties for women to become leaders were having clear expression, strong motivation in deciding to do something, and getting ready to take risks in every situation. The selection of a female leader must come from a resolution of the community, voluntary female, and the encouragement from government. In one community or ethnic group, there should have one female leader to work for female rights, especially in sensitive tissues. Community policy that encouraged the development of women's health services can be achieved under female leaders.

Discussions

Barrier determinants of health service accessibility among Thai ethnic women

The obvious obstacle determinant of health service accessibility among Thai ethnic women was the social determinants. The social determinants were more potent than medical efficiency such as medical technology, health personnel, and healthcare center proportion. The World Health Organization defined social determinants of health as the conditions or circumstances in which people were born, grow, live, work, and aged. These conditions were shaped by political, social, and economic forces (Islam, 2019). From the results of this study, all of the determinants found in this study were related to social dominants. Thai ethnic women had not given much importance to the medical efficacy of Thailand, but they thought

that the difference in social determinants of their groups was the main barrier. The results of this study were consistent with the previous studies that showed the influence of race, ethnicity, and social determinants affected on health service accessibility among ethnic groups (Walker *et al*., 2016). Moreover, social determinants were related to inequality in ethnic groups (Chang *et al*., 2014).

Thai ethnic women's health was related to the several ethnicities and the difference in culture and tradition of the ethnic group. There was much healthcare behavior among these groups. Past studies showed race, ethnicity, and socioeconomic status affected their health status (Gold *et al*., 2006). There was a fact that ethnic women had poor health than ethnic men health because of the inequality among the ethnic group (Gerritsen and Deville, 2009). Men always had more chances to access health services than women due to womanhood. The reducing process of this gap was very important to manage the health service accessibility of Thai ethnic women. The previous study showed that the development of innovation such as providing health education and ethnic Interpreters was a good process for overcoming barriers (Santoyo-Olsson *et al*., 2011).

The difference in language between ethnic groups and health personnel was the main barrier to social determinants. The inefficiency of communication strongly affected Thai ethnic people's health status, especially Thai ethnic women. The shared language between ethnic groups and health personnel was very essential. The ethnic interpreters were very important to solve this problem and the interpreter service needs potential for improvement (Binder *et al*., 2012). The previous study showed that many ethnic minority patients still had low health literacy. The understandable language was the beginning of good healthcare, so ethnic interpreters were necessary to promote ethnic health (Fransen *et al*., 2013). The other study showed that the ethnic patients who used interpreters were more likely than language-concordant patients to report having a question about their care or about mental health they want to ask but did not (Green *et al*., 2005). From the supporting studies, the development of ethnic interpreters was important, and the high quality of ethnic interpreters will solve the misunderstanding of language problems between ethnic groups and health personnel. However, the development of ethnic interpreter services should involve policy development.

The policy will facilitate the promotion of ethnic interpreter services (Bischoff, 2020). It was a sustainable health promotion way for the ethnic group.

Humans still were an important tool to reduce barrier determinants of health services accessibility among Thai ethnic women

The inequality reduction and the promotion of health service accessibility among Thai ethnic women processes will become from the human drive. Disempowerment was still a major problem in ethnic groups especially ethnic women. At this moment, men generally earn more than women, own more than women, are better educated, and dominate community and national institutions. This gender imbalance harmed the health of women and millions of women are still missing as a consequence (Ehrhardt *et al.*, 2009). The management of women's human rights was still the main determinant to solving this problem. The previous study reported that there were 6 strategies to study and develop women's human rights; 1) Become familiar with women's human rights to incorporate them into the research 2) Push gender as mainstream in the research 3) Tap the expertise of local grassroots women's rights reformists 4) Represent women's equity and equality in the organizational infrastructure 5) Disseminate the findings to policymakers for advocating and improvement 6) Publicize the specific and global oppressions driving women's human rights (Baptiste *et al*., 2010). Studying women's human rights was an important way to develop women's human rights management. The previous study showed the attitude towards women's and men's equality was the main point that affected the oppressive of women. Adjusting attitude processes should start with parenting, learning in the schools, community, media functioning, and collaborating with relevant organizations in the development of the curriculum on women and men equality along with responsive policies (Rossutham, 2022).

On the other hand, the application of health behavior theories was an interesting way to push women's human rights such as the empowerment theory. The empowerment among ethnic women was very important to reduce the barrier determinants including health services accessibility. Empowerment was the process to increase the power of a low-power group and become a high-power group. It was the interpersonal process providing the proper resources

to increase the ability and effectiveness of the group to reach the goals (Brady *et al.*, 2019; Lean *et al.*, 2019). In previous studies, a high level of empowerment was associated with positive reproductive health outcomes (Varkey *et al.*, 2010; Shooshtari *et al.*, 2018). The increasing confident level of ethnic women will make women brave to have the decision-making, communicate with health personnel, participate in society, improve their health behavior, and seek health information when they want to receive treatment. It will increase the levels of confidence and satisfaction to overcome the barriers and it was the one process that caused the pushing of related policies and laws to solve this problem. However, the studies about the present problems of ethnic women's health were essential to stimulate the policy related to inequality reduction among ethnic women.

The integrative medicine between conventional medicine and ethnic medicine

Integrative medicine is an interesting medical service for many people around the world because it can holistically solve the illness recovery needs of the patient that had many dimensions (Roberti di Sarsina and Iseppato, 2011). Many ethnic populations still had lower levels of access to the healthcare center. Moreover, ethnic women faced many challenges when they came to a healthcare center, and they often had a greater need for medical care owing to higher levels of morbidity and comorbidity. Integrative medicine will help to balance health services and it showed the possibility to settle integrative healthcare enters in a remote area that had ethnic diversity. Effective integrative medicine for ethnic groups should be combined between conventional medicine and ethnic medicine in those areas. Initially, changing the health beliefs and health cultures of ethnic people was a relatively difficult determinant. Creating an integrated healthcare center was a linked plan to develop health service accessibility for ethnic groups. Past studies showed that many women still demanded integrative medicine for reproductive health services (Schürger *et al*., 2018). Women were the highest utilizers of integrative medicine for various reasons. Integrative Medicine represented a more "female energy" in the field of medicine, which was needed even more today as healthcare moves toward value-based care and out of high-cost and high-harm care (Schürger *et al*., 2018).

Many health problems and healthcare needs are unique to ethnic groups. Becoming aware and sensitive to the plight of minority women, and learning about ethnic cultures were crucial, initial steps for policymakers and service providers (Lin-Fu, 1987).

Conclusion

The inequality problem among Thai ethnic women still occurred especially ethnic women's health problems. The origin of the inequality problem came from the difference between their cultures and traditions which caused the restriction of females' human rights. All Thai ethnic women need human rights and decision-making to get the proper healthcare services. The development of information, knowledge, the ethnic leaders, and the ethnic interpreter among the Thai ethnic group was an important process to solve this problem and reduce the gap in society. However, the drive for policies that were conducive to Thai ethnic women, changing and cultivating attitudes toward sexual oppression early, the empowerment processes of Thai ethnic women, and the contribution of integrative medicine for Thai ethnic women were sustainable guidelines for promotion the of Thai ethnic health.

Researchers will study the creation of development in implementation processes in health services accessibility among Thai ethnic women to continue the results from the present study and carry out the development of the Thai ethnic women project in the future.

References

Baptiste, D., Kapungu, C., Khare, M. H., Lewis, Y., & Barlow-Mosha, L. (2010). Integrating women's human rights into global health research: An action framework. *Journal of Women's Health, 19*(11), 2091-2099. https://doi.org/10.1089/jwh.2010.2119

Binder, P., Borne, Y., Johnsdotter, S., & Essen, B. (2012). Shared language is essential: Communication in a multiethnic obstetric care setting. *Journal of Health Communication, 17*(10), 1171-1186. DOI: 10.1080/10810730.2012.665421

Bischoff, A. (2020). The evolution of a healthcare interpreting service mapped against the bilingual health communication model: A historical qualitative case study. *Public Health Reviews, 41*(19). doi:10.1186/s40985-020-00123-8

Brady, S., Lee, N., Gibbons, K., & Bogossian, F. (2019). Woman-centred care: An integrative review of the empirical literature. *International Journal of Nursing Studies, 94*, 107-119. https://doi.org/10.1016/j.ijnurstu.2019.01.001

Chang, T. E., Weiss, A. P., Marques, L., Baer, L., Vogeli, C., Trinh, H. T., Clain, A. J., Blais, M. A., Fava, M., & Yeung, A. S. (2014). Race/ethnicity and other social determinants of psychological well-being and functioning in mental health clinics. *Journal of Health Care for the Poor and Underserved, 25*(3), 1418-1431. doi: 10.1353/hpu.2014.0138.

Ehrhardt, A. A., Sawires, S., McGovern, T., Peacock, D., & Weston, M. (2009). Gender, empowerment, and health: What is it? How does it work? *Journal of Acquired Immune Deficiency Syndromes, 51*(Suppl 3), S96-S105. doi: 10.1097/QAI.0b013e3181aafd54

Fransen, M., Harris, V. C., & Essink-Bot, M. L. (2013). [Low health literacy in ethnic minority patients: understandable language is the beginning of good healthcare]. *Nederlands Tijdschrift voor Geneeskunde, 157*(14), A5581.

Gerritsen, A. A., & Deville, W. L. (2009). Gender differences in health and health care utilisation in various ethnic groups in the Netherlands: a cross-sectional study. *BMC Public Health, 9*, 109. doi: 10.1186/1471-2458-9-109.

Gold, R., Michael, Y. L., Whitlock, E. P., Hubbell, F. A., Mason, E. D., Rodriguez, B. L., Safford, M. M., & Sarto, G. E. (2006). Race/ethnicity, socioeconomic status, and lifetime morbidity burden in the women's health initiative: a cross-sectional analysis. *Journal of Women's Health, 15*(10), 1161-1173. doi: 10.1089/jwh.2006.15.1161.

Green, A. R., Ngo-Metzger, Q., Legedza, A. T., Massagli, M. P., Phillips, R. S., & Iezzoni, L. I. (2005). Interpreter services, language concordance, and health care quality. Experiences of Asian Americans with limited English proficiency. *Journal of General Internal Medicine, 20*(11), 1050-1056. doi: 10.1111/j.1525-1497.2005.0223.x.

Islam, M. M. (2019). Social determinants of health and related inequalities: Confusion and implications. *Frontiers in Public Health, 7*, 11. doi: 10.3389/fpubh.2019.00011

Lean, M., Fornells-Ambrojo, M., Milton, A., Lloyd-Evans, B., Harrison-Stewart, B., Yesufu-Udechuku, A., Kendall, T., & Johnson, S. (2019). Self-management interventions for people with severe mental illness: systematic review and meta-analysis. *The British Journal of Psychiatry : The Journal of Mental Science, 214*(5), 260-268. doi: 10.1192/bjp.2019.54.

Lin-Fu, J. S. (1987). Special health concerns of ethnic minority women. *Public Health Reports (Washington, D.C. : 1974), 102*(4 Suppl), 12-14.

Millar, J., Abrams, D., Christian, J., & Gordon, D. (Eds.). (2007). *Multidisciplinary handbook of social exclusion research*. Wiley.

Moss, N. E. (2002). Gender equity and socioeconomic inequality: A framework for the patterning of women's health. *Social Science and Medicine, 54*(5), 649-661. DOI: 10.1016/s0277-9536(01)00115-0

Phillips, J. K., Cockrell, S. A., & Parada, A. N. (2018). Integrative health for women. *Primary Care: Clinics in Office Practice, 45*(4), 719-729. https://doi.org/10.1016/j.pop.2018.07.009

Ranganathan, M., & Bhopal, R. (2006). Exclusion and inclusion of nonwhite ethnic minority groups in 72 North American and European cardiovascular cohort studies. *PLoS Medicine, 3*(3), e44. https://doi.org/10.1371/journal.pmed.0030044

Redwood, S., & Gill, P. S. (2013). Under-representation of minority ethnic groups in research--call for action. *The British journal of general practice : the journal of the Royal College of General Practitioners, 63*(612), 342-343. doi: 10.3399/bjgp13X668456.

Roberti di Sarsina, P., & Iseppato, I. (2011). Why we need integrative medicine. *The EPMA journal, 2*(1), 5-7. doi: 10.1007/s13167-011-0065-2.

Rossutham, P. (2022). kān songsœ̄m khwāmsamœ̄phāk ying chāi nai mummoṇg khoṇg khon run mai nai sangkhom Thai [Promoting equality between women and men in the perspective of the new generation in Thai society]. *Journal of MCU Social Development, 7*(1), 220-230. https://so06.tci-thaijo.org/index.php/JMSD/article/view/254281 (In Thai).

Santoyo-Olsson, J., Cabrera, J., Freyre, R., Grossman, M., Alvarez, N., Mathur, D., Guerrero, M., Delgadillo, A. T., Kanaya, A. M., & Stewart, A. L. (2011). An innovative multiphased strategy to recruit underserved adults into a randomized trial of a community-based diabetes risk reduction program. *Gerontologist,* 51(Supp1) , S82- 93. doi: 10.1093/geront/gnr026.

Schürger, N., Klein, E., Hapfelmeier, A., Kiechle, M., & Paepke, D. (2018). Demand for integrative medicine among women in pregnancy and childbed: A German survey on patients' needs. *BMC Complementary and Alternative Medicine, 18*(1) , 187. doi: 10.1186/s12906-018-2249-y.

Shooshtari, S., Abedi, M. R., Bahrami, M., & Samouei, R. (2018). Empowerment of women and mental health improvement with a Preventive approach. *Journal of Education And Health Promotion, 7*, 31. doi: 10.4103/jehp.jehp_72_17

Thai Civil Rights and Investigative Journalism. (2022). Open the statistics of Thai women being sexually abused-violent, more than 7 people/day. Retrieved Dec 23, 2022, from https://www.tcijthai.com/news/2022/3/current/12248.

Varkey, P., Mbbs, Kureshi, S., & Lesnick, T. (2010). Empowerment of women and its association with the health of the community. *Journal of Women's Health, 19*(1), 71-76. doi: 10.1089/jwh.2009.1444.

Walker, R. J., Strom Williams, J., & Egede, L. E. (2016). Influence of race, ethnicity and social determinants of health on diabetes outcomes. *American Journal of the Medical Sciences, 351*(4), 366-373. doi: 10.1016/j.amjms.2016.01.008.

Williams, D. R. (2002). Racial/ethnic variations in women's health: The social embeddedness of health. *American Journal of Public Health, 92*(4), 588-597. doi: 10.2105/ajph.92.4.588.

World Health Organization. (2010). *Poverty, social exclusion and health systems in the WHO European Region*. https://www.euro.who.int/__data/assets/pdf_file/0004/127525/e94499.pdf

World Health Organization. (2022). *Tackling structural racism and ethnicity-based discrimination in health*. Retrieved Dec 23, 2022, from https://www.who.int/activities/tackling-structural-racism-and-ethnicity-based-discrimination-in-health.