

**A STUDY OF THAI WOMEN AS HEALTH TOUR PARTICIPANTS
IN RELATION TO LIFESTYLE AND LEISURE PRACTICE**

PIMMADA WICHASIN

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ABSTRACT

The main aim of this research study was to explore the participation of Thai women in domestic health tours, more specifically the 'preventative' type of health tour. The aim of this kind of tour is to encourage the participants to change their lifestyle to healthier ones, in part so that they can prevent illness or, in some cases, lessen the effects of an existing illness. The research investigated the respondents' participation in these tours both in relation to their leisure patterns and lifestyles and to their adoption of a healthy lifestyle.

In order to achieve the overall aim and objectives of this research, an extensive review of the literature supported the primary research study which involved a participant observation study of a commercially-organised preventative health tour. Subsequently, two sets of interviews were undertaken with Thai female health tour participants with the second set being undertaken three years after the first series. The primary data obtained were rigorously analysed both qualitatively and quantitatively to determine the range of socio-demographic and other factors which determine the leisure patterns and practices of Thai women, their participation in health tours, and their adoption of healthy lifestyles.

The results clearly demonstrated that age was the most important determinant of leisure choices, practices and patterns of the respondents the majority of whom were drawn from the upper middle and upper classes of Thai society. In terms of their adoption of a healthy lifestyle experience, age was also the key determinant.

In addition, the data obtained from the first series of interviews were analysed both qualitatively and quantitatively to investigate the existence of demonstrable groupings of health tour participants. According to the qualitative data analysis, it suggested the existence of five such groups while the quantitatively-based cluster analysis indicated the existence of three groupings. The comparability and credibility of these groups are discussed and a random sample of the five qualitatively-determined groups were interviewed a second time, primarily to investigate their adherence to, adoption or rejection of a healthy lifestyle. The results of the first and second series of the interviews demonstrated that health tour participation led to the adoption of a healthy lifestyle for slightly less than half of the respondents.

The results of this study indicate that, contrary to what may have been anticipated, the factors that influence and determine the leisure and lifestyle practices and choices of Thai women living in major urban environments show many similarities with those in Western society although the underlying cultural milieu is founded on different cultural foundations.

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CHAPTER 1

INTRODUCTION

1.1 Tourism In Thailand

In the early day of Thai travelling, it was mostly related to religious pilgrimage to Buddhist temples or holy place. Before World War II, religious tourism was popular among the Thais and they travelled mainly by coach or train and they always stayed at friends' or relatives' rather than staying in the hotel. Tourism facilities at that time seemed to cater for international tourists rather than the domestic one. However, after 1987, the economy of Thailand grew quickly. As a result, domestic tourism has grown. In the Sixth Development Plan (1987-91), tourism was identified as a source of employment, as well as means of economic decentralisation, environmental conservation and infrastructure investment (Kontogeorgopoulos, 1999, p.317).

After World War II and the Vietnam War, the number of international tourists increased, especially American tourists. Thailand was famous for 'Rest and Recreation'. Seaside resorts were booming. Unfortunately, in the 1970s and 1980s, Thailand's reputation was damaged by the reputation of sex tourism.

After the war ended, the Americans left and there were more Japanese, Arabian and European tourists. These were predominantly business tourists and Thailand changed from the place for rest and recreation into place to come for relaxing while doing business. Therefore, more high-end amenities were developed such as hotels, travel services, exclusive clubs and golf courts. In the meantime, the inexpensive accommodations and tourism facilities were still available for the backpacker (Kaosa-ard, et.al,1998).

In 1997, Thailand faced a financial crisis. Also, in relation to tourism, the tourist arrivals from East Asian countries declined. However, the Thai government still viewed tourism as a saviour of the country. TAT launched the campaign 'Amazing Thailand' in 1998-1999 to attract the international tourists. This campaign was considered very successful for branding Thailand. This campaign reflected the point of view of Thai government which perceived promotion and marketing were the most important aspects of tourism management (Kaosa-ard, et.al.,1998) Again, in the Eighth Plan (1997-2001), Thai government involved tourism with other aspect of national development programme with the reason that tourism has the export-oriented quality as same as other products (Kontogeorgopoulos,1999).

Tourism Authority of Thailand (T.A.T) did the 'Amazing Thailand' campaign again in the year 2000 with the highlight of the attractions of spas, hospital and herbal products (Cohen, 2006).

In 2003, Thailand faced the SARS problem. Also, there was the Tsunami situation in 2004. This decreased the visitors to come to the country. However, from 2005, the growth rate of the visitors started the increase and was predictable that the growth rate would be increasing and be stable till 2008. The only risk which would decrease the growth rate relates to the political problems by Muslim asking for independence of the four provinces in the Southern part of Thailand.

Table 1:1 The target of tourism in Thailand from 1997-2005 (TAT, 2006b)

Year	International						
	Tourist		Avarage	Average Expenditure		Revenue	
	Number	Change	Length of Stay	/person/day	Change	Million	Change
	(Million)	(%)	(Days)	(Baht)	(%)	(Baht)	(%)
1997 ^{/1}	7.22	+0.41	8.33	3,671.87	-0.92	220,754	+0.63
1998 ^{/1}	7.76	+7.53	8.40	3,712.93	+1.12	242,177	+9.70
1999 ^{/1}	8.58	+10.50	7.96	3,704.54	-0.23	253,018	+4.48
2000 ^{/1}	9.51	+10.82	7.77	3,861.19	+4.23	285,272	+12.75
2001 ^{/1}	10.06	+5.82	7.93	3,748.00	-2.93	299,047	+4.83
2002 ^{/1}	10.80	+7.33	7.98	3,753.74	+0.15	323,484	+8.17
2003 ^{/1}	10.00	-7.36	8.19	3,774.50	+0.55	309,269	-4.39
2004 ^{/1}	11.65	+16.46	8.13	4,057.85	+7.51	384,360	+24.28
2005 ^{/1}	11.52	-1.51	8.20	3,890.13	-4.13	367,380	-4.42

Year	Domestic						
	Thal Visitor		Avarage	Average Expenditure		Revenue	
	Trlp	Change	Length of Stay	/person/day	Change	Million	Change
	(Million)	(%)	(Days)	(Baht)	(%)	(Baht)	(%)
1997 ^{/1}	52.05	-0.79	2.31	1,466.00	+11.57	180,388.00	+14.66
1998 ^{/1}	51.68	-0.72	2.37	1,512.70	+3.19	187,897.82	+4.16
1999 ^{/1}	53.62	+3.02	2.43	1,523.55	+2.29	203,179.00	+7.42
2000 ^{/1}	54.74	+2.08	2.48	1,717.77	+12.75	210,516.15	+3.61
2001 ^{/1}	58.62	+7.09	2.51	1,702.70	-0.88	223,732.14	+6.28
2002 ^{/1}	61.82	+5.45	2.55	1,689.52	-0.77	235,337.15	+5.19
2003 ^{/1}	69.36	+12.20	2.61	1,824.38	+7.98	289,986.81	+23.22
2004 ^{/1}	74.80	+7.84	2.60	1,852.33	+1.53	317,224.62	+9.39
2005 ^{/1}	79.53	+6.33	2.73	1,768.87	-4.51	334,716.79	+5.51

1.2 Research rational

The provision of a subsidised health care system for their own population is a feature of many developed countries. Thailand also provides a subsidised health care service for the Thai population, and in practice, there are four schemes of health insurance, which are;

1. Civil servants medical benefit scheme. It was introduced in the 1960s for civil servants and their dependants
2. Low income card scheme. This was introduced in the 1970s, providing free care to low income families and individuals, elderly people, children under 12 years, and people with disabilities
3. Voluntary health card scheme. This was introduced in the 1980s and this scheme is predominantly for the rural population and is funded through equal matched payments from the household and Ministry of Public Health payments
4. Social security scheme. This was introduced in the 1990s and it protects workers only and is compulsory for all private firms with more than one employee (Towse, Mills and Tangcharoensathien, 2003).

Even with these four schemes, not all the Thai population gain complete health benefits. As a result, the role of government in reinforcing healthy lifestyle patterns as a form of preventative medicine is not strong. Finally, in 2002 the campaign '30 baht treat all' was introduced under the rule of former Prime Minister Taksin Shinawatra. This campaign aimed to merge the four schemes into one universal scheme to remove overlaps in coverage and improve equity. With this campaign, people pay 30 baht (50 pence) for each visit or admission to the health care service.

As a result, educational public health campaigns for preventative medicine and healthy lifestyle are being reinforced by the action of governments. The overall effect, in many cases, is to encourage people to increase their interest in the use of their leisure time to improve their health. Originally, the healthy lifestyle ideal was deeply rooted in Thai culture from ancient times. For example, Thai food is quite healthy in its emphasis on fresh ingredients and flavour (TAT, 2001a, p.2). Most of the ingredients used in Thai cooking have medicinal benefits from plants, herbs and spices which ensure a nutritious balanced diet and well-being. Besides, Thai massage claims to restore balance among the elements because it is combined with yoga and acupressure techniques. The massage techniques are known to lessen disorders such as epilepsy, the early stages of paralysis as well as more common ailments including fevers, headache, backache, stomach ache and other pains stemming from tension (ibid).

Before the arrival of modern medicine, herbalists played the dual role of doctor-pharmacist. Formerly, village doctors were monks or former monks since Buddhist temples were the centre of learning, not only of religion but also of more worldly matters like astrology and medicine. Furthermore, Thai people have always known the value of matching bodily fitness with mental health through the influence of Buddhism, the national religion. Meditation plays an important role in sustaining healthy lifestyle. Through meditation, the practitioner seeks some degree of detachment from the material world and draws on inner peace for the sense of well-being.

It is noticed that Buddhism and traditional Thai food play an essential part in the healthy lifestyle of Thais in the past. Along with numerous benefits, the urbanisation, modernisation and Westernisation of Thai society has also discouraged the traditional way of life of Thai people. For example, the dietary habits of Thais changed from eating home cooked healthy food rich in herbs to out of home and fast food. The religious habit of Thai has also changed. Temple participation and meditation are abandoned due to the pace of life in the city. In the meantime, modern medicine has been widely introduced and the lifestyles which can be preventative were neglected due to the changing belief that illnesses can be cured by modern medicines. Therefore, the recent government public health campaigns urge Thais to look back to their own roots and lead the healthy traditional way of life.

Alongside the campaign from the Ministry of Health, health tourism was domestically and internationally promoted by Tourism Authority of Thailand. It is one specific feature related to the healthy lifestyle. Thailand is quite well known in Asia for its tourism industry and health tourism is one of the upcoming popular forms of modern tourism. The Thai government views health tourism as a rising star and plans to promote Thailand as a centre of excellent health of Asia.

In this research, domestic health tourism is the main interest. According to the review of the literature, four main categories of health tourism destinations in Thailand emerge. They are amenity resorts and hotels with spas, day spas, destination spas and health resorts and lastly medical-oriented destinations. From those four types, the medically oriented destinations are more focused. The medical orientation can vary from preventative health tours to cosmetic surgery. In this case, the preventive health tour is the focus of the research study. This kind of tour refers to the tour set in natural environment which offers well-being practices relating to food, exercise, meditation, colonic irrigation, stress control, heat treatment and massage. In other words, health tour practice urges the participant to get back into their own roots and live closer to nature. Mostly, the aim of this preventative health tour is to encourage

the participants to change their lifestyle into healthier ones so that they can prevent illness. Also, there is a belief that changing lifestyle can lessen some of illnesses such as diabetes, rheumatoid arthritis, gout, high blood pressure, cancer, etc.

This research focuses in this kind of tour because, being different from other types of health tourism, the health tour organisers teach health tour participants to practice a healthy lifestyle by themselves. Health tour participants are not being pampered like in spa tourism or medical tourism. This research intends to investigate if there will be any lifestyle changes after learning how to lead healthy lifestyle after participating in health tour it will also study the participation in health tours by Thai women who have caring roles in the family, therefore, they can be the main influence in their families for leading healthy lifestyles.

1.3 Main aim and objectives

The aim of this research is to explore the participation of Thai women in health tours in relation both to their leisure patterns and lifestyles and to their adoption of a healthy lifestyle. The research has five objectives which are;

1. To examine the concept of leisure and lifestyle of Thai women. The general concepts of leisure and lifestyle will be achieved by a secondary review of the literature while the concept of leisure and lifestyle of Thai women will be investigated through primary research
2. To examine the concept and development of health tourism in Thailand. This objective will be accomplished by the literature review.
3. To identify factors affecting the participation in health tourism by Thai women. To achieve this objective, primary research by semi-structured interviews will be undertaken.
4. To determine if there are distinct and demonstrable categories of health tour participants. This objective will be explored through the analysis of primary data.
5. To investigate the relationship between participation in health tour and the adoption of a healthy lifestyle. To reach this objective, a second series of semi-structured interviews will be carried out three years after the first interview among the same sample to compare and contrast their adoption, or otherwise, of healthy lifestyles.

Apart from this specific aim and the associated objectives a more general question arises namely that will there be differences between the priorities, patterns and leisure practices of Thai women, given that the cultural and ethical values in Thai Society are based in Buddhist teaching and women in western societies, whose culture historically embody Judeao-Christian values. This question is relevant not least because much of the research and resulting

theoretical development into women's leisure has been conducted and developed in western society

1.4 Methodological approach

This research has been conducted with the data collected over the course of three years and there was the follow up stage due to one of the objectives, which is to investigate the relationship between participation in health tours and the adoption of a healthy lifestyle. Three years are considered to be an appropriate time scale because it is long enough to investigate the pattern of lifestyle of the health tour participants after they joined the tour. This research applies the pragmatic paradigm where the main concern is to achieve the aim of the research without being too concerned about which paradigm is superior. The pragmatic paradigm supports both qualitative and quantitative methods at various stages in the research depending upon the research questions and objectives. A 'qualitative' approach was applied to explore the participation in health tours by Thai women with their leisure patterns and lifestyles and it was conducted in a natural setting with the use of participant observation and the semi-structure interview as data collection methods. At the same time, this research adopted a quantitative approach due to the fact the primary research also contains quantitative data collected during the in depth interviews. This quantitative data needed to be analysed by quantitative analysis, and it was also possible to quantitise the qualitative findings and include these in a quantitative analysis.

There are seven phases in the methodological progress. They are the literature review, participant observation, first series of interviews, qualitative analysis, quantitative analysis, second series of interviews and comparative analysis. The literature review phase was the period devoting for collecting the secondary data as background for the primary research. After reviewing all related literature, primary data collection had to be conducted. This consisted of participant observation phase and interview phase. In the participant observation phase, the researcher joined a health tour in December 2002. This activity encouraged familiarity with some of the sampling populations, which helped to run the next phase, interviews, smoothly.

One hundred Thai female health tour participants were chosen for the semi-structure interviews. The participants were divided into two main groups, the experienced health tour participants and the current health tour participants. The experienced group comprised 50 women who had joined a health tour six months earlier and the current group were women who joined the tour in December 2002, the time of the first phase of interviews. The reason for dividing the participants into two groups was to determine if behavioural lifestyle changes

in relation to the health tour participation can be observed over the course of six months. This pattern of changes can be compared to the result of the second interview in the next three years to investigate if health tour participants adopt the lifestyles they learnt from health tour. Interviews were conducted among the 'current' group of participants to determine their reactions immediately after they had participated in a health tour so that these behaviours can be compared to those revealed in the second interview.

The analysis phase employed both qualitative and quantitative techniques. The qualitative analysis phase was undertaken using s QSR NVivo software. As a result, the concept of leisure, healthy lifestyle and the participation of health tours were explored and the categories of health tour participants were determined based upon the adoption of a healthy lifestyle. Quantitative analysis was undertaken using cluster analysis (SPSS software) in order to identify relationships between dependent and independent variables and to determine if there are distinct and demonstrable categories of health tour participant. As a result, the health tour participants were categorised by two methods, QSR NVivo and Cluster analysis in order to identify similarities and differences between the groups emerging from the application of these two analytical approaches. The next phase was the follow up phase, which are the second series of interviews. The objective of these interviews was to investigate the relationship of participating in health tours and the adoption of a healthy lifestyle. In this follow up phase, 25 percent of women from the group emerging from qualitative analysis were chosen selected. The last phase was the comparison of the findings from the first series of interviews phase with the finding from the second series.

1.5 Contribution to knowledge

The result of this research will contribute as;

1. Methodological benefits.

- o The use of multiple methodological approaches will inform the approach adopted by subsequent researchers.
- o This research gives more understanding about and support for the pragmatic paradigm.
- o The use of longitudinal study can be example for the further research about the changes through the period of time.

2. Social benefits

- o The investigation of this research can help Thai government in promotion the holistic self-care and preventative medicine to Thai populations. The findings from this research can help the government to identify the key characteristic of women who can change their lifestyle into healthier ones so that the

government know which group need to be emphasised. Also, this research focuses on Thai women. With the caring role, women can have influence over the family members.

3. Marketing benefit

- o This research also furthers the understanding about health tour participation. In particular, it will provide a better understanding about health tour participants.
- o As this research suggests a categorisation of health tour participants, it will assist health tourism supplier in term of marketing strategies.

1.6 Limitation of study

1. The limitation of time. In the first interview, the researcher spent four months interviewing a hundred female health tour participants. However, for the second interview, the researcher had only one month available.
2. The limitation of the population.
 - a. The specific group of population. Due to the participants of this research are the particular group of people, the finding of the research cannot be generalised or adopted to other countries. The participants of this research are health tour participants. The least expensive health tour course costs around £100-150 for three days, while other health tours are more expensive. Clearly in a Thai context, the majority of participants are middle class, upper middle class to upper class. Thus, the finding from this study cannot be extrapolated to the Thai population in general.
 - b. The size of the population. There is the relatively small numbers of the sample particularly in the second interview. In the first interview, a hundred female health tour participants were chosen. As a result of the analysis, eight categories of health tour participants arose. One of the objectives of the research is to investigate the adoption of a healthy lifestyle in relation to health tour participation. Therefore a second interview was conducted three years after the first one. One quarter of the respondents allocated to each of the five qualitatively determined categories were randomly selected for interview. Due to the small size of the population in the second interview, changes in lifestyle patterns can be observed but can not be expressed in statistical terms.

3. The limitation of time and costs. The cost both in terms of the time needed and the travel costs, of undertaking face to face semi-structured interviews with respondents living in Bangkok was very considerable consequently it was not possible to conduct a second series of face to face interviews and the second series of interviews were conducted by telephone.

1.7 Structure of thesis

This research has ten chapters. They are as shown below;

Chapter 1: introduces the study. It consists of the brief background knowledge about tourism in Thailand, rationale for the study and introduces the situation of health tourism in Thailand. It provides a brief concept of the area of study, and presents the aim and objectives, the methodological approach adopted and indicates both the contribution to knowledge the research will provide whilst identifying the limitations of the study.

Chapter 2: presents the general concept of leisure and lifestyle starting from the contrasting view of leisure and the concept of leisure for this study. The increase in leisure and leisure motivations and demands are also reviewed. Next, the examination of leisure participation, leisure socialisation and leisure constraints is illustrated. A range of topics relating to women and their leisure are introduced, these are, the concepts of leisure by women, women and their leisure opportunities, women and constraints upon their leisure, work and leisure, the transformation of women and leisure and gender tourism. The concept of lifestyle is discussed followed by a review of the arguments about consumerism and consumption in relation to class structure. In addition the theory of Pierre Bourdieu's *Distinction* is referred to while the relationship of lifestyle and class is also discussed. Finally, the connection of lifestyle and health is investigated.

Chapter 3: describes the relationship of health and tourism followed by the definitions of health tourism and the history of health tourism. Moreover, the factors giving rise of health tourism are examined. Since one of the objectives is to categorise health tour participants, earlier research about health tourism consumers is reviewed. After reviewing the literature, the characteristics of health tourism consumers are grouped based upon the emphasis placed upon health by the holiday makers. Four types of health tourists are identified as being; leisure health holiday tourists, pampered tourists, well-being tourists and medical tourists. Health tourism destinations are then reviewed from the perspective of health tourism consumers. These are the amenity resorts and hotels with spas, the luxury spas, the destination spas and health resorts and the medical health centres. Next, the health tourism characteristics of different regions are presented starting with health tourism in Europe, the US, Asia and

then Thailand. Lastly, the health tourism destinations in Thailand are reviewed followed by an overview of domestic health tourism in Thailand, the main focus of this research.

Chapter 4: discusses the nature of Thai society by indicating the generic values of Thai society in term of gender, age, income, education, occupation and religion. Next, nine characteristics of Thai society: ego orientation; grateful relationship orientation; smooth interpersonal relationship orientation; flexibility and adjustment orientation; religious-psychical orientation; education and competence orientation; inter-dependence orientation; fun-pleasure orientation; and achievement-task orientation are presented. Then, the class structure of Thai society is introduced and other characteristics of Thai society are illustrated. Also, the differences between urban and rural Thai society are discussed. Lastly, two essential changes, demographic and economic, which have given rise to the changes in Thai society, are revealed as these changes affect the status of Thai women.

Chapter 5: discusses the methodology applied in this research to achieve the aim. This chapter presents the paradigm adopted in this research, and the ethical considerations. As this research applies both the qualitative and quantitative approaches a comparison of both approaches is discussed. Lastly, the seven phases of the methodological process are illustrated.

Chapter 6: is the qualitative findings chapter about leisure and lifestyle of Thai women. The findings were obtained from the first semi-structure interviews of health tour participants about leisure and healthy lifestyle. This chapter can be divided into two main parts. The first part provides the findings about views towards the leisure patterns of the participants, their perceptions of the importance of leisure activities, their leisure activities and their family leisure activities. Also, the relationship of work and leisure is presented in this part ending with the participants' opinions towards the patriarchal system of Thai society are demonstrated. The second part is about healthy lifestyle of participants. The attitudes towards 'healthy lifestyle' of participants are portrayed and so are motivations of leading healthy lifestyle.

Chapter 7: is the qualitative finding chapter about health tour participation of Thai women, in which data collected by the participant observation and the semi-structure interview is presented. To begin with, this chapter presents the journal style report from what the researcher observed while participating in health tour. Then, the findings from the semi-structure interview are illustrated beginning with the motivations for participating in the health tour, the decision making process before joining the tour and the actual participation in health tour. Next, the post health tour effects are presented such as the satisfaction and benefits from health tour. Then, the categorisation of health tour participants emerging from

the qualitative analysis is discussed. Lastly, this chapter presents the comparative findings of the first stage interview and the follow up interview, which took place three years after the first interview. Healthy lifestyle adoptions of health tour participants in relation to their health tour participation after three years are revealed and the rearrangement of the groups emerging from the changes were discussed.

Chapter 8: describes the relationship of initial qualitative findings with the demographic profiles of the health tour participants. There are ten individual demographic variables are analysed quantitatively along side with the initial qualitative findings. They are age, marital status, educational attainment, subject studied, educational institution, career, income, accommodation type, accommodation ownership, car ownership. The findings in this chapter are divided into three main parts, which are women and leisure, women and healthy lifestyle and women and health tour participation. Lastly, the categorisation of health tour participants emerging from the quantitative analysis is discussed.

Chapter 9: provides a discussion of the relationship between the findings of the primary research and the theoretical underpinning emerging from the literature reviews. The discussion chapter is argued based upon the main aim and objectives. It starts from the exploration of the leisure pattern of health tour participants following by their health tour participation and their healthy lifestyle adoption.

Chapter 10: provides a conclusion of the thesis and recommendations for future research.

CHAPTER 2

LEISURE AND LIFESTYLE

This chapter provides background knowledge about leisure and lifestyle. To begin with, various definitions of leisure are introduced and discussed. Factors contributing to an increase in leisure activities are then explored followed by an introduction to various theories of motivation and an explanation of the needs for leisure. Thereafter, leisure demand, leisure participation, leisure socialisation and leisure constraints are reviewed. The relationship of women and leisure is then presented starting from a definition of leisure by women leading to leisure opportunities and leisure constraints of women. The section then develops with a discussion of work and leisure of women with a particular focus on the increasing individualisation of women, the transformative idea of women and leisure and gender tourism. Next, the section introduces the concept of lifestyle, followed by the theory of consumerism and the relationship of consumption, class, social status and lifestyle. Finally, those factors affecting the popularity of lifestyle are mentioned along with Pierre Bourdieu's *Distinction* theory. Lastly, the relationship of leisure, lifestyle and health is illustrated.

2.1. Definition of Leisure

The word 'leisure', originates from the Latin 'licere' which means 'to be permitted' or 'to be free' while the French word 'loisir' means 'free time' which mostly relates to the English word 'liberty' and 'license' (Goodale and Witt, 1980). Godbey proposed the definition of leisure as 'living in relative freedom from the external compulsive forces to one's culture and physical environment so as to be able to act from internally compelling love in ways that are personally pleasing, intuitively worthwhile, and provide a basis from faith' (Godbey, 1999, p. 12). However, leisure is somehow defined in terms of 'freedom from constraint', 'opportunity to choose', 'time left over work', 'free time after obligatory social duties have been met'. The concept of leisure is various and there are many analytical approaches and views of leisure proposed by many theorists.

2.2. Contrasting views of leisure

2.2.1. Leisure as time

Historically, Aristotle referred to leisure as 'available time'. It is the time free from the necessity to work. Leisure is the time for thought, contemplation, philosophy and self-

development for happiness. It leads to aesthetic, spiritual or intellectual enlightenment through a search of understanding (Torkildsen, 1983, p.26).

Haywood et.al. (1989, p.2) defined leisure as residual time which was viewed as unobligated time as 'discretionary time to use is relatively freely chosen ways, when the obligations of work and subsistence have been met'. Goodale and Witt (1980) also defined free time as the residual time after the account of work time, sleep time and for personal care were taken. It was a time in which one is relatively free of economic, social or physical restriction or consumption. Conceptually, free time is considered ideal and unattainable and it allows for preferential behaviour while obligatory time involves the expectation of a particular kind of behaviour (Goodale and Witt, 1980).

2.2.2 Leisure as activity

Classically, leisure was perceived as the activities which enlightened and educated. In the present day, leisure is described as a 'cluster of activities' (Torkildsen, 1983, p.26). Leisure is seen as a range of activities in which people choose to participate during their free time. And the activities are characterized as playful and pleasurable and are often referred to as recreation (Haywood et. al., 1989). The International Group of the Social Sciences of Leisure states that: 'Leisure consists of a number of occupations in which the individual may indulge of his own free will whether to rest, amuse himself, to add to this knowledge, or improve his skills disinterestedly or to increase his voluntary participation in the life of the community after discharging his professional, family and social duties' (Torkildsen, 1983, p.27). Kelly (1991) and Stanley (1976) also defined leisure as activity as well but he stressed that the quality of activity or the person engaging in the activity should be concerned.

Max Kaplan (cited in Stanley, 1976) pointed out that anything or any specific activity can become a basis of leisure. Some of the main suggested elements are;

1. an antithesis to work as an economic function
2. a psychological perception of freedom
3. a minimum of involuntary social-role obligations
4. a range from inconsequence and insignificance to weightiness and importance

2.2.3. Leisure as freedom

Pieper (cited in Torkildsen, 1983, p.27) stressed this idea as 'Leisure, it must be understood, is a mental and spiritual attitude. It is not simply the result of external factors. It is not

inevitable result of spare time, a holiday, a weekend, or a vacation'. Leisure includes elements such as perceived freedom, intrinsic motivation and concentration on the experience rather than external ends (Kelly, 1991). Neulinger (cited in Kelly, 1991) took an attitudinal approach by viewing leisure as a concern with people's attitudes and perceptions. Leisure was the perception of free choice for the sake of doing or experiencing. He argued the essential criteria for leisure is the condition of perceived freedom. Gordon Dahl (cited in Stanley, 1976, p18) wrote 'the leisure that people need today is not free time but a free spirit, not more hobbies or amusements but a sense of grace and peace which will let us beyond our busy schedules'. To de Grazia (cited in Tolkinsen, 1983), leisure was a state of being free of everyday necessity. He thought that leisure perfected man and held the key to the future.

2.2.4. Leisure as functional

Leisure performs useful functions for individuals and for society. According to Dumazedier (cited in Haywood, 1989, p.4), leisure has three primary functions, which are relaxation, entertainment and personal development. Also, leisure is seen as a means to achieve socially desired and approved ends. It is described in terms as 'therapeutic', 'remedial'. It is less concerned with defining how leisure is best identified and measured than with how leisure is used. In terms of a functional approach, it is concerned about people's lifestyle. Functionally, leisure is associated 'with health and fitness for its own sake; with self-fulfilment through the mastery of skills and knowledge; with social cohesion through the sharing of common interests; and with community development through collective action and sociability'. From the social perspective leisure, is seen as a means to promote self-growth and help others. Leisure should serve a useful purpose. However, this may lead to a stressful attitude toward leisure in which achievement during leisure activity is over emphasized (Leitner and Leitner, 1996). Max Kaplan has attempted to combine the various concepts of leisure into a compound definition as;

Leisure consists of relatively self-determined activity/ experience that falls into one's free time roles, that is seen as anticipation and recollection, that potentially covers the whole range of commitments and intensity, that contains characteristics, norms and constraints and that provides opportunities for recreation, personal growth and service to others'

Cited in Haywood, 1989, p.8

2.3. The increasing significance of leisure

Godbey (1999) has discussed a number of factors that influence the increase in leisure in the present. They are presented as follow;

1. The increased production of material goods through the application of technology.

2. The creation of labour saving devices for household maintenance and other essential duties.
3. The decline of the influence of social institutions such as the church and the family in establishing roles for individuals in all aspects of life. This leads to the greater extent will of human beings since fewer usable guidelines for behaviour exist.
4. Differences in attitudes toward pleasure. Today, people have become more pleasure seeking than in the past, when in the western world they were influenced by the Puritan concept.
5. Substantial increases in the education level of individuals have led to an expansion of interest in various activities.
6. Lack of physical weariness formerly associated with many forms of employment. Work for many today requires less physical energy. Therefore, individuals can enjoy a variety of leisure activities that require intensive energy.
7. An increase in discretionary income which gives rise to increases in leisure spending and the potential to participate in many activities.
8. Greater potential for choice among women and minorities for broadening their activities, especially leisure outside home.
9. Earlier retirement and later entry into the labour force
10. Deferred marriage and smaller families.

2.4. Motivation and needs for leisure

The nature and process of leisure is motivational. There are many theories about motivations and needs for leisure as described below.

2.4.1. Maslow's hierarchy of needs

Maslow's theory (1954) is one of the most widely referred to and used theories of motivation. The concept of this theory is that individuals have a number of needs, which fall into five broad classifications;

1. Physiological Needs: hunger, thirst, rest, sex, exercise etc.
2. Safety Needs: Protection from danger; the need to exist under the system of rules and boundaries. Freedom from fear and anxiety.
3. Love and Belongingness Needs: Socialisation and intimacy such as friendship, affection, receiving love.
4. Self-esteem Needs: Recognition and achievement, self-confidence, reputation, prestige.
5. Self-actualisation Needs: Realizing one's full potential, self-fulfilment

Leitner and Leitner (1996) proposed examples of recreational activities that could contribute to meet each of the needs of Maslow's hierarchy;

1. Physiological Needs: Running, bicycling (exercise), Dining out (Hunger, thirst).
2. Safety Needs: Tennis, Volleyball, Soccer (All are activities with rules and boundaries).
3. Love and belongingness Needs: Volunteer work, membership in organisations or clubs and socialising (All of these activities involve social interaction).
4. Self-esteem Needs: Art work (receiving praise for complete projects raises self-esteem) tennis (beating opponent feels great).
5. Self-actualisation Needs: Drama, performing music (each of these activities is limitless potential for improvement and help developing a variety of skills and abilities), (Leitner and Leitner, 1996, p. 87-88).

2.4.2. Tillman's theory of leisure needs

Having considered Maslow's hierarchy, Tillman (cited in Torkildsen, 1983, p.80) had opinions that needs are not necessarily set in hierarchical order. Needs can be overlapping and occur simultaneously. He examined needs and identified ten aspects which were important in determining the leisure needs of people.

1. New experience like adventure
2. Relaxation, escape and fantasy
3. Recognition and identity
4. Security-being free from thirst, hunger and pain
5. Dominance- to direct others or control one's environment
6. Response and social interaction-to relate and react to others
7. Mental activity-to perceive and understand
8. Creativity
9. Service to others- the need to be needed
10. Physical activity and fitness

2.4.3. Iso-Ahola's model of causality of leisure behaviour

Iso-Ahola's model represents causes of leisure behaviour, which can be divided into two causes; open causes and hidden causes. Another interesting aspect of this model is that situational influences and social environment affect both the open and the hidden causes of leisure behaviour. Situational influence refers to the specific situation in which the leisure

behaviour is occurring. The Social environment, meanwhile, refers to more general ideas about social norms that affect leisure behaviour in a broader sense (Leitner and Leitner, 1996).

2.5. Leisure demand

Stanley (1976) presented his ideas about factors affecting the demand for leisure in *The Sociology of Leisure* as;

1. Time available. In the present day, normal working hours have been reduced and some firms introduce flexible working hours which offer greater opportunity to change work patterns and the leisure day. Moreover, there are now more public and employment-based annual holidays, especially with the increasing length of the paid holiday entitlement. These lead to the growth in the holiday industry. Leisure time can vary from the evening, half day, whole day, weekend or long weekend.
2. Money available. People having increasing incomes leads to increasing leisure participation. However, it is difficult to make a correlation between low income and low cost pursuits or between high income and more expensive pursuits.
3. Class position. It is always measured in terms of broad occupational groups. Like Kelly's theory (1991), it was found that the higher-status occupational group had a much wider recreational experience than others.
4. Level of education. The curriculum in educational system introduces students to an increasing range of 'interest' leisure activities.
5. Car ownership. This helps increasing participation in leisure pursuits as a whole and in certain activities in particular such as those out of home leisure activities. For example, the vacation can be taken by car such as the scenic drives, picnics, going to the beach.
6. Stage in the life cycle. The leisure activities will vary between ages.
7. Demographic and Geographical factors. These factors influence the level and type of demand for leisure activities.
8. Traditional and current attitude toward leisure and recreation. These affect the level of public support to establish leisure facilities of different kinds of leisure activities.

2.6. Leisure participation

Heywood et.al. (1989) proposed the following four propositions about leisure participation as;

Proposition 1: People choose their leisure activities. Without this choice, the idea of leisure would have no meaning. There are various factors which describe personal choices in

participating leisure activities. These are free time from work and other obligations, how the time is spread across the day week or year, where one lives in relation to distribution of leisure facilities and lastly individuals' circumstance in amount of money they are willing or able to spend on leisure and their physical and psychological capabilities.

Proposition 2: People's choice of leisure is circumscribed by a number of acknowledged conditions. Torkildsen (1983) classified factors affecting leisure choice into three main categories:

1. Individual, personal and family influences. These factors are considered as age, stage in family life-cycle, gender and education.

- Age and stage in family life-cycle. The availability of time is concerned and it is found that the greatest amount of free time appears at the age of adolescent and the retired, rather than the middle age group who live under the pressure of time. Even though the active leisure activities decline with increasing age, home-based leisure activities are still popular in the middle age group. Life-cycle change is another factor affecting the leisure participation. Participation may increase with increased age with the result of children leaving home or a persons retiring from work as well. Age can influence in term of level of fitness and energy but reduction in family and work responsibilities can have much more influence for leisure participation.
- Gender. Females have constraint in leisure participation. The two main reasons are family commitment and way of their upbringing which does not include pursuits like physical recreation. Women take greater part in 'cultural activities' than physical activities while men take part in active sports and sport spectatorship.
- Education and educational attainment. The type of education, the length of education and the education attainment have great impact to the leisure participation as they are related to upbringing, class, occupation, income and other factors. It is found that the higher the qualification, the greater the degree of participation.

2. Social and situational circumstances. These factors include home, school, work environment, income, mobility, time, social class, and social roles and group belonging.

- Income. It is related to leisure participation. Higher amount of income leads to a rise in leisure participation. Since income is related to education and social class, it is not surprising that higher income groups participate in a greater volume and variety of activities. The choice of activities and the

amount of money that people can spend on the entrance fees, equipment, and travel and so on are dependent on disposable income. The unemployed will have little disposable income. Families with highest income tend to spend a smaller amount of their income on essentials such as food and clothing and greater income on non-essentials such as recreation. The lower income groups prefer / wish to have more income to have more leisure. Personal property is another factor influence the leisure choice. People with more income and more personal property tend to have a wider choice for leisure pursuits.

- **Social class.** It can be 'a grouping of people into categories on the basis of occupation' (Torkildsen, 1983, p.96) while occupation is closely related to others such as education, income and mobility. From the UK General Household Survey, it was found that 'it was professional workers who tended to have the highest participation rates in leisure activities and the unskilled worker who had the lowest rates' (ibid).
- **Social climate.** This refers to a complex of factors in addition to those which relate to age, gender, income, occupation and education. They can be attitudes and value of people in their social setting. Emmet (cited in Torkildsen, 1983, p.97) undertook research of social climate proposed the word 'social filter' to present the factor controlling people who use particular facilities and affecting the behaviour of those people. They influence people's adoption of attitudes and behaviour appropriate to the situation. And behaviour can become habits. Leigh pointed out that 'The habits of leisure and habits of mind as well as habits of behaviour' (ibid).

3. **Opportunities.** They give the possibility for a person to participate in leisure activities. Opportunities can come in various forms such as available resources and services, political policies, management styles and system, community leadership, support and accessibility and so on. Griffiths (cited in Torkildsen, 1983, p.97) stated in the conclusion from his study in Greenwich that 'accessibility' is the key factor influencing recreation participation .And it is defined as 'ability to participate'. He explained about the accessibility as followed:

- **Perception.** It is experienced as it is seen, heard, smelt, felt and tasted. The way people perceive leisure facilities and activities will influence their participation. Positive perception of leisure opportunity will enhance the desire and motivation to participate.

- Access and supply. Apart from transportation which can influence leisure participation, the actual location of the leisure facilities has great effect as well.
- Awareness. If people do not know that leisure facilities exist, there is no opportunity for them to participate. Awareness can be created by enhancing the people to see, to hear or to read about the leisure pursuits.

Proposition 3: People's leisure activity is related to the ways in which society is structured by social class, gender and race.

Proposition 2 points out the awareness of individual about their leisure constraints while this proposition emphasises social divisions given rise to differences and inequalities in leisure. These include material inequalities of income, availability of free time, access to leisure resources and cultural inequalities, in perceptions of appropriate behaviour and meaning of activities for different participants (Haywood, 1989, p.125). Gender is a social construct and relates to society's conception of the attitudes, qualities and roles appropriate for men and women (ibid. p.126) The term race or ethnicity refers to a cluster of beliefs, attitudes and behaviour which distinguishes one social, racial or cultural group from others (ibid. p.143).

Proposition 4: People's leisure activity is related to unacknowledged conditions of existence. They are the basis for attitudes, perceptions and values which both facilitate and constrain leisure choice. Apart from Haywood (1989), Kelly (1991) also believed that the differential opportunities to pursue leisure are indexed by many variables such as gender, race, occupation, income, education level, marital status etc. This he called the 'Social Determination model. He also proposed the 'Economic and Opportunities model' which stated that:

- The lower class, the poor and disinherited are excluded from the opportunities and resources that others take for granted because they have no discretionary income. Therefore, their leisure tends to be the activities that cost free and without travel and high equipment costs.
- The very wealthy can travel and purchase access of special resources to demonstrate their leisure styles.
- One element of class is education. It is an essential aspect for economic opportunity and social space in which tastes and ability are developed.
- Economic resources to purchase or rent access to leisure opportunities are indexed by social class. People in the status of upper investment segment of economy, managers and professionals have more control over their work schedules and are able to integrate work and leisure schedules flexibly (ibid).

2.7. Leisure socialisation

Siegenthaler and O'Dell (2000) conducted research about the influence of family members upon leisure participation. They emphasised the two-sided social interactions involving pairs such as parent-children or husband-wife. This is called dyadic (two person) relationships. This research clarified the role of the family towards leisure socialisation. As individuals interact, verbally and nonverbally, they influence one another's preferences and options. Also, partners in long-term relationships have a great effect on each other. Stokowski and Lee (1991) claimed that individuals who have a strong bond with the family are likely to do their leisure activities with their family members. As a result, their leisure choices are influenced by family members.

Concerning the idea of partners and attitudes towards leisure choices, it is suggested that sharing leisure time within the family influences personal and social development and may define the nature of the relationship. For couples, in the beginning of their courtship, they might share their leisure interest and continue into marriage (Orthner et al., 1994). Orthner (1976) believed that married couples tend to choose leisure activities that enable them to interact as they desire and that reinforce their marital pattern. The leisure activities can be the joint or independent leisure. Hill (1988) also suggested that the similarity of values and leisure activities within couples contributes to marital satisfaction and marital stability. Locke (1951) compared happily married and divorced couples and found that happily married couples are more likely to agree on recreation needs and the value of spending time together. Gerson (1960) reported that marital satisfaction of college couples is enhanced by similar leisure attitudes.

Parents have long been acknowledged as the primary sources in shaping the attitudes and behaviours of children and adolescents (Kelly and Kelly, 1994). Six major domains of family behaviour in which the family environment can theoretically influence a child were identified by Child development research. They are physical development, emotional development, social development, cognitive development, moral and spiritual development, and cultural and aesthetic development (Landesman, Jaccard, and Gunderson, 1991). Parents are the role model for their children in the early age by guiding their children to develop their self-concepts and thinking process, which leads to the development of the attitudes and values. As the children are growing up, they are not dependent upon their parents and move their interests to peer influence or their own interdependence. Most of the studies emphasise the parental influence upon childhood and early adolescence. Little research has been conducted

in the case of the long term influence of parents on the adult children (Cooney, 1997 cited in Siedenthaler and O'Dell, 2000).

In term of leisure, parents can guide the positive attitudes about leisure in general or negative attitudes about various forms of leisure (Hultsman, 1993). Orthner (1994) suggested that children who were encouraged to have a positive idea about leisure activities and made choices about their own leisure demonstrated the positive idea about leisure when they mature. Leisure behaviour may change in early adulthood as individuals attend college and experience greater independence and fewer constraints (Raymore, 1995 cited in Siegenthaler and O'Dell, 2000). In most cases, however, leisure behaviour patterns are stable across the transition from adolescence to young adulthood. Kelly (1977) found that more than 60% of leisure activities engaged in during adulthood began with family during childhood.

2.8. Perceived freedom in leisure and leisure constraints

Neulinger (1981, p.15) defined perceived freedom 'as a state in which the person feels that what he/she is doing is done by choice and because one wants to do it.' Mannell and Kleiber (1997) pointed out that perceived freedom is a matter of degree. Rusbult and Arriaga (1997) proposed 'The theory of interdependence', which suggested that family members were influential in developing the patterns of attribution. Individuals who experience high levels of perceived freedom in leisure perceive themselves to be competent and able to control what happens before, during, and after leisure participation. Those who have low levels of perceived freedom in leisure may perceive helplessness in leisure and rely on others to provide opportunities for leisure (Ellis and Witt, 1986 cited in Siegenthaler and O'Dell, 2000).

Jackson (1997) defined leisure constraints as reasons, perceived or experienced, why an individual is inhibited in or prohibited from leisure-activity. Early work by Crawford and Godbey (1987) described three categories of constraints: intrapersonal, interpersonal, and structural. *Intrapersonal constraints* include perceptions of oneself that primarily shape the expression of preferences. Perceived self-skill, kin and non-kin attitudes, and perceived appropriateness of activities are examples given for this category. The *interpersonal* category includes constraints that are results of relationships with others. Examples include the inability to find a partner or friends with whom to pursue the desired leisure activity, insufficient money and time availability, and too many family obligations. *Structural constraints* involve resources and reasons that intervene between leisure preferences and activity participation. This category includes constraints such as transportation and facility availability, and the availability of opportunity. Jackson and Godbey (1993) claimed that

some people were more successful in negotiating constraints than others. Crawford et al. (1991) proposed that leisure participation depends on the individual's ability to recognise and overcome each constraint as it arises. However, non-participation may occur because of inability to negotiate multiple constraints (Crawford et al., 1991). An individual who can move beyond constraints should perceive greater leisure freedom. (Mannell & Kleiber, 1997). Jackson (1990) found that individuals who had the greatest desire to participate in leisure activities reported the fewest constraints while those who had less desire to participate reported more constraints. Jackson et al. (1993) pointed that successful negotiation of constraints may enhance the leisure experience.

2.9. Women and leisure

2.9.1. Definition of leisure by women

From the study of Shaw (1985) about both men and women, it is found that women did not consistently classify the same events as work or leisure. Sometimes shopping and childcare were work, and sometimes they were leisure activities. However, the common elements in a definition of leisure included: enjoyment, relaxation, lack of evaluation, freedom of choice, and motivation. Deem (1986) also found that for women leisure typically involved the idea of free choice. Henderson (1994) argued that leisure as a concept is difficult for women to define and that it is better to use terms such as: enjoyment, pleasure, relaxation, and sociability. From the study of Martinson, Schwartz and Vaughan (2002), the broad idea of leisure was proposed as a multi-dimensional concept. Sometimes the participants wanted time alone, while at other times they sought engagement with friends, family, or significant others. As Diane1 reflected;

I have two definitions of [leisure]. Leisure for me, into myself, is spending time with the dog, reading . . . Many times those are activities I do alone . . . There's also another definition of leisure that's kind of related to other people. Swimming is certainly part of that, but I value that in a very different way. Another aspect was whether leisure was the focus of their energy as a primary activity or secondary to another activity.

As Connie puts it

I have two kinds [of leisure]. I have the kind where you come home from work and you sit on the couch, and your primary activity is something amusing like watching TV or reading or doing that kind of entertaining activity . . . when it's the primary activity. Whereas, if it's during a work thing, like . . . doing personal email . . . it's a secondary activity; I would count it as a charge break. It's still leisure, and I feel the need to intersperse it throughout my workday or else I just go nut.

Martinson, Schwartz and Vaughan, 2002, p.36

Considering the idea of leisure, a number of participants talked about taking a little time off from their work such as checking email or scanning an online humour journal. They did this to keep their energy up during their work time. This conforms with the pattern that Deem (1986) and Henderson et al. (1989) who found that women tend to engage in less visible 'minute vacations', short periods throughout the day when they take time just to be alone.

2.9.2. Women and leisure opportunities

In the past, a large amount of research has been carried about women and leisure and it was found that, compared to men, women had less opportunity for leisure participation. Some women were even restricted from realising their leisure opportunities. They believed that they had no right to leisure and this belief placed a severe limitation on their construction of time for leisure and attitudes towards leisure. Feminists suggested that women were often oppressed and powerless in leisure as in other spheres of their lives.

From the study of Biererma (2003), it is suggested that girls and women were subordinate to the dominant patriarchal system of power by the hidden curriculum teaching in school. The hidden curriculum includes gender roles, a devaluing of women, silence and invisibility, submission to male power and acceptance of role contradictions. Women and men were reemphasised the gendered power relations through out their lives (Biererma,2003, p.5). In some way, women are hardly aware of this gendered power relations and never question this.

Henderson and Bialeschki (1991) suggested the word 'entitlement' of leisure which was viewed as 'empowerment'. Lacking the sense of entitlement to leisure is viewed as a leisure constraint, which can be referred to any factor that intervenes between leisure and satisfaction with one's leisure. The constraints affect both the leisure preference and leisure participation.

2.9.3. Women's constraints of leisure

There are many factors forbidding women to pursuit leisure activities as they intended.

- Household obligations and family commitment is linked to the societal expectations about women's role expectations in the family. Women are expected to accept the domestic responsibilities, even if they are employed outside the home. The domestic tasks are unpaid work for women as if they perform the 'second shift' duties compared to men. And women who are employed outside of the home are often faced with the 'superwoman syndrome' of trying to do both her work and the domestic work. They try so hard to balance their responsibilities outside and inside the home (Willming and Gibson, 2000, p.125). Research about women and leisure time was

conducted by Griffiths and it was found that the young women he interviewed saw their adolescent and early adulthood as a time to have fun before they had to settle down and become tied down with the family responsibility. Women have the ethic of care. They neglect their own leisure opportunity to take care of others' need. Women may feel guilty if they spend time at leisure when they feel that they have so many other obligations (Henderson and Bialeschki, 1991). The ethic of care is a major subjective constraint that reduces women's enjoyment of leisure. The only choice of leisure is to combine a leisure activity such as watching the TV with a family or domestic responsibility such as childcare or housework.

- **Erosion of need for self-worth.** Women may recognise the need for self-care through leisure but in the condition that they have to have their sense of self-worth. And this sense is eroded in girls and women by a patriarchal social structure. Traditionally, family arrangement gives men authority over women. Women's unequal access to leisure was related with their husband's degree of control over their leisure participation, husband's labour force schedule and demands and women's financial dependence on men (Willming and Gibson, 2000) There is evidence that male control over female leisure and evidence of violence being used by husbands against their wives for questioning their authorities (Rojek, 1989).
- **Body image and fear of violence.** They have high level of fear of violence which will affect the pleasure in participating leisure pursuits at the night time. Women feel frightened or nervous about going out alone at night. In addition, low body image, low self-esteem and lack of confidence may reduce the chance of women to participate in particular activities such as swimming and aerobics. It may decrease the pleasure of pursuit because these activities have the social context that emphasis a women's appearance (Shaw, 1989).
- **Gender stereotype of activities.** Activities such as going to the cinema, music, theatre, leisure classes, going to park, seaside show little gender difference. But some activities are considered to be appropriate for males and others appropriate for females. Images of appropriate activities are cultivated through early the stages of life, different movement in physical education, and media portrayals of femininity and masculinity. Therefore, sports which do not contradict to the images of femininity are swimming, dance, gymnastics, figure skate and tennis while males traditionally prefer boxing, rugby, and football (Shaw, 1994).
- **Problems of space.** There are fewer institutional or public spaces where women feel free to attend alone. Women rarely have chance to go to the place that traditional

male venues as pubs, working men's clubs, some sport clubs, leisure centres and health clubs. Unless they are accompanied by men, they are tended to be considered as 'loose', 'looking for a man', which made women feel threatened by the sexual harassment of men in these contexts (ibid).

2.9.4. Women, work and leisure

Paid work outside the home has a great impact in changing women's view toward leisure. Throughout the industrial revolution, the labour of women was required. This helped women overcome educational discrimination and become economically independent. Burchell and Rubery (1994) undertook a research through the Social Change and Economic Life Initiative funded by the Economic and Social Research Council. They examined the differences which appear to be opening up to female labour force. The procedure identified five labour market segments, in three of which women were represented in significant numbers.

1. Primary- well paid, high social class, with a progressive history of career advance.
2. Stickers- much less well-paid, but with highest degree of satisfaction in their job situation, and little desire to change. Stickers tend to be slightly older than members of other groups.
3. Female descenders – a labour market segment, characterised by the lowest levels of pay, and the highest proportions of job changes to jobs of the same or worse status and pay. Women were unevenly distributed between the three categories, 25% being in the primary category, 46% being stickers and 30% descenders.

There is some debate about the impact of employment on women's leisure. The constraining effect of the 'double shift', in which women's paid work is combined with an additional domestic workload on a scale unmatched by their male partners, has been extensively documented. In contrast, being in paid work increased women's financial resources and social networks heightened their sense of entitlement to personal leisure and offer a contrasting scenario to the constraints of the domestic domain (Deem, 1982, 1986; Chambers, 1986; Green et al, 1990, Wimbush, 1986). Paid work enhances women's feelings of self-respect and power to influence domestic decision-making. It provides them with an independent identity separate from being someone's wife or mother. Another major advantage of paid work is the possibilities it affords for companionship and close friendships with other women (Green, et al., 1990).

From the study of Deem (1986), it was found that women could be empowered in their leisure through their involvement in employment. The demands of outside employment encouraged women to feel that they had the right and deserved to have time and space for their leisure

pursuits. It appears to endow women with 'more status as individuals in their own right'. Deem advocated female employment as an enabling device to improve women's access to leisure by giving them greater control over their lives than those who were unwaged. Economic independence can be a means for the wife to negotiate equality between her and her husband (Willming and Gibson, 2000). It was because these women had money which encouraged more household help and also led to the belief that they could organise their day better to plan for work, family and personal leisure.

From the study of Prassek and Bloks (1991), it is found that highly educated women in well paid jobs can usually afford child care facilities and usually employ domestic help and purchase time saving household appliances more often than lower educated and lower income women. They also have opportunities in their career lives and they still find some times to undertake professional courses in the evenings. Consequently, they feel more satisfied with their lives even when their full time work does not leave much time to spend with their families. In such circumstances, women had not only more money to spend, but also 'felt they had right to pursue leisure activities of which their husband disapproved', such as going to the pub with friends. Being employed was not only associated with a stronger feeling of entitlement to leisure, but also with greater freedom of choices in types of activities (Pahl, 1989).

2.9.5. Individualisation of women

One way of defining individualisation is to describe it in terms of the personal actualisation of one's potentials in different situations. Self actualisation in an immaterial sense means living one's life according to one's own ideas instead of living it according to traditional norms and values (Prassek and Blok, 1991). For men, to achieve their personal material goals as well as the immaterial values could be done by pursuing a working career. For women, the main realisation of their potentials mostly used to be concentrated in the home and family life. The choice for a professional career has only recently been available to the majority of women. One aspect of individualisation is the achievement of emotional and financial independence. Economical independence can be achieved mainly by working in a paid job. The participation of women in the employment force is therefore an important factor in the process of individualisation.

Prassek and Bloks (1991) conducted the research about the individualisation of Dutch women in the 1980s for the NIPO organisation in Netherlands. It was found that in 1988, women had a more or less equal relationship in terms of authority with men. Women tend to increase their independence within or outside relationship and the family. About 61% of the respondents

think that it is important to have their own room in the house. Women like to spend their leisure time without partner and children (76%) and go on holiday without partner or children (49%). It is not necessary to live with a partner (28%) and having own friends apart from the partner is very important (74%).

From the study of 1988 women, Prassek and Bloks categorised women into five segments concerning their individualisation. These are as follows;

1. **The Pioneer.** Most pioneers are between 25 and 40 years old. They are highly educated (56% while in the total sample this number is 23%) and have the highest income. Singles are strongly represented among pioneers (31% the mean is 21%). About 54% of the respondents in this group have a job and 23 % have a domestic help (mean 14%). Many of these women have made arrangements for their children while they are working. Pioneers think about themselves as independent women and they want the position of women in society to change (77% mean 46%). Pioneers are less satisfied with their lives, the amount of leisure time, the allocation of tasks in their households and the amount of affection they get than the other respondents but they are more satisfied about their own intelligent and the contact with their partner.
2. **The Supporter.** Supporters have a positive attitude toward individualisation but they don't give expression to these ideas. Supporters are mostly found in the age groups 30 till 45 years old and 55 years and older. They have an intermediate or higher vocational education. In this group, there are many women with a lower income and they usually have a partner and children. Supporters don't have jobs. They are housewives. They think of themselves as caring and responsible but they believe it is important to be independent.
3. **The In Between.** They consider the family as their basis but this doesn't mean that they hold on to traditional role patterns. The in between is 25 to 45 years old and has and intermediate educational level. Very often they are married (85% mean 67%) and have a part time job (42%). It is their task to do the household. Help with household chores is unusual (11%). When they work, their children are at the kindergarten. Their partner and their children are described as the most important people in their life. They are very satisfied with their life, their family and their allocation of tasks in the household but they would like to have more leisure time. They sympathise with the non-traditional ideas but they feel that the opportunities for women in society have already improved a lot.
4. **The Counterpart.** They are 45 years of age or older. They have a low to intermediate educational level. Singles are well represented in this group (35%, mean 16%). They

own a car (25%) and have their own room in the house. They have the domestic help. Most of them are unemployed. One can describe them as conservative women who believe that society is changing too fast and immorality is rising.

5. **The Traditionalist.** Traditionalists can be found in all age categories. They are married (82%, mean 67%) and a housewife with an average income and a high educational level (64%, mean 38%). They take care of the children and household activities. These women are satisfied with their traditional role patterns (80%, mean 49%). Sometimes they miss social contacts. The traditionalists are waiting for societal changes. Things are fine the way they are.

From the five patterns of women, it is seen that the attitudes towards individualisation correlates strongly with education. Age is also important but this relationship is less strong. Although this result is from a study conducted in 1988, one can expect the process of individualisation to continue since the educational level, secularisation and the proportion of working women increases. So, the numbers of pioneers, supporters and in between will grow.

2.9.6. Transformation Ideas of women and leisure

Women became be aware of their position within society and believe that leisure is the right of all. Family, business, politics and other constraints will be transferred into less social constructs by applying the principals learned through leisure and recreation experiences. (O'Neil, 1991, p.199). According to his study, Willming found that mothers with children could negotiate and resist domestic responsibilities associated with motherhood to pursue more meaningful activities. They found the way to escape from the 'super woman' syndrome. One way to negotiate the domestic responsibilities was to resist the expectation that their house had to be spotless and presentable to others. They felt that they did not need to keep their house looking clean as the way their mother's generation did (Willming and Gibson, 2000).

Henderson and Bialeschki (1991) undertook research about women's perceptions of leisure and evaluated the result as there were four major themes emerging from the analysis;

1. The emerging definition of leisure for these women was having choice, with the underlying prerequisites of having opportunities to choose either to do something that one personally wanted to do or to do nothing, and choose whether others were to be involved in the activity. There were two views of the prerequisites of leisure to women. Firstly, women viewed leisure as they had opportunities such as 'quiet time for myself', 'when I don't have to do anything', 'time to regroup to think through

things', 'making oneself feel good', 'doing nothing'. And another view was they had no obligation to others such as 'when I don't have to listen to other people', 'when I don't have to answer to others', 'not having any commitments', 'to have private time' and 'doing something you want to do and not something someone else wants you to do' (Henderson and Bialeschki, 1991, p.59).

2. The women in the study believed that they were entitled to leisure. And there were two typologies of women. One group definitely accepted as 'Of course' and another group accepted with the condition like 'Yes, but'.
3. Although almost all the women indicated that they were entitled to leisure in some way and that leisure was important, leisure was not a priority in their life. They clearly separated their lives into work, leisure and family and saw leisure as separate aspect of their lives that had some value but lower priority than other aspects.
4. Much diversity existed among women in their participation of entitlement to and priority for leisure (ibid).

The results of the research demonstrate the challenge of traditional constraints on women's time and activities. These women took time for themselves and engaged in activities that met their need for relaxation.

2.9.7. Recreation activity and leisure experiences of women

Historically, around the 1830s, leisure activities were home-based activities and sport activities such as jumping rope, badminton, riding, shooting. Upper class women would belong to clubs with appropriate facilities such as tennis. Most of the early recreation activities for 'western' women in the 19th century were outdoor-oriented because there were no indoor recreation facilities and outdoor activities were considered healthy for women. Any activities that emphasised beauty and aesthetic appeal in keeping with the female image were more acceptable from the viewpoint of society at that time. In the early 20th century, it was still more important for women to look good than to win. People, especially men, wanted women first and foremost to have a neat and attractive appearance. From 1930 to 1950, women continued to make small gains in their public leisure activities. Much of women's leisure was still home-centred and was a function of family and sex-role expectation. However, from 1960 onward recreation and leisure for women was perceived as an issue of freedom and equality (Bialeschki, et al., 1989).

However, in the 21st Century, there are still some reproductions of femininity through leisure participation. They are the pursuit of some physical activities such as aerobics, keep fit and

yoga. Also, the atmosphere generated in these classes often promotes the importance of physical appearance and the need for women to fit the societal ideal of the slim body image (Shaw, 1991). Thus, although aerobics participation for women may provide fitness and fun, another outcome of such participation may also be the reinforcement of women's concerns about their body image and the values society place on women's weight, shape and appearance (Frederick and Shaw, 1995). In these ways, the very act of participation can be seen to reinforcing traditional ideas about femininity.

From the study of Parry and Shaw (1999) about the role of leisure in women's experience of menopause and mid-life, it is suggested that all women had established leisure as a part of their lifestyles. Each woman chose a different form of leisure activities and experiences which provided the different meanings and conceptualisations. For example, some of the leisure activities the women reported included reading, baking, going to the theatre, working, exercising, and gardening. Some focused on the social interactional aspects of leisure and enjoyed activities such as spending time with family and friends or participating in group activities such as golf. Some women enjoyed solitary leisure pursuits such as painting or knitting. All of them were involved with some forms of physical leisure activity such as participation in Tai Chi, or having membership at a workout facility. These women felt that the physical leisure activities could give them the physical benefits. It was considered important to their health and well-being. Women in menopause period are faced with physical challenges as they recognise their aging process. The media has heavily promoted the benefits of exercise, therefore, women in this period of their lives considered exercise as physical activity to improve their health and lessen their illness risk.

On the contrary, less active form of leisure can provide enjoyment and positive self-attitudes. For all of the women in the study, leisure allows them to focus on themselves in a positive way and it seemed to facilitate the development of positive self-attitudes. All of the women were doing activities for their own pleasure. They also do some new leisure activities such as golf lessons, writing a book, going back to school, and speed walking.

2.9.8. Gender tourism

Regarding to the relationship of gender and tourism, gender can play the part of female labour in tourism industry and female as a role of the guest. As for the part of female labour in tourism industry, Jones(1992 cited in Foley and McGillivray, 2000) noted that although many studies showed that women dominated the tourism and hospitality sectors, only 4 % of middle/senior management were women. From the study of Foley and McGillivray (2000), three in four of female interviewee admitted that they needed to prove themselves in the male

dominated upper level job in the leisure industry. Sometimes, they put their career at the first priority in their life before their family or their own leisure time.

Apart from the struggling in the male dominated upper level jobs in the leisure industry, women are also portrayed very traditionally in the tourism promotion message. With the fact that in this day working women are one of the main targets for the tourism promotion, it is expected that tourism advertisement should target the better educated and independent working women with the strategy to portray them in the new position. Nevertheless, from the reviews of various researches, women are still portrayed in a 'traditional stereotype' in the mass media. The traditional stereotype can be referred to women with the image of domestic, sexy, helpless, non competitive, shy and passive (Sirakaya and Sonmez, 2000, p.354).

Goffman (1979) studied about gender portrays in print media. He found that the printed advertisement sample represented the gender role stereotype with the use of camera angles and photographic techniques to overemphasize men's actual size and height comparing to women. Also, the gesture of women in the advertisement looked submissive to men. Women were presented as passive while men were presented in an active role. For example, men were presented in doing sport while women were presented as touching something softly.

Heatwole (1989, cited in Sirakaya and Sonmez, 2000) proposed five hypotheses to explain the reason why women were portrayed in revealing and suggestive ways in the advertisement. Firstly, the advertisements suggested the warm surroundings with the presentation of women in swimming suit. Secondly, it aimed to attract male travellers with the presentation suggesting that there were beautiful women at that destination. Thirdly, it suggested female fantasy to look beautiful to attract women. Fourthly, this kind of advertisement was presented to attract visitors to the destination which was not that beautiful. Lastly, the picture presented that the destination was a place to indulge himself or herself.

Sirakaya and Sonmez (2000) studied the gender image in state tourism brochures and their findings supported the former literature about gender inequality. They cited Simondson (1995, p.23) and compared their work to hers.

'tourist brochures, and the imagery contained within them, are examples of the traces left by power, and can be considered the visual evidence of the points of contact between superior and inferior social groups who exist in a power relationship.'

Simondson's study was about the power relationship in the context of race and primitivism. She studied about the use of Aboriginal people in tourism promotion. Same argument can be applied to their study about the power relationship in the context of gender relations.

Regarding to the role of women as travellers, as mentioned earlier in the part of recreation activities and leisure experience of women, before the World War II, there was the clear distinction between leisure activities of men and women. While men did most of the out of home leisure activities, women mostly pursued the indoor ones. Since then, women entered into labour force and they became more independent. Outdoor leisure activities became practiced widely. (Collins and Tisdell, 2002).

According to Smith and Clurman (1997), "Women (have become) independent operators in the marketplace" (p. 212) and in the 1990s are an "increasingly influential market force" (Warner 1993, p. 22 cited in Pennington-Gray and Kerstetter, 2001, p.50) Talking about the working women, they are generally more educated, more economically independent and have more flexibility to travel than the homemakers who stay at home and raise families. In tourism and hospitality industries, women are regarded as consumers who play the essential part in the decision making process of families (Sirakaya and Sonmez, 2000).

Now, female travellers represent 50% of the pleasure travel market (Pennington-Gray and Kerstetter, 2001). Swain (1995) also mentioned about the need to focus on women who travel. Pennington-Gray and Kerstetter, (2001) undertook the study about the benefit sought by university-educated women who travel for pleasure. It is found that the benefits that were most important to them were those which were related to natural surroundings, education, shopping, family and excitement. They also found that education influenced the benefits sought through travel. For example, the participants mentioned about the benefits of travel as 'to increase my knowledge of different places' and 'to seek intellectual enrichment' (p.197). In contrast to previous researches by others, they found that the safety dimension was not a very important benefit in the pleasure vacation because the majority of the participants travelled with one or more people. They suggested that this might cause from the evaluation of the various destinations before they made a decision. These women travellers might eliminate the unsafe destinations from their list so safety was not the priority benefit in the pleasure travel. In contrary, women who travelled for business trip, safety might be the very important benefit because they could not choose their own destination. Pennington-Gray and Kerstetter also clustered the participants and three groups emerged, rest and relaxation seekers, family/social seekers and action seekers.

Apart from travelling more than in the past, women have an increasing potential to travelling solo. According to Travel Industry Association of America (TIA), it is estimated that nearly one quarter of US travellers (about 35 million adults) have taken a vacation by themselves in the past three years and 47 percent of this are female. The motivation is mostly the travel for

pleasure. Also, the survey conducted by the Association of British Travel agents showed that two in three people in relationships would like to holiday alone. Historically, women who travelled were from middle class background because this background provided them time, finances and social networks to realise a journey (cited in Chiang and Jogaratnam, 2006).

The study of Chiang and Jogaratnam (2006) about the motivation of women travelling solo found that 'getting to know how other people think,' 'how they live their lives' and 'exploring other cultures' were very important factors when they travelled alone. This suggests those female travellers who take a solo trip want to have new experiences and understand different ways of thinking and being in the world. Also, the solo travelling marks the sense of being independent to them. Women travelling alone can be the way to build confidence in their skills and self-care

Chiang and Jogaratna (2006) compare the differences of travel experience of women with men's. Three points were identified. Firstly, women tend to seek for experiences which are not related to their traditional stereotype, which are being domesticity, dependence and confinement. For example, from the research of Leeming and Tripp (1994), young women seek for more adventure and physical activity through their travel. Secondly, women have the distinct needs when they travel. For example, men seek for action and adventure without being scared of taking risks while women seek for cultural and educational experiences with security as a priority (Mieczkowski, 1990). Apart from that, the decision making process among men and women are different. Collins and Tisdell (2002) stated that most of their reviews in the mid 1980s in this area found out that husband dominated the decision-making process in family with children at home while they made joint decision in a family without children. The reviews also presented that the male dominance was stronger in families than among couples and children had little influence on the decision making process. The study of Nichols and Snepenger (1988) about the decision making of men and women found that women took shorter trips, spent less money and included fewer sporting-related activities while travelling than men. From a more recent study by Fodness (1992 cited in Collins and Tisdell, 2002), the result is opposed to the earlier studies. It was found that women were more of a dominant decision maker in the families with children at home. Thirdly, women travellers face more challenges than other kinds of travellers. Therefore, the main concern of women traveller is safety and security.

2.10. Lifestyle

Kelly and Freysinger (2000) refers to lifestyle as 'it consists of the bundles of activities and objects that make up our lives' (p. 68) These activities might distinguish out lives to be

different from others or vice versa. Various lifestyle typologies were proposed. One of them is the typology called 'Claritas'. It is the lifestyle typology based on consumption. This typology aims to identify markets for variety of goods and services and emphasises consumption, leisure, life course and location. The types can be kids and cul-de-sacs who stress parenting, pools; patios who have affluent elite tastes, the executive suites with high status cultural pursuits and lastly the upward-bound who are the young individuals interest in aerobics and the gadget. For more understanding, the next section discusses consumption in relation to lifestyle.

2.10.1. Consumerism

People can consume if they or others work. An objective of working is to be able to consume the product of one's own or someone else's labour or to enable another person or persons to do. In market economies where people work for money, they are presented a huge array of choices and invitations to spend and consume. Producers compete to sell goods and services by attempting to increase the attractiveness of the products through design, advertising and other market strategies. These processes generate the consumer culture. When most people have sufficient spending power to make consumer choices, consumer culture can become mass culture. What they choose to consume gives a sense of who people feel they are, their social identities and self-concepts. Consumption can construct the individual's conception of the kinds of people that they would like to be (Bocock, 1992). Also, Baudrillard (1988) argued that consumers do not purchase items of clothing, food, body decoration, furniture or a style of entertainment, etc. in order to express an already existing sense of who they are. Rather, people create a sense of who they are through what they consume. People try to become the being they desire to be by consuming the items that they imagine will help to create and sustain their idea of themselves, their image, and their identity. Consumption has become an active process involving the symbolic construction of a sense of individual identities. This sense of identity should no longer be seen as given to people by membership of a specific economic class, or social status group or directly by ethnicity or gender. Identities have to be actively constructed by more and more people for themselves.

2.10.2. Consumerism as a dominant culture

Consumerism has become increasingly central in people's life goals in some societies. Lury (1996) presents consumer culture as the material culture that has been dominant in Euro-America throughout the second half of the 20th century. People have been willing to work hard and long in order to satisfy their consumer aspirations. More and more goods and

services become commodities which are produced for and purchased by more and more people. These goods and services are packaged as commodities to be acquired by anyone who will pay the price. Holidays are bought as packages. Excitement and experiences can be bought by visiting theme parks. All types of experiences become things to buy. Goods and services are designed, packaged and promoted to make people aware of their availability and what the purchase will do for them. Consumers do not acquire just the material products but also the associated meanings. Being seen in the right restaurant, night club or holiday resort, and wearing the right brand label on one's shirt or trousers, advertises on individual's membership of 'people like that' (Robert, 1999).

2.10.3. Consumption, class and social status

The concept of social status and has its roots in the sociological perspective of the German sociologist, Max Weber (1864-1920). Weber expressed the view that social status was important, and the new bases of status had developed in modern industrial capitalism. Weber defined the term 'class' as follows;

The term 'class' refers to any group of people who have the same typical chance for supply of goods, external living conditions, and personal life experiences, insofar as this chance is determined by the...power... to dispose of goods or skills for the sake of income in a given economic order... 'Class situation' is, in this sense, ultimately a 'market situation

Weber, 1970, p. 181-182

According to Weber (1970), classes are normally formed in market places and in labour markets in the case of class to which the working population belonged. The basic condition of 'class' lies in the unequal distribution of economic power, which leads to the unequal distribution of opportunity. Status groups can be identified by degrees of prestige or honour that are attached to their style of life. He formulated the concept of status in such a way as to encompass the influence of ideas, beliefs and values upon the formation of groups without losing sight of economic conditions. Class and status play key roles in stratifying society and they are expressed through the lifestyle of different groups. He conceives lifestyle as a mark of status which enables a person to be recognised as belonging to a group. He believes that class positions depend on how people earn their money while their status depends on how they spend it. Social status groups use patterns of consumption as a means of establishing their rank or worth and differentiating themselves from others. All status groups use some markers to demarcate themselves from others. The markers they use to do this include group values about consumption such as the types of housing, furnishing and decoration; the type of

music they enjoyed; the kinds of clothing which are worn; the type of transport they used (Bocock, 1992).

Status groups are defined by a common lifestyle. It is more than a set of stylish characteristics which set a social tone and maintain boundaries between prestige groupings. Rather, 'a status group stands for a way of life; and such groups are consequently involved in a constant struggle for control of the means of a symbolic production through which their reality is constructed. Such struggles are the essence of status politics' (Page and Clelland, 1978, p.226). While there may frequently be a correspondence between class and status, they can nevertheless be seen as independent systems of classification. It is possible to conceive of an individual with high economic class but low status and vice versa.

2.10.4. Consumption and lifestyle

The notion of lifestyle emerges as part of the attempt to capture the set of changes in consumers' patterns of purchasing. Lifestyle may differ, not only between social class, as in the past, but also within social classes. Featherstone (1987) defined lifestyle as follows;

The term 'lifestyle' is currently in vogue. While the term has a more restricted sociological meaning in reference to the distinctive style of life of specific status groups, within contemporary consumer culture, it connotes individuality, self-expression, and a stylistic self-consciousness. One's body, clothes, speech, leisure and pastimes, are to be regarded as indicators of the individuality of taste and sense of style of the owner/consumer.

Mike Featherstone, 1987, p.55

In modern day society, lifestyle is not adopted through tradition or habit. The modern man, living in a consumer culture, makes lifestyle a life project. They display their individuality and sense of style in relation to the assemblage of goods, clothes, practices, experiences, appearance and bodily dispositions they design together into a lifestyle. The modern individual within a consumer culture is made conscious that he speaks not only with his clothes but his home, furnishings, decoration, car and other activities which are to be read and classified in terms of the presence and absence of taste (Featherstone, 1996, p.84). Willis (1990, p.137-138) has defined the relationship between marketing and lifestyle as follows;

The early history about marketing was precisely about separating consumer groups into socio-economic categories so that products could be aimed at them more exactly. Modern marketing, however, has moved on from delineating socio-economic groupings to exploring new categories of lifestyle, life stage and shared denominations of interest and aspiration. This is a crucial moved such it attempts to describe market segments not from 'objective' point of view but from the point of view of the consumer.

2.10.5. The popularity of lifestyles

Reimer (1995) presents four main reasons for the popularity of lifestyle concept. The first two reasons are based up on changes in the social structure which result in changes in people's way of life while the other two reasons refer to how academics have set about dealing with such changes. They are as follows;

1. Process of individualisation resulting in greater degrees of freedom and choice in a rapidly changing world.
2. Growth of a new middle class who are well-educated and well represented in service or communication professions.
3. Increasingly high academic profiles of debates concerning post-modernity in which the emergence of new value and lifestyles appear to play a key role.
4. The influential contribution of Pierre Bourdieu's work on lifestyles.

As the aim of this part is to give greater understanding about leisure, lifestyles and health and to demonstrate the relevant relationship, the theory of Bourdieu and the lifestyles of the new middle class will be discussed.

2.10.6. Pierre Bourdieu's *Distinction*

Pierre Bourdieu carried out a study in the 1970s in France and published the result in his *Distinction: A Social Critique of the Judgement of the Taste* (1984). He analysed the way in which status and class groups differentiate themselves one from another by patterns of consumption which help to distinguish one status group's way of life from another. His approach is called 'Structuralist' because he concentrated upon the structure of symbols and signs in their respective analyses of modern consumption (Bocock, 1993).

Bourdieu presents a theory of consumption and consumer lifestyles. He introduced the term 'habitus', which he defines as the everyday knowledge of cultural capital that reflects the routine experience of appropriate behaviour in particular cultures and subcultures. It is referring to the unconscious disposition, the classificatory schemes, taken-for granted preferences which are evident in the individual's sense of the appropriateness and validity of his taste from cultural goods and practices- art, food, holidays, hobbies, etc. (Bourdieu, 1984). Human experience is determined by habitus which not only operates on the level of everyday knowledge ability, but is inscribed onto the body, being revealed in body size, volume, shape, posture, way of walking, sitting, way of eating, drinking, amount of social space and time an

individual feels entitled to claim, degree of esteem for the body, pitch and tone of voice, accent, complexity of speech patterns, body gestures, facial expression, sense of ease with one's body. He argued that 'lifestyles are the systematic product of habitus, which perceived in their mutual relations through the schemes of the habitus, become sign systems that are socially qualified' (Bourdieu, 1984, p.172). He argued that a variety forms of capital could be seen to exist in a variety of social fields such as those of education (educational capital), economic wealth and income (economic capital), and aesthetics and taste (cultural capital). Acquisition of such capitals within these social fields allows for the formation of social groups. He discussed the processes involved in developing culturally appropriate forms of taste. From this point of view, lifestyle is about behaving in culturally accepted ways. It depends upon the cultural capital of the person concerned. It implies that the more cultural capital people have, the more extravagant their lifestyles are likely to be. However, there is a hierarchy of taste whereby certain activities are deemed more culturally appropriate than others. Lifestyle therefore plays an active role in upholding social hierarchies because some people have more access to cultural capital than others. The dominant class unconsciously gained the cultural capital such as cultural knowledge, beliefs and disposition in home, family, social networks and organisation. Being in the dominant class also gets more chance to be successful in life. So, group contexts and influences play a key role in the construction of people's lifestyles.

Bourdieu's research in French society produces a series of correlations relating the relative possession of cultural and economic capital to lifestyle. His research resulted in the following observation:

1. High volumes of economic capital. This relates to occupations in industrial and commercial management which in turn are related to a 'taste' for such as business meals, second homes, foreign cars, water skiing, tennis and the commercial theatre. This group aims to gather money capital, real estate, factories, shops, shares and bonds. Their way of life is in some ways like the conspicuous consumption patterns which Veblen (1872) has observed in his analysis of the American nouveaux riches in the late nineteenth century. However, this group tends to be less flashy and consume less conspicuously than the nouveaux riches in North America or in Europe.
2. High volumes of cultural capital. This relates to occupations in higher education, the professions, and the arts which in turn are related to a 'taste' for such as artistic 'avant garde', fringe theatre, intellectual games, backpacking, cycling. This group is called the bourgeoisie. He argues that the forms of intellectual and cultural capital are distinct from economic forms. This intellectual capital can be obtained from the

educational systems of modern industrial, capitalist societies. The group which earn the cultural capital through the education is called the petite bourgeoisie. They invest in cultural and education capital in order to be able to talk and write about culture, to create new cultural products, from philosophical and social science texts, to novels, paintings, building, films, television programmes, clothes, furniture and interior décor. The bourgeoisie and petite bourgeoisie are different in terms of perception towards themselves. Whereas the bourgeoisie has a sense of ease and confidence in their body, the petite bourgeoisie is uneasy with his body, constantly self-consciously checking, watching and correcting himself. Therefore, the attraction of body maintenance techniques, the new forms of exercise, cosmetics, health food, where the body is treated as a sign for others and not as an instrument. The petite bourgeoisie is the natural consumer because they search for the self-expression, fascination with identity, presentation and appearance.

2.10.7. Lifestyle and the middle class

Bourdieu suggested that people unconsciously recognise and reveal their own social position through a complex process of classifying themselves and others in terms of preferences for activities, possessions and performances. He also mentioned about the 'embodied cultural capital'. Manners and mannerism, posture and bearing, body shape, presentation and accent are embodied. These are reproduced and represented in many situations revealing social origins and position (p.108).

He stated that body could represent social class because different groups and classes cultivate different types of body and also engage in different type of body practices. The middle classes (junior executives, the medical services, school teachers, and the feminist) engage in the health-related concern activities such as the controlled diet and healthy lifestyle. These people are not confident about their body and will take a lot of exercise for the perfect body. This is the group of the petite bourgeoisie. This does not happen in the bourgeoisie, who are from the privilege background which has their own family tradition, early training and obligatory manner.

From the study of Warde (2006), he found that difference in educational level is an important indicator for the body maintenance. The higher level of the education people gain, the higher level of physical activity is involved for body maintenance. The educated middle class had attitude towards exercise as duty to assume a personal responsibility for taking care of the body. The implication is about the presentation of self and self-identity.

Mills (1972) claimed that 'the leisure of many middle class people is entirely made up by attempts to gratify their status claims. Just a work is made empty by the processes of alienation, so leisure is made hollow by status snobbery and the demands of emulative consumption...when the job becomes an insecure basis or even a negative one, then the sphere of leisure and appearance become more crucial for status' (Mills, 1972, p.141).

A description of Davidson, a new and affluent suburb of Sydney, Australia, illustrates the connections between leisure or the symbols of leisure and lifestyle and status.

People who live there are uniformly young, upwardly mobile and ostensible affluent. They did not fall into Davidson; they aspired of it...Davidson is about land, houses, garden and swimming pools. It epitomises the successful attainment of the Australian dream for much of the working and middle classes.....There is a stark obsession with expensive accessories, hobbies and consumer durable. Speedboats on the front lawns abound, and every house has a double garage.

Horin et al., 1985, p.1

Wynne (1998) studied the construction of social position among the new middle class residents on the Heath, an upmarket private housing development in North West England. He explored how different groups of residents developed different lifestyles, involving different uses of neighbourhood and other facilities. The Heath residents are divided into two different types of people. One lifestyle group was sport, avant-garde theatre productions and select 'a la carte' or self-constructed holidays. Their lifestyle and social identities were quite different from those of a group composed mainly of managers and the self-employed who participated in a drinking culture, bought expensive home furnishing, meals in steak houses, tickets to big shows in big cities and package holiday. He also emphasised that nowadays, middle class social identities are typically rooted not in the people's work but in their types of consumption and leisure practices.

Savage and his colleagues (1992) analysed the spending and activity patterns of the upper middle classes using data from large-scale market research in Britain. They distinguished three lifestyle groups among the highly educated professionals. First, public sector professionals having 'ascetic' lifestyles characterised by sport, healthy living and high culture pursuits. Second, managers and bureaucrats with below average consumption of high culture pursuits and sport activities, and with an otherwise undistinguished consumption profile. Finally, a group identified as exhibiting the characteristics of a 'postmodern lifestyle', defined as one lacking in any organising principle in terms of the direction of taste, but rather expressing an interest in both high and popular culture pursuits.

Eijck and Mommas (2004) conducted leisure and lifestyle research focusing on three segments of the Dutch upper middle class, namely civil servants, private sector employees and self-employed. As a result of their traditional cultural elite (e.g., government officials, teachers) as traditional job security, a modest income and above-average cultural resources, it is suggested that they expected the middle class employed in the public sector will demonstrate a leisure pattern as same as Bourdieu's (1984) notion of legitimate culture. In general, their consumption pattern is likely to do activities that require much time but little money as the traditional cultural elite invests in cultural capital such as time rather than material resources such as money. For example, they expected that the middle class working in the public sector are supposed to read books or visit museums rather than going to the bars or dance halls. In contrast, members of the middle class working in the private sector are likely to do less of those cultural activities. They are likely either to be more oriented toward commercial forms of entertainment or combine a certain interest in forms of culture with more popular or sociable forms of leisure such as visiting receptions and having outdoor dinners. This depends on their level of organisation and market orientation. The research expected that members of the new middle class working in the private sector participate more in popular activities than the public sector and self-employed members and engage more in sociable activities than the public sector workers. However, the result indicated that the self-employed leisure is likely to be more sociable and more costly expected. The importance of their social network, their image, and their "narrative of the self" demands a socially active lifestyle incorporating receptions, outdoor dinners, or going out in general. Their leisure activities are costly. For example, their cultural participation will be more likely to include attending performing arts than reading.

Maguire (2002) argued about the middle class and performance of body as the main concern of the middle class. The performance of the body can be referred to experience of exertion, illness, aging and body function. He also argued that the media had a great effect in emphasising the performance and appearance of body and that health and appearance had become a main concern in consumer culture, especially of middle class culture. This he suggests began with the expansion of middle class and lifestyle consumption in the 1960s when healthy leisure became part of a lifestyle pattern while at the beginning of the 1980s, exercise became popular worldwide under the influence of media promotion. Maguire studied which sections of the population read fitness texts. He demonstrated that this material is read largely by the middle class, especially women who outnumber male readers of fitness literature nearly two to one. In this research nearly half of the participants subscribed to a health magazines and knew about the health tour from these. Maguire suggested there were four relationships between fitness and consumers, who are middle class men and women.

Firstly, they are the changes in types of occupations. Since the late 1970s, the changes in labour market gave rise to the new middle classes, who are the groups of people whose works require they give regard to their appearance and presentation such as public sector officers with managerial and technical skills, private businessmen, estate agents, public relations etc. These kinds of careers encourage individuals to look after their health and appearance to ensure their livelihood. Maguire called this a 'body-for-others'. Secondly, they are the changes in social, political and athletic roles of women. This encourages women to view physical development as part of a new, empowered lifestyle. Thirdly, health care promotion encourages the idea of empowerment to both men and women as they have the power to control their bodies and health. Finally, there is the increasing ability of the media to affect the interest of consumers. In conclusion, Maguire argues that there are two factors affecting the rise of appearance and health concern in society. They are the creation of fitness as a lifestyle and leisure industry focused on the care and improvement of body and the interest of the new middle class and women in self-improvement, empowerment and health education (p.454).

2.11. Leisure, lifestyle and health

Contoyannis and Jones (2004) defined lifestyle as 'a set of behaviours which are considered to influence health and are generally considered to involve a considerable amount of free choice' (p.965). In using this definition, there is no implication that other characteristics of an individual's environment, both natural and social, are inconsequential. In the context with health, Wiley and Carmacho (1980) have defined lifestyle as 'discretionary activities affecting health status that are a part of one's daily life' (cited in Schank and Lawrence, 1993, p, 1236). According to the research conducted in 1965 with 7000 individuals in Alameda County, California, it is suggested that there were seven lifestyle factors influenced physical health status. They are diet, smoking, exercise, alcohol, sleep, weight (for height), and stress. Apart from stress, Contoyannis and Jones tried to measure the six factors among their research participants. Being asked about the idea of healthy behaviour, the participants gave the answers as sleeping well, taking breakfast, not smoking, consuming alcohol prudently, exercising and not being obese. According to the result of the research, participants in higher social group are leading healthier lifestyle than the lower social class groups. Koivusilta et al. (1999) posted that the interaction between social class and health-related lifestyle may arise from the economic possibilities and other contextual factors such as the organic food maybe expensive. This can limit the poor to have a healthy diet. Or living without car limits some forms of sports or exercises. For educational attainment, a similar pattern exists. The higher educated participants are healthier than the lower ones. For the employment status variables,

the part-time workers were in the healthy lifestyle groups. Those that are unemployed and who work shifts are more likely to have an unhealthy lifestyle. Lastly, those with a completely healthy lifestyle are more likely to be female and younger than those in other groups. Those who live with other smokers and whose parents both smoked are more likely to have an unhealthy lifestyle (Contoyannis and Jones, 2004).

2.11.1. Lifestyle and physical culture

Leisure can be functioned as self-improvement activities. Exercise and fitness can be the distinctive elements to express the relationship between self-improvement and lifestyle. After jogging boomed in the late 1970s, the fitness and health industry dramatically grew due to various benefits such as the decreasing stress, blood pressure, back pain, body fat, and blood glucose and triglyceride level. A large amount of research showed that regular exercise increased lean body mass, heart and lung function, immune function, blood vessels, blood flow, muscular strengths, flexibility, bone density and balance (Howell and Ingham, 2001). The mark of the 80s lifestyle is the 'Yuppie'. They were defined by their personal consumption, style and attitudes rather than their social position in the labour force. They simply live to buy. They are always linked to the fine cuisine, the automobile and other aspects of urban culture. Not only the material commodities were consumed by the Yuppies, the commodity form of their self and the body were consumed. This leads to more of the physical culture.

2.11.2. Leisure, lifestyle and spiritual well-being

In this day, spiritual well-being is considered as an important part of overall health based on the holistic view that health is multi-dimensional and includes physical, social, emotional, mental, and spiritual health (Heintzman and Mannell, 2003). Spiritual well-being was defined as 'A high level of faith, hope, and commitment in relation to a well-defined world viewer belief system that provides a sense of meaning and purpose to existence in general, and that offers an ethical path to personal fulfilment which includes connectedness with self, others, and a higher power or larger reality (Hawks, 1994, p. 6 cited in Heintzman and Mannell, 2003, p.208).

It has been found that leisure or leisure lifestyles influence overall health and spiritual well-being (Heintzman, 2000). Two studies of Ragheb (1989, 1993) suggested that people's leisure can be related to spiritual wellness. In a U.S. study of a random sample of 361 adults, Ragheb (1989) explored the respondents' leisure participation, motivation, attitude, satisfaction, and constraint scores with their physical, intellectual, emotional, social, and spiritual well-being

scores. It was found that positive attitudes and beliefs about leisure were most strongly associated with spiritual well-being. In his second study, Ragheb (1993) conceptualized overall wellness as having five main components: physical, mental, emotional, social, and spiritual. The purpose of the research is to investigate whether leisure participation and satisfaction were related to perceived wellness. Frequency of leisure participation and level of leisure satisfaction were found to be positively associated with overall perceived wellness, including spiritual wellness.

In summary, this chapter illustrated the background concept of two main interests, which were leisure and lifestyle. To begin with, the contrasting views of leisure were discussed such as leisure as time, as activities, as state of being and leisure as functional. Also, various factors given rise to leisure demands were illustrated following by the theories of leisure needs. In term of leisure participation, four propositions were given. Firstly, people could choose their own leisure activities. Leisure could not have any meaning if leisure is not freely chosen. Secondly, people's choices of leisure were circumscribed by many conditions such as individual or family influences, social and situational circumstances and opportunities in doing leisure activities. Thirdly, people's leisure activity was related to the ways in which society was structured by social class, gender and race. Lastly, people's leisure activity was related to unacknowledged conditions of existence. They were the basis for attitudes, perceptions and values which both facilitate and constrain leisure choice.

Regarding women and leisure, in the past, women had less opportunity participate in leisure activity than men due to many constraints such as household obligations and family commitment, erosion of need for self-worth, gender stereotype of activities, body image and problem of space. In this day, paid work of women plays essential part in changing women's view of leisure participation. Women also became more individualised.

The second main interest was the concept of lifestyle. Consumerism became the culture of everyday life. Consumption could construct the conception of kinds of people they would like to be. Class could be identified by economical resources while status can be identified by consumption style. This is to say that lifestyle could be the mark of status. Various researches about lifestyle and middle class were reviewed in this chapter. Lastly, the concepts of lifestyle and health were discussed. The next chapter presents the background of health tourism starting from the definition of health tourism, history of health tourism, growth of health tourism. Also, researches about health tourism consumers are reviewed. Lastly, health tourism in different levels is illustrated including domestic health tourism in Thailand.

CHAPTER 3

HEALTH TOURISM

Health has been an essential motive for travelling since ancient times. People simply travelled to nearby rivers and mineral springs for their curative properties and for relaxation. For example, people dipped and bathed in the Nile, in the Ganges, in the Yangtze, and in the River Jordan to be cleaned physically and spiritually (Goodrich, 1993). Many demographic, economic and lifestyle development gave rise to the growth in health tourism. For example, the aging population, the fascination with fitness and alternative therapies, for health maintenance and healing, and the nature of the health care system all these have contributed to the growing popularity of health tourism in recent decades.

Today health tourism comes under the label of special interest tourism. According to Loverseed (1998), travellers no longer concern themselves about only being at the destination, they aim to participate, learn about and experience the place they visit. They are in pursuit of more meaningful experiences, which will teach them something about themselves and about life. As people became more conscious about health, fitness and nutrition, it will, therefore, be beneficial for them if they have a chance to discover how to relax, how to remain healthy and even live longer, at the same time as enjoying a break from the routine of their daily life.

This chapter reviews the literature on health tourism by: considering the relationship between health and tourism, providing a historical perspective of health tourism, tracing the growth of health tourism, discussing the relationship of tourism and body, demonstrating the tourism specific advantages of health tourism, reviewing, categories of health tourism consumers, reviewing health tourism destinations in different regions of the world and concluding with a consideration of health tourism in Thailand.

3.1. Health and tourism

In 1976, the World Health Organisation defined health as 'A complete state of physical, mental and social well-being, not just the absence of disease or infirmity' (Jafari, 2000, p.272).

Concerning the word 'tourism', it was defined by the WTO as 'the activities of persons travelling to and staying in places outside their usual environment for not more than one consecutive year for leisure, business and other purposes' (WTO, 1993).

In connection with the root of these key words, strong linkages between the two can be seen. Tourism is a generic term usually used to describe many aspects of recreation and holiday taking. These terms in turn can link to the concept of healing and integration of body, mind and spirit. For example, the term recreation is associated with renewal, recharging, rejuvenation and revitalising the physical body. Moreover, the term holiday is derived from the 'holy days' or special days of rest and celebration. The holy days typically link to the rituals and festivals when people may anticipate a physical appreciation along with the spiritual dimension (Pollock and Williams, 2000). Throughout history, the search for health and well-being has long been the motivation of travellers. For example, the earliest documented form of holiday taking is pilgrimage tourism. Raju (1994 cited in Hunter-Jones, 2000) suggested that the central motive for the holidaymakers to make a sacred journey in former times was to improve their spiritual health and repay the wrongs of present day. Burkart and Medlik (1989) also proposed that health was the subdivision under the heading of other motivations of travelling apart from holiday, business and common interest tourism.

Moreover, travel motivation can be linked to Maslow's Hierarchy of Need theory, as discussed in the preceding chapter. Maslow (1954) proposed the following listing of needs arranged in the hierarchy;

1. Survival-hunger, rest, thirst, activity;
2. Safety- security, freedom from fear and anxiety;
3. Belonging and love- affection, giving and receiving love;
4. Esteem- self-esteem and esteem from others;
5. Self-actualisation-personal and fulfilment;

Health tourism can fit in the first two hierarchies. Travelling to obtain relief from tension can be seen as seeking to satisfy a basic survival or physiological need. Such motivation is for physical and mental relaxation. It can be seen that physical motivation can be related to health tourism because this motivation can be linked to the refreshment of body and mind. In addition, travelling for health can be interpreted as a way of attempting to satisfy one's safety needs. People can protect themselves and assure their longevity by taking care of body and mind. Health tourism can be seen as one way of assuring this (Mill, 1992). Besides, health tourism can also relate to the fourth and fifth levels in the sense that some people went to health tourism destinations in order to be accepted in the society or fulfilling their personal needs.

Health can be one of the motivations for decision making when planning for a holiday but its significance varies in intensity. One may travel for obtaining surgery, for example, while one may want to improve general fitness while being on a holiday by doing some sport (Laws, 1996).

3.2. Definition of health tourism

The precursor of the World Tourist Organisation, the International Union of Tourist Organisations, identified health tourism as '*a provision of health facilities utilizing the natural resources of a country, in particular water and climate*' (IUOTO, 1973, p.7). Goodrich and Goodrich (1987) defined health tourism as '*an attempt on the part of the tourism facility or destination to attract tourists by deliberately promoting its health-care services and facilities in addition to its regular amenities*' while Hall (1992) considered health tourism as primary motivator for the special interest tourism. Van Sliepen (in Goeldner, 1989, p.7) defined health tourism as (1) staying away from home (2) health as the most important motive and (3) done in a leisure setting. He identified five components of health tourism market as;

1. Sun and fun activities;
2. Engaging in healthy activities but health is not the central motive (adventure and sports tourism activities such as hiking, cycling and golf);
3. Principle motive for travel is health such as sea cruise or travel to a different climate;
4. Travel for sauna, massage and other health activities as spa or health resort;
5. Medical treatment.

According to Kasper (1996, cited in Mueller and Kaufmann, 2001), Health tourism is

the sum of all the relationships and phenomena resulting from a change of location and residence by people in order to promote, stabilize and, as appropriate, restore physical, mental and social well-being while using health services and for whom the place where they are staying is neither their principle nor permanent place of residence or work

Mueller and Kaufmann, 2001, p.7

3.3. History of health tourism

The earliest forms of tourism included visiting holy mineral springs. There is evidence from the Neolithic and Bronze ages that the water sources at Gritsy and St Sauveur in France, Forli in Italy and St Moritz in Switzerland were used in a ritual or sacred way (Smith and Jenner, 2000). In 2000 BC, the Babylonian word for the physician signified 'one who knows water'. In Greek mythology, many springs were the miraculous powers of healing and by the fifth century BC, the belief in the medicinal waters was well incorporated in the practice at the 'Asclepicia', which was built near the mineral or thermal springs (Gilbert and Van de Weerdt, 1991, p.5). Dating back to the earliest empires, it is said that Plato's ailments were cured by a hot sea water bath. Hippocrates also observed that the ocean cures men's diseases (Spivack, 1997, p.65).

In the Roman Empires, 'water' was used for treatment, fitness, and fun. The mineral springs were considered as having therapeutic benefit and being the social meeting places which had prominent architectural forms (Gilbert and Van de Weerd, 1991). Public bathing was established during the second century BC and in 33 BC, free public baths were introduced in the form of an institution which had one monument hall leading to another with hot baths, tepid baths, cold baths, message rooms, gymnasium, playing fields and library. In that era, mineral springs were called 'thermae' (Anderton, 1988). The term 'thermalist' was explained by Lowenthal as a term to indicate people who 'take a water' at the Spas, chiefly in Britain and Central Europe (Witt and Witt, 1989). Thermae could be the place for people to pay homage as much to human being as to the Gods. The Romans also discovered thermae that were still in use and established the shrine all over Europe (Gilbert and Van de Weerd, 1991).

The practice of taking the waters spread across Europe after the Roman Empire. However, after the fall of the Roman Empire, Christians reacted strongly against how their ancestors had behaved in the past and consequently, water culture fell into decline for many centuries (Gilbert and Van de Weerd, 1991). However, in the Middle Ages, thermae were developed to be of social significance again. The idea that thermal springs could have medical properties was firmly established by Bishop of Pamiers. He undertook the Inquisition Register for 1318-1325 and found out that the Sulphur baths at Aix les-Thermes were believed to cure skin diseases including ringworm, scabies and leprosy (Smith and Jenner, 1998). However, many years later, many public baths were closed during the epidemic of syphilis that swept across Europe in the last part of the fifteenth and early sixteenth century (Gilbert and Van de Weerd, 1991).

In the Renaissance era, visitors could only spend a set amount of time at the baths. Therefore, much time was left for other activities (Gilbert and Van de Weerd, 1991). The European thermae were patronised by the upper classes people such as princes, politicians, property-developers and medical men. These aristocrats created the thermae in the form of the Spas, which were considered as leisure centres. They established pavilions for the healing waters, ancillary buildings, assembly halls, promenades, hotels, casinos, and shops (Anderton, 1988). There was a shift in emphasis from health to pleasure and the relationship between health and recreation could be seen in the structures of most spas (Wightman and Wall, 1985). Later the emphasis shifted from leisure back to seeking the curative powers of the springs and development of health routines. This arose from scientific advancements in water therapy, which led to the creation of smaller specialised spas (Jamot, 1987 cited in Gilbert and Van de Weerd, 1991).

Spas is an acronym derived from the Latin 'solus per aqua', which means 'health by water' (Loverseed, 1998). This term originated from the name of an ancient town near Liegin in Belgium,

where people suffered from illness for centuries but eventually found the way to cure themselves by drinking and bathing in the water of the therapeutic springs (Jariyavet, 2001). In many European countries, the term spas has a distinct tourism connotation as a health resort with a variety of core products and services related to the use of mineral springs or thermal baths and a set of ancillary recreation and lodging facilities designed to appeal to the special interest tourist (Williams et al., 1996, p.12).

The spa culture of the past with its social and therapeutic elements is giving way to modern concepts of health tourism. In the late 19th century, the health benefits of the sea and mountain were promoted and popular among the emerging urban middle class due to the overcrowding pollution occurring in the big cities. In the US and other developed countries without traditional thermal spas, they expanded the definition of spa to include health resorts, centres and institutes that promoted healthy lifestyles. Health farms emerged in the early 20th century. During the early 1970's, the definition of spa was changed by the growth of health consciousness. The services provided emphasised fitness and a good diet. At the present day, health tourism is growing rapidly due to various reasons which will be explained in the next section.

3.4. The growth in health tourism

Many factors gave rise to the growth of health tourism. The principal ones are mentioned below;

3.4.1. Growing interest in health and fitness

There has been a growing interest in health and well-being amongst the population of the developed world over the last 30 years. Modern society has an increased awareness of health issues and a desire to enhance longevity. This has been brought about by the general pace of life, environmental issues and a genuine desire to feel better and live longer. Horner and Swarbrooke (1998) suggested that the post modern movement encouraged a growing interest in health. Consumerism is also the key to understanding this aspect of modern society. The media such as television programmes, magazines, books, newspapers etc. heavily promote the idea of inner well being and outer health. McCracken (1990) suggested that the images used in the media emphasise the beauty of female and male human bodies and the healthy living and fitness (cited in Laws, 1996). Similarly, Featherstone (1982) indicated that generally, people in modern day society pay more attention to improving their personal appearance. There has been the obsession of weight loss and the establishment of organizations such as Weight Watcher's to help people to monitor their regimes.

Many people nowadays, have therefore, increased their interest in the use of leisure time to improve their health and beauty. Horner and Swarbrooke (1998) stated that the use of leisure time might

range from a few hours or a weekend to a whole vacation. People tend to have a desire for improvement of their health. A Louis Harris Survey reported that 77 percent of all Americans at home or work participated in some regular exercise activity and 56 percent of all Americans considered the availability of health facilities important when planning their vacation (Spivack,1998). Therefore, many resorts and hotels have begun to develop spa facilities and health treatments within their complexes.

3.4.2. Alternative medicine

Alternative medicine has become increasingly accepted in medical society and by health companies (Loverseed, 1998). In 1997, 42 percent of American spent \$21 billion on non-traditional medical therapies and products (Ross, 2001). Alternative health is a mixture of different beliefs and techniques. The principles are outlined as follows (Shealy, 1996; Elupoulos, 1999);

4. The body has natural ability to heal itself;
5. Health and healing are state of emotional, mental, spiritual and physical balance.
6. Basic and good health practices build the foundation for healing;
7. Healing practices are individualised;
8. There are seven specific fields of the alternative medicine as follow (Kuhn, 1999):
9. Herbal medicine;
10. Diet and Nutrition. These focus on health maintenance and illness prevention;
11. Mind/ Body interventions. We can influence disease with our mind;
12. Alternative systems of healing such as acupuncture and Aired (The Indian art of natural healing);
13. Manual healing methods. These include a variety of touch and manipulation techniques;
14. Bioelectromagnetics. It is the study of living organisms and their interactions with electromagnetic fields;
15. Pharmacological and Biological treatments. These include drugs and vaccines;

3.4.3. Shifting consumer values

There is a trend of shifting from material things to experiences. Travellers are becoming more interested in improving themselves intellectually, emotionally and physically, than making money, getting promoted at work or acquiring the clothes, houses and cars. Harmsworth (1990) stated that 'We are no longer satisfied with material benefits. We desire better lifestyles to help us cope with increasing pressure and to enhance the quality of our lives' (Harmsworth, 1990, p.12). Human beings seek for meaning, self-fulfilment and self-autonomy, which lead to the higher quality of life. The health tourism facilities like spas and wellness centres can provide 'space and place' allowing

guests to seek harmony, balance and permanent lifestyle with the healing atmosphere (Pollock and Williams, 2000).

3.4.4. Increased stress

Work can create great pressure and impinge on one's personal time and space. Therefore, the need of having a more balanced lifestyle is recognised. Harmsworth (1990) mentioned that some companies place emphasis upon the need for greater health and fitness amongst their employees, and was recognising the benefits of preventative therapies. A study by the Office of Disease Prevention and Health Promotion for the US Department of Health and Human Services reported that 81% of work sites with more than 50 employees had health and wellness programmes established (Spivack, 1998).

A holiday can be one way to reduce stress arising from work and the changing pace of life. Most of the today's employers view holidays as 'vital to health and well being'. Taking a mini break is a new trend for the post modern society. It tends to be more relaxing than long holidays because it requires less planning, preparation, money and time (Pollock and Williams, 2000). There is a growing trend to use health resort or hotels offering health amenities for seminars, conferences and incentive travel in order to encourage the guests to improve their health as well as discuss business (Horner and Swarbrooke, 1998).

3.4.5. The mature leisure market

The increasing numbers of elderly people will affect the demand for health tourism. Brown (1995) stated that the first of the baby boomers (born between 1946 and 1964) would be reaching their 50s from the mid 1990's onwards. Mature people do not see themselves as inadequate, in fact they had a very young image of themselves, and want to stay fit and live longer. In the past, these baby boomers used their bodies and minds as machines to help them get ahead in the world. Decades later, these boomers are older and wiser. They seek for healthy ways to cope with their stressful lives. Health holidays, which highlight the combination of integrating the body, mind and spirit, can fulfil their needs. In the US, baby boomers make up almost a third of the population and are very conscious of the need to keep healthy and preserve their youthful look. They can be the major market for the health tourism. They spend about US\$ 1 billion annually on anti-aging treatment only (Loverseed, 1998). In 2001, there were 78 million of them in the United States alone and the boomers represent 60 percent of the spa market in the US (Ross, 2001).

3.4.6. The demographic market trends

Apart from the growth of the number of old people, another demographic trend affecting the growth of health tourism is the ratio of men to women in each country. Mostly, women live longer than men and they are likely to be single or widows. Harmsworth (1990) indicated that the working and individual female health market is increasing.

3.4.7. The health care system

The health care system itself in some countries encourages the residents to go for a health tour. For example, there are the long waiting lists for patients in England and Canada. Therefore, those patients tended to fly abroad in search of medical care. Also, cost can be the factor. For example, a cataract operation in France is cheaper than in England and it is even cheaper in India (Ross, 2001).

With regard to the growth of health tourism in the present day, many tour operators offer a variety of health tours. HealthyTravelNet.com listed a variety of 'Aroma Tours' including a 'Provence Aromatherapy Retreat' which includes meeting with aroma therapy experts and visit to distilleries of essential oils. It also has yoga-for-golfers tours to Hawaii. Mindbodytravel.com offers 'High Feminine Healing-A Sacred Women's Tour to Bali' which includes 'yoga, meditation and connection' mask making 'a purification ritual at a spring in one of Bali's most sacred temples' and two Spa treatments. HolidayBank.co.uk lists tour operators such as Thermalia Travel which arranges 'health and beauty vacations in Spas around the world' and Palmland Tours, offering 'Ayurvedic health holidays' at a lake resort in South Western India (Ross, 2001).

Moreover, cruise lines and hotels all over the world offer special fitness and wellness facilities to serve the need of clients. For example, the US famous destination Spas Canyon Ranch announced plans to build two cruise ships of its own. Each ship will be equipped with amenities such as 50,000-square-foot, state-of-the-art-gym, studios, and a rock climbing wall, a jogging track, 35 Spas treatment rooms, and a beauty salon. In addition, they will have a health and healing centre staffed by physicians, health educators, nutritionists, exercise physiologists, physical therapists and others (Ross, 2001). Even the airlines provide the ideas and opportunities for everyone to have healthy trip by providing a higher quality of travel environment including more frequent changes of air in the cabin and catering and seating facilities on board which reflect passengers' health concerns. Some airlines offer simple exercise advice or massage service to the passengers (Laws, 1996).

Health tourism places emphasis on physical and mental well-being. It is likely that in the future, health tourism will place more emphasis on mental health because of the increased stress in society.

There will be a growth in tourism related to stress relief and mental well-being. This may be involved with the growing popularity of retreats where the emphasis is upon spiritual recreation and relaxation (Ross, 2001). The growth of health tourism helps generating the benefits to the destinations. These tourism specific benefits will be explained in the next section.

3.5. Body and tourism

Veijola and Jokinen (1994 cited in Crouch and Desforages, 2003) discussed the relationship of holiday and body experience as they involve with activities such as the sunbathing, dancing and drinking.

Crouch (2003) discussed about the body and the surrounding as the body provides a point of 'affordance' between ourselves and our surroundings. Questions about the 'the increasing recognition of the plurality of senses that give access to the world' and the fact that tourism 'demands new metaphors based more on 'being, doing, touching and seeing rather than just 'seeing' have consequently been recognized' (Cloke and Perkins, 1998 cited in Crouch, 2003,p.1949).

Yarnal, Hutchinson and Chow (2006) undertook the research about the female fire fighter who learn about their bodies and use their bodies to be embodied. Goffman (1972 cited in Yarnal et.al. ,2006, p.155) mentioned body as a source of meaningful action that has potential to transform a situation by serving as a source of learning and knowing. Yarnal et.al. argued that the female fire fighter camp accommodated embodied learning in the sense that the structure of the camp encouraged the opportunities for the fire fighter to use their body in risky situations. The female fire fighters also had freedom to experience many ways of being physical without fear of external judgments by men. Apart from that, the activities in the camp encourage the participants to increase the sense of body control and competence. This gives confident to the participants to have more understanding about their bodies' potential.

Some feminist researchers talked about the theory that women used their own bodies in leisure context as sources of power and freedom from dominant discourse. Yarnel, et.al (2006) referred to Foucault (1980, p.106) as stated 'Bodies become docile and normalised through bodily discipline and self-surveillance'. People do the self-monitor to reaffirm and the dominant discourse. The self-monitoring can be done through fashion, diet, exercise and buying health products to make the body perfect.

Leisure and tourism provided the space to explore the role of expressive, sensual and elusory faculties of the body. The distinct example about the idea of embodiment is the beach experience.

People do to the beach to be touched by the sun, smell the seaweed, build sand castle and play ball games. She mentioned 'the desire to put one's feet or body in the sand, to be in the water, can be understood as meaning embodied-feel, touch, fluid and possibly not speakable' (Game, 1991, p. 177).

Another obvious example of the relationship of tourism and embodiment is the adventure tourism. This type of tourism requires the physical challenge. This creates the thrills and heightens new sensory experience of the participants. It is like the test of their bodies (Cloke and Perkins (1998 cited in Pons, 2003).

Crouch (2003) also stated that leisure and tourism activity had the unique feature of mobility. He further explained mobility as to arrive, at a space of distinct cultural and bodily encounter, where the individuals feel enable to negotiate his/her life differently (p.31). He gave example of the caravanner who described his experience at the ford. The caravanner stated that

'Caravanning, it all makes me smile inside. I mean, everyone just comes down to the ford and just stands there and watches life go by. It is amazing how you can have pleasure from something like that. I just sit down and look and I get so much enjoyment out of sitting and looking and doing nothing. We wake up in the morning, open the bedroom door and you're like breathing air into your living'

Weardale, 1997 cited in Crouch, 2003

Crouch explained that this man expressed the embodiment experience by feeling his body, encountering the space between the vans, smelling the different air.

3.6. Tourism specific advantages

Health tourism can provide many benefits to tourism destinations as shown below:

1. Health tourism can help countries and destinations diversify their overall tourism products and position themselves for a changing consumer market (Spivack, 1998).
2. Health tourism provides an opportunity for the reassessment and modernisation of existing facilities, which in turn can stimulate investment and create a significant impact on local economies. Health tourism will contribute to regional development because it will generate employment, increase government revenue and diversify the economy within many areas (ibid).
3. The development of spa tourism and health tourism can act to preserve natural resources such as hot springs, lakes, lagoons and seas (ibid).
4. The less seasonal characteristic of health tourism encourages the health-related activities to be taken place every month of the year. Moreover, health tourism can be combined

with other less seasonal tourism activities such as business and conference tourism. It can also be combined with some specific type of tourism such as ski tourism or sport tourism.

5. The repeat characteristic of many spa treatments requires the person under treatment and his or her companions to stay for a period of days
6. Spas and health-related activities help the hotel to fill beds. Harmsworth (1990) calculated that during the low season of 130 days in England, Spa facilities would improve normal hotel occupancy projections by some 14 percentage points. In a 250 bedroom operation, there would normally be about 8700 bed nights. Over the whole year, Spa facilities would increase the bed nights to around 16,500.

3.7. Research about the characteristics of health tourism consumers

Various researches about health tourism have been conducted. Interestingly, the main finding of each demonstrates the similarity of the characteristics of health tourism consumers. Viccriat (1984) conducted a survey of the international customers for health care products at the resort at Albano, Italy. The results indicates that the main market is 40-60 years old (50% over 55), female (59%) professional or middle and higher management with high incomes. Becheri (1989) suggested two distinctive groups of the health tourists. Firstly, the 'average' customers, who is an independent, self-employed professional or higher level manager, 35, 40 to 50 years old who are successful in their economic life and turn to be interested in their health. The second group is the thermal spring patients who have lower incomes. Goodrich and Goodrich (1987) analysed the characteristics of 206 health travellers who visited many countries, they demonstrated that;

- Average age is 39
- Average education is bachelor degree
- Average annual household income is \$ 41,000
- Average numbers of persons in family is 4
- Married 146 = 71 %
- Single 60 = 29%

Stanton (1992) reported on the characteristic of the health farm goers at Champneys, UK, as the AB socio-economic group. However, there is the market for the lower income group who save up to visit health farms every year. The majority of the customers are professional career women. The average age is 40-50 years old and most of them came on their own (60-90%) Their motivations are relaxation, slimming and detoxification.

CHRAQ (1993) presented the results of a survey conducted in Innova, US, by Health Fitness Dynamics, a spa consulting group, surveying 2000 spa users in 1992 at 27 US spas. It was found that the majority of the spa users were female (75%), married in their mid-forties having professional careers with an annual household income of \$100,000. They like to visit the spa with family or friends. In the two years of the survey, it was found that these women on average visited a spa five times due to their hectic lifestyles and the influences of media promotions.

Health Fitness Dynamics (HFD) (1997, cited in Monteson and Singer, 2004) conducted the study of North American spa-goers. It identified that 74 percent of spa goers were women and who had professional and executive occupations. Before this in 1992, HFD conducted a study about North American spa-goers and identified that the typical spa guest in those days were women who did not work. Therefore, the time they spent in spas was different. In the past, women could spend a week or two weeks for spa retreat while more recently spa goers can go for shorter vacations or weekend breaks.

It would thus appear that health tourism consumers are mainly professional career women aged between 35-50 years old with high incomes. They visited health tourism destinations for relaxation to beat the stress caused by their hectic lifestyle.

3.8. The characteristics of health tourism consumers

However, the concept of ‘health tourist’ is still diverse, especially when considering their purpose of travel. In this study, the concept of health tourists is categorised into four types, which are; leisure health holiday tourists, pampered tourists, well being tourists and medical tourists. This category is based on the degree of the health purpose starting from travelling for relaxation to the extreme case such as travelling for medical purposes.

Table 0:1 Characteristics of the health tourism consumers

Type of the health tourists	Characteristics
1. Leisure health holiday tourists	Relax at the destination using the health facilities at the hotel.
2. Pampered tourists	Aim for beauty treatments
3. Well being tourists	Use health facilities to improve their minds and their bodies
4. Medical tourists	Obtain the medical treatments at the destinations

3.8.3. Leisure health holiday tourists

With no intention of obtaining serious health treatments, the leisure health holiday makers seek relaxation and convalescence. They engage in healthy activities but health is not the central motive. These consumers seek a holiday with a combination of recreation and health (Gilbert and Van de Weerd, 1991). This leisure health tourism market can attract the hyperactive and sports-oriented market who seeks a holiday destination providing health amenities. Mueller and Kaufmann (2001) name this group of holiday makers 'independent infrastructure users', who will not place emphasis upon guest care, health information or professional know-how but appreciate wellness amenities. These include daily exercise programmes, thermal swimming pools (indoor and outdoor), swimming pools (indoor and outdoor), fitness facilities, sauna and steam room and outdoor sport facilities (Goodrich and Goodrich, 1987)

3.8.4. Pampered tourists

These kinds of tourist are interested in their overall physical appearance and mental state. (Horner and Swarbrooke, 1998) Pampering involves offering people an experience that makes them feel good with the services such as various baths such as eucalyptus baths, floral baths and Turkish baths massages, herbal wraps and herbal teas, cellulite treatments, fango packs (mud), sunbed use, exfoliating scrubs and beauty treatments (Ross, 2001; Goodrich and Goodrich, 1987). They like to purchase beauty products, beauty therapies, holiday spas or food products.

3.8.5. 'Well being' tourists.

Approximately, 70% of people undertaking health tourism want to improve their sense of well-being. They want to relax at the destination using the health facilities with the aim of improving their health and quality of life through the integration of mind body and spirit. Health tourism can be seen as the offering of products and services that are designed to promote and enable the customers to improve and maintain their health through a combination of leisure, recreation and educational activities in a location removed from the distractions of work and home (Loverseed, 1998). Mueller and Kaufmann (2001) used the term 'wellness' instead of well-being by citing the concept of wellness from the American doctor Halbert Dunn who in 1959 wrote for the first time about wellness. It is defined as 'an overall sense of well-being which sees man as consisting of body, spirit and mind and being dependent on his environment' (Dunn, 1959 cited in Mueller and Kaufmann, 2001, p.6). They also expanded Ardell's interpretation about wellness as 'a state of health featuring the harmony of body, mind and spirit, with self-responsibility, physical fitness/ beauty care, health nutrition/diet, relaxation (need for de-stressing)/meditation, mental activity/

education and environmental sensitivity/ social contacts as fundamental elements (Mueller and Kaufmann, 2001, p.6).

3.8.6. Medical tourists

Regarding the fourth types of health tourists, Goodrich and Goodrich (1987, p.217) defined health care tourism as ‘an attempt on the part of the tourism facility or destination to attract tourists by deliberately promoting its health care services and facilities in addition to its regular amenities’. The health care services can include medical examinations by qualified doctors and nurses at the resort or hotel, special diets, injections, vitamin-complex in takes, special medical treatments for various diseases such as arthritis and herbal remedies. This concept places emphasis on the health care elements as additional tourism product components (ibid.). The motivations of the customers for the health care products vary from genuine preventive health-care to a more narcissistic beauty health care. Age and social environment are major factors in this motivation process (Gilbert and Van de Weerd, 1991).

According to the review of the literatures, there are plenty of health tourism destinations seeking to serve the health tourism consumer. However, health tourism providers or destinations can be categorized into four main types as amenity resorts and hotels with spas, luxury spas, destination spas and health resorts and medical centres.

Table 0:2 Characteristic of health tourism destinations

Types of health tourism destinations	Characteristics
1. Amenity resorts and hotels with spas	General resorts and hotels with the add in spas and fitness facilities
2. Luxury spas	Beautiful locations spas for beauty purpose
3. Destination spas and health resorts	Place offer the lifestyle changes for guests
4. Medical centres	Centre or hospital offer various medical treatment from vitamin injection to plastic surgery

3.9. Categories of health tourism destinations

3.9.3. Amenity resorts and hotels with spas

The health component is the supporting feature of these resorts. Fitness programmes have been added as a complement to other activities at these resorts and hotels. In the 1990’s, adding spa and fitness facilities in a hotel and resort has almost become a marketing necessity for resort owners and operations. The reason is not just because health-conscious holiday-makers want them, but also because offering spa services can boost revenues, increase occupancy rates in the off-season and

increase the sales of high profit items such as food and alcohol. Holiday-makers view spa and fitness facilities as a 'value added' service and are often prepared to pay higher room rates at a resort which has a health centre and spa facilities on site. People who go to amenity resorts and hotels with spas and fitness facilities are not as focused on health as those who take their holiday at the destination spas and health resort. They want to relax, but they also want to have fun (Loverseed, 1998). International hotel chains such as Marriot, Shangri-La and Hyatt, which target the international business traveller and up market leisure traveller have incorporated leisure centre, gyms, swimming pool and some beauty treatments such as facial and message (Horner and Swarbrooke, 1998).

3.9.4. Luxury spas

Luxury spas are mostly situated in beautiful and peaceful locations. These spas attract customers who want to relax and be pampered. Originally, they were established for women emphasising beauty treatments and therapies. These spas offer aromatherapy, reflexology, message, facial, slimming body and treatments (Harmsworth, 1990). Individuals with high levels of disposable income spent in part on pampering themselves have encouraged the growth of luxury Spas. Richard Beldon, a board member of ISPAS suggested that 'People have more money to spend than they did ten years ago and are happy to spend it on luxury for themselves, which is why luxury spas are booming' (Clark, 2000, p.23). In the 1990's, luxury spas were famous for pampering. However, nowadays, these luxury spas also offer medical components for their guests. It is the mix between the unpleasant necessities of health care with the pleasant settings. For example, the guests could have a full body massage in the morning and do the medical check up for a whole body in the afternoon. The medical staffs in these spas are well-educated. For example at, the high end spa 'Canyon Ranch', the nurses and the physicians dress in sports clothes and the medical doctors all graduated from the Ivy Leagues universities (Nathan, 1996).

3.9.5. Destinations spas and health resorts

They attract people who are interested in lifestyle changes as well as having a holiday (Loverseed, 1998). The main goal of the customers is to obtain mind, body and spirit well being. The destination spas and health resorts offer physical exercise, relaxation therapies, therapeutic touch therapy, aromatherapy, hydrotherapy and life skills education, along with all the usual attractions that one finds at normal resorts such as a scenic setting, good food, recreation activities and sport activities. Generally, the destination spas and health resorts have the same characteristics as the health farms in England. Health farms are defined by Harmsworth (1990) as an operation which can have indoor and outdoor facilities, both active and passive, and a wide range of treatments,

therapies and lifestyle programmes designed to pamper, relax and generate a positive physical and mental well-being for all clients. The health farm participants aim to obtain self improvement where sport, exercise, beauty treatment and mental well-being are practiced.

Harmsworths (1991) undertook a survey of 12 spas and health farms in England and explored the facilities as the intensive treatments and facilities and the additional treatments. The inclusive treatments and facilities include the pool, sauna, steam room, spa pool, peal, herbal bath, consultation, sun bed, tennis, squash, outdoor activities, gym, exercise classes, aquarobic exercise, yoga classes, relaxation classes, facial, massage, aromatherapy massage, underwater massage, osteopathy, body treatment, acupressure and water therapy. The additional treatments included men's facial, massage, aromatherapy, shiatsu, reflexology, body wraps, nutrition consultation, jet douche, bust treatment, hydrotherapy, flotation, slender tone, acupuncture, physiotherapy, osteopathy, chiropody, sun bed, self-tanning, hair care, waxing treatments, manicure and pedicure, make-up, remedial yoga, counselling and alternative therapy. Currently the line between the hotel with spa facilities and the health farm is becoming less clear. The only difference is that the price in health farm will be per person per night including treatments, all meals, the use of facilities and exercise classes and the consultation with doctor. On the other hand, the hotel with spa facilities charged the price per room and the spa facilities will be charged extra (Harmworth, 1991).

3.9.6. Medically oriented centres

They usually incorporate medical histories, physical examinations, cancer screening and body fat testing into their holiday packages. They often have doctors, registered nurses and holistic health counsellors on their staff or working as consultants (Loverseed, 1998). Originally, the medical centres emphasis the curative effects of mineral or hot waters. They are the traditional spas resorts or thermal resorts which have natural mineral springs, thermal baths and thermalism. Spa treatments can be based on mineral water, mud and herbs, which help to cure some illness such as digestive problems, asthma, gout, metabolic dysfunction, rheumatism, and gynecological problems (Horner and Swarbrooke, 1998). There are many ways in which human beings can take advantage of the nature-based beneficial properties of spas, namely;

- Hydrotherapy of bathing therapy (the most traditional Spas treatment) ;
- Thalassotherapy (with the use of sea water in various ways or algotherapy with the use of seaweed);
- Drinking therapy (therapeutic water can influence directly digestive and other internal organs, blood circulation and can also introduce various valuable minerals and other elements to the body in a naturally balance composition);

- Breathing therapy (breathing in the spring's natural gases) ;
- Cave therapy (a newly developed method of treatment appropriate mainly for respiratory problems that requires the person to stay for a certain period in the steady atmospheric conditions) ;
- Pelotherapy (with external mud treatment) ;
- Climatotherapy(when taking advantage of climates, humidity, sun and sea) ;

Nowadays, the medical facility does not necessarily need to be situated near the natural resources with the therapeutic properties. They can be the natural health centres or the hospital that offer the medical health tours.

Cosmetic surgery tourism is one type of the medically orientated centres. It has been growing in popularity in the past decade. Many tour companies offer all inclusive vacation packages including plastic surgery, which is a mix of vacation and surgery in the hospital (ASPS, 2005). In some countries, cosmetic surgery tourism is much cheaper than in the US, U.K. or Canada. For example, the 'tummy tuck' in the US is \$ 6000 but it is only \$ 2000 in Costa Rica or face lift in the US is \$ 9000 while it is only \$ 3000 in Malaysia (NBC,2005).

3.10. Health tourism In different regions of the world

In this section, health tourism in Europe, the US and the Asia Pacific including Thailand will be reviewed.

3.10.3. Health tourism In Europe

Europe has the tradition of water based therapy which has been continually practised up until the present time. The healing aspects of water are accepted as a separate branch of medicine, which can be called 'social medicine' (Spivack, 1998). In European countries, spas are considered an important complement to alternative medicine as well as being very popular holiday destinations. Spas play a significant role in the national health system, especially in Germany and Eastern Europe. This trend leads to the diversification within the spa towns.

In the 1960s, health clinics and health care clubs were created in Europe offering more treatments than simply the use of the water. Spa tourism or thermal tourism had changed to health tourism. Many health care centres created massage clubs, health clubs, fitness, marine therapies, diet therapies and physio-therapies, aesthetic treatments, detox treatments, various 'sports and gymnastics, steam baths, oxygen, health education, relaxation, hydrotherapy etc. (Becheri, 1989). In Smith and Jenner's article (2000), it is pointed out that according to the figures from ESPA, around

20 million people across Europe (including Russia) visit spas and spend more than 120 millions bed nights at them. Germany is said to be the biggest European market for mineral springs and medical spas followed by Italy, France Switzerland, Austria, Spain and Portugal. It can be noticed that health tourism in Europe has emphasised the preventive and curative qualities of mineral water since ancient times. In the US, health tourism is quite different in the sense that health tourism consumers shifted their interest from taking the water into beauty treatments and lifestyle changes.

3.10.4. Health tourism in the US

In the US, before the Revolutionary War, maintaining the European culture, residents of the American colonies travelled to many mineral springs, seaside resorts and spas. The rich and famous including early presidents such as George Washington and John Adams were attracted by spas. However, the serious health tourism business in the US began in 1939 when Deborah and Edmond Szekely opened a \$17.50 a week bring-your-tent Spas and healthy living retreat, which became the renowned Rancho La Puerta fitness resort. In 1958, Deborah moved north to the San Diego area where she created the Golden Door, a luxurious destination Spa known for its lavish individual service and successful mind-body programme (Ross, 2001).

A natural mineral spring is not essential for health tourism or spa tourism in the US. The US based International Spas and Fitness Association (ISPA) defines a spa as 'a place where active and sustained use of natural therapeutic agents and health giving elements are applied within an hospitable environment over a period of time' It promotes and defines the Spa experience as ' time to relax, reflect, revitalise and rejoice' (Smith and Jenner, 2000, p.42).

On the other hand, some health resort owners and operators consider the word 'spas' as an old-fashioned word which concern only pampering and beauty treatment. So, they create the new phrases for the spas as 'lifestyle resorts' 'longevity centres' 'holistic wellness program' or 'fitness vacations' (Spivack, 1998) Moreover, the holistic approach to health tourism became to be popular in the US. This trend leads to the development of the holistic health farms and holistic health resorts in US. The US spas tend to shift from the European focus on facilities and services designed for medical patients to those concerned with health motivated travellers. Following the health tourism movement in Europe, the US health tourism sector grew rapidly with the curative aspects of water and leisure-health elements which place emphasis on fitness, well-being and longevity. This is reflected in an overall trend in worldwide health care which is the movement from health treatment to health promotion and disease prevention (Spivack, 1998).

The Louis Harris survey (1992, cited from Spivack, 1998), reported that 77% of all Americans at home and work participated in regular exercise and 56 percent of American considered the

availability of the health facilities in their accommodation for their vacation plan. In the US, open-minded physicians have helped to promote the acceptance of spa treatments or alternative treatments among the medical establishment. Some High-profile and famous doctors, who regularly appear on television or on the lecture circuit, wrote books about wellness as well as running their own practices (Loverseed, 1998).

3.10.5. Health tourism in Asia

Medical tourism in some countries in this region attracts international tourists because medical treatments in the USA are far more expensive when compared to ones in Asia. In Canada, patients are frustrated with the long waiting times for health treatment. This is also true in England where patients are often frustrated by the long waiting lists for treatment by the National Health Service but cannot afford to purchase private practice. For other international tourists, it is a good chance to combine the tropical holiday with some medical treatments (NBCNews, 2005)

Currently Malaysian tourism continuously promotes medical tourism in the country. The guests can combine a complete medical check up while staying in a luxury resorts in Malaysia. As well as promoting the educational tourism, Singapore is also promoting health care tourism (Henderson, 2004). India also aims to be an international up market health care destination for those who could not wait on the long waiting lists for medical treatment in their home countries such as Canada and the UK. Besides, the cost of the treatments in India is cheaper than in those countries. In 2003, India attracted approximately, 150,000 medical tourists. However, it is still behind Thailand which attracted as many as 1,000,000 in the same year (The Economist, 2004). It is obviously seen that people in different regions have the same demand for health tourism. This new trend in health tourism is marked by the trend toward globalisation. The most critical factor for urging health tourism is 'a quest for edu- and enter-tainment', where education and entertainment merge to offer personal development opportunities (Buharis, 2001, p. 70). Besides, the ecology and environmental concern led to an idea of a return to nature, the search for isolation and the concern for hygiene and health. These two essential factors affect to the growth of the special interest, which health tourism is included.

As mentioned earlier, the media enhances familiarity with the new global lifestyle. These influences also affect the lifestyles of Thai population. The next section will illustrate health tourism in Thailand including the category of health tourism destinations and the development of the domestic health tourism market.

3.11. Health tourism in Thailand

After Thailand faced the economic crisis of 1997, and the SARS outbreak in 2004 discouraged the tourists from Europe, America and Australia were discouraged from travelling to Thailand. More recently the second round of bird flu in Thailand added the fear of some tourists. Apart from that, the terrorism in the southern part of Thailand decreased the number of inbound tourists (Euromonitor, 2005). Tourism is always viewed by Thai government as an “economic stimulant” or an engine of economic growth for Thailand. It was intended that a number of new tourism niche products that would be developed such as agro-tourism, auto-adventure, soft adventure and ecotourism, MICE, golf and diving, health and spa, medical check –up as well as Thai foods and cooking schools (TAT, 2001a)

In Thailand, the spa and health tourism concept is quite new even though a number of Asia's premiere spas are located in the country, including Shiva-Som, Oriental Spa and the Banyan Tree Spa. Thai Airlines, TAT, has begun promoting health and wellness tourism for the last eight years. In 1999, the first Health Travel Show was organised in Bangkok, bringing together a number of hospitals, health farm, meditation retreats, even temples. And now, many of them are linking with the tour operators to improve the packaging of their products to cater to an international market (Muqbil, 2000). In 2000, two major conferences convened in Thailand with the aim of promoting health and spiritual tourism to Thailand. The first conference was held in Chiang Mai from Feb 12-19 called Silver Dove 2000 aiming to promote the healthier, more ecologically aware lifestyle and exchange issues ranging from alternative and nature medicine to hypno-therapy and crystal healing. Another major conference was held in Phuket from April 28-30 for the Asia Spa Summit 2000 (ibid). In 2004, TAT set up Health Expo 2004 to stimulate domestic health tourism. Health tourism sales achieved annual growth rates of about 40% over the last few years of the review period and revenue for 2004 is expected to be about Bt7,000 million. Thailand also aims to become a "medical hub" in Asia too. In short, large numbers come to Thailand as medical tourists, primarily for the very low prices and good service (Euromonitor, 2005). Thailand is now continuously promoted to be a health and spa destination with traditional therapies such as Thai massage combined with exotic locations and levels of service. Government agencies such as the TAT, the Export Promotion Board and the Ministry of Public Health are all supporting this campaign to combine health with travel and recreation. Moreover, long stay vacations in Thailand are heavily promoted by the TAT. The four main categories of the long stay guests coming to Thailand are the retired market, health market, education market and sports market (TAT, 2001 b).

Health tourism is perceived as one important way of improving the length of stay and revenue. TAT believes that the new concept of long stay health tourism can attract the tourist who is looking for

both a holiday and an opportunity to be rejuvenated, concerning health and enjoying recreational activities. The combination of achieving security, safety, healthy, happiness and satisfaction is the ultimate goals. Apart from having a good time in the exotic location during the long stay in Thailand, tourists will have a chance to experience the natural healing, health care, traditional massage and herb practices. They can experience Thai cuisine with natural ingredients placing emphasis on medical herbs and a concern for diet. In the past, Thailand was viewed as being famous for sex tourism and the message about the 'massage' in health tourism always led the tourists into the misconception because the massage always gives the idea of brothels. However, TAT tried to combat this idea by promoting the health tourism in a large global exhibitions and seminars by setting up booths with skilled Thai masseurs. This has been successful proven by the numbers of health and spa resorts opened up in Thailand since 1998.

Now, Thailand is acclaimed as home to Asian's first internationally-accredited hospital and an established the reputation as 'Spa capital of Asia'. Health tourism is quite a promising activity in generating foreign exchange for country. According to the 2003 forecast projected by Thailand's Ministry of Public Health (MPH), hospitals in Thailand will be treating a total of 730,000 foreign patients generating an estimated 19.826 billion baht in foreign exchange earnings for Thailand. The Thai government also sees the potential of the development of Thailand's health care services. Therefore, the government aims to establish Thailand as leadership in three fronts, which are 'Health Tourism Hub of Asia', 'The Wellness Capital of Asia' and 'Thai Herbs for Health'. The main destinations targets are the touristic provinces as Bangkok, Phuket, Samui and Chiangmai. (TAT,2006).

3.11.3. Categories of health tourism destinations in Thailand

In Thailand, health expression can be found in many forms. It can be found in Thai cooking emphasising on balance and widespread use of medicinal herbs; in the traditional Thai massage; in natural health centres; in spas and health resorts where the equipment is modern but the remedies are derived from natural herbs and local wisdom; and in the hospitals with the medical systems and qualified medical staffs. Health tourism destinations in Thailand can be categorised into four main types; the amenity resorts and hotels with spas, day spas, destination spa and health resorts, and medical oriented health destinations.

Amenities resorts and hotels with spas

Spas have today become a serious industry for Thai resorts and hotels. They continue to grow. As a result, many Thai hotels have converted their beauty salons and upgraded their fitness centres into spas to attract customers who are choosing resorts and hotels with spas over those without the spas.

Day spas

They offer the spa facilities on a daily use basis. Nowadays, the day spas are mushrooming in every region of Thailand. They are growing faster than any segment of the spa industry. Mostly, the day spas are situated in the cosmopolitan areas, especially in the complex department stores. Although the day spas do not cater to holiday makers, they are promoting a healthier way of life and introducing a wider public to the benefits of spa treatments. Day spas are viewed as source of new clients for health and spa tourism because it is likely that people who enjoy day spas will want to try taking a holiday at a destination resorts or spas (Loverseed, 1998).

Destination spas and health resort

Most of the Thai health resorts aim to encourage prevention rather than cure by helping the tourist to take responsibility and action for the quality of life. The Thai health resorts offer the chance to indulge in natural therapies and traditional wellness treatments that have been practiced from generation to generation. Wide ranges of health treatments for the stage of well-being are provided in all of the health resorts. Most of the treatments are the traditional medicine and natural healing techniques, which are called 'New Age' by Westerners. As a matter of fact, these methods are not new but actually ancient Eastern techniques. The treatments include relaxation, massages, acupuncture, aromatherapy, ayurveda, pilates, body conditioning, water treatments and herbal therapy.

The concept that the mind is a powerful tool in the condition of the body plays a great part in the holistic approach practiced in Thai culture. Thais believe that lasting health comes from within the body and mind; how we feel about ourselves and the world around us directly affects our physical state and outward appearance. Therefore, along with the traditional physical treatments, most of the health resorts provide the 'mind' exercises in order to encourage the psychological benefit. The 'mind' exercises originate in Asian with the belief that human beings can only look and feel good if their own bodies and spirits are working together in healthy harmony. These 'mind' exercises are - Tai chi, Chi Kung, Yoga, meditation, Water Shiatsu therapy and Yoga wave movement (Benge, 1999).

The most famous and forefather of international health resort in Thailand is Chiva-som International health resort, in Hua-Him about 120 miles from Bangkok. This resort offers the revitalising therapy both traditional Asian healing and Western style treatments. Now, it has begun to export its brand of health tourism to Portugal, India, Mexico City and Los Cabos (Pandey, 2001).

Medical oriented destinations

In the side of the medical treatments, the former director of the TAT, Seree Wangpaijit , said there is a huge market for the country to attract the health conscious international travellers given the size and quality of the local health care industry. The leading private hospitals are promoting their expertise and stepping up efforts to serve the international community. (ATTA, 2002). The private hospitals were mushrooming like hotels during the boom years of the early 1990s. After the economic crisis in 1997, these hospitals lost business to less expensive public hospitals. Therefore, these private hospitals had to shift their focus to the international market. In 1999, the TAT issued new directive to travel agents, suggesting that they offer their clients health tourism packages. Thai travel agents proposed with the country's medical bargains and hospitals found their new solution to remain on the good financial status. These hospitals are staffed by qualified medical staffs and equipped with the latest technology. There are many overseas trained doctors and specialists who are multilingual to ensure that there will be no language barrier. Most of these private hospitals have established partnerships with first-class international medical schools and health care institutions from Europe and the US. Their services include physical check-ups, internal medicine, general surgery, gynaecology, paediatrics, dentistry, orthopaedics, cardiology, emergency treatments and more (ATTA, 2002). The sale campaigns of medical tourism in Thailand focuses on the cheap, world class-facilities and technology and Thai hospitality. Thai hospitals can offer the same service standard as in developed countries but at much lower prices. It is estimated that the cost of medical care in Thailand is about one-half to one-third of that in Singapore, one-fifth of the cost in Europe and one-eighth of that in the US (ibid).

Thai Airways International's tour package, Royal Orchid Holiday, combines Asian holidays with a comprehensive medical check-up, including abdominal ultrasound, chest and barium stomach X-rays and a complete laboratory analysis of blood, urine and stool samples, with airfare and hotel packages, Thai cooking courses, a visit to Planet Hollywood and a calypso cabaret show. The tourist can get a written report sent to their hotel within three days. And they can get these services from Bamrungrad Hospital, a modern medical complex in Bangkok that has international amenities such as Starbucks and McDonald's in the lobby (Talbot, 2001). Apart from the private hospital, medical treatments can be obtained from the health centres. These health centres mainly focus on the holistic medicine and natural health treatments. These health centres are run by the medical doctors who are interested in holistic medicine. Apart from offering the services like other health resorts such as Thai massage, acupuncture, diet counselling and vitamin therapy, hydrotherapy, meditation, yoga; the health centres offer the detoxification, cleansing and fasting. These health centres are more popular among the Thai health tourist because of the much lower cost than those health resorts which aim to attract the international market.

This chapter provided the general background of health tourism with the relationship of health and tourism. Also, the historical aspect of health tourism was illustrated. In this day, health tourism is growing in tourism market due to many factors, which are the growing interest in health and fitness, the growing interest in alternative medicine, the idea of the preventative treatment, the shifting consumer values from material things to experiences, the increased stress, demographic market trends and the health care system.

Various researches about the characteristics of health tourism consumers were reviewed in order that these can be compared to the result of the finding from this study. Apart from this, regarding to the degree of purpose of the health related- travelling, the researcher divided health tourism consumers into four types, which were; leisure health holiday tourists, pampered tourists, well being tourists and medical tourists. Health tourism destinations were also divided into four main types as amenity resorts and hotels with spas, luxury spas, destination spas and health resorts and medical centres.

Health tourism in regional levels was portrayed including health tourism in Thailand. Health tourism was highly promoted by TAT with the aim to make Thailand as Asian medical hub. Four categories of health tourism were found in Thailand. They were the amenity resorts and hotels with spas, day spas, destination spa and health resorts, and medical oriented health destinations.

3.11.4. Domestic health tourism in Thailand

Thailand was formerly known as an agricultural country before the mid 1980s. Since then, the country has been transformed into an agro-industrial economy. Foreign investment has brought about the modernisation of Thai society. In 1990s greater westernisation and the trend of globalisation have continued where many Thai people now have access to everything necessary for a modern global lifestyle. Modernisation had greatly extended the range of employment opportunities open to people migrating into the city, especially Bangkok, the capital city of Thailand. Almost all the major domestic and foreign companies are located in the capital, as are all government ministries and most of the countries leading educational, sporting and cultural facilities.

Western influence has been instrumental in creating a new taste for new fashions and lifestyles, reflected in such things as golf and tennis, delicatessens and boutiques, music and drama, libraries and popular games, architecture and interior decoration. Fast food from the West such as hamburgers and pizzas, have become popular with young and old alike. The move towards industrialisation and urbanisation has resulted in changes in lifestyle. A study in Bangkok revealed that 42% of those over 15 years consume fast foods and only about 25% take exercise.

Consumption of alcohol and tobacco are on the increase, with 22.8% of the population aged 15 years and over being regular smokers. Suicide in the metropolis of Bangkok has increased due to the stress of the city life (Country Health Profile, 2002).

People in the city work harder and longer hours in order to maintain their western style of consumption. Work-related occupational diseases include lead poisoning, silicosis, asbestosis and hearing loss due to excessive noise level (ibid). The stress of the city makes leisure activities vital, and the weekends find city inhabitants dedicated to having a good time.

Due to the environment and pace of the city life, the middle upper classes living in the city try to find ways to improve their health. Participating in health tours is one of the alternatives. As mentioned earlier, this research places emphasis upon the lifestyle change of Thai people in terms of health aspects. Therefore, searches for those health tours which are popular among Thai people were conducted. A review of health magazines, websites and leaflets in Thailand indicated two leading health tours, which are the Cheewajit tour and Balavi tour. The Cheewajit tour was set by Dr. Satis Indrakamhang. He is a certified medical doctor who worked in the US until he retired. In the past when he was in the US, he faced a severe cancer and was treated by modern medicine. However, he could not recover from cancer. He desperately searched for the alternative methods and natural therapy was the answer. Therefore, he studied more about holistic therapy, acupuncture and alternative medicine. Eventually he recovered from cancer and moved back to Thailand. Since then, he has promoted his 'Cheewajit concept' to the Thai population. Dr. Satis set up the Cheewajit club in Bangkok and then launched the monthly Cheewajit magazine to publicise the concept of Cheewajit. Cheewajit means 'life and mind'. Practitioners of 'Cheewajit' consume natural foods to support the body's immune system against disease and to maintain their general physical and mental health. In general, the conventional teaching about health is related to taking daily portions of the five nutritional food groups, getting plenty of exercise, and going to see the doctor when sick. By contrast, 'Cheewajit' focuses on consuming 'natural foods', exercising steadily, calming the mind by positive thinking and meditating. It is believed that Cheewajit can treat some illnesses which are difficult to treat such as diabetes, high blood pressure and cancer. These illnesses are caused not only by microbes but also by bodily irregularities triggered by eating habits and emotional volatility. The core of Cheewajit is natural therapy using food as medicine mixing this with the integrated and alternative medicine. In addition exercise and coffee detoxification are essential.

Concerning Cheewajit food, followers are encouraged to eat brown rice and cut out white rice, pork, chicken, beef, sugar or any products from white sugar, fat from palm oil or meat. The proportions of food per meal are brown rice 50%, vegetables 25%, grain 15% or alternatively protein from fish once or twice a week and miscellaneous foods such as soup and fruits 10%.

Besides, the RC (a Rejuvenating Concoction) is promoted for consumption, this comprises a water-based extract made from boiling mixed grains and it is said to help the elimination of fatigue. As mention earlier, the Cheewajit practice encourages colonic irrigation with coffee. This is designed to eliminate toxins from the body. Doing colonic irrigation plus sauna and exercise will, it is argued, give most benefits. Dr. Satis also designed the stick exercise for people of every age to do. It can help to increase the strength of body and the flexibility at the same time.

The popularity of Cheewajit concept urged people to consume more natural foods. The Thai Farmers Research Center Co.Ltd. conducted a survey of 1,231 Bangkok residents on their 'herbal health supplemental food consumption', it was found that age is considered as a significant factor in determining health issues, since people pay more attention to their health as they grow older. The survey revealed that 54.9 percent of the respondents had sampled supplementary health foods at one time or another. Those who used such products said they wanted to build up their health, to stay healthy and to prevent sickness. The five most popular health supplements were unpolished rice, beans, herbal tea, garlic capsules and vitamins (Thai Farmers Research Centre, 1998).

The second health tour organiser is Dr. Banchop Choonhasawadikul. He is the certified medical doctor who is interested in alternative treatments. After he graduated from medical school, he went to China to take full course of acupuncture at the Institute of Chinese Medicine, Dongzhimen in Beijing. Afterward, he set the Balavi clinic in Bangkok combining Western medicine and acupuncture. In the meantime, he also learned more about the science of functional food and Vitamin therapy, fasting for health and colonic cleansing, Thai tradition medicine and the modern researches on herbal medicines. He did comparative studies on hydrotherapy and Thai herbal steam bath, floor aerobics and hydro-aerobics.

He opened the Balavi centre for alternative treatment. It is the medical centre partly for ill people and partly for people who come for the detoxification programmes. There are five and ten day detoxification programmes designed for those who would like to heal their natural health by themselves by the combination of diet control and activities. The diet can be tailor made for each individual's problems such as a fasting for health diet, an anti-diabetic diet, an anti-cancer diet, Yin-Yang improving diet etc. The activities are day time activities due to their being insufficient accommodation. The programme starts at 7.00 AM and lasts until 5.00 PM.

The regular activities in these courses are:

- Diet control
- Meditation
- Lectures on Natural Health

- Acupuncture
- Solar bathing
- Thai herbal steam bath
- Upper colon cleansing (as choiced) - low colon cleansing (coffee enema or vegetable broth enema according to clinical indication)
- Aroma or Thai traditional massage
- Hydro-aerobics and Sauna
- Sub-conscious control training
- High dose of vitamin infusion (for some one with clinical indication) and other vitamin therapy
- Thai herbal anti-cancer medicine (as clinical indication)
- Chinese herbal medicine for Yin-Yang balancing (as clinical indication)

He also organises health tours which take place in a natural setting offering some of the programme described above depending on the themes of the tour. For example, the aqua health tour, the fasting health tour, the body and mind tour, among others.

The next chapter provides the background knowledge about nature of Thai society, which includes the generic values of Thai society and the nine characteristics of national Thai characters. The class structure and characteristics of Thai society are also discussed as well as the different characteristics of urban and rural Thai. Lastly, two factors affecting changes in Thai society are discussed.

CHAPTER 4

THAI SOCIETY

This chapter introduces and illustrates the nature of Thai society and sets the particular national context within which this thesis is based. The chapter begins with an introduction into the generic values of Thai society with a breakdown of values provided by gender, age, income, education, occupation and religion. The chapter continues with the identification of nine characteristics of the national Thai character. Thereafter, the chapter introduces a discussion on the structure of Thai society by class before providing a thorough examination and review of the core characteristics of Thai society based on a study conducted by Komin (1991). Thereafter, a critical overview of the differences that exist between the urban and rural population is briefly discussed as rapid urbanisation has been one of the major events affecting Thai society in the last 30-40 years. The chapter closes by identifying the two key factors, namely the demographic and economic changes that are affecting Thai society and impacting upon contemporary life in Thailand today.

4.1. Generic Values of Thai Society

One of the most significant studies to date that explores the nature and dynamics of Thai society was conducted by Komin in 1991. This study investigated Thai values by designing a Thai Value Survey using a multi-stage multiple-sample technique drawing from people of different strata of Thai society identified by cultural-geographical regions and occupations. In total, 2,469 respondents in the survey were chosen from the 1978 national sample and 2,149 respondents were from the 1981 National Rural Sample. Questionnaires of the Thai Value Survey were developed whereby an in-depth anthropological study was undertaken. Although, this research was conducted over 15 years ago, it still resonates strongly in contemporary Thailand. In her study, Komin (1991) broke down her discussion of values by six criteria, namely: gender, age, income, education, occupation, and religion.

4.1.1. Gender

For gender, she suggests that Thai men and women both attach high cultural value to the need to be grateful, honest and sincere, polite and humble, kind and helpful with lower values attached to the need to be ambitious, hardworking and broad minded. However, Thai women are more concerned about family happiness and security and peacefulness ascribing lower values for equality and freedom. In contrast, Thai men are more concerned about societal

issues such as national security, power and politics as well as the values of self-esteem and success in life indicated by career, position in society and power. Men also long for freedom, social recognition and attach much value to status and wealth. In comparison with Thai women, Thai men are not so family-orientated.

4.1.2. Age

With regard to age, as expected different age groups demonstrate different values. For example, 15-19 years olds have a high sense of self-esteem, are independent and are more concerned about appearance than any other age group. They seek true friendships, fun and excitement in life and dream of being successful in the future. For 22-29 year olds, their first interest is success in life followed by an intimate mature loving relationship. Their perception about the world and life is quite idealistic although the people in this age group are quite broadminded, imaginative, creative, ambitious, hard working and courageous in speaking up and standing up for their beliefs. For 30-39 year olds, after experiencing the negative side of their careers, their point of view and values change in that they seek equality and justice. They also demonstrate a low sense of self control and calm with this age group demonstrating the period of highest dissatisfaction and bitterness. As for the next age range (40-49), only two distinctive values characterise them. They demonstrate a high sense of obedience and respectfulness but low self-esteem. This may be the transition period through which they need to blend into for future success and social acceptance. For 50-59 year olds, often at the peak of their careers, their interests are focused on broader values such as national security and world peace. They also emphasise the idea of being honest and sincere with excitement in life and wisdom-knowledge not uppermost in their interests. Finally, for those of 60 and above, the tendency is to seek enjoyment after they retire from their careers. They have a high sense of a comfortable life with high social recognition and inner peace. Besides, they attach much importance on religious-spiritual leaning and philosophical contemplation in search of wisdom.

4.1.3. Income

Referring to Komin's survey (1991), the rich and the poor do not significantly differ in terms of broader social values such as national security, world peace, the spirit of brotherhood, freedom and equality. Also, material concerns such as having a comfortable life, pleasure and status-wealth are common values. The values of competence and achievement mark a significant difference between the rich and the poor in Thailand. The richer group place great emphasis on success in life, wisdom-knowledge, responsibility, honesty-sincerity, capability

and high self-esteem while the poorer group's concerns are religiously and humanist-oriented such as their religious and spiritual life, forgiving, interdependent, mutual and help, caring and considerate, loving and affectionate and obedient and respectful nature.

4.1.4. Education

The less educated Thais are more aware of community and religion but less on their self achievement. The humanist-orientated values such as grateful, caring-considerate, kind-helpful, forgiving, mutually helpful and obedient and respectful are in favour of the less educated Thai. In contrast, the highly educated are more interested in themselves by having a high sense of values in success in life, family security and happiness, self-esteem, a comfortable life.

4.1.5. Occupations

With regard to occupation, as expected, different occupations demonstrate different concepts of values. For example, farmers have a high sense of national security and of the religious spiritual life and community oriented values but show little engagement in aiming for a comfortable life. They focus on the relationship values such as care and consideration with high ideals regarding loving and affection as well as the idea of obedience and respect, especially with regard to the elders and local persons such as teachers and monks, and authority figures such as government officers. In contrast, labourers are more anxious about political issues, ego and self actualisation characteristics such as self-esteem, being independent and courageous. Compared to farmers, the skilled workers pay more attention to themselves and their daily lives rather than their success, but they still have high values of being kind and helpful. Nevertheless, they care less about self-control, being polite and humble and calm-cautious. With a higher educational background than farmers, labourers and skilled workers, employees and businessmen are highly aware of their own self-esteem and their family while being less concerned about social and political issues of justice and equality with the very low level of kind-helpful values. On the other hand, government officers are highly concerned about national security, family happiness and security, one's ego self-esteem, one's achievement and success in life with a high value of responsibility, education and being polite and humble.

4.1.6. Religious behaviour

Komin's 1991 survey of 2,341 respondents included the question 'In the last year, how many times have you gone to the temples to pray and to listen to Buddhist sermons?' with the

responses of never; 1-20 times; and over 20 times. Of the 2,341 respondents, 25 % never attended (non- religious); 56.5% attended 1-20 times (less religious) and 18.5% attended over 20 times (highly religious). It is shown that three quarters of the sample demonstrate an interest in commitment to religion which is in fact far higher than most countries.

In comparing the values of the non religious and the highly religious, as expected, it is revealed that highly religious Thais have a high sense of national security and religious-spiritual life followed by values of world peace and brotherhood spirit with a high community orientation. Worldly life goals such as, a successful life, the need for intimate friendship and relationships, or a world of beauty, pleasure and excitement are not their main interest. They have a sense of respect to the elderly and knowledgeable and religiously good persons and place considerable emphasis on moral values such as being grateful, forgiving and mutual help. In contrast, the non religious Thais care less about the national security and religious-spiritual life but more on success in life, self- esteem and freedom, close relationships and some worldly aspects such as beauty, excitement, fun-loving and pleasure.

4.2. Thal National Characteristics

In Komin's 1991 study, the nine characteristics of Thais were identified as: ego orientation; grateful relationship orientation; smooth interpersonal relationship orientation; flexibility and adjustment orientation; religious-psychical orientation; education and competence orientation; inter-dependence orientation; fun-pleasure orientation; and achievement-task orientation.

With regard to ego orientation, Thai people have a very big ego with a strong sense of independence and dignity. They may look friendly, calm and polite on the surface. However, they can be easily annoyed or frustrated if the sense of their self or family is insulted, hence Thais are quite concerned about losing face in public. Thais always avoid situations which can cause them to loose face in front of others. The second characteristic of Thais is the grateful relationship orientation. Thai people have a very strong sense of gratitude and aim to pay back debts of gratitude. For example, in general, after Thais start working and earning a living, they would give some money to their parents, buy nice gifts for them, build them a new house or pay for their parents to travel to show their gratitude.

Thirdly, Thais tend to have smooth, kind and no conflict interactions by being polite, humble, non-assertive and appearing relaxed by smiling and being friendly. According to Komin's survey, the top eight values of Thai's which characterise the quality of 'social smoothing' are being caring and considerate, kind and helpful, responsive to situations and opportunities, self-controlled and tolerant-restrained, polite and humble, calm and cautious, contented and

social relation. Among these eight values, the core value of Thai society is care and consideration. It has the highest significant value. As mentioned earlier about Thais ego, therefore, 'one shall be careful not to hurt another person's feelings' (Komin, 1991 p.145). For example, one should not criticise or reject another person's kindness or good intention even though it is contrast to one's own feelings. Sometimes, one has to sacrifice one's inconvenience or the feeling of disagree in order that one will not hurt others and this will make the atmosphere more pleasant and smoother.

Thai society favours persons who are polite and humble with a degree of tolerance and restraint. Thai people have a low degree of aggressiveness except when their ego is insulted. People who have soft and polite appearances are always successful in Thai society. It can be observed that people who graduated abroad with highly competent, straightforward and outspoken characteristics are not as likely to be in the high position in the organisation due to their strong characteristics. Therefore, it is widely found that many organisations are run by individuals who are less qualified than their employees. However, the soft and pleasant personality of the executives ensures smooth interactions in the organisations due to the concern of not hurting anyone's ego.

The fourth characteristic of Thais is flexibility and adjustment orientation. For Thais, change is logically a matter of course. Positively, this attitude encourages the idea of acceptance and survival. However, this characteristic can lead to a decision shifting behaviour pattern such as changes in principle, position or political affiliation. The flexibility and adjustment orientation of Thais can be partly influenced by the Thai characteristic of religious-physical orientation. Theravada Buddhism is the national religion of Thailand. In the past, the Buddhist temples served the society as centres for social welfare such as the place for boys to learn how to read and write, the place for children to play, the place for traveller to seek for food and lodging. Temples could also be the health centre when someone was ill and needed traditional medicine and treatment. Buddhism plays an essential role for Thai people; especially the ones who live in rural areas, the less educated and the poor. Thai people like to make a merit and attend the year round religious ceremonies. In everyday life, one is supposed to make a merit in the form of offering such as offering to those who need and the monasteries (Phongvivat, 2003). Merit making can be performed on occasions such as birthday, new house, new company, new building, new car, celebrations of anniversaries, etc. including the festivals, customs and religious days.

Most Thais follow the Buddhist rules of behaviour which are known as 'Precepts'. They are to refrain from killing and harming living things, including people and animals. This can be

an answer as to why some Thai people are vegetarians. Other precepts are refraining from stealing or invading someone's privacy, from sexual misconduct or immorality from lying and from taking intoxicants. In general, Buddhists are against war and violence with the great respect for all the living things. The norms for a Buddhist are to purify the mind and develop wisdom including self-awareness, self-actualisation, self-discipline and self-transformation so that the individual can understand others. The Buddhist way of life is a life in which the material possessions are minimised (Browell, 2000).

One aspect of Buddhism which is most closely related to Thai society is karma. Thais always believe in karma in the sense there are good karma and bad karma. There is a belief that each person is born unequally as a result of the predestined goodness or the good karma. Also, Thai people believe that doing the good deeds for good karma will lead to the good things in a later life or even after life. The bad karma is generally used in the negative events such as bad fortunes, tragedies, injustice etc. If something bad happened to someone, it is believed that it was the result of the bad karma, which can come from the last life or this life's behaviour. It is believed that 'bad karma catching up on you' (Komin, 1991, p.178).

Thais also believe in the idea of a chain of rebirth. Life does not begin with birth and end with death. People can be reborn both in form of human beings or animals. The form of rebirth depends upon the karma from the previous life. Referring to the doctrine of Buddhism teaching, all human satisfaction is impermanent and leads to suffering. Humans being cannot feel completely fulfilled and always want more. The only way to be released from suffering is to stop the cycle of rebirth by reaching nirvana. In Thai belief, the search for nirvana is through merits and good acts. These can bring the good effects to later life. On the contrary, bad acts cause evil consequences.

Another national characteristic of Thais is education and competence orientation. In Thai society, education is perceived as a mean to climb up the social ladder and achieve a high salary in your career. Rarely is knowledge acquired for knowledge sake. As stated earlier, Thai people have great sense of ego and face. Therefore, the external things such as education, career, and possession are part of the identifications for being respectful in society.

Interdependence orientation is one of the Thai national characteristic and it is found strongly in Thai rural communities. Two distinctive features which differentiate the rural Thai society and urban Thai society are the religious values and the community oriented brotherhood spirit. In the rural community, neighbours help each other in essential situations such as illnesses, death, birth, wedding etc. There is a very close relationship between each household in Thai village society. For example, the farmers will walk to the fields and return together.

They help each other throughout the rice-growing process from planting to harvesting. They also help in building new houses in the village.

On the other hand, Thailand is known as a 'land of smiles' as a stereotype image of Thai people. From the point of view of others Thais are nice, friendly, easy-going and enjoy everyday pleasures by not letting trouble disappoint them. This kind of myth is not entirely true. According to Komin (1991), it is found that the private sector and the lower class in Thailand work very hard, they are more concerned with work rather than fun loving or pleasure. The Bangkokian and the government officers tend to prefer fun over work and are known for their lack of the efficiency in job performance.

Lastly, according to Komin's research, the achievement values of being ambitious and hardworking to succeed in achieving one's goal are ranked very low compared to other values. These kinds of values are found to be highly ranked in only two groups, which are Thai business man and the Thais of Chinese descent. The Chinese migrated to Thailand long time ago and built up their career and success in Thailand by their value of hard work.

4.3. Class Structure of Thai Society

Underpinning much of this discussion is the study conducted by Supap in 1991. This study is a compilation of secondary research about Thai society and culture during her lecturing days in universities. Supap (1991) explains that the class structure of Thai society is based upon wealth, status, prestige, power and righteousness. Class structures have originated in Thai society many years ago at a time when people were classified in terms of their ownership of land. In this earlier period, there were three classes in Thai society; which were government officials and nobles, free men and slaves. Later on, there were more classes due to a number of factors including: lineage, political position, government position, power in economics and politics, wealth, educational level, and occupation. According to these factors, eight classes are identified.

1. Supreme - refers to the king, the queen, the royal family and the high level of the aristocrats.
2. Elite- refer to the prime minister, the privy councillors, statesmen and the politicians in the government.
3. Upper class- includes high position government officers, generals, the director generals of departments, the presidents of the universities.
4. Upper-middle class- refers to the intellectual, the senior lecturers, the professors, leading business men, famous writers, scholars.

5. Middle class- refers to the general government officers, merchants, graduates and post graduates from abroad, lawyers, lecturers.
6. Lower-middle – refers to the low educational level people or graduate from vocational schools.
7. Upper-lower - refers to the clerks, employees, the mechanics, painters, and builder.
8. Lower-lower – refers to unskilled labourers.

The respondents in this research mainly belong to the middle class, upper middle class and upper class.

The Thai middle class

The middle class in Thailand emerged due to the economic development in the 1950s. The rapid growth of the economy gave a chance to an expansion in occupations in trade, banking, manufacturing as well as the increasing demand for professional occupations. Those who worked in these areas were middle class who graduated from universities from Thailand or abroad, especially the United States (Koanantakool and Askew, 1992).

Vichit-Vadkan (1979) studied the Bangkok's middle class in the mid 70's. She considered the emergence of the middle class as a new phenomenon, a by-product of social modernisation, which was associated with the diversification of economic and occupational roles and status (p.17). She described the characteristics of them with two main aspects. Firstly, it is a minimum amount of security over their source of livelihood and secondly, a positive sense of identification with their occupation and social status in society (p.10). She identified the occupations of the middle class as consisting of the low to medium ranked civil servants including university or college educated teachers and academics, employees of state enterprises, professionals, employees of banking and other business institutions, members of the police and military forces excluding the higher ranks and Chinese, Thai and Indian shopkeepers. The reason she included the low ranked civil service in the middle class section was because of the prestige and security of the jobs.

As a result of the political changes in Thailand in 1970's, one subgroup emerged among the middle class. It is called 'technocrats'. Korff (1989, cited in Koanantakool and Askew, 1992, p.45) defined technocrats as professional, administrative and clerical workers who increased from 4.2% of total labour force in 1975 to 7.2% in 1986. Thanaphonphan (1989, cited in Koanantakool and Askew, 1992, p.45) explained the job description of the technocrat as those whose job was to monitor the implementation of economic and fiscal policies, analyse, and project economic conditions and develop certain policies. Those who work in the Ministry of Finance and the Central Bank are the most important group. In 1980's, there was the rise of

another subgroup, which is the 'rentiers'. It is referred to the land owners, property developers and real estate businessmen (Korff, 1989, cited in Koanantakool and Askew, 1992).

Eosiwong (1993) proposed that Thai middle class shared some similarity with middle class in other countries. The similarities are they operate in modern institutions, organise on a legal-rational basis, emphasise individualism, share a worldview based on the market exchange model and demand cultural products with popular appeal. However, the Thai middle class have their own cultural aspects such as attachment to and dependence on the culture of the ruling elites, a tendency to need to display material status conspicuously, the persistence of the notion that merit and power are closely linked and the persistence of traditional form of personal relations.

4.4. Understanding Thai society

Referring back to the seminal study conducted by Komin (1991), a number of different interpretations of the characteristics of Thai society were proposed. These include:

4.4.1. The 'loose structure social system' interpretation

John Embree (1950, cited in Komin 1991) compared Thai cultural traits with those of other cultural groups and characterised Thai society as having a loose social structure as indicated by the following features;

1. Allows considerable variations in individual behaviour;
2. Relatively low levels of concern regarding the observation of common rights and duties;
3. A lack of long-term obligations;
4. Showing no strong sense of duty and responsibility in family relations, to parents, spouses or children; An almost determined lack of regularity, discipline and regimentation in Thai life.

There is a controversy about Embree's theory. For example, Suvannajata (1976) proposed that Thai society is well patterned and predictable influenced by the idea of gratitude in social relationships. She discussed two types of relationships in Thai society as (1) The transactional or contractual relationship, which is voluntary and outwardly directed and non-lasting, and (2) the 'closed personal' and 'psychologically invested' relationship, which is based on 'gratefulness'. This relationship gives the sense of obligation which is enduring, stable and reliable (Suvannajata, 1976 cited in Komin, 1991).

4.4.2. The 'Individualism' Interpretation

This interpretation is related to Embree's interpretation of Thai society as having a loose structure. Phillips (1965) stated that Thai people had a 'profound sense of self-concern and freedom of choice' as major characteristics of the loose structure of Thai society' (cited in Komin, 1991, p.206). Due to the individualism of Thai people, they hardly show any sense of solidarity, obligation, commitment or loyalty beyond their own personal values. It is suggested that Buddhism might play important role in the individualism of Thai people in the sense that each one has to be responsible for his own salvation. Then, they have a tendency to take a lighter responsibility towards society than to their personal responsibility. The Thai individualism gives the ideas of permissiveness, non-violence, tolerance, lack of involvement, etc. Thais have always considered themselves as having free and independent souls. They are friendly and polite to others. They sometimes please each other and fulfil each other's expectation. However, they do it because they want to, not because others expect them to do or because the situation demands it.

Thai 'individualism' encompasses a different idea, than that of American individualism. Individualism in the Thai social relationship context refers to a 'belief that the individual is an end in him (her) self, and as such ought to realise the self and cultivate his or her judgment, notwithstanding the weight or pervasive social pressure in the direction of conformity with the views, needs, or goals of some in-groups or of the society' (Komin, 1991, p.7). On the other hand, Waterman (1984, cited from Komin, 1991, p.7) characterised American individualism as;

- a sense of separate personal identity
- striving for self actualisation
- internal locus of control
- principled moral reasoning, with emphasis on equity in interpersonal relations

Hofstede (1984, cited in Komin, 1991) collected data from 40 countries in search of the typology of 'individualistic-collectivistic' culture. When comparing Thai individualism with American individualism, the differences are very clear, as suggested in table 4.1

Table 0:1 Hofstede’s ‘Individualism-Collectivism’ dimension of national culture

Thai individualism	American Individualist
In society, people are born into extended families or clans who protect them in exchange for loyalty	In society, everybody is supposed to take care of himself Herself and his/her immediate family
‘We’ consciousness holds sway	‘I’ consciousness holds sway
Identity is based in the social system	Identity is based in the individual
The involvement with organisation is moral	The involvement with organization is calculative
The emphasis is on belonging to organisation; membership is the ideal	The emphasis is no individual initiative and achievement; leadership is ideal
Private life is invaded by organizations and clans to which one belongs; opinions are predetermined	Everybody has a right to a private life and opinion
Expertise, order, duty, and security are provided by organisation or clan	Autonomy, variety, pleasure and individual financial security are sought in the system
Friendships are predetermined by stable social relationships, but there is need for prestige within these relationships	The need is for specific friendships
Belief is placed in group decisions	Belief is placed in individual decisions
Value standards differ for in-groups and out-groups (Particularism)	Value standards should apply to all (Universalism)

4.4.3. The ‘Buddhism’ interpretation

As stated earlier in this chapter, the individualism of Thais may be derived from the Buddhist concept of working for one’s own karma. Therefore, Thai people are not group oriented. They are also non-committal, indifferent, smiling and emotionless because Buddhist teaching emphasises detachment. However, the Buddhist interpretation cannot fully explain why Thais are materially oriented and form and status oriented. Therefore, this interpretation fails to explain Thai social behaviour.

4.4.4. The ‘affiliation’ interpretation

In contrast to the individualism interpretation, Wichiarajote (1973) described Thai society as an affiliative society, in which people are dependent upon each other. He proposed that the basic drive of individual behaviour is to build up the networks of personal relationship. This is the highest need of affiliation. Thais are in need of friendships, love, warmth and social acceptance. As a result, the personality is portrayed as one of low self confidence, low self-discipline and low self-respect. Therefore, Thais experience disappointment, insecurity, frustration and loneliness. This interpretation gives the idea of negative personality of Thais.

4.4.5. The ‘cultural theme’ interpretation

Smit Smuchan (1979, cited in Komin,1991) suggested that Thai behaviour could be explained by three dominant cultural themes. They are personalism value, emphasising the survival of

survival of self as well as the dependence on other persons for the same survival purpose, fun-loving values including present-time consumption or indulgence, abhorrence of hard-work and the abundance in material generosity and merit accumulation values including the belief in karma and the predestined luck and fortune for each person. As a matter of fact, the cultural themes are derived from the three interpretations which are loose in structure, the Buddhist value and the individualism interpretations.

4.5. Differences between the Urban and Rural Population

Where people were raised and brought up appears to play an important part in the different values of Thai people. This is particularly noticeable among those living in urban and rural environments where patterns of behaviour contrast. For example, in a study conducted by Srisantisook (1999) it is found that rural people are different from urban people in that they place different levels of importance on values in education, being superior, merit making, superstitions and karma, fun loving, pride in their roots and gratitude. With regard to education, in the past, children were allowed to study 4 years in school in a compulsory educational system following by helping their parents in the field. In the present day, Thai farmers face many difficulties. As a result, they try their best to give the highest level of education they can for their children so that their children can have knowledge and work in other professions which are better than farming. Because they have insufficient budgets, some rural parents asked their sons to become monks so that they can have a good education at the temple.

Rural people also value security in life by respecting the rich with the perception that they work very hard to earn money to provide financial security for their family. With regard to merit making, rural Thais are more attached to Buddhism and merit making than are the urban Thais. The temple is the centre of the community. Sometimes, they make too much merit without thinking about their financial resources. Because of their poverty, they hope that their good deeds will bring them the better life conditions as a result of the good karma. If they cannot have a better condition of in their present life, they may see it in the next life. Not only being religious but Thais also are fun-loving and such fun is always related to the religious day or festival. Besides, they have a belief in superstitions and karma in the sense that they are in a good condition of life as a result of their predestined karma. Their bad luck occurs because of their bad karma. Furthermore, they believe in the supernatural. For example, most rural Thais are farmers; if there is not enough rain, they will worship god to ask him to produce more rain. Or if their children are very ill, they consider it as a bad luck and they seek help from monks.

Concerning the pride in their roots, many rural Thais migrate to the city to work in the factories or organisations. However, it is only temporary migration. After earning enough for a sufficient living, they move back to live in their village. One of the reasons can be the attachment to the values of gratitude. They come back to their home village and take care of their parents as paying a debt of gratitude. In contrast, urban people place different levels of importance on having reasons in doing anything, time management, westernisation, luxury, power and self-centred. With regard to values about reason, due to their higher education and career, urban Thais consider any situation happens by causes whereas the rural Thais still believe in superstitions. Apart from that, urban people have strong values about time. In the city, their work time is quite strict compared to the flexible work time in the fields of farmers in rural area. Therefore, people in the city are more aware about time

Westernisation plays important role in urban society. Thais in the city are in favour of people who graduated abroad and the products which come from the West. Urban Thais, especially teenagers and the younger adults, try to copy the Western way of living. Enjoying luxury is one of the core values for the city Thais. They like to spend without rethinking about their own financial status. One of the reasons is that they want to look economically powerful due to the praise of power in society. Lastly, the self-centred characteristic of urban Thais is reflected in the sense that they tend to break many of the rules, particularly those associated with driving in urban area and queuing for their own sake.

4.6. Changes In Thai society

More recently, due to two essential changes, demographic and economic, Thai society has been changing.

4.6.1. Demographic changes

During the past three decades, demographic patterns have been changed by a decline in fertility rates. The population size was 34.4 million in 1970, 44.8 million in 1980 and 54.5 million in 1990. The growth rate is 2.74%, 2.65% and 1.98% respectively. The latest survey of the total fertility rate by the Survey of Population Change in 1991 indicated the total fertility rate from the least three decades is 6.3%, 4.9% and 2.7% respectively. The life expectancy of males and females increased from 55.2 and 61.8 years in 1965-1966 to 67.7 and 72.5 in 1991 (Pananiramai, 1997). The proportion of the senior population is increasing. Due to the longer life expectancy of women, the senior population mostly comprises women.

4.6.2. Economic changes

Regarding economic changes, compared to the past Thai economy has become more industrialized and commercialised, which has been beneficial for Thailand due to the creation of a need for more labour. In 1960, the National Economic and Social Development Board (NESDB) were established and the national economic plan was released. This increased the development of the infrastructure and the expansion of the industry. The changing economic patterns influenced the changing lifestyle of rural people from rural living to one of modernisation and consumerism.

Thailand suffered from the 1973 and 1979 oil shocks which led to problems of inflation and external debt. In turn, the country emphasised more on export promotion after a long period of support for imports. During the period 1986-1990, the economy of Thailand grew again particularly in regard to labour-intensive industries such as textiles, food processing and electronic parts assembly (NCWA, 1995). These changes caused an internal migration of Thais in search of job opportunities. The mobility of the population in Thailand is characterised by;

1. a town-born migration from both the rural and urban areas,
2. a countryside-born migration from both the rural and urban areas, and
3. a seasonal migration

According to the statistics, town-born migration in urban areas increased while rural-born migration, especially countryside to countryside decreased. The seasonal migration can be the farmer from the rural area migrating to the city or other rural areas after the seasonal production is finished. The seasonal migration can be the migration to the foreign countries, especially the Middle East region. The motivation for the migration is employment and there is the rapid growth of the urban employment while the rural employment is static (Paraniramai, 1997). As a result of the demographic and economic changes, there are some aspects of changes in the status of women in Thailand which are changes in education, economic participation, social structure, marriage and divorce pattern, family structure and family roles.

4.7. Changes in a status of Thai women

Due to the decreasing numbers of kids in household, the cost of education is lower. It reduce the cases in which older female siblings had to resign from school to take care of younger siblings. Besides, the economic changes have led to increased demand for female labour. This

has encouraged women to study more. According to the survey (ibid) about educational attainment by gender over 1960-1990, it is shown that the school enrolment in Thailand has increased for both males and females. However, the rate of increase is more rapid for females.

As a result of the increase of the female labour, women from rural area migrate from the countryside to work in factories due to the fact that factory work can provide a more stable income than agricultural work. Women have more opportunities to be economically independent. Many women change from being home-based workers to work in these sectors. Compared to other Asian countries, Thai women have a better status in the labour force. Many women are in high ranking positions in the public and private economic sectors. However, gender discrimination still exists in the labour force. There are some positions which are offered only to men and it remains legal to advertise positions which specify gender preference. There is also the wage gap between male and female labour (Paraniramai, 1997).

These economical changes of Thai women have also led to changes in social structures. Choowattanapakorn (1990) argued that Thai society is marked by hierarchical traditions in which Thai people are in different social positions. For example, children are taught to pay respect to their seniors and people of higher status such as parents, grandparents, teachers and monks. As mentioned earlier, the idea of repayment to parents is really strong in Thai culture. Thai children are taught to regard mother as everything in their lives as Mulder stated;

Your mother loves you more than anybody else. She has given birth to you: you have grown up because of sucking her blood. She has been feeding you bad caring you. She knows what is best for you. You should return her love, be thankful to her, respect her, yet in all your life you will never be able to repay her for the overflowing goodness she has done for you. Never, never forget to return the goodness that she has to you, be grateful and fulfil your filial obligation.'

Choowattanapakorn, 1990, p.97

Therefore, children have a sense of obligation to take care of their parents. From the study of living arrangements of the elderly in Thailand by Knodel and Sittitrai (1995), it is found that most Thai's refused to let their parents move into an institution for elderly people. Daughters, especially the younger daughter, are always expected to take responsibility for taking care of the elderly parents. If parents do not have daughter, the youngest son is in charged. Through socialisation, daughters were taught the caring role in order to provide personal care for their parents.

In the past, the young countryside villagers moved to work in town temporarily after the harvest season. Today, they tend to move to town permanently due to inadequate rainfall and

the low prices for their products. Besides, the rapid growth of Thai economy in 1985-1990 encouraged the unskilled worker to move from agricultural sectors to the manufacturing sector. Therefore, it seems that the elderly are not taken care of as well as in the past.

With regard to marriage and divorce patterns, various studies show that Thai women had a high degree of freedom in time and choice of marital partner. Apart from that, there are more single women who remain single until they are 50 years old. Also marriage is postponed among Thai women today compared to the practice in the past. The changing patterns of the marriage in Thailand are influenced by changes in women's education, urbanisation and increasing employment opportunities for women. These changes are caused by economic development. The higher education of women leads to higher job opportunities in the labour market. As a result, marriage is postponed. Besides, postponing marriage is more likely to turn into single hood for women than men. Regarding divorce, the registration data indicates that the rate of divorce between the years 1981-1990 increased from 7.9 % to 9.7 %. Remarriage is increasing as well and divorce is today more acceptable in Thai culture. However, compared to divorced men and widowers, divorced women and widows have a lower possibility of remarrying.

Not only has the marriage and divorce pattern changed causing demographic and economic changes but it has also resulted in changes in the patterns of Thai families. Traditionally, the Thai family is an extended one. However, from the Thailand census, (1992) the household size declined from 5.73 in 1970 to 4.37 in 1990. The average households in rural area are a bit larger than ones in urban areas in 1980 and 1990. In 1990, the percentage of nuclear family was 67.58% while extended family and non-family types were 26.25% and 6.16% respectively.

The families in the city tend to be the monogamous nuclear family. In the past, monogamous practice was not strict in Thai society because the rich could have as many wives as they wanted as long as they could take care of them. At that time, Thailand had more extended families which comprised the nuclear family and their relatives. The nuclear family has the advantage that there is the sense of freedom, economically and socially. Nevertheless, parents may need to hire a babysitter to take care of their children. Conversely, in the extended family, the grandparents help take care of the baby (Supap, 1991)

In terms of the role of family, by tradition, the husband is considered to be the leader of the family by earning income to support the family members. The husband is also in charge of the decision making. The wife is trained to be housewife who takes care of the house and the children. Through the socialisation process, men and women are trained to lead traditional

roles in the sense that sons have to prepare themselves to be the leaders of the family while daughters need to learn how to take care of the home. However, in the urban community, men and women are nearly equal because of the influence of westernisation which suggests that husband and wife have equal right in decision making process in household. This balance is due in part to the higher educational and work status of women. However, in rural area, there is still the patriarchal society (NCWA, 1995).

Regarding housework tasks such as house cleaning, washing and cooking, these are still considered as women's work even though women have out of home careers resulting in the double role of women. However, in some urban families, the husband may help with some housework or in some cases; the housework is done by a maid. Concerning family life, the relationship of husbands and wives are based on the mutual respect, understanding and faithfulness. Some families have conflict because they do not follow these norms. Most of the conflicts in Thai society are due either to double marriage registrations caused by unfaithful husbands, keeping a mistress or mistresses or to domestic violence.

Women are expected to take care of the children from pregnancy onwards. In term of the sexual preference of the child, Thai who are of Chinese descendants prefer a boy to a girl so that the boy can carry on the family names. As mentioned earlier, the girl is trained to be responsible for housework while the boy can go out and enjoy life. At the same time, the boy is taught about how to make a living. One more aspect in Thai culture is the daughter is expected to take care of their elderly parents because the relationship of parents and children are based on the gratitude. Mother earns gratitude from giving birth and taking care of children. Son shows gratitude by being a monk while daughters take care of their elderly parents.

Parents always take care of their children no matter they are grown up or marry and leave the house. Children always stay with their family until they get married so that they can take care of their parents as a method to pay the debts of gratitude. In the rural area, mostly, the new married couples stay in the house of the wife's parents and help their in-laws to do the field works. The period can be last from 2-10 years. They may move out when there is someone taking care of parents, or when they have children. In the past, the married couples always built their house near the wife's family with the reason that the family can look after their daughters and make sure that the husbands do not use their power in a wrong way in the household.

In summary, this chapter provided the background knowledge about Thai society. The generic values in Thai society were illustrated according to gender, age, income, education,

occupation and religious behaviours. Nine characteristics of Thai people were also presented. They were ego orientation; grateful relationship orientation; smooth interpersonal relationship orientation; flexibility and adjustment orientation; religious-psychical orientation; education and competence orientation; inter-dependence orientation; fun-pleasure orientation; and, achievement-task orientation.

The class structure of Thai society was also presented. Different interpretations of characteristics of Thai society were proposed as the 'loosely structure social system' interpretation, the 'individualism' interpretation, The 'Buddhism' interpretation, the 'affiliation' interpretation and the 'cultural theme' interpretation. Also, the differences between the urban and rural Thai population were discussed. Rural people were shown to be different from urban people in the sense that they placed different levels of importance on values in education, being superior, merit making, superstitions and karma, fun loving, pride in their roots and gratitude. Demographic and economic changes in the past three decades had great effects on many aspects of the lives of Thai women such as education, the changing female labour and lastly the role of women in family and society.

The next chapter is the methodological chapter which explains the process of how to undertake this research study starting from the literature review, the primary data collection which is succeeded by the use of participant observation and primary interviews, the data analysis of both qualitative and quantitative analysis, the follow up interviews and the comparison of the findings of the first interview and findings of the follow up interview.

CHAPTER 5

METHODOLOGY

This study is an explanatory case study with the data collection undertaken over the course of three years which aimed to investigate the participation in health tours by Thai women in relation to their leisure patterns and lifestyles. This chapter reviews the methodology used in this study in order to meet the aims and objectives of the study. The adoption of the pragmatic paradigm is defended and related. Ethical considerations are discussed, followed by a review of the concept of the case study. Then, both qualitative and quantitative research approaches are discussed and approaches to both secondary and primary data are introduced. The methods of data analysis adopted are reviewed and the limitations and constraints of conducting this research are clarified. Lastly, a summary of the methods employed is provided and the timetable of this research study is discussed.

5.1. Paradigms

This study uses a mixture of methods by combining semi-qualitative and quantitative data in the data collection and analysis stage. Concerning the mixture of methods approach, there have been various discussions about which paradigm should be used. There are a range of paradigms available to social science researchers which include positivist, interpretive social sciences, critical theory, feminist perspective, post modern and the pragmatism paradigm. The positivist paradigm views the world as being guided by scientific rules which can explain the phenomena through causal relationship. It is mostly used in quantitative studies. On the other hand, the interpretive social sciences paradigm is mostly used in qualitative studies due to the view of the world as having multiple realities and explanations to explain the phenomena rather than one causal relationship. The critical theory paradigm is similar to the interpretive social sciences paradigm in terms of the real world setting and the view of the world it adopts. However, critical theory views the world involving to oppression, subjugation and exploitation of minority groups. The aim of this type of paradigm is to bring about change. The feminist paradigm views the world as patriarchal and the study aims to cause some changes. The post modern paradigm views the world as chaotic where there is no one truth to explain the phenomena. In the use of mixing both methods, researchers propose many positions about which paradigm should be used. In this study, the belief is that a single paradigm should serve as a foundation of the use of the mixture of methods. A review of the literature indicates that the pragmatism paradigm is widely used among researchers. Trow summarises the view of many (1970, p.149 cited in Jennings, 2001 p.135) in suggesting that

we should 'get on with the business of attacking our problems with the widest array of conceptual and methodological tools that we possess and they demand'. Therefore, the main concern is not which paradigm is superior but the way to achieve the aim of the study.

In order to achieve the aim of this study, the pragmatism paradigm has been applied. Tashakkoori and Teddle (2003, p.21) stated that;

1. Pragmatism supports the use of both qualitative and quantitative research methods in the same study and within multistage programmes.
2. Pragmatist researchers consider the research question to be more important than either the method they use or the paradigm underlies the method.
3. Pragmatism rejects the forced choice between post positivism and constructivism.
4. Specific decisions concerning the use of mixed methods or qualitative methods or quantitative methods depend on research questions.
5. Pragmatism presents a very practical and applied research philosophy.

They also suggest that 'Study of what interests and is of value to you, study it in the different ways that you deem appropriate, and utilise the results in ways that can bring about positive consequences within your value system,' (p.21). It is shown that pragmatism look at the destination of research, not the origin of the ideas.

5.2. Ethical considerations

Most of this research involved people. Therefore, there are ethical issues to consider. Miles and Huberman (1994) identify 11 ethical issues which the researcher needs to pay attention to through the research process as being;

1. *Worthiness of the project.* A number of studies about health and spa tourism are found in Thailand. However, they are mainly about the international market. There is no single study or information available about health tourism for the domestic market, especially about Thai female participants. Thus, this research provides the first academic study about the participation of Thai women in health tours run by Thai doctors aiming for lifestyle changes of the participants. The research sought knowledge concerning health tour participation by Thai women is explored as was knowledge about leisure patterns and healthy lifestyle practices of Thai women. Generally, in Thailand, women put family needs first and take the role of wife and mother as the highest recognition and expression of their femininity. Therefore, their leisure activities have some effect upon their family members as does their participation in health tours. The outputs of this study can potentially effect to the

promotion of health and well being not only among the female participants but also their family members or their peers. Besides, the categorisation of health tour participants can be developed for market segmentation for the advanced marketing research for health tour organisations. In addition, the government can use the analysis of study as background knowledge to promote the health and well being of Thai population.

2. *Competence boundaries.* The researcher took the research methods courses prepared by both Service Management School and the Graduate School in Bournemouth University about how to carry out a research study within an academic environment.
3. *Informed consent.* Before data collection was undertaken the participants were informed about what the study was all about and why it was being conducted. When the researcher took part in the health tour as a participant, the health tour participants were told about the research and their permission for interviewing obtained. As for those whom the researcher had never met before, telephone contact was made and the situation about research explained before conducting the interview. The ethical issue is the doubt from the participants why and from the researcher obtained the information such as their telephone number and their address. The information about the health tour participants were obtained from the health tour organizers given that they would be used for educational purpose only. This point was clarified among the health tour participants. They were satisfied and willing to help and being part of the research.
4. *Benefits, costs, reciprocity.* Each party gains benefit from taking part in the research in the sense that the researcher has a chance to gather the very useful information for the project while the participants fulfil their good intention. In relation to Thai culture, being helpful is a strong characteristic of Thai people as well as the idea that doing good deeds brings good karma. All health tour participants were very helpful.
5. *Harm and risk.* In this study, the ethical implications were seriously considered. There is no harm to the participants physically, mentally and emotionally. It can be considered the emotional harm in the case that the participants told the story about their past illnesses or about their relatives who passed away by illnesses. However, those participants were eager to talk about this kind of topic and to be examples for others to lead healthy lifestyle. Besides, in health tour participation, there was the activity called 'table talk' which encouraged health tour participants to talk about their past experiences about health and everyone was willing to do so. Therefore, the problem of emotional harm was not evident in this study.
6. *Honesty and trust.* The researcher was very truthful to the participants by informing everything about the study and any information the participants would like to know

such as the university that the researcher studies, when the researcher will finish the study or even the private questions such as the hometown of researcher, the age and the family.

7. *Privacy, confidentiality and anonymity.* It is suggested that the researcher should be aware that the use of records could present particular problems in relation to confidentiality. In this case, the participants were asked before being recorded during the interview. All of the participants were willing to be recorded.
8. *Intervention and advocacy.* The researcher did not observe any harmful, illegal or wrongful behaviour by others during the study. Therefore, intervention and advocacy were did not take place during the research process.
9. *Research integrity and quality.* The research was conducted carefully, thoughtfully and correctly concerning the moral issues.
10. *Ownership of data and conclusions.* The data from the research is owned by the researcher. However, once the thesis is completed, copies will be located in the University library
11. *Use and misuse of results.* It is guaranteed that the results from this research will not be used in the wrong way.

5.3. Case study

This study is an explanatory case study about female health tour participation in Thailand. The explanatory case study aims to answer the question 'how' and 'why'. Yin (2003) defines the scope of a case study as an empirical inquiry that 'investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident' (p.13). Case studies are used when the researcher wants the contextual conditions to be covered. Yin also points out that the case study is a research strategy comprising full research process beginning from design, data collection techniques and specific approach to data analysis.

The dictionary of sociology terms defines a case study as;

'a method of studying social phenomenon through the thorough analysis of an individual case. The case may be a person, a group, an episode, a process, a community, a society, or any other unit of social life. All data relevant to the case are gathered, and all available data are organised in terms of the case. The case study method gives a unitary character to the data being studied, by interrelating a variety of facts to a single case. It also provides an opportunity for the intensive analysis of many specific details that are often overlooked with other methods'

Theodorson and Theodorson, 1969 cited in Punch, 2005, p.145

From this definition, Punch (2005) gives additional details about the four characteristics of a case study. Firstly, the boundaries between the case and the context may not be clearly seen. However, the researcher needs to clarify them as much as possible. Secondly, the case is a case of something. The case has to be identified what it is all about from the unit of analysis to the idea of the analysis. Thirdly, the case should be holistic in a sense that the wholeness, unity and integrity of the case should be preserved. Lastly, it is likely to use the multiple sources of data collection in the case study.

Yin (2003) proposes that there are three different types of case study, the critical case, the unique case and the revelatory case. The critical case is the case in which the researcher has a clear hypothesis and the case will be chosen for the better understanding of the situation which the hypothesis will hold or will not hold. The unique case is the case focusing on clinical studies. Finally, the revelatory case exists *'when an investigator has an opportunity to observe and analyse a phenomenon previously inaccessible to scientific investigation'* (p.44). This research is categorised as the last type of case study. Berg (2004) points out that many qualitative researches use the case study approach as a guide to their research by focusing on the single phenomenon, individual, community or institution. Then, the phenomenon will be unfolded as a main aim of the research. The holistic description and the explanation are focused in the case study method. There is the criticism about the case study that it reflects the bias of the researcher in the sense that the value system of the researcher would influence the presentation of the facts and the analysis of the case. Nevertheless, it is argued that bias can occur in any stages of the research process such as the questionnaire designing stage. Cresswell (1994) seeks out the solution by suggesting the use of triangulation of methodologies to avoid bias.

This study is a single revelatory case study. One of the rationales for the single case study research is it requires the follow up research. This is the study of the same single case at two or more different points of time. The main interest of this kind of study is to identify how certain conditions change over time. This study spent three years in collecting data to investigate the leisure and lifestyle of the health tour participants.

5.4. Qualitative and quantitative approaches

5.4.1. Qualitative approach

Cresswell (1998) defines qualitative research as 'an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports details views of

informants, and conducts the study in a natural setting' (p.15). He also points out the characteristics of qualitative research as it takes place in the natural setting with the diversity of data collection methods. In qualitative research, the researcher is a key instrument of data collection and the focus is on the meaning and perspectives of participants. In the analysis process, the data will be analysed, in part, inductively. In this study, the main aim is to investigate the participation of Thai women in health tours. Consequently, understanding the experiences from the health tour of these women is essential. Therefore, a partly 'qualitative' approach was appropriate for particular aspects of this study. However, it was not possible to investigate in detail the responses of the respondents as it was only feasible to undertake one detailed interview at each stage of the research. Consequently, it is recognised that this research was unable to build the 'complex holistic picture' that would emerge from a qualitative analysis. Nevertheless, the 'open' free elicitation nature of the interviews provided greater insight into the leisure, lifestyle choices and practices of Thai women than would have emerged from an interview that was tightly structured and made no allowance for respondents to respond in their own words to open questions.

5.4.2. Quantitative approach

The quantitative approach is an approach which views the world as there is only one truth. The aim of the research is to search for the causal explanations by testing the hypothesis. Burns (2000) describes the four characteristics of the quantitative approach as control, operational definition, replication and hypothesis testing. The strengths of this approach are precision and control. The precision comes from the quantitative and reliable measurement while the control comes from the sampling and design. However, there are the limitations to the quantitative approach. Bryman (2001) discusses the critique of the quantitative approach in that he asserts that the quantitative researchers fail to distinguish people and social institutions from the world of nature. They treat the social world as if it is set in a natural order. This approach also, he suggests, discourages human beings from thinking freely. The mechanical tools tend to exclude the notion of freedom and choice for the respondents. Also, it fails to address people's ability to interpret their experiences. Many writers have tried to draw out the contrasts between qualitative and quantitative research and Rodwood (2006) summarises these as shown in table 5.2 below;

Table 5:1 Qualitative and quantitative approaches to research

	Qualitative	Quantitative
Aim	<ul style="list-style-type: none"> • Exploration of participants' meaning, gaining understanding of human experience • Generating theory from data 	<ul style="list-style-type: none"> • Search for causal explanation • Testing hypothesis • Prediction, control
Approach	<ul style="list-style-type: none"> • Broad focus • Process-oriented • Context bound, mostly natural setting • Getting close to data 	<ul style="list-style-type: none"> • Narrow focus • Product-oriented • Context-free, often in artificial setting
Sample	<ul style="list-style-type: none"> • Participants, informants • Sampling units such as place, time and concept • Flexible sampling which develop during research 	<ul style="list-style-type: none"> • Subjects, respondents • Pre-determined
Data collection	<ul style="list-style-type: none"> • In-depth, non-standardised interviews • Observation/ fieldwork • Documents, photographs, video 	<ul style="list-style-type: none"> • Measurements • Questionnaires • Standardised interviews • Tightly structure observation • Documents • Randomised controlled trails
Analysis	<ul style="list-style-type: none"> • Thematic and content analysis by coding and categorising • Grounded theory, Ethnographic, Phenomenological analysis 	<ul style="list-style-type: none"> • Statistical analysis (Descriptive and inferential)
Outcome	<ul style="list-style-type: none"> • A story, a theory, an ethnography 	<ul style="list-style-type: none"> • Measurement results
Relationship	<ul style="list-style-type: none"> • Direct involvement of researcher • Research relationship close 	<ul style="list-style-type: none"> • Limited involvement of researcher • Research relationship distant
Philosophical assumptions	<ul style="list-style-type: none"> • Intepretivist: Human being differ from the material world 	<ul style="list-style-type: none"> • Positivist: Belief in universal • Laws, objectivity and neutrality

In regard to the summary of the differences between the qualitative and quantitative approach, it is suggested that this study is in part qualitative in the sense that it aims to explore the participation in health tours of Thai women with their leisure patterns and lifestyles and is set

in the natural setting. The data collection methods employed to achieve this were participant observation and detailed interviews. This study is also partly quantitative because it reflects upon the quantitative data collected during the in-depth interviews. This quantitative data lends itself to quantitative analysis and allowed this study adopting both qualitative and quantitative approaches. Therefore overall study is considered to be a quantitative study because the interviews were semi-structured partly 'open' interviews, not the series of in-depth interviews which ideally should characterise a qualitative study. Besides, this study not only aims to investigate the participation of Thai women in a health tour in relation to leisure and lifestyle but also aims to test the assumption about the relationship of women and leisure behaviour in Thailand comparing to the Western society.

5.5. Data collection

This study requires several phases of both secondary and primary data collection

5.5.1. Secondary data collection - the literature review phase

The first data to be investigated when doing research is the secondary data, which has been defined as 'information collected for a purpose other than that of the researcher in this sense the researcher becomes the secondary user of the data' (Finn, 2000, p.40). The secondary research process establishes a good understanding of the subject area. Secondary data can be found in a number of different sources such as written materials including amongst others books, journals, newspapers, theses, magazines, brochures, reports, Internet and non-written material such as television and videotapes. Secondary data forms the foundation of the literature review. Punch (2005) suggests that in a traditional research, the literature review plays as a part of the research planning and question development stage. Cresswell (1994) suggests that when adopting a qualitative approach, the literature should be used as the methodological assumptions in the sense that it should be used inductively so that it does not directly influence the questions used in any subsequent interviews. The literature review is only used to frame the problem in the introduction of the study. The literature review in this research is divided into three main concepts of; leisure and lifestyle, health tourism and Thai society.

With regard to leisure, there are reviews of the definition of leisure, increasing leisure activities, leisure motivation, leisure demands, leisure behaviour, leisure participation, leisure socialisation and leisure constraints. As all the respondents of this research are female, the concepts of women and leisure are reviewed including perceptions of leisure by women, their leisure opportunities and constraints, the relationship between women, work and leisure and

lastly the transformation idea of women and leisure. In relation to lifestyle, the ideas of consumerism, consumption and social class were reviewed as is Pierre Bourdieu's theory of Distinction and various propositions of the relationship between lifestyle and social class and the relationship between lifestyle and health. With regard to health tourism, the relationship between health and tourism is discussed. In addition, a historical perspective of health tourism, the growth of health tourism and tourism specific advantages of health tourism are explored. Moreover, the categories of health tourism consumers and health tourism destinations are illustrated. Finally, health tourism in Asia and in Thailand in particular was investigated.

In order to establish background knowledge about the nature, attitudes and values of Thai people, the concept of Thai society was researched beginning with the generic values of Thai society with a breakdown of values provided by gender, age, income, education, occupation and religion. Next, the nine characteristics of the national character were identified followed by the essential characteristics of Thai society. The different values between the rural and urban society are then discussed. Lastly, the changes in Thai society resulting from economic and demographic changes were investigated.

In addition to these topics, the literature concerning methodologies was reviewed. In a qualitative approach, various methods can be applied for data collection, which include focus groups, observation and interviews. The focus group can be thought of as a semi-structured group interview because the participants are 'interviewed' together at the same time. The purpose of using the focus group is to determine point of view, opinions and attitudes towards concepts or forecast the future issues. The discussions in the focus group also enable richer data collection (Jennings, 2001). However, it is difficult to conduct a focus group in Bangkok due to the participants living throughout Bangkok with the additional complication of the continuous and severe traffic jams. Since Bangkok is a big city, the creation of a sense of trust for asking the health tour participants to join the focus group is idealistic rather than realistic. In addition, establishing focus groups for this study would be very complicated due to the large number of participants and the differences in the times when they would be available. Therefore, participant observation and semi-structured in-depth interviews were chosen as the most appropriate methods of collecting primary data and were thoroughly investigated. The questions for the interview were informed by the principal themes explored through the literature. The three main themes are given below;

Questions about leisure

- Importance of leisure
- Importance of individual leisure comparing to family leisure
- Leisure time
- Leisure participation
- Leisure constraints

Questions about healthy lifestyle

- Attitudes toward healthy lifestyle
- Motivations of leading healthy lifestyle
- Perception of the word healthy lifestyle
- Perceptions of their own health comparing to their peers

Questions about health tour participation

- Motivation of health tour participation
- Pre purchase searching
- Attitudes towards health tour
- Perceptions of friends towards health tour participation
- Time available for health tour
- Cost of health tour
- Regime of health tour
- Complaints about the health tour
- Changes after health tour participation
- Benefits of health tour participation
- The encouragement of friends to lead a healthy lifestyle
- The encouragement of friends to join the tour

Apart from the three main themes, closed-ended demographic questions were included. They were age, marital status, educational attainment, subjects studied, educational institutions attended, career, income, accommodation type, accommodation ownership and car ownership. All the questions were tested in a pilot study before being used in the reported interviews.

5.5.2. Primary data collection – the participant observation phase

Participant observation attempts to understand and interpret the meanings and experiences of a group from the insider's perspective. This method seeks to reveal the meanings of the phenomena of people in their life. The participation of the researcher in the setting has an effect to the accuracy and truthfulness of the data collection (Cole, 2005). Participant observation is used to explain what goes on, who or what is involved, when and where things happen, how they occur, and why from the standpoint of the participants. Things happen as they do in particular situations (Jorgenson, 1989, p.1). The appropriateness of using participant observation in research is also described by Jorgenson (1989) as a method that should be used when;

- The phenomenon is little known or explored such as newly formed movement;
- The views of the insiders are contradictory to the outsiders such as ethnic groups or subcultures;
- The phenomenon is obscure from the view of the outsiders such as mental illness or religious ritual;
- The phenomenon is hidden from the public view such as drug using.

He also points out the proper circumstances for the use of participant observation as:

- the research problems is concerned with human meanings and interaction viewed from the insiders' perspective;
- the phenomenon of investigation is observable within an everyday life situation or setting;
- the researcher is able to gain access to an appropriate setting;
- the phenomenon is sufficiently limited in size and location to be studied as a case;
- study questions are appropriate for case study;
- the research problem can be addressed by qualitative data gathered by direct observation and other means pertinent to the field setting (p.14).

Jorgenson (1989, p.14) defines seven basic features of the participant observation as:

1. a special interest in human meaning and interaction as viewed from the insiders or members of particular settings and situations;
2. location in the here and now of everyday life situations ad settings as the foundation of inquiry and method;

3. a form of theory and theorising stressing interpretation and understanding of human existence;
4. a logic and process of inquiry that is open-ended, flexible, opportunistic, and requires constant redefinition of what is problematic, based on fact gathered in concrete settings of human existence;
5. an in-depth, qualitative, case study approach and design;
6. the performance of a participant role or roles that involves establishing and maintaining relationships with natives in the field;
7. the use of direct observation along with other methods of gathering information.

Participation observation is chosen in this study due to its advantages as it could investigate the behaviours in the real world setting and enable the researcher to be aware of how the interview respondents describe and construct their world. Participant observation was undertaken to provide an opportunity to know and observe the health tour participants by joining the health tour. As the researcher is the participant observer, it is easier to describe how the participants construct and describe their world (Jennings, 2001). In this study, participant observation helps the researcher to be aware of the general characteristic of health tour and health tour participants. Besides, being part of the health tour participants encouraged the researcher to know other participants leading to the smooth encounter for the semi-structure interview later on.

The role of the researcher was that of an overt participant. The researcher had to contact the health tour organiser for authorisation to conduct the participant observation. In the beginning of the health tour period, the role of the researcher was that of the complete participant and had no chance to introduce oneself. Later on, the purpose of the health tour participation was made clear so that the other participants could be invited to participate in an in-depth interview.

The researcher found it very easy to be in the position of health tour member because she was always interested in health matters and how to take care of own health due to the past experience about the illness of family member. Therefore, the researcher was pleased to learn more about healthy lifestyle so that she could practice this and tell other people in the family.

The health tour staffs were very friendly and helpful. It might be because they led the Cheewajit lifestyle. They look active, young, kind and peaceful at the same time. With these characteristics, the researcher saw them as a role model and would like to be like them.

In the health tour, apart from declaring oneself as a researcher, she declared an intention to get rid of the old bad habit and start a fresh new life. The researcher was given a warmly support by everyone in the group. As for those who experienced health tour before and continued leading healthy lifestyle, they kept on reminding the researcher about how great it was to lead healthy lifestyle and encouraging the researcher to maintain the healthy life. At that time, the researcher felt like living in the utopia, where everyone was generous and helpful. The atmosphere was great. The food was delicious and all the activities encouraged healthy life.

The researcher had ever wondered if this kind of environment occurred in the health tour scene only because everyone left all the burdens and city lives behind and started to live the new healthy life in the friendly environment. However, the question was answered when the researcher went to conduct the interview at their houses, their officer or somewhere else in Bangkok. All of the interviewees were so helpful and hospitable.

As one of the tour member, the researcher had a chance to meet new friends and listened to their life stories in the tour. Some stories are very heart-warming while some are very depressed. Nevertheless, this helped the researcher seeing the world in the new angle. Besides, seeing severely ill women being so lively, friendly, kind, positive and enjoy every aspect of the tour impressed the researcher, especially when they showed their energetic gesture in helping the researcher as much as they could. This encourages the researcher to reflect on her own as physically strong but somehow mentally weak comparing to those members of the tour who are ill, leading to intention to try to do better both for herself and others. It can be said that this was the life changing experience. With the realization that illness and death could happen to anyone in any time regardless of class, gender or ages, the researcher felt the strong intention to lead the worthier life so that if death comes in one day, the researcher would not be regret of the past life about not doing well enough.

As a position of participant, the participation in health tour gave a beneficial result. As a standpoint of the researcher, this method is considered quite successful because the researcher could get the insight experience of health tour and the researcher could blend in very well with other participants, which made thing easier for the next step. However, the researcher was emotionally involved with the ill participant. It was quite hard to try to maintain the position of a researcher when talking to them.

When the researcher looked back on the participant observation and thought about the problem occurred during this method, one problem happened. It is the record keeping. The researcher joined the health tour as one of the member. There were a lot of activities to be

occupied. Thus, it was quite hard to find the chance to record the field note immediately. For example, the tour members had to get up at 3 in the morning. Before bedtime, there was the relaxation session and most of the time, people fell asleep including the researcher in this activity.

When analysing how effective of the participant observation of the researcher, it is regarded as effective one because the researcher experienced the meaning and interaction viewed from the insider’s perspective. Also, the findings from the observation enrich the findings from the interview. When interpreting and analysing the results of the primary research enquiries, the distorting potential of the research personal involvement and interest in health topics was recognised and addressed by rigorous adherence to a range of analytical methods.

5.5.3. Primary data collection - the Interview phases

Referring to the interview, various definitions are given as Jennings (2005) and these are summarised in table5.2 below;

Table 5:2 The nature of interviews.

Writer and Year	The nature of Interviews
Palmer (1928:169)	The conversation of human being are an important part of the data of social research, as well as an important part of social research technique
Maccoby and Maccoby (1954:499)	a face-to-face interchange in which one person, the interviewer, attempts to elicit information or expressions of opinions or belief from another person or persons
Dexter(1970)	Interviews are conversations with a specific purpose
Oakley(1981)	Interviews are pseudo-conversations with historically determined protocols. Interviews should be founded on a ‘relationship of mutual trust’ and be ‘non-hierarchical’
Burgess (1982:107)	Conversation is crucial element in a field research
Hammersley and Atkinson (1983:126)	Interviews must be viewed...as social events in which the interviewer (and for that matter the interviewee) is a participant observer...
Mishler (1986)	An interview is a joint product of what interviewees and interviewers talk about together and how they talk with each other. The record of an interview that we researchers make an then use in our work of analysis and interpretation is a representation of that talk
Denzin (1989:103)	An interview is like a conversation
Seidman (1991:3)	At the root of in-depth interviewing is an interest in understanding the experience of other people and meaning they make of that experience
Bailey (1994:176)	The interview is a special case of social interaction between two persons...with related etiquette
Rubin and Rubin (1995:2)	Qualitative interviewing is more than a set of skills, it is also a philosophy, an approach to learning
Kvale (1996: 14)	The qualitative research interview is a construction site for knowledge. An interview is literally an inter view, an inter-change of views between two persons conversing about a theme of mutual interest

There are three types of the interview, which are structured interviews, semi-structure interviews and unstructured interviews. The structured interview is a questionnaire based interview with pre-coded answers. The interview is conducted according to the order in the questionnaire (Saunders, Lewis and Thornhill, 2000). A semi-structured interview is an interview in which the interviewer had a list of questions about the phenomena. The interview goes basing on the list building up more structure although the order of the interview issues is not as listed. Unstructured interviews are less formal. Berg (2004) compare the differences between these three types of interview as shown in table 5.3 below;

Table 5:3 Interview structure continuum of formality

Structured Interview	Semi-structured Interview	Unstructured Interview
<ul style="list-style-type: none">• Most formally structured• No deviations from question order• Wording of each question asked exactly as written• No adjusting of level of language• No clarifications or answering of questions about interview• No additional questions may be added• Similar in format to a pencil-and –paper survey	<ul style="list-style-type: none">• More or less structured• Questions may be reordered during the interview• Wording of questions flexible• Level of language may be adjusted• Interviewer may answer questions and make clarifications• Interviewer may add or delete probes to interview between subsequent subjects	<ul style="list-style-type: none">• Completely unstructured• No set order to any questions• No set wording to any questions• Level of language may be adjusted• Interviewer may answer questions and make clarifications• Interviewer may add or delete questions between interviews

Jennings (2001) points out that the advantage of the semi-structured interview is that it allows the determination of multiple realities due to the freedom from constraints of the interviewee. Also, attitudes, opinions, expectations and values can be explored and clarified in detail. This kind of interview also creates a relaxed atmosphere in the interview setting. Therefore, the semi-structure interview is well suited to the nature of this exploratory study in gaining insights about the participation of health tour by Thai women.

In this study, two types of questions were asked in the interview. They are ‘free elicitation, qualitative open-ended questions designed to obtain detailed knowledge about health tour participation and closed questions for the demographic details. Bryman (2002) points out the advantages of the open-ended question as the participants can freely answer questions in their own words. Unlike the close-ended questions, the participants are not suggested any kind of answers, which avoids the idea that the level of knowledge and understanding of the issues be

tapped. Besides, the open-ended questions allow the researcher to explore in the realm one has limited knowledge. The close-ended questions also give the great advantages in the sense that they are easy to process and enhance the comparability of answers with the post coding method. Besides, the close-ended questions help the researcher to have more understanding about the questions by suggesting the answers. Lastly, they are also easy for interviews due to their fixed structure.

Questions for the interviews

The open-ended questions provide the qualitative data while the close-ended questions provide the quantitative data. The qualitative data is defined as empirical information about the world, not in the form of numbers while the key concept of quantitative data is related to quantity and numbers. In other words, the quantitative data are the information about the world in the form of numbers by the measurement process. The measurement process is a process which assigns the numbers to things, people, event or phenomena following the rules (Punch, 2005). These two types of data create the mixed methods in the sense that the both two types of data were mixed during the analysis stage.

The open-ended questions ask about leisure, healthy lifestyle and health tour participation and are compiled based upon the ideas emerging from an analysis of the secondary data. Before doing the main data collection in Thailand, the set of questions were piloted and tested. They were sent via email to Thailand and undergraduate students in Chiangmai University Thailand, under the supervision of an experienced researcher, were hired to conduct interviews of 100 randomly selected women in Chiangmai. After receiving the responses, a second draft for the semi-structure interview questions were compiled for the in depth interviews for the Thai women who participated in health tours. The participants of the research were selected by stratified purposive sampling. 'The logic and power of purposive sampling lies in selecting information-rich cases for study in depth' (Patton, 2002, p.69). This sampling focuses on specific cases which provide the useful information for research questions. The type of the purposive sampling is convenience sampling, which refers to 'the selection of participants for a study based on their proximity to the researcher and the ease with which the researcher can access the participants' (Jennings, 2001, p.139).

The first series of interviews were undertaken with a sample comprising 100 individuals who had taken part in one of two health tours organised by two different companies, Cheewajit Company and Balavi Company, with fifty participants from each tour company. These two companies are currently the two major providers of health tours for the domestic Thai market. Female participants, who are the majority of the health tour participants, are the focus of this

research. Fifty participants from each company were divided into two groups, current participants and experienced participants. There are twenty five people in each group. The division was made in order to compare the differences between experienced health tour participants and current ones.

5.5.4. Data analysis- the qualitative analysis phase

Due to the nature of the in-depth interview questions, which included open questions to ask about what, how and why, and which resulted in large amounts of the data emerging from the interviews, Computer Assisted Qualitative Data Analysis (CAQDAS) was applied to help reorganise and determine the concepts or themes of these data. There are various software programmes for qualitative data analysis for example, Metamprph, Max, QUALPRO, QSR N6, Atlas and Meca. Before choosing the software for use in research, five main concerns were reviewed, which were the compatibility with the analytical approach, the ease of use, the product support and upgrade path, the supportive learning community and the costs of the software.

In this study, the QSR NVivo N6 programme (Non-numerical Unstructured Data) was used due to its compatibility of those five concerns mentioned above. N6 helps to handle the large scale and complex processing data by allowing interactive coding as well as the automated coding by searching words, phrases, expressions or statements that are considered to reflect the answer for the research questions. Also, it can run sets of searches over different sets of documents and store these for subsequent review. The analytical approach is that of code-based theory building. Therefore, the programme helps in dividing the text into segments, attaching codes to the segments and displaying the segments with the given codes. Also, the programme takes over the kinds of marking up, cutting, sorting, reorganising, and collecting the data which previous researchers were required to do manually.

Although various computer programmes can perform some of the tasks mentioned above, QSR NVivo is able to give more in terms of helping to make connections between codes and developing the higher-order classifications and categories (Miles and Weitzman, 1995). Cresswell (1998) argues that the advantages of this software as it can store and organise files by establishing the document file from word processing programme and store information with the NVivo programme. It can also help searching for themes and crossing the themes. Besides, this software can provide a 'tree diagram' a hierarchical tree of categories based on root node (theme) at the top and parents and siblings in the tree. Cresswell provides a table summarising the N6 procedure as shown below;

Table 5:4 Data Analysis Elements, Writing objectives, and NVivo procedures by Creswell (1998)

Data analysis elements	Writing objective	NVivo programme
Create a template for analysis	Develop a visual data analysis plan	Create a tree of steps in analysis into which data segments are placed
Create headings in the manuscript for major themes	Create major themes in study in words of participants	Create a node based on short phrases found in the text; create titles in this node as they appear in analysing the texts.
Title the manuscript	Create a title in the words of the participants--to make report realistic, to catch attention of readers	Create a node based on short phrases found in the text; create alternative titles in this node as they appear in analysing the texts
Include quotes in the manuscript	Identify good quotes that provide sound evidence for the themes, description, interpretation and so forth	Create a general node and place all good quotes in that node; create a node for quotes under each themes or category of information
Phrase study in words of participants	Locate commonly used words or phrases and develop them into themes	Use word search procedure, string or pattern search, and place contents into a node; spread text around the word (or phrase) to capture the context of the word(or phrase)
Create a comparison table	Compare categories of information	Use matrix features of programme
Show levels of abstraction In the analysis	Present a visual of the categories in the analysis	Present the tree diagram
Discuss metaphors	Find text in which metaphors are presented and group into categories	Set up one node for metaphors with children of different types of metaphors; place text in nodes by types of metaphors

In the NVivo programme, the raw psychographic data or the data from attitude questions was coded and grouped into 'Nodes' or 'Themes'. Reviewing the qualitative data from the N6 programme enabled broad ideas about health tour participation by Thai women to be given while in addition, five groups of health tour participants emerged. In order to achieve the next step of research, which are to identify factors affecting the participation in health tour by Thai women and to group the participants in relation to the quantitative data, the relationship between quantitative data (demographic data) and the qualitative data (psychographic data) was explored.

5.5.5. Data analysis - the quantitative analysis phase

In this stage, the relationship of the psychographic and the demographic data was explored. To begin with, the qualitative data was input into the NVivo programme. The demographic

data was not included in the Nudist analysis but was introduced into the SPSS programme. Also the themes of qualitative data from NVivo were recoded into the SPSS programme so that the relationship between demographic and psychographic data could be explored. The raw data required for quantitative analysis is essentially binary data. Consequently, data emerging from the free elicitation questions has to be coded for quantitative analysis. Bazeley (2003) states that the transfer of qualitative data into the quantitative one is acceptable for the purpose of the statistical analysis. This process leads to the production of what may be referred to as 'quantitised' data.

Then, cross tabulations and chi square tests were performed to investigate the relationship between and psychographic variables the demographic factors which affect to the leisure pattern of Thai women including practice healthy lifestyle and health tour arose. However, the next step of the analysis had to be completed in order to reach the next objective which is researching the grouping the health tour participants in relation to the demographic and qualitatively determined variables. In this stage, cluster analysis was employed. It is a way of grouping a set of data based upon the premise that the members of a group have greater similarities to one another than they have with those that are not-members, or that members of different groups have considerable dissimilarity one with another. Cluster analysis was chosen due to its ability to group the most similar ones together. Then the individuals are linked hierarchically to other groups. These groups are joined in the single group. The average linkage method of cluster was used because it was the commonest and widely used providing the efficient result (Shennan, 1997).

5.5.6. Primary data collection - the follow up interview phase

As this study is case study with data collected over the course of three years, a further series of interviews was conducted three years later in order to compare the changes in the lifestyles of the respondents in relation to their health tour participation over this period of time. In the second survey, the interview was conducted with 25 participants attending the health tour three years ago by the random selection for twenty five percent of members of five groups emerging from the qualitative analysis. The reason for focusing on the groups emerging from qualitative analysis rather than those from quantitative analysis is the follow up interview aiming to investigate changing patterns of lifestyle after the respondents had attended the health tour. Groups from qualitative analysis were formed by lifestyle changes while groups from quantitative analysis were formed by the relationship of psychographic and demographic data.

Table 5:5 A number of participants for the follow up phase

Group	Number of participants	Number of participants Chosen for follow up interview
N1- Completely change	20	5
N2- Partly change	12	3
N3- No change	17	4
N4 - The Determine	31	8
N5 -The Stable	19	5

In this follow up phase, telephone interviews were chosen instead of face-to-face interviews. The advantage of the telephone interview is that it avoids the very considerable time and costs associated with travelling in Bangkok to undertake face-to-face interviews. The telephone interviews were conducted by speaker phone and recorded as were the earlier face to face interviews.

Questions for the follow up interviews are as below;

- If the participants joined health tour again, how many time, when, where, what health tour organisation and what programme?
- If they did not join health tour again, why?
- After the first interview, is there any change for healthy lifestyle adoption?

If yes,

- Why did they change and what were the benefits? What are their motivations for healthy lifestyle adoption?
- How is their health now? If they were ill before, are they better?
- Do they completely change or partly change?
- Are the changes temporarily? If yes, why didn't they continue the healthy lifestyle?
- What do they do to keep up healthy lifestyle if it is the permanent changes?
- Do they meet health tour members and do health activities together?
- After attending the health tour, do they have more interest in healthy stuffs like health magazines, television programme about health or health lecture?
- Did they encourage people around you to have a healthy lifestyle?

If no

- Why didn't they change lifestyle?

- As for those who have been practicing healthy lifestyle for a long time, ask them more about their current health regimes and activities.
- As for those who cannot lead healthy lifestyle, ask them about their reasons.
- What are the obstacles to forbid them not to have a healthier lifestyle?

5.5.7. Concluding analysis - the comparison phase

This phase is the last phase of the research. After transcribing and translating data from the follow up phase, this data was compared to the data obtaining from the interview phase in order to identify the changes of the health tour participants. The finding from the comparison is a further result of the study.

5.6. Limitations and constraints

The limitation of the secondary research is a major problem for this study. It is difficult to find the literature review in specific topics such as the literature about the relationship of Thai women and leisure, Thai women and healthy lifestyle and Thai women and health tour. Only broad topics were found such as Thai society, Thai women, leisure and lifestyle, health tourism. With this problem, the primary research about those parts mentioned above had to be conducted.

There is also the limitation of the survey due to the small amount of the sample. With 100 participants, this study cannot be generalised. Besides, the study is the case study which does not aim to generalise. Another limitation occurred in the participant observation phase. The researcher attended only Cheewajit health tour run by Dr. Satis due to the limitation of time. Both Cheewajit and Balavi tour were set at the same time during the long holiday. Therefore, considering the distance of the location of tour, the Cheewajit health tour was chosen to be attended. The Cheewajit health tour was set in Chiangmai, hometown of the researcher, while the Balavi health tour was set about 1000 kilometres away from where the researcher lives. Therefore, the researcher had no chance to attend the Balavi tour and could not explore the meaning of health tour experience from the view of the insider on this tour.

5.7. Summary of the Implementation of the methodological approach

The timetable of the research process is presented in table 5.6 as shown below;

Table 5:6 Timetable of the research

Year	Duration	Phase	Research process
2001	October-December	Literature review Phase	Start compiling literature and shaping up the research proposal
2002	January-March		Finish the proposal
	March- June		Review more literature about <ul style="list-style-type: none"> o Leisure in general o Lifestyle o Health tourism o Thai society
	July-August		Review methodology and design research method
	September		Pilot test
	October-November		Redesign questions for the interview
	December	Participant Observation Phase	Go back to Thailand for survey and attended health tour
2003	January-March	Interview Phase	Semi-structure interview 100 of female health tour participants
	April-June		Transcribe and translate interview tape
	July-December	Qualitative Analysis Phase	The application of N6 for the open-ended questions
2004	January	Quantitative Analysis Phase	The use of SPSS for close-ended questions
	Febrary- December		Determine the relationship between the psychographic data (data from N6 which was re coded in SPSS)and demographic data in by using cross tabulation and Chi-Square
2005	January-April		Grouping the health tour participants by cluster analysis
	May		Transfer viva
	June-September		Determine the differences among groups
	October		Design the methods for the second survey
	November-January 2006	Follow up Phase	The second survey in Thailand
2006	February – April		Transcribe and translate interview tape
	May - August	Comparison Phase	The analysis
	September - December		Write up the thesis
2007	January - July		Write up the thesis

In summary, the methodological approach of this study is divided into five stages and seven phases. The first stage is the secondary data collection stage consisting of phase 1, the literature review. Next is the primary data collection stage consisting of phase 2, the participant observation and phase 3, the primary interviews. Stage three is the data analysis

consisting of phase 4, the qualitative analysis and phase 5, the quantitative analysis. The fourth stage is the second primary data collection consisting of phase 6, the follow up interviews. Lastly, it is the concluding analysis stage consisting of phase 7, the comparison phase.

To begin with, in the literature review (phase 1), secondary research was conducted so as to provide background knowledge for the primary research. In this phase, literature about leisure, lifestyle and health tours were reviewed along with knowledge about Thai society. All these reviews informed the theories, ideas and questions for the primary research. In the primary research stage, inductive approaches were applied due to the nature of the information sought. The inductive approach emphasises gaining an understanding of the meanings of the phenomena, and research context by the use of the qualitative data collection.

In this study, participant observation (Phase 2) and the semi-structured interviews (Phase 3) were conducted to gain an insight regarding the participation of Thai women in health tours. Participant observation took place on a Cheewajit health tour set in Chiangmai, Thailand while the interviews took place in the homes of the participants in Bangkok and Chiangmai province. Two kinds of questions were asked in the interview, these were open-ended questions asking about attitudes and leisure behaviours in health tour participation and close-ended questions for the demographic section.

In the qualitative analysis phase (Phase 4), the qualitative data collected from the interview was analysed with the help of NVivo software. In this phase, it is expected to get the answers of the psychographic questions and build up the themes, which gave more understanding about leisure behaviour of female health tour participants in Thailand. Beside, the health tour participants were grouped in five groups basing on this initial finding. However, to determine if there were distinct and demonstrable categories of health tour participants in relation to the quantitative data, the themes emerging from the NV software were quantified in order to be analysed with the initial quantitative data, which is the demographic data, by the use of the SPSS. This leads to the quantitative analysis phase (Phase 5). In this phase, the cross tabulation and Chi Square test were run for the above purpose. After that, the cluster analysis was proceeded to identify the groups of health tour participants in relation to their demographic and psychographic factors. Three groups emerged.

Next, in the follow up interview phase (Phase 6), in order to investigate the changes in relation to the health tour participation over the period of time, the second interviews were conducted with the same populations. However, not all 100 participants were interviewed. Twenty five percent of participants from each five groups from the qualitative analysis were

chosen to be interviewed. Lastly, it is the comparison phase (Phase 7). The findings from the qualitative analysis phase were compared with the findings from the follow up phase to explore the behavioural changes of the health tour participants.

The succeeding chapters present the results of this research. Chapters 6 and 7 provide the qualitative findings containing three main themes, which are the leisure, healthy lifestyle and health tour participation. In chapter 7, the categorisation of health tour participants emerged from the results of qualitative analysis from the first interviews and the categorisation of participants emerged from the results of comparative analysis from the follow up interview were discussed. Chapter 8 is composed of the results from quantitative analysis and the alternative categorisation of health tour participants emerged from this analysis.

The next chapter illustrates the results from the interview phase about leisure and healthy lifestyle of health tour participants. The concept and importance of leisure are reviewed as well as the attitudes of participants towards 'healthy lifestyle' and their motivations to lead ones.

CHAPTER 6

QUALITATIVE FINDINGS: LEISURE AND LIFESTYLE

This chapter reviews the findings of the first phase of semi-structured interviews of health tour participants about their leisure and lifestyles. With regard to leisure, the participants' views are explored together with their perceptions of the importance of leisure activities. In addition, the leisure activities of the participants, the influence of their husbands (if applicable) and their families are investigated. Spending on leisure activities and the freedom of choice regarding leisure activities are also examined as is the relationship of work and leisure for the participants. Lastly, the participants' opinions of the patriarchal system of Thai society are presented.

With regard to the relationship of participants and their leading of a healthy lifestyle, this chapter examines the participants' attitudes towards 'healthy lifestyle'. Irrespective of how participants lead their lifestyle, questions about their motivations for leading a healthy lifestyle were asked with various replies given. Lastly, their perceptions towards their own health as compared to the health of others of the same age were reviewed.

6.1. Women and leisure

6.1.1. Views of leisure

Participants were asked about their point of view of the word 'leisure'. A variety of responses were provided in that leisure refers to a variety of activities which can be done either alone or in a group.

The idea of having individual leisure activities is described as;

'When talking about leisure, I am thinking of practicing meditation, reading, listening to chill out music and doing exercise'.

'When talking about leisure, I am thinking of travelling in the natural scenery'.

'The word leisure makes me think of staying at home, being by myself and relaxing. Sometimes I am thinking of driving to a natural setting'

The fact that leisure is considered as group activities is evidenced by statements such as;

'I am thinking of the activities that I do with my friends such as watching movie, listening to the music, eating out and playing cards'.

The point most highly emphasised about leisure is that it is an activity that provides relaxation for the doers;

'Talking about leisure, I am thinking of the activities that make me feel relaxed'.

'Leisure conveys the idea of entertaining and relaxing activities'.

6.1.2. Importance of leisure

All participants perceive that leisure is very important to their lives. Various reasons were given to support this. Firstly, leisure brings happiness to their life. For example;

'I think that it is important to life because we are happy when we do it. It is part of life'

'Leisure is important to my life. If I don't have any leisure, life will be so boring and dull'

'It is important to my life because it help to beat the stress and seriousness in life'

'It is so important to life because it fulfils my life'.

Secondly, for those who like to do exercise as a leisure activity, they gave the reason that leisure gave benefit to their physical health. Also, mental health benefits were mentioned. One woman said;

'It is important to life because it will make your life improve in terms of physical and mental health'.

Thirdly, the retired women and housewives perceive leisure as the activities that occupy their free time.

'It is good that I have something to do in the free time so that I will not have time to think about nonsensical things or negative things because I am alone in the house'.

Fourthly, participants view leisure as a social activity which can help them avoid loneliness.

'Exercise in the fitness gave me the new society and friends'.

'I think that it is important to life because it can help me to relax. It is a chance to meet people to share same opinion'.

'Leisure is relaxing and we need to socialise with people'.

Fifthly, some people use leisure as an escape from the hectic everyday life. Leisure time is the only time they can do something for themselves.

'It is important to life because it is relaxing. It is something for me apart from working hard for children in the past'.

'It is important because it makes me relax and forget the bad thing in life'.

Sixthly, leisure activities are viewed as the source of knowledge for some participants. Two women claimed;

'Leisure is important because it fulfils my life. And I have more knowledge from my leisure activities'.

'It is important to my life because it gives me a chance to learn new things'.

6.1.3. Leisure activities

Leisure of participants

Participants were asked about their past, present and future patterns of leisure. Overall, their past leisure patterns related to both at home and out of home leisure such as reading books, watching TV, listening to the radio, gardening, playing music, exercise, travelling, going out with friends, eating out, shopping, beauty-related leisure and partying. However, some women accepted that they rarely found the free time for their leisure in the past.

'I was never free in the past. I even had to bring my work to do at home everyday'.

'In the past, I worked so hard that I rarely had free time. I had to go to bed at midnight and get up at 4 am the next morning for my work'.

According to the findings, it is obvious that only a few participants took exercise in their past leisure. Most of them started to do so seriously after experiencing some illnesses or after they attended a health tour.

'When I was young, I loved to go out and have fun with friends. Now, I am getting older. I like to stay at home gardening or going out for exercise'.

'Now, I am doing yoga in the evening everyday apart from doing the stick exercise in the morning. I can say that most of my free time is devoted to exercise because I know it is good for my health'.

The majority of participants accepted that they have maintained their past leisure pattern and activities until the present day. They have added additional leisure activities such as exercise, travel or meditation to their life. The latter two activities are very popular among the elderly.

In many cases, women claimed that they had more time for their leisure after the maturity of their children or the death of their husbands. Two women claimed that;

'I just started to travel a lot after the death of my husband. When he was still alive, I only had in home leisure activities. But now, I am free and can go wherever I want and whenever I want'.

'When my children were young, I rarely had my own leisure time. I devoted my life to the family. I raised my kids by myself. I had little time for my leisure activities which are watching TV and read books. Now, my children are all grown up. I have so much free time for myself. I go travelling more often. I also go out for singing, eating out, listening to music and dancing. I do exercise everyday too. I do the brisk walk. In the future, I may concentrate more on going to the temple and meditation'.

However, there are some people who still cannot find the time for their leisure in the present day lives.

'I am still as busy as I was before because I have a house rental business. I have to take care of it. I have little time for reading magazines. I hope that I will have more time for myself in the future because as I become older, my work should be less than it is as the moment'.

Regarding future leisure, the participants gave various kinds of ideas of their interests such as the idea of paying more attention in Buddhism and doing meditation.

'In the future, I would like to go to the meditation path and do the yoga. I think that yoga is good for your body and your concentration'.

'I want to spend more time in the temple and do meditation there'.

Some would like to apply for the short courses such as bakery class, diving, and Chinese language.

The idea of doing social work or charity work was also mentioned. For example;

'I want to do charity work. I think that I have everything in my life. I should give something back to the society. I may be the volunteer for a charity society. It will make me happy. I think that if the mind is strong and happy, it will lead to a strong body. I think if I am ready, I should help other people'.

When the participants were asked about their three favourite leisure activities, travel and out of home leisure such as meeting friends, going for a movie, eating out are in first place. However, they accepted that they cannot do these out of home leisure as often as they wanted because of financial restrictions. They may have a chance to travel 1-3 times a year. Individuals who can travel every month or at least 6 times a year are rarely found.

In-home leisure such as reading, watching TV, gardening, sleeping, house cleaning, listening to music, cooking, doing handicrafts, chatting are the second and third favourite leisure activities. These kinds of leisure are undertaken very often compared to out-of-home leisure. Some people also do meditation at home rather going to stay in the temple. Interestingly, everybody included reading in their favourite leisure activities.

Leisure of husbands

When asking the participants about their husband's three favourite leisure activities, they mentioned both in-home and out-of-home leisure. The majority of their husbands like to do in-home leisure such as reading, watching TV, gardening, taking care of the house, DIY.

Leisure of family members

Most family leisure activities are out-of-home leisure such as travelling, eating out, watching movies, shopping, exercise, or going to the temple. However, some in-home leisure such as taking care of the house, chatting and taking care of grandchildren or pet at home can be part of family leisure.

6.1.4. Leisure choice

All of the participants claimed that they have the freedom to choose their own leisure. Nevertheless, comparing family leisure to their own individual leisure; most of the participants view their own leisure as less important. If they have to choose between family leisure and their leisure, they will postpone their own leisure to another time so that they can join family leisure. Some try to understand their own leisure when they are alone in the house so that they can join in the family leisure when they are with the family members. Only a few participants said that their leisure is more important than the family leisure.

6.1.5. Money spent on leisure

From the interview of 100 participants in term of the sums of money they spend on leisure, it was found that twenty percent of participants spent more than fifty percent of their disposable income on leisure activities while fifteen percent of them spent more than thirty percent of their income. Twenty five percent of the participants spent approximately ten percent of their income on leisure. Lastly, two percent of the participants accepted that they spent all their disposable on leisure. Their husbands gave all the salary to them. Therefore, they used their husbands' money for the necessity in family and used their own salary for their own leisure activities. As for the rest, the spending was below 10% of their income.

6.1.6. Work pattern

Work patterns can be divided into two types. The first type allows participants to choose their free time while the second type is the office hour type. More than half of the participants (66%) are of the first type. They can be freelance workers, housewives, business women or retired. The second type (34%) is the ones who work in the government and private sectors.

6.1.7. Free time

It was found that slightly more than half of the participants have flexible free time, which is due to the nature of their career. Therefore, more than half of the participants stated that they could have all day free time or spend any time as they wanted. Comparing the participants' free time with men's free time, 30% claimed that men have more free time than them. The main reason is their double role from full time job and house work.

'Men have more free time than me because I have to work and take care of home at the same time'.

'I think that I have less free time than men because I have to take care of my husband, children and sometimes even grandchildren. I always have a full time job. I also have the salon business. Therefore, I work quite hard'.

In some case, the natures of their job give them less free time than their husband.

'I have less free time than my husband because of the type of my work. Although I don't have to take care of my family, I have to work so hard that I hardly have any free time'.

Fifty nine participants (59%) perceived that they had more free time than men. Most of the women in this group were retired women and the housewives who did not have a full time job. Two of the participants claimed that;

'I am retired. I do not have to work anymore'.

'I am a housewife but I have three servants in my house. So, I do not have to do the house work'.

In another case, the nature of the job created a different use of free time. For example;

'I think that I have more free time than my husband because he has more responsibility in business. His work is continuous. As for me, I still have time for myself'.

One woman claimed that she had more free time than men because her husband helped her to do housework.

'I have more free time than my husband because he works harder than me and he helps with the house work too'.

Eleven participants (11%) thought that they had equal or less free time than men. Their main concern is how they can manage their time to make themselves to be free.

'I don't think that I have as much free time as men but I think that it depends on how we manage the time'.

'I have equal free time as men because it depends on how I manage my free time'.

'I think that both men and women have equal free time but it depends on their time management'.

6.1.8. Women and the patriarchal system

This section discusses the opinions of the participants towards the patriarchal system in Thai society. As a result of the interviews, two main groups appear which are a group of people that believe in the patriarchal system and the group that do not believe in it. The numbers of people in each group are slightly different. There are forty four participants who believe in the patriarchal system while fifty six do not.

Various reasons are given by those who believe in the patriarchal system. The first reason is their original family system. They grew up in the environment of patriarchal practice. Therefore, they tend to behave like their mother in their own family. For example;

'I believe in patriarchal society because we behave like this since ancient time. My parents always teach me like that'.

'Thai society is still a patriarchal society because men are expected to take care of women. I still believe in the patriarchal society because my mom's generation practiced that. I grew up in this kind of environment'.

'I think that Thai society is still a patriarchal society because I always like to give respect to my husband. I want him to be responsible in everything so that I can have free time for myself. Sometimes, we have to pretend to be so foolish that he will be proud of himself. It is not good to behave as the domineering wife. And we have to behave as if we are inferior to him'.

Some respondents commented that the patriarchal system is very prominent in Thai society because they can see examples all around them.

'I think that Thai society is 60% a patriarchal society. It is not completely a women dominating society as women have more education and are more confident and have higher job positions than in the past'.

“Thai society is still a patriarchal society because no matter how tough women are, society still thinks that men are superior to women. People give more respect to men”.

Even though full time jobs heighten women’s role in society, the burden of housework still makes them think that they are inferior to men.

‘I think that Thai society is still a patriarchal one because even though both husband and wife have full time job, the society always thinks that men have more power than women. It is so hard to find men to help with the housework. I think that the full time job and house work make women tired enough. So, there is no point to fight for women’s rights to make them more tired’.

As mentioned earlier, the second group is the group that does not believe in the patriarchal system. This group is more educated and can earn a living by themselves. For this reason, they do not have to depend on men.

‘Thai society is not a patriarchal society because now Thai women have more freedom than in the past. They have their own full time job. They can earn money by themselves without depending on their husband’.

‘I do not think that Thai society is a patriarchal society because I am divorced and I can stand by myself. I do not need to depend on a guy’.

‘Thai society is not the patriarchal society because I always depend on myself. I have taken care of my 7 children alone after my husband died 40 years ago’.

In some cases, women have more power than men in the family. However, in public, they have to pay respect to husbands to make their husbands not to lose face in public.

‘Thai society is not the patriarchal society because women have more roles in family and society. In fact, husband are scared of wife in Thai society but in front of others, wife always give respect to husband’.

‘I do not think that Thai society is the patriarchal society because even though it seems that men are the leader of family, in fact, wives manage money in the household. Sometimes, women even have better job and higher salary than husband. Women act as if they are the hind legs because they just want to show their respect for their husband in society’.

Two women even claimed that they are the leader of the family.

‘I do not think that Thai society is exactly a patriarchal society. It depends on couples. In my house, I am the leader of the house because I have a stronger financial status. I can earn more than my husband’.

‘I do not believe in patriarchal society because I can do anything I want. And I am the one who tells my husband to do this and that’.

One woman commented that it seemed like men had more power in society because they showed themselves off more than women did.

'On average, I think that Thai society is not a patriarchal society but it seems that men seem to be powerful because they like to show off their power in public and women let them do so

For some women, the burden of household work is the key to pinpoint the patriarchal society. They think that they do not live in the patriarchal society because they have servants for the housework. The free from housework burden make them feel that they are as equal as men.

'I do not think that Thai society is the patriarchal society. Nowadays, there are servants. Women do not have to do the traditional role. Women work outside home and can earn a living'

6.2. Women and healthy lifestyle

In this section, participants were asked to give their opinions about their attitude towards the phrase 'healthy lifestyle' and the motivations for them to lead this kind of lifestyle no matter how they currently live. Finally, their perception towards their own health compared to their friends was discussed.

6.2.1. Attitude towards healthy lifestyle

Participants were asked about their attitudes and ideas towards the term 'healthy lifestyle'. According to the response, healthy lifestyle can refer to both physical and mental aspects. Physical aspects include life without illness, practising a healthy life, leading an active life, leading a natural life while mental aspects refer to happiness and success in life.

Physical

- Life without illness

For many respondents a healthy lifestyle is considered to be a life without any illness combined with minor aspects such as an independent life, natural life and happy life. Some of the comments are shown below;

'Healthy lifestyle in my opinion is life without illness. You can do every activity as you want'

'Healthy lifestyle in my opinion means the life that you are strong enough to do whatever you want'

This idea has been emphasised by the direct and indirect experiences of illness. Recognising how bad the illness was led these women to the idea of what is the healthy lifestyle.

'Healthy lifestyle in my opinion is the life without any cancer or the toxin in your body. In the past, I had to have my womb removed because of a toxic cyst. I knew how bad it was. My hormone balanced changed a lot. I really wish I could be the same person without any illness.'

- Practising a healthy life

Eating healthy food and doing regular exercise are also regarded as the essential parts of having a healthy lifestyle. In one case, healthy food consumption and regular exercise had been practiced for a long time before attending the health tour. In other cases, these activities have been encouraged by health tour participation. Many people accepted that they never thought of either taking a regular exercise or eating healthy food until they attended the health tour. Doctors on the health tour gave examples of the results of having an unhealthy lifestyle, which led them to realise the importance of good food and regular exercise. Therefore, when being asked about the healthy lifestyle, these two activities were widely mentioned. For example;

'Concerning the phrase 'healthy lifestyle', I am thinking of the right way of eating. You have to eat non-chemical food and emphasise a lot of vegetables. I also think of doing exercise, travelling, relaxing, reading the books which can give me the knowledge about health, taking care of my health, reading religious book and doing meditation'.

- Leading a active life

The idea of being active and energetic was raised when asking about healthy lifestyle. Most of the people who gave these answers are the elderly who wish they could turn time back to be younger again so as not to be a burden to others. Some commented that;

'In my opinion, the healthy lifestyle means life when your body is active, energetic and fresh. Moreover, you have a clear brain and peaceful mind'.

'In my opinion, healthy lifestyle is a life without being a burden to the people around you'

- Leading a natural life

Following nature is one of the aspects of having a healthy lifestyle. This idea is central to the Cheewajit way of living. It is the idea of living close to nature, eating natural food and leading the natural way of life. Two respondents gave the comment as;

'Healthy lifestyle in my opinion is the simple life following the nature. It is life without fighting. It is a peaceful life'.

'Healthy lifestyle is the life close to nature and lead as natural way of life as possible. I have the winter house on the top of the mountain. My family likes to go there when we have time'.

Interestingly, one respondent gave a brief lecture about having a healthy lifestyle based on the lecture of Dr.Satis from the Cheevajit tour. She said;

'Dr.Satis said that healthy life was composed of five elements. The first one is eating good food, which means you have to eat less sugar, meat, milk and eggs. You have to eat a lot of vegetable. Secondly, it means the sufficient sleep. You should go to bed around 9 pm and get up at 5 am. I did it for a while and felt so fresh. Thirdly, you should do exercise regularly. Good exercise is the one you have to do till you reach your peak of heartbeat. It is the cardiovascular exercise. Firstly, it will be very exhausting in some point but later on, the hormone will be released from the body and make you feel fresh. Fourthly, you should rest and relax your mind everyday. This rest can be encouraged by doing the meditation. Finally, you should enjoy your work'.

Mental

Importantly, having mental happiness is a part of a healthy lifestyle as well as physical strength. Physical strength can be encouraged by food and exercise while the mental strength is encouraged by meditation, concentration and overcoming seriousness. Meditation, as a matter of fact, has been practiced for a long time, since the beginning of the Buddhism era. Therefore, it is related to the religious practice. Many comments have been explained as examples below;

'The healthy lifestyle is a life with happy mind. I think that mental part is very important. Having a good mental part, which means being pious and meditation practice, can affect to the positive physical part'.

'Healthy lifestyle is the life you have healthy mind and body. It is the life you are strong and have no illness. You are happy with life and you give something back to society as much as you can.

'You are happy with life and also have a very kind heart to inferior people'.

It was noticed that these women have the idea of being good Buddhists and would like to do good deeds for society with the belief that doing good things could inspire the happiness. However, some women thought that a happy mind could originate from the fun in life. One of the respondents commented that;

'Healthy lifestyle is life that you have fun with your friends and do the activities you like'.

In some case, healthy lifestyle was referred to life without seriousness. They did not think about anything else such as happiness or physical strength. The examples are shown below;

'In my opinion, the healthy lifestyle is the life without seriousness or any struggle in life. I want to have a very good life. I am old already and need a rest but I still have to earn a living. The economic is so bad that my kids have to struggle as well. So, I do not expect them to take care of me. That's why I have to find the way to earn a living. I think of healthy person as the one who can sit at home and have money to spend without doing anything'.

'Healthy lifestyle means life without seriousness. And it is the life which you feel that you have enough'.

Interestingly, the ideas of healthy lifestyle of the latter two quotations are very contradictory. The first one would like to have more money to spend without thinking of how to earn it while the last one is more modest and being very Buddhism like. It was widely accepted among the respondents that the balance of mental and physical aspects is considered one of the major component of the healthy lifestyle. For example;

'Healthy lifestyle' conveys the idea of having healthy body and mind. I am thinking of balancing my work, health and mind at the same time'.

'When talking about healthy lifestyle, I think of the harmony of body and mind (like doing exercise and meditation). And I think of the perfect daily schedule. Each person has his own lifestyle. If we can make the day run smoothly plus having a chance to do the activity we like, I think that it is such a perfect schedule'.

The idea of not being lonely is one of the aspects of having a healthy lifestyle for the elderly. Most of them are left at home, either alone or with the maid, while the other family members go to work. Therefore, the loneliness is unavoidable. As a result, having a chance to socialise with people in the same ages positively affects their mental health. One commented that;

'I am thinking of having the activities to do and no loneliness. I have a happy life and I am the member of the senior clubs. I always go to travel with the people in the club. At least, we are in the same ages'.

6.2.2. Motivations of leading healthy lifestyle

This part aims to find out why the participants became motivated to lead a healthy lifestyle. The following four motivations emerged: as a leisure pursuit, illness and health-related activity, cosmetic concern and socialisation.

Leisure pursuit

A number of participants also considered that health-related leisure had a very positive impact in that their entire frame of mind was considered 'cleansed' and 'refreshed' after having taken exercise. For example;

'If I do exercise, I continue until I start to sweat. Thereafter, I feel very happy, refreshed and light in my body.'

'I like to participate in many activities, especially physical exercise because it makes me feel so much more relaxed.'

'When I have time, I like to watch television and do some exercise. I like undertaking the 'Stick exercise in particular. However, I also like to walk a great deal because it is the easiest way for relaxing.'

Illness and health

1. Physical

Physical motivations for leading the healthy lifestyle include experience of fitness, preventative medicine and failure in the use of modern medicine, illness cure and childhood environment.

- Experience of fitness

Indirect and direct past experience of severe illness is a factor that encouraged some of the participants to be more interested in health-related activities. Indirect experience related to seeing friends who die painfully from serious illness such as cancer. This scared them and motivated them to find a way to try to avoid these illnesses. They accepted that they did not want to be ill and die painfully like their friends and relatives. A variety of examples are given below;

'I was interested in health matters because my mom and my niece were ill with colonic cancer. I felt scare of getting it because it may be genetic matter. Therefore, I read a lot of Cheewajt magazine to search for more knowledge about how to take care of myself. I even learned to do the coffee detoxification by myself.'

'I have been interested in health since I was 35 years old. Now, I am 63 years old. When I was 35, my dad got the heart disease. He had to control his food strictly. That made our family members realise how bad the sickness was. He had to take medicine all the time. He had to have a by pass operation in the USA when he was 69 years old. From seeing that, I started to take care of myself in terms of food. I stopped eating fat and began to eat more vegetables and fruits. I started to go for aerobic class since then. Even now, I am still doing aerobic half an hour a day'.

'Ten years ago, my mom died from cancer. So, I was afraid to get cancer as my mom did because I have known that gene is part of the cause of cancer'

The direct experience of serious illness also encouraged the participants to lead a healthy lifestyle.

'After I was diagnosed as having a cancer in my stomach, I changed to lead the healthy lifestyle so that I can live longer'.

'I had problem of diabetic. Only a healthy lifestyle could help me to recover. Since then, I became very strict in leading healthy lifestyle'.

For some participants, although they wish to have good health, they are very much against the taking part of any regular exercise. They, however, recognised that exercise is good for them, and especially their health. For example;

'I like passive activity more than active one but I have to do exercise regularly because it is good to the health. I do exercise one hour a day. I do the stick exercise learnt from Cheewajit trip'.

'I like inactive leisure activity like lying down on the bed reading books but I do exercise regularly because I want to be healthy and strong. Also, I want to maintain a good shape'.

'When comparing the passive and active nature of activities, I prefer more passive pursuits such as reading books rather than physical exercise. I do, however, do exercise as I realise that it is useful for my health'

One participant accepted that exercise helped her to improve her immune system and become stronger.

'In my leisure time, I like to do exercise. I go to aerobics on Monday, Wednesday and Friday. In the past, I was ill easily comparing to my friends and relatives. After I did the regular exercise, I noticed that I had a better health. I believe that exercise could help to prevent illness.'

Thailand's past economic situation those in the private sector felt insecure about their job. Therefore, the idea of getting ill in an unstable situation is considered to be a serious matter. Therefore, healthy lifestyle practice is in needed. One participant said;

'The reason for being interested in health is because of the economic status today. I don't know when I will be laid off from the company. If my health is fine, I can survive. But if I have a serious illness, what will I do then? I pay for life insurance but I do not think that it includes every illness.'

- Preventative medicine and the failure of modern medicine

Preventative medicine has been paid more attention than the curative medicine because of the rise of new illness from new viruses. Moreover, the modern medical team cannot apparently find ways to cure some of these new illnesses. Therefore, more and more people believe that it is better to take care of themselves and become stronger so that they will not be infected by some new viruses. Apart from new illnesses, there are still some old illnesses that cannot be cured by modern medicine such as cancer, diabetes, heart attacks. Thus, preventative medicine has become more popular. One participant commented that;

'I have been interested in health matters for four years. A lot of people die from cancer, which is caused by bad habit of eating. When I heard about the practice of Dr.Satis, I was interested in it. And I began to practice the Cheewajit way.'

Apart from the fear of getting severe illness, the failure of the use of modern medicine to cure their illnesses leads to the interest in the alternative medicine for participants. Some of the participants had body weakness as before and had tried modern day medicine to cure their weakness before but it seemed not to be efficient. As an alternative, they turned to practice preventative and alternative medicine by changing their lifestyle, which had proved very successful. Thus, they have been continuing this practice until the present day.

- Illness cure

It is observed that the participants increase their interests in health because they have some illnesses, of which some part can be cured by modern medicine but importantly, a healthy lifestyle is needed. The illnesses can be both of a major and minor nature. The major ones may include cancer, heart problems and the minor ones can may be thyroid; diabetes; symptoms of age such as pain in knees, back, arms, leg, feet; migraine; low blood pressure and asthma.

One of the participants was diagnosed with the serious fourth stage cancer six years ago before the interview took place. She underwent modern day medicine treatment including chemotherapy and medicine. After the treatment, she was told by the doctor that she would have only three months to survive. Therefore, she turned to the Cheewajit practice as the last hope of her life. Then, she became better and lived longer than was predicted. Now, she has a very healthy lifestyle in term of food, exercise and detoxification. Illness seems to be a major catalyst for the participants to pay more interest in health matters. If they did not have illness in the first instance, they might not change their lifestyle. For example;

'I have been interested in health for about 10 years. I got the first stage of breast cancer and went for the operation after the operation; I started to read big piles of health magazines and health books. As a result, I changed my eating habit. I turned to eat the Cheewajit food. I also started to walk four times a week and go swimming sometimes.'

'I have been taking care of myself seriously for one and a half year because the pain in the knees. I control my food. I do exercise four times a week. I control my weight not to get fat.'

'I had an ovarian operation three years ago. Since then, I became more interested in health matters. I started to take more care about food and started to do exercise. I also go for yoga'.

For some of the participants, knowing that their illnesses were caused by their bad lifestyle, they were willing to change. Some of the examples are;

'I have been interested in health activities since I was 30 years old. I was seriously ill at that time. I couldn't eat anything. I got a gastric ulcer and heartburn. I threw up every time when I ate something. I lost about 10 kilograms. So, I tried to change my eating habit and take more care of food. I avoid too much salty, sour, sweet, hot and spicy food. I try to eat neutral tasting food. And I start to stretch my legs and arms before going to bed. I do not like hard exercise.'

'I think that I had many illnesses in the past because I did not have a healthy lifestyle. I ate the unhealthy food. And I took too many medicine till I got allergic with them.'

The belief that exercise can beat stress encourages people to practice it more frequently. Consequently, this belief is claimed to prove to be right;

'Three years ago, I started my own tailor shop. I had a lot of responsibilities. I felt so weak and tired from work. When I went to the salon, I even slept on the hair washing bed. Now, I am in the early 40s. I am getting older and my body is not as strong as in the past. I realized that I didn't take a good care of my body at all. So, firstly, I started taking some vitamin and medicine. However, it was too expensive and not effective that much. So, I started doing exercise. There is the gym near my house. I applied to be the member. So, it is like we forced ourselves to go because we paid a lot for membership. And I began to have friends in the gym. I now have a new social circle. I am happy with that. And I am happy when I sweat. If someday I cannot get sweat, I will feel uncomfortable. So, I go for exercise regularly.'

'I have been interested in health since I experienced serious work related stress. I thought that exercise would help me to beat the stress. So, I went for it and it was really effective. It is good for the blood circulation and releases some growth hormone to make you younger'.

Interestingly, the stress of the spouse of the participants can be another reason for the growing interest in health activities, especially family exercise. The wives were always the ones who

encouraged family exercise for the sake of their husbands. Two of the participants commented that;

'My husband is a business man who has a lot of pressure from work. When he has a lot of pressure, his health became worse and worse without his realising it. He had to entertain his business guest by bringing them to eat, drink and night life entertaining. So, he slept late, he drank, he smoked. So, I and he thought that we gave most of our time to people. Why didn't we set the time for ourselves? So, we started jogging together after work. After doing that for some period, we could see the difference in our body. We had a better health condition. In the past, I always got migraine but after jogging, I rarely had it. We even joined the marathon. Since then, we always set the time for exercise in our daily routine. Even we went abroad or out of home, we had to do exercise. If we don't do it for only a day, we feel strange.'

'In the past, my husband was always ill from the work stress. Then, we and our children started to go for exercise together in the park in the morning and he got better. Since then, we went on doing it.'

- Childhood environment

Growing up in a healthy environment can be another factor for participants to be interested in health matters. Some participants have been encouraged to take care of themselves since they were young. One participant argued that since ever since she could remember, her mum kept telling her that having a good health is the best thing in life. She considered eating as giving medicine to her body.

2. Mental

The majority of participants claimed that the fact that they undertook health-related activities for the sake of their own health made them feel good.

'I am happy with my exercise and eating habit because I know that I will have a good health condition. If I do not take care of myself, I may feel worried that I may have severe illness. But now, at least, I know that I do my best'.

'Having no illness makes me feel safe and happy even though it needs a lot of care'.

Cosmetic

In addition to the above, some participants consider that there are wider cosmetic reasons and benefits to be derived from exercise. Leisure time exercise is considered by some as the starting point for taking care of themselves and paying attention to their beauty.

'In the past, I was interested in beauty things rather than matters of health. I tried to avoid sweet and oily food. I was scared of being fat'

and old. However, one year ago, I subscribed to the Cheewajit magazine. Then, I became more concerned about health than beauty'.

'In the past, I liked to take exercise, and visit beauty salons and spas. Now, although I still do the same activities, I realise that more exercise can help contribute to my beauty. I primarily do exercise because it is good for my health'.

The first main reason is that they want to have good figures. One participant attended the class teaching about the healthy lifestyle when she studied abroad. And since then, she turned to be obsessed in exercise and healthy food. She said;

'I loved this course because it was such a big challenge for me. At that moment, I was really obsessed in exercising. I played tennis, did jogging, swimming and cycling. When I did many exercises that I felt too tired to eat a lot like in the past. And after I learned about nutrition, I took more care of the food I eat. For example, when I go to eat KFC, I will get the chicken skin out and use the tissue to absorb the fat from the chicken before eating them. My dad said that he didn't want to go to eat out with me. He felt shameful of my behaviour. Anyway, from that time, I became thinner with more knowledge about how to lead a healthy lifestyle'.

'I am very interested in health matter because I am scared of being fat. I even went for the weight reduction course in a Mission hospital. However, I am not interested in the plastic surgery at all. I pay more attention in the lifestyle rather than the surgery. I have been taking care of myself and concerning about getting fat since I was 40 years old.'

Another respondent also referred to her concern about putting on weight;

'I want to have a very good shape. My problem is I have a lot of clothes in my wardrobe but I cannot wear them or when I wear them, I am not self-confident at all. Sometimes when I tried the dress at the shop, I wore the corset to tighten my waist and tummy. They looked fine. So, I bought them but when I tried them back home, I couldn't wear them when I took off the corset. That's so bad'

Also, some of the participants wanted to look young. In the past, they liked to go to the spa and beauty treatment centre to make their skin look younger. However, when they read more women magazines, they realised that beauty should come from within. Thus, they turned to the health matter. Two of the participants stated that;

'The interest in health came from the concerning about beauty. At first, I tried everything to make myself look younger. I read a lot of women and health magazines searching for beauty tips. Finally, I realised that I should be beautiful from inside which the magazine called Beauty from within. So, I changed my focus to health matter. I want to be healthy in term of mind and body. So, I started practicing meditation, taking care of food and going for exercise'.

'I have been interested in health since I became teenager. In fact, I should say I was interested in beauty matter before health. I tried my best to keep myself look younger and fresh. I am working with Thai Airways. So, the look is quite important. I always take care of what I eat till I become get used to it. However, later on, I emphasised more in health rather than the look. It helps me a lot to beat the seriousness from work'.

Socialisation

- Social activity

Exercise is also considered as a vehicle to socialise with people who share similar interests. This is particularly so among the elderly. With considerable amounts of free time, the fear of being lonely does in some cases serves as a major catalyst for undertaking some kind of activity. Therefore, for predominantly social reasons, the elderly like to join exercise groups where they can meet people of the same age, can share their interests, points of view, and can take other activities together once the exercise period has ceased. One elderly participant mentioned that;

'When I have free time, I like to go travelling and take exercise. In particular, I like to do the stick exercise. I went to join the stick exercise group at the park. It is quite fun to meet new people who share the same interest'.

Large groups of people, with the majority being of a mature age, are now commonplace in the parks of Bangkok conducting stick exercises. From six o'clock in the morning groups spend up to one and a half-hours taking exercise. After that, they like to have breakfast together in the park until late morning. Sometimes they will have an appointment to do some activities together in the late afternoon. There is a real sense of community among many of the participants and, thus, is consistent with exercise being considered a leisure time pursuit.

In addition to the trend among participants of the stick exercise to form social groups, there are also moves toward groups of participants of aerobics, especially in the evenings. This activity is actually one encouraged by the Ministry of Health in that the government is encouraging people to take up exercise as a means to counter the threat of illness and pre-empt health-related problems for the future.

To date, this campaign has been really successful. Many people have joined aerobics groups all over the country. In these groups, people get to know each other and the park and the activities become a focus for socialisation.

- Family culture

There is also an issue with regard to the family, and the role played by health and exercise in developing family culture. Most of the respondents accepted that they like to bring up their children to exercise together ever since their children were young. However, when the children grow up, many of them decide to partake in their own leisure. Some children naturally changed their preferred sport, which on occasions, sometimes led their parents to change their preferred sport also with many of them wishing to continue taking sport with their offspring. For example, one woman said;

'In the past, when I had time, I liked to play sport. I played badminton. I was in the basketball team since I was young. And after High School until I graduated from university, I was a member of the university basketball team. Since having a family, I turned to tennis and badminton so that I can play with my family member'.

One respondent accepted that she did three kinds of exercises. One is for herself. One is for her husband and the last one is for her children. Another one accepted that she did three kinds of sport with her husband. She said;

'I and my husband really love doing exercise. We like to go for swimming, tennis and aerobic dancing together. I also try to encourage my children. Everybody in my family plays sport. My eldest son has been playing golf since he was 9 years old. The middle daughter is a member of the basketball team at university and my youngest son is a member of the university football team'.

Some respondents expressed a viewpoint that pressure from friends and relatives was instrumental in their undertaking regular exercise. For example, one participant stated that;

'In fact, before I went to USA, my family supported me a lot in term of doing exercise. I remembered that we had all work out equipments at home. My parents like us to do the in home activities rather than going outside'.

Another interesting point for gaining the interest in health is the need to satisfy peers and relatives. One participant accepted that she applied for the gym because her customer wanted a friend. So, she went for that. Later on, she got addicted to the gym.

One participant accepted that she did some health activities to satisfy her mum. She said;

'I do not just begin to be interested. I have been interested in health activities since I was young. My mom supported me a lot in term of exercising. When I was kid, my mom encouraged me to go for swimming and tennis. And I know that if I am strong, I can do many activities as I want and I can fully throw all my energy for that.'

One of the participants stated that;

'In fact, I am not the one who is interested in health but my parents like to live in a natural way of life. So, they like to grow their own vegetables and cook food from their crops. So, I live in that kind of environment which make me very healthy comparing to other friends'.

Curiosity

Some turned to be interested in health because they were curious about the Cheewajit practice. In the past, they rarely paid any attention in health matters. They neither did exercise nor controlled their food. Later on, the Cheewajit practice became popular. So, they became interested in it, practicing it and got effective results. Since then, they became more concern with the health. For example;

'When Cheewajit practice firstly became popular 10 years ago, I wondered about the efficiency of it. Therefore, I tried it and it was very good. Since then, I have been continuing it till now'.

'I heard a lot about the Cheewajit practice. I wanted to try and see the result. After I tried doing the practice, I could see the change in my body. Therefore, I take more care of myself in term of food. I also do exercise and meditation'.

6.2.3. Perception towards their own health

Apart from the participants' attitude towards the healthy lifestyle pattern, their perceptions towards their own health were discussed. The participants were asked to compare their health condition with their friends who were of the same age. Four kinds of responses arose, which are having a better health than friends, same health condition as friends, worse than friends and depending on the original health.

Better than friends

Two main reasons were given to support the idea that the participants had better health than their friends. They are physical care and mental care. The participants believe that they took more care of themselves than their friends which was responsible for their better health status.

- physical care

The fact that the participants have always been taking care of themselves assured them that they were in the better health status than friends. Generally, the physical condition was mentioned rather than the mental condition when being asked this question. Some participants

claimed that their healthy conditions result from their strict eating habits and some from their regular exercise. The idea of having strict eating habit is expressed as;

'I think that I am in a better health condition than friends because I do not have illness. I think that it is caused by regular control of my eating habit. I will never follow my need in term of eating. I always choose to eat the healthy food. It sounds hard but it is not so difficult to do'.

'Comparing myself to friends, I think that I am in a better health condition because I stop eating the hot an spicy food, big meat and a lot of bad stuffs. I eat only fish, vegetables and fruits'.

'I am sure that I am better than my friends in term of health. I have been the vegetarian for 25 years already. I think that being vegetarian play important part to have a good health'.

Regular exercise is another reason which ensures the health tour participants to think that they have a better health than their friends. Two of the participants stated that;

'Comparing to friends, I think that I am in a better health status because I have been doing regular exercise for 2 years already. I can notice the difference of my body before and after the exercise period. I feel more active'.

'Comparing me to my friends who are in the same age, I consider myself is in the much better health condition because I started doing exercise since I was young while my friend just started to do exercise 2-3 years ago. Some people get cancer. Some gain a lot of weight. Some got the joint problem and back problem. It seems that they are not in the good condition anymore'.

- Mental care

A lot of woman mentioned that they had the healthier life than their friends because they were more pious than their friends. They always prayed and did meditation every night before going to bed. Most of these people believed in the holistic cure, which includes the care of body and mind.

Same as friends

The same level of health status has been expressed from some participants. The fact that the participants and their friends have the same interest in health related activities influences them to emulate each other to have a healthy lifestyle. They and their friends like to exchange knowledge about health and help each other to maintain the good health both for themselves and family member. One woman commented;

'Now, I and my friends are in the same state of health because we are growing older. We have to see the doctor as appointed. We are the member of the Golden year club. It is the club for the menopause women. We always like to go for the health lecture together'.

Worse than friends

- **Illness**

The main reason for this perception is illness, both major ones such as cancer and minor ones such as asthma and migraine. The experience of having had an operation also encouraged the participants to think that they were weaker than their peers. It may be the fact that in some case, the operation leaves the patients weak afterwards no matter how long ago it took place. However, some women, especially the elderly have problems with their thoughts about the operation. There has been a belief in Thai society among the older generations of the bad effect operations can cause. Therefore even though there is nothing wrong with these women, they never considered themselves to be healthy. One woman stated;

'Comparing myself to my friends, I think that they are better than me because they did not undergo the operation like me. And now, I still have to take the hormone'.

Insomnia can be the reason for the participants to perceive themselves as the weak person comparing to their friends. One of the women in this group said;

'Comparing myself to my friend, I think that they are in a better health condition than me because they have a chance have enough sleep. If I have enough sleep, I believe that I will be in the same health status as them or even better.'

- **No care of themselves**

Apart from the illnesses which influenced some participants to perceive themselves as being unhealthy compared to their friends, the nature and lifestyle of the participants is another factor. Some participants admitted that they hardly took care of themselves in term of both eating habit and exercise. Being regarded as an enjoyable and social activity for Thai people, eating is not an activity to stimulate healthiness. Therefore, hardly any of the participants in this group took care of what they ate. Besides, these women are not likely to pay any attention to the regular exercise. These two factors led them to their perceiving their bad state of health. One stated;

'Comparing myself to my friends who are the same age, I think that I am not as strong as them. I don't take care of myself in term of

food and I hate exercise. I like to go out to have meal with friends and spend time chatting with them for many hours.'

On the contrary, some women did not even have time for eating properly because of their busy work schedules. They accepted that they were workaholics and could not find the time to have the proper and healthy meal. Let alone the exercise. Some of the examples are;

'Comparing myself to friends, I think that I am in a worse health status than them because I am quite serious from work. I cannot stop working until the late of the day. I am workaholic. I have no time for any other activities'.

'I have no time for healthy activities. I am so serious about my work. My body is very stressful. I am turning 40 years old but I have a lot of white hair. I become to be a very serious person, easy to be tired. I rarely eat. The seriousness causes the fat in my body and I rarely have a period like ordinary women'.

'In the past, I never paid attention in health matter. I worked so hard that I felt too tired to bother thinking of my health'.

Depend on health when born

From the findings, there were some people who perceived themselves as being in a better health status than friends, and vice versa. On the other hand, some participants could not give an exact answer to the enquiry because of the idea of their original health condition when they were born. They perceived that the original health condition played an essential role in their present health status. Some respondents claimed even though that they tried hard to take care of themselves, their health is still in a bad condition compared to friends who did not have to make an effort in taking care of themselves. Some of them commented that;

'I studied in the USA before. I just came back less than a month ago. Comparing myself to my friends here, I am in a much better health condition but it is opposite to friends in the States. My friends there like to do outdoor sports and they are so strong. I am weaker than them even though I do a lot of exercise. It may cause by their genes and body figure. I am the Asian and they are Westerners'.

'Comparing to my friends, there are both type of people who are better and worse than me in term of health status. Some friends don't have to take care of themselves at all but they are so strong while some friends are sick all the time. I think that it depends on what god give to you too.'

To conclude, all participants view leisure as important in their lives for a variety of reasons such as leisure bringing happiness, physical benefits, and friends from leisure club among others. More than half of the participants claimed that they could have flexible leisure time. However, it does not mean that they can have a lot of free time except for those who are retired. When comparing their free time with men, the majority of women considered

themselves having more free time than men due to nature of their job. Regarding their ideas about healthy lifestyle, various answers were given such as the need to practice a healthy life, without illness life, a life that is natural, a life that is not too serious and an active life. Also, healthy lifestyle can refer to peace of mind and the balance between body and mind. The participants lead healthy lifestyles due to a variety of motivations such as leisure activities, preventative medicine, illness cure, cosmetic, socialisation and curiosity.

The next chapter will illustrate the findings from the qualitative analysis obtained from the participant observation in health tours and semi-structured interview about health tour participation. Then, the characteristics of health tour participants are also discussed. Lastly, the comparative findings from the follow up phase are illustrated.

CHAPTER 7

QUALITATIVE FINDINGS: HEALTH TOUR PARTICIPATION

This chapter provides results from qualitative data collections, which are the participant observations and the semi-structure interviews. The first part of this chapter explains the observations made by the researcher as a participant in a health tour. The observations are reported in a journal style from the start of the health tour. Next, the findings about health tour participation resulting from the semi-structured interviews are presented, including motivations for participating in a health tour, the decision making process before joining the tour and the actual participation in the tour. Subsequently, the post health tour effects, such as the satisfaction and benefits of participation are reviewed. The next part presents the categorisation of health tour participants that emerged from the qualitative analysis. There are five groups of participants based upon their adoption of a healthy lifestyle in relation to health tour participation. They are: the completely adopted group, the partly adopted group, the non adoption group, the determined group and the stable group. The last section is the findings from the follow up interview which was conducted three years after the first data collection phase. This section determines if they maintain their good intentions. Also, this finding illustrates if the three groups derived from the respondents who had taken a health tour six months before being interviewed continue to lead the same healthy lifestyle.

7.1. Findings from participant observation on the Cheewajit health tour

In this research, three types of primary data collection were conducted. They were participant observation, semi-structured interview for the first phase of primary data collection and telephone interviews for the second phase of data collection. In the first phase of data collection, participant observation was followed by semi-structured interviews. Participant observation was undertaken on the Cheewajit 'Spartan' health tour for four days from 7-10 December 2001 in Chiangmai province, about 60 kilometres from Changmai town centre. The Cheewajit health tour is offered 12 times a year. It is a three days course in a natural resort in the outskirts of Bangkok. However, once in a year, there is a 4 days course in Chiangmai province. It is called the Spartan health tour. This course is an intensive course compared to the normal course because it is a more demanding course designed for those who have been practicing Cheewajit for a while. However, there are a lot of newcomers in this health tour. The aim of the Spartan tour is to have strong and healthy body with a pleasant mind. The strong and healthy body refers to being able to;

1. Get up very early in the morning.
2. Walk a long distance.
3. Exercise and massage.
4. Take care of the living area as healthy living space
5. Climb up a thousand steps.

The pleasant mind refers to;

1. Leading a simple, peaceful and happy life.
2. Taking care of yourself.
3. Being able to sleep in a big hall with other people.
4. Have positive thinking.
5. Be able to solve the problems of life.
6. Be able to live with other people.

On the transfer bus from Changmai railway station tour members talked about health tour practices. Some of them had attended a Cheewajit tour before and shared their experiences with the new members. For example, one lady who had joined the regular Cheewajit health tour in Bangkok a year before said she had subsequently completely changed her lifestyle to a healthier one. Therefore, she wanted to test herself to see if she could manage to join tougher health tours like the Spartan tour. She is the mother of two children and she looks so much younger than her real age. She claimed that she encouraged her family to lead the Cheewajit lifestyle. Some of them talked about how they knew about the Cheewajit tour and how they knew Dr. Satis and why they came on the tour. For example, they knew about Cheewajit from women's magazines, from Cheewajit magazine itself and from friends. Most of them knew about Dr. Satis from talk shows on television. He was a guest on many talk show programmes to promote the Cheewajit lifestyle. The Cheewajit movement has been a major movement in relation to the health of Thai people in the past decade. The health tour participants also talked about their opinions towards the books written by Dr.Satis.

On the bus, there was no sign of tiredness or worry from the tour members. All of them seemed to be ready for the health tour activities. However, it was noticeable that most of the new participants who had never experienced a health tour before were scared of the colonic irrigation. They kept on asking the ones who had experienced the health tour before about it and the former health tour participants comforted them. The idea of eating Cheewajit food seemed not to discourage the tour members because they were eager to try real Cheewajit food prepared by the wife of Dr.Satis. Some mentioned in the bus that they would ask the permission from Dr.Satis to see how they cook Cheewajit food. Also, the stick exercise was not the problem for the newcomers.

Apart from talking about the tour practice, the tour members also talked about their families. For example, which school is the best school for their children, how to take care of them, children's life in Bangkok. It was noticeable that most of the participants came from middle to upper middle class because they talked about the very expensive private schools or the international schools where the tuition fees are very high.

It is proved to be easy to make friends with the health tour members because they were very friendly and had a very positive attitude. As for those people who came by train from Bangkok, they knew each other more from the 'the ice breaking' activities in the train. The night before on the train, the tour members were separated into five teams. Each team was given the name as the colour, these five teams joined in a series of easy activities to get to know each other.

The bus arrived at the accommodation around 9.30 am. The accommodation of the Spartan tour is not as comfortable as the general Cheewajit health tour set in natural resort nearby Bangkok. The accommodation belongs to Dr. Satis. It is a big house in a natural setting opening only twice a year for the Cheewajit 'Spartan' tour set by the Cheewajit magazine and the another Cheewajit tour set by the Cheewajit club only. Therefore the Spartan tour is considered to be the special Cheewajit tour.

In term of accommodation, the women were assigned to sleep together in two big rooms while the men slept in tents. There were only 10 % of men among the tour members. Most of men came with their wives. Less than 5 men came individually. Each colour group slept together in the same area.

At 10 am, all the tour members received the 'super healthy' welcome drink, made from vegetables, in the dining area. In the meantime, Dr.Satis came to introduce himself and talked briefly about the nature of the tour. When Dr. Satis arrived at the dining area, it was obvious that all the tour members adored him and perceived him as someone in a very high position. They seemed to have a very strong faith in him. Some tour members took out their camera and took a photo of Dr.Satis. Next, the staff team demonstrated how to do the colonic irrigation. Again, looking at the faces of the first time health tour participants, they were really scared and uneasy during the staff demonstration.

At 11 am, it was lunch time. The food in the tour was very healthy comprising nuts, grain, vegetables, brown rice, tofu and fish. There were various kinds of delicious food cooked from the above ingredients. Dr. Satis's wife demonstrated how to create varieties of food from the healthy raw materials. There were many people asking her questions about food. This tour is

different from other health tours in the sense that the tour members were encouraged to learn how to lead healthy lifestyle by themselves in a long run and the food is the essential part of the process. Therefore, it is important to give the tour members the idea about how to cook healthy food. During the cooking times, the tour members asked if Dr. Satis would publish the Cheewajit cook book. He told them that it was in process. In the meantime, some of the tour members who experienced Balavi health tour stated among the tour members that in Balavi tour, Dr. Banchop brought all of his books to sell at the end of the tour and it looked too commercial. There were some arguments among the group whether it was good to bring books to sell at the health tour. Some wanted it because they did not have time to go to the bookshop but some stated that it was too much for them because it seemed that health tour turned to be too commercial rather than the tour which encouraged people leading healthy lifestyle. Also, the tour members perceived that Chewajit health tour was the non-commercial health tour. They argued that in the beginning, they perceived this tour was a bit expensive. However, when they saw the activities and the food, they realised that it was not easy to do and all the staff had a very strong intention to promote how to lead healthy lifestyle for Thai people rather than thinking about profit.

After finishing lunch, there was the 'Table Talk' activity, a discussion in public in the front part of the dining area. In joining the health tour, there was the application process. Not everyone who sent the application form could join the tour due to the restricted seats of tour member. In the application form, the applicants had to fill in their personal details, their past illnesses and their motivations to join the tour. Staff would give priority to those who were in need of joining a health tour such as cancer patients or someone who had some uncured illnesses. Later, they would consider other health tour applicants. However, this tour was the Spartan tour which was the tour set for testing the strength of mind and body. Therefore, not so many ill people would like to join the tour due to the fear of becoming worse because of the hardship from the tour. However, there was one cancer patient in the group. She was asked by staff to do table talk and she talked about her experience of illness. Later on, more of the health tour members also talked. Those members who did a table talk were firstly asked by the staff if they were comfortable about it. Some members revealed that they were ill in the past and practiced the Cheewajit way until they recovered. Some got minor illness and sought for suggestions from Dr.Satis.

This table talk activity seemed to make tour members more aware of illnesses and strengthen their intention to lead a healthy lifestyle. Also, after listening to the table talk, tour members showed more concern about their friends and family who had a potential to develop illnesses. They discussed among themselves about how their relatives had the same symptoms of those

described or how similar their relatives and friends lifestyles were to the one who had the illness. They told themselves that they would go back and try to encourage these people to lead a healthy lifestyle.

In the afternoon, all tour members had to do the colonic irrigation and sauna to eliminate toxin. It was noticed that the first one who did colonic irrigation were the experienced health tour participants. Most of the first time health tour participants were very reluctant and spent very long time sitting and standing under the trees making a decision if they would do it. Most of them did it while few confessed that they did not do it as they felt scared of the procedure undertaken in public. After the colonic irrigation, the tour members went for sauna. In the sauna room, most of the health tour members talked about the experience of colonic irrigation. It is obviously seen that all of them praised Dr. Satis and his wife. They talked about their background knowledge about him, his past cancer, his books and his devotion to promote healthy lifestyle to Thai people. Again, some who experienced Balavi health tour compared Dr. Banchop with Dr. Satis. It seemed that these two tours are rivals in the perception of health tour members.

After finishing the detoxification activities, Dr.Satis spent four hours giving lectures about how to lead the healthy life. He gave a chance for all members to ask questions. There were various kinds of questions being asked from how to take the vitamin to the severe illness such as cancer. At 6 pm, it was dinner time. This time, Dr.Satis's wife did not demonstrate the cooking in the dining area. However, many health tour members asked to observe her cooking and helped her preparing the ingredients in the kitchen. The relationship of the tour members and staffs were like a family. Some tour members helped cooking, some helped in cleaning the house, some helped tidying the garden. Nobody asked them to help but they all were willing to do it.

After dinner, it was table talk time again and later on, the tour members learned how to do the meditation and how to relax for a deep sleep. This activity was set in the sleeping area. When Dr.Satis taught the members about how to relax for the deep sleep, some even slept at that moment. The tour members were supposed to sleep at 10pm. However, they just kept on talking till the late night about their new experience from the tour. Most of them gave a compliment to the tour and they felt really grateful for Dr.Satis that he devoted himself to help people. They stated that Dr.Satis had everything and it was not necessary for him to do it. He could live happily with his wife as a retired couple. However, he did it for the sake of Thai people. Most of them also gave compliments about the Cheewajit food. They stated that

they would gain weight because they enjoyed eating more with the fact that the food was healthy and they felt good to eat them.

The next morning, the tour members had to get up at 4.30 am. At 5 am, they were given the energy water made from the mixed of grain to energise their body. In the meantime, Dr.Satis asked the members to look at the stars in the sky. He told the tour members to appreciate nature. At 5.30, all the tour members had to walk to a waterfall situated 5 kilometres away from the accommodation. Nobody talked much during the walking time because it was still early and it would disturb the neighbourhood. Most of the tour members came from Bangkok. They really appreciated the environment and atmosphere. Some said they had to get up very early also but just only to get stuck in the traffic jam but this time, it was different. They felt like they lived in the ideal world. It was peaceful and quiet in the natural setting. Some members were surprised how they could get up early and did not feel tired or sleepy. They could even walk to the waterfall for 5 kilometres. They wondered about themselves if they could do it individually. Some analysed that it was their strong intention and the group motivations.

At the waterfall, the tour members had to do the stick exercise. It took nearly one hour to learn and to practice. Some of the tour members complained that it was hard. However, most of them tried their best to do it as much as they could. After the stick exercise, the members learnt how to do reflexology. Next, the breakfast was served at the waterfall, followed by a further table talk. The researcher was asked to do table talk. The staff knew that the researcher came for health tour for research and the table talk was the best way to encourage people to recognise the researcher in order that it would be easy when asking the tour members for interview after the tour ended. Therefore, the researcher told the tour members that the research about health tour was conducted and the researcher might need some help from the tour members. All of them said they were happy to help and give the interview. Some gave the name cards and contact numbers to the researcher. It has been only two days since the researcher met the group. However, they were surprisingly helpful and friendly. After breakfast, the tour member had to do the colonic irrigation and sauna again. This time, everyone seemed to be comfortable about it. In sauna room, the colonic irrigation was not the main topic anymore. The tour members talked about their lives, jobs, families and other miscellaneous topics.

Then, it was lunch time and table talk again. After lunch, the tour members walked to a cave and a temple in the forest and practiced the meditation there. The way to go to the cave was hilly and long distance. It was really tiring. Therefore, each member encouraged each other to

walk. Some stopped along the way to buy coffee and / or an energetic drink, which they were not allowed to consume. They confessed that they could not live without coffee, especially in the hard time like climbing the hill. At the temple, the tour members practiced meditation.

At 5 pm, all the members came back to the accommodation. There was one hour free before having dinner at 6 pm. Some went to take a shower while some helped cooking and cleaning. Some took a rest and slept and some chatted with each other. Ironically, Dr.Satis and his wife caught a cold. The staff said he worked too hard in the past few weeks. The tour members were worried about him and some were even worried about the future of Cheewajit practice if Dr.Satis passed away. They would like to encourage people to know about Cheewajit and focus on Cheewajit practice instead of focusing on Dr.Satis himself.

At 6pm, the member had dinner and did table talk. At 8 pm, the tour members did the meditation and went to bed at 9pm. This night, there was no talking among the tour members because they were very tired from the activities. They slept straight away.

The next day, it was raining. The main activities such as stick exercise, reflexology, colonic irrigation, sauna, table talk, lecture from Dr.Satis and meditation were practiced as before. However, the plan to walk into the forest was changed into group activities. As mentioned earlier, each member belongs to the group which has colour and symbols. The staff set up the stations and prepared a game for each station. Each group had to do the game competition in relation to health. The tour members enjoyed this activity because it reminded them of the fun time when they were young. However, concerning the benefit from this activity, they stated that they could not gain much from it apart from having fun. Some gave a comment that it was not necessary to do it but they could see how much effort staff did for them not to let them be bored in the bad weather. They appreciated the intentions of the staff.

The activities on the last day were the same. Before leaving, each member was asked to take a photograph so that the staff would put it with personal detail in the memory book of the tour. The group photos were also taken. The tour members seemed very sad to finish the tour. They exchanged telephone numbers and planned to meet again. In the evening, they went to catch the train back to Bangkok.

7.2. Health tour participation

This section begins with a discussion of the motivations of the health tour participants followed by a review of the stage of decision making from the pre purchase search and the participants' attitudes towards the health tour affected by the information obtained from the

search. The perception of their peers towards their health tour participation will be presented as well as the participants' analysis of the regime of the health tour. In order to review the participants' experience of and satisfaction with the health tour they were asked if the health tour had met their expectations and about their perception of themselves after the health tour compared to the pre health tour period and if the health tour participation changed the lifestyle of the participants. The discussion regarding changes in lifestyle is based upon information came from interviews with 50 participants who attended the health tour six months before the interview.

7.2.1. Motivation of health tour participation

From the findings, eight motivations for joining the health tour emerged. They are health and physical well being, relaxation, beauty concern, socialization and travel, meeting the famous doctor, escapism, curiosity, and pleasing the persuaders.

Health and physical well being

- Improvement of general fitness and well being

Due to concerns about both major and minor illnesses, some participants expected that the health tour would teach them how to practice a healthy lifestyle so that they could do it at home having finished the tour and improve their health. In addition, some participants had the experience of the inability of various methods to cure their illnesses regarded alternative medicine and lifestyle change resulting from health tour participation as other possible cures.

'The main motivation to go for health tour is an attempt to try a new way of curing my knee pain. In the past, I went to see many doctors who were experts in bone matter. They gave me a lot of medications but I was not better. So, I wanted to try this alternative way'.

'I have thyroid problem and now I am taking the medicine. I am quite scared of the long term side effect. Therefore, I want to stop it and try the alternative way, which is Cheewajit'.

- Illness protection

A large number of participants believed that health tour participation can help them to learn how to protect their illness, especially illnesses that cannot be completely cured such as cancer. One participant said;

'I am scared that I will get cancer someday from the genetic link. So, I want to protect myself before it is too late'.

Interestingly, one participant mentioned that she did not want to have any illness because it was unfair to her family.

'I feel that it is unfair if I do not take care of myself now. I may be ill in the future and I have to let my son and my husband take care of me. I do not want to be a burden to them. I feel pity them'.

- Improvement quality of life

Some of the participants wanted to improve themselves in term of health activities such as exercise or food. They use the health tour as the stimulant to urge them to accept the healthy lifestyle. For example;

'I wanted to go because I wanted someone to force me to be healthy. Later on, I hope that I will continue the practice'.

'My main motivation to go for the tour is the need to change my lifestyle. I need someone to emphasise to me the bad effect of having an unhealthy lifestyle. And I need the healthy environment'.

- Knowledge

The majority of the tour members accepted that their motivation to go on the tour was to gain knowledge about how to lead the healthy lifestyle with the hope that they would practice it in the future.

'The motivations for me to go for health tour is I want to know the right way to practice the healthy lifestyle so that I can do it after the tour end'.

The specific knowledge which can be obtained by health tour participation was discussed such as the food, the stick exercise, water therapy, meditation and coffee detoxification. Two examples are as shown below;

'I want to learn how to do the stick exercise. I saw it briefly from the magazine and I thought that it was interesting, useful and suitable for people at my age'.

'I read the book about the practice and was interested in it. I thought that there were so many useful activities in the tour such as the stick exercise, detoxification, and meditation. Also, there was the nutrition dimension in the tour. I felt that I would gain a lot of knowledge from this tour'.

Most of the participants in this group wanted to gain knowledge in order to take care not only of themselves but their family members.

'The main reason for me to go for health tour is that I wanted to know about healthy practice and adapt it for my family'.

'I wanted to have a better health from the practice of the tour and know how to maintain being healthy. Also, I want to pass on the knowledge I gained from the tour to my friends and family'.

Relaxation

A lot of people find that health tour participation is a kind of relaxing and fun activity, especially if doing it with friends

'In fact, I consider myself knowing a lot of health matter but I still like to go for the health tour because it is like charging the battery and I have a chance to travel in different places. I feel so much better in term of my mental part after the tour'.

Beauty concern

A few participants accepted that they went on the health tour with a secret reason namely that they wanted to regain a youthful look from the health tour and its long-term practice. They believed that the detoxification and the practice can make them look younger in a short time.

'I hope that it is another way to make me look young and healthy'

Socialisation and travel

A lot of elderly participants claimed that they joined the health tour because they would like to meet people who share the same interest or people who were in the same age so that they could continue contacting them and doing some health activities together later. Some elderly stay at home alone. Therefore, health tour participation is an opportunity for socialisation for them. For example;

'You may wonder why I like to join the health tour so often. The reason is I and my husbands are getting older. We feel bored of travelling abroad. So, we think that we better join the activities that we can find people who share the same interest with us. I gain more new friends from each tour. And my husband is the representative of some health tour group also. And now, he is the leader of the stick exercise at the park everyday in the morning'.

'I want to meet people who share the same interest'.

Some people thought that it was good that they could have a chance to travel and take care of themselves at the same time. However, some people were motivated to go for the health tour by the setting rather than the health tour itself. They gave the reason as;

'My main motivation to go to the health tour is I want to go to the sea. I have never swum in the sea before. And the tour advertised

that we would stay in the luxurious hotel. So, I wanted to try it. In fact, I didn't think about the health at that moment. As I told you, I was in a lazy mood'.

The famous doctor

Meeting the doctor was one of the motivations for some of the health tour participants, especially meeting Dr. Satis. In some way, Dr.Satis was portrayed as the devoted doctor who moved from USA to Thailand in order to help Thai people to be safe from the cancer by the behaviour change theory. Two of the participants said;

'I wanted to go to the Cheevajit tour because I want to meet Dr.Satis and ask him some questions '.

'I really adore Dr.Satis. I read every book that he wrote. He was very kind and sincerely willing to help us. I came to the tour because I wanted to meet him. It is once in a lifetime opportunity'.

Escapism

As for some people, health tour participation can be some kind of escape from the reality. For examples;

'The main motivation for me to attend the health tour is that I want to find the time for myself. I want to get away from work and old environment. Also, I have a chance to live in the healthy lifestyle during the tour. I do not have to cook for myself. Everything is prepared. I feel really relax from it. I just need to be with myself'.

'I wanted to get out from my daily life, change place and want to have a better health'.

Curiosity

Curiosity plays an essential part for some people to attend the health tour. The changing lifestyle practice seems to be the new thing for them. Therefore, they joined the tour in order that they would know how it was exactly like. For example;

'I read Cheewajit magazine and learn a lot of new things but I had never tried it. Therefore, I would like to try it and see if it is efficient as the magazine said'.

'I heard about the practice but I was not sure what it was. Thus, I decided to try it for myself.'

Pleasing the persuader

In some case, the participants did not plan to go for the health tour but their peers persuaded them to go. Therefore, they went only because they wanted to please their peers.

'My daughter wanted me to go with her because she wanted me to learn about the healthy lifestyle. In fact, I did not want to go at all but I felt scared that my daughter would be upset'.

'I went to the health tour because one of my customers asked me to go. I wanted to make her happy. So, I went for it'.

7.2.2. Decision making and health tour participation

In this section, the process of decision making regarding health tour participation will be discussed beginning by reviewing pre purchase aspects. The information obtained from these sources informed attitudes towards the health tour. In some cases, a comparison of health tour organiser occurred. Apart from that, time and money factors are the main focus for the decision making. Lastly, the discussion about the difficulty level of the regimes from this tour is presented.

Pre purchase searching

Information about health tours can be derived from books, magazines, newspaper, radio, television, internet, health lectures and peers.

- Books and magazines

Most of the Cheewajit tour members knew about the Cheewajit practice and health tour from the books written by Dr.Satis. Also, the monthly Cheewajit magazine gave the health tour schedule to the readers. The majority of the Chevajit health tour participants accepted that they got the information about health tour from the magazine. Some of the examples are;

'My husband subscribed the Cheewajit magazine. He began reading it first and suggested me to read it too. And I have all the books of Dr.Satis. That as why I knew about the health tour schedule'.

'It was two years ago. In the past, I bought the books of Dr.Satis and bought some of the Cheewajit magazine. So, I knew about Cheewajit health tour.'

Dr. Banchop who organizes the Balavi tour does not produce any magazine even though he has written a lot of books about the practice. Some of the Balavi tour members knew about the Balavi centre from the information Dr.Banchop mentioned at the end of his books. Therefore, they went to the Balavi centre or called the officer to ask about the schedule of the health tour. Some applied for the membership of the centre so that they could get the monthly leaflet about the latest health news and the health tour schedule.

- Radio

Radio is another media channel for the participants to get the information about health tour.

One woman claimed that;

'I knew about the health tour from the radio. There is health programme at 5.30-6 am. The DJ will tell you when and where the health activities will be set. Anyway, as a matter of fact, I attended so many lectures that the organiser's gave me the year round timetable of the lecture and health activity'.

- Newspapers

Both Dr. Satis and Dr.Banchop write articles in the newspapers. Therefore, people know more about the practice and the tour from the newspapers.

- Lectures

Dr.Satis and Dr.Banchop always give health lectures in universities and hospitals. Therefore, the practice and the health tour are promoted widely.

'I know about health tour because my friend asked me to be a member of Balavi centre and we went together to listen to the lecture from the doctors. So, I heard about the health tour from the lecture. I thought that it would help to get a better health. And I will gain more knowledge about health'.

'One day, I went to the lecture of the Balavi centre about cancer. It was the first time I learnt about health tour As the Balavi centre successfully provides alternative way to cure the illnesses, I believed that health tour would be good also'.

'I knew about the health tour because I attended the lecture about bones in the elderly. They gave the information about health tour. I read about health tour before and was interested in it but never thought about it seriously. However, I began to take it serious after listening to the lecture. I thought that it would be very useful for elderly people like me'.

'I went to listen to the lecture about cancer and the doctor from Balavi centre came to give the lecture. He has also got his own programme in Cable TV. I thought that he was an expert in the alternative medicine as well as being reliable because he has a medical doctor certificate. Therefore, I believe that he would mix the modern medicine with the alternative medicine in the health tour'.

'I was interested about Cheewajit because Dr.Satis gave a lecture in public and I always followed his lecture. Also, I subscribed to the Cheewajit magazines and I have all Dr. Satis's books, I got a very positive attitude towards Cheewajit health tour because I knew how it was like before I attended. I thought that it was very useful'.

- **Television**

Only Dr.Banchop has his own health programme on cable TV every Thursday afternoon. Therefore, it seems that he has more distribution channels than Dr.Satis. According to the interview, most of the Balavi health tour participants got the information of his tour from this TV programme. It is noticeable that most of the Balavi health tour participants are retired people and shop owners who stay at home watching the TV all day. Two of the participants claimed that;

'I knew about the health tour from cable TV programme run by Dr.Banchop. In this programme, he suggests how to lead a healthy lifestyle. There was the advertisement about the health tour in this programme. The theme of this health tour is the water therapy. It is like the normal health tour but emphasis more in the water therapy. The tour would bring us to Trang province which has many beautiful islands and sea'.

'I watched the Cable TV of Dr.Banchop's health programme and saw the advertisement of the health tour. It was said that it would be the real detoxification tour, not the normal health tour. Therefore, I thought that it would be the very strict health tour which helped to make my body cleaner even though I have taken care of myself very well. Also, I wanted to try the coffee detoxification because I never tried it before'.

- **Website**

Apart from the television programme, the Balavi health centre of Dr.Banchop has a website, which is <http://www.balavi.co.th> Therefore, it gives a chance for people who surf the net to know about the health centre and health tour.

'I was interested in health tour because I read books and magazines about it. I also knew about the Balavi centre from the website'.

'I am interested in health tour by myself. I read about it on the internet'.

- **Peers**

Friends and relatives have a great influence to the participation of the participants, especially the senior relatives. Some accepted that they knew about health tour from the persuasion of friends. For example;

'I was interested in health tour because my friend told me about it and persuaded me to go'.

'My friend told me about the health tour. She went to Balavi centre before and got some information about it. So, she told me in order that she could have companion'.

Parents or senior relatives, who previously attended the health tour, played the important role for the younger family member in term of health tour participation. The examples are expressed as;

'My mom sent me for the health tour. She was the member of the Cheewajit magazine and went for health tour first and she thought that it was very useful. So, when she finished the course, she sent me to the next course. My mom wanted me to know how to take care of myself in the right way'.

'My older sister and my parents experienced it and thought that health tour was very good. So, when the new course opened, she told me to go'.

'I knew about health tour because my mom asked me to accompany her'.

On the contrary, some of the elderly participants accepted that they went to the health tour under the persuasion and the force of their daughter's will. In Thai society, children are expected to take care of their parents when parents get older. It is obviously known that the daughter is more caring to their parents than son. Therefore, it is not surprising to see the elderly come with daughter or under the persuasion of daughter. For example, two of these groups said;

'I was interested in health tour because my daughter asked me to go for it. Before that, I did not know anything about Cheewajit before'.

'My daughter persuaded me to go for this health tour. I was quite ill in the past but I did not have any intention to go for health tour at all. Later on, my daughter watched the TV and read book about health and health tour and she wanted me to go'.

- Direct experience

Some of the Balavi health tour participants got the direct experience to get the information about the tour.

'I was interested in health tour because I went to Balavi centre for taking the acupuncture in my knee to heal the pain. I saw the leaflet about the detoxification tour going to Kanjanaburee province. So, I went for it'.

7.2.3. Resulting attitude towards health tour

After obtaining the information about health tour from various sources, both positive and negative attitudes were expressed.

Positive

A large number of the participants believed that health tour participation could encourage them to lead a healthy lifestyle. Some thought that the practice could overcome their illnesses while some thought that it could give them the cosmetic benefit. In other case, the respondents had a positive idea towards the health tour but did not think about attending it until their peers encouraged them.

- Changing lifestyle

The belief that participating in the health tour would enable them to lead the healthy lifestyle was widely held by the participants. Even though some have been practicing the healthy lifestyle before health tour participation, they still have this kind of attitude. Therefore, they expected to change their lifestyle and became healthier under the encouragement of health tour participation. The idea of changing eating habits and exercise habits go together. The examples are given as;

'I would like to learn about the practice. I had a strong belief that I would be a different person after the tour. I wanted to go because I wanted someone to force me to be healthy'.

'I was interested in health tour because I read in the Cheewajit magazine about the experience of people who went for it. It was very interesting and good to the health. And I wanted to learn more of how to take care of myself. You can see that I got the very positive idea towards the tour before I went'.

- Overcoming illness

In some cases, participants thought that health tours could help them to overcome their illnesses. Most of their illnesses cannot be cured completely by modern medicine such as the migraine, high blood pressure, diabetics. These kinds of illnesses may respond to a continuously healthy diet and exercise. Hence, they believe that health tour participation is an alternative way to overcome illness.

Besides, the illnesses of peers and relatives stimulated them to pay closer attention to the health tour. Alternatively, others had a positive attitude to the health tour since they knew about it but had never paid inattention to it until they faced the indirect experience of illnesses. Some expected to learn more about health from the tour so that they could suggest the practice to their peers and relatives. For example, two of the participants claimed that;

'In the past, I read Cheewajit magazine and books written by Dr.Satis. They are very good. However, I did not follow the practice. I always postponed it. Later on, my friend got a cancer, which led me to think that it was a time to start learning about how to lead healthy lifestyle because we could not know what would happen to us. Therefore, I thought that if I took care of myself very well, it could help preventing the sickness. And the health tour should be the starting point to learn how to lead a healthy lifestyle'.

'I have heard about health tour for a long time already but never had a thought of going for it. Then, my relatives were ill from cancer and brain problem. My mom got cancer too. At that moment, I felt that if I went to the health tour, I could know more about health and I could advise people. I wanted to have the real experience of the health tour'.

- **Beauty**

The belief in beauty was still expressed in some respondents when being asked about the attitudes towards the health tour before they participated. Some thought that health tour could help to make their skin look younger than the real age. One woman said;

'I knew about health tour from my friend. She told me briefly about it and I thought that it might help me to be more healthy and younger'.

- **Peers encouragement**

Some people got the positive attitudes towards health tour but never thought of attending it until they got a confirmation and encouragement from their peers. For example;

'I was interested in health tour because I read about it from the Cheewajit magazine. I never thought of going for it until my colleague went to the tour and she confirmed that it was really good. I believed her and wanted to go for it'.

Nevertheless, there are still some who did not have any interest in health tour at all but still wanted to try because of the persuasion of friends. For example;

'I knew about health tour because my friend asked me to go with her. I did not have any illness and never thought about trying it. I saw the programme in the Cable TV under the encouragement of my friend and thought that it was interesting'.

'At first, I did not know exactly what Cheewajit was. I just knew that it was something related to health, diet and 'you are what you eat'. My mom wanted me to know how to take care of myself in the right way. My mom is the member of Cheewajit magazine and ever went to the tour. She thought that it was very useful. That's why she encouraged me to go.'

'As for the Cheewajit tour, I have heard about it but did not know what exactly was. I knew that doing the detoxification was good to health. My friend's mom applied to the tour for me. My friend was sick so often. So, her mom wanted her to try the health tour. My friend asked me to go with her and I decided to go for it.'

Negative

Not only were positive attitudes pointed out by the participants, negative ones were also expressed. The idea of the tour having a high price existed among some participants. They compared the price of health tours to general sightseeing tours and thought that the health tour was more expensive. One respondent commented that;

'I thought that health tour was so expensive. It was such a waste of money. I did not want to go but my daughter forced me to go. So, I had to go.'

7.2.4. Comparison among health tour

The participants were asked about their comparison among the health tour organisers before their decision making. Two kinds of responses were expressed, the group who compared the health tour between two companies and the group who did not.

Make a comparison

The comparison between Cheewajit health tour and Balavi health tour were made among the participants before they made a decision. The Cheewajit health tour participants claimed that when comparing two doctors from each health tour, Dr. Banchop of Balavi was more businesslike than Dr.Satis of Cheewajit. They thought that Dr.Banchop of the Balavi tour thought too much about the profit rather than attempting to help people. One respondent who went for both Cheewajit and Balavi tours made the following detailed comment;

'Long time ago, I went with Dr. Banchop's health tour first. In the beginning, the tour was very good and became popular very quickly. Then, Dr.Banchop seemed to be more businesslike. So, I turned to Cheewajit tour. Dr.Satis is 60 years old and never thought about any profit. He really devoted his life to help people. In the early day of Dr.Satis's tour, most of the tour members had some illnesses, both minor and major ones. Dr.Satis had a very strong intention to help them. And there were many volunteer staffs to help because they saw the good intention of him. Therefore, the price of the tour was not expensive comparing to Dr.Banchop's. Now, not only the ill people go for the tour of Dr.Satis but also a lot of healthy people join the tour to learn how to lead a healthy lifestyle. I like Dr.Satis because he taught us a lot in term of how to take care

of ourselves after the tour while Dr.Banchop did not. He wanted us to go to his health care centre and use the service there instead.'

Definitely, the price comparison was the main factor for the decision making process. Women who attended the Cheewajit tour considered that the Cheewajit tour was much cheaper than the Balavi tour, and vice versa. The tour members of Cheewajit tour viewed the tour as;

'I compared the Cheewajit with Balavi tour. I think that Balavi tour is too businesslike and it is so expensive'.

'I compared Dr.Satis's tour with Dr.Banchop's tour. I think that Dr.Banchop's tour is too expensive. However, I do not know about the activities in the tour and I have no friend who went with that tour before. So, I have no idea about it'.

Not only was the comparison of Cheewajit tour and Balavi tour made. The Cheewajit tours were compared in regard to the two different Cheewajit organisers. The original organiser was the Cheewajit club and the second one the Cheewajit magazine. Some people who gained an insight into the Cheewajit tour thought that health tour set by the Cheewajit magazine was far more expensive than the tour set by the club. The reason is that the staffs of the club were voluntary while the staffs of the magazines were hired. One respondent commented;

'I think that the health tour set by the Cheewajit magazine is expensive comparing to the tour set by Cheewajit club. Anyway, I have never been to the tour set by the club'.

Apart from the price comparison, the practices of Cheewajit and Balavi health tours were compared. For example;

'I compared the Balavi tour with the Cheewajit tour. I think that in term of Cheewajit practice, I can do it at home by myself. I read a lot of Cheewajit books and practice Cheewajit way sometimes. I feel that Cheewajit does not offer new things for me. Therefore, I did not need to go for the Cheewajit health tour.'

'I do not like the Cheewajit practice even though I know that my lifestyle is the Cheewajit one. However, as for the Cheewajit practice, we have to mix the grain altogether. For example, you have to mix oat, wheat, nut etc. altogether. I like to eat separately. I think that I will have more knowledge if I come with Balavi. In my opinion, Cheewajit is nothing new for me. They taught us to eat vegetables which are the same practice as mine. So, I do not think that I will get anything more'.

No comparison

Some participants never considered comparing the health tour organisers. Two reasons were given as lack of information and loyalty.

- No information

Because of the lack of information about various health tours, some participants never compared health tours they wished to attend with others. It implies that each company has its own group of customers. Two women made the remarks;

'I never compared this health tour with others because I did not have any information about other health tour. I knew about this health tour from the magazine and thought that it was interesting. So, I went for it.'

'I never compared this tour with other health tour because I was lack of information about others and I was too lazy to find out some more.'

A few participants did not know anything about health tours. Therefore, they never bothered comparing the health tours they would attend with others. The information source was only from their peers who persuaded them to go. Peers compared the health tour for them and provided a brief picture of health tour for them. One participant said;

'I never compared the tour with others. My friends told me about this tour and I went for it. Some friends told me that as for Cheewajit tour, the doctor was not as good as Balavi one'.

- Loyalty

The concept of Cheewajit health tour and Balavi health tour are both well known among some participants. However, they still insist to go for the same organiser because they would like to remain associated with the practice they knew first instead of confusing themselves by going for two doctors of the different practices. Two women gave opinion as;

'I never compared this health tour with other company. I always go for this doctor'.

'I did not compare this tour with other. I always stick with the Balavi one'.

7.2.5. Perception of peers towards health tour participation

Apart from the attitude of the participants about the health tour, the perception of their peers towards their health tour participation was questioned. Two kinds of responses were expressed. They are positive and negative perceptions.

Positive

Being asked about the family's perception towards their health tour participation, most of the participants stated that their family fully supported them. One woman accepted that her family even pushed her to go for the health tour. She said;

'They wanted me to go. They thought that this would be good for me. They wanted me to do exercise. They really supported me a lot and were concerned that I would change my mind'.

Some women were persuaded to go to the health tour because of their health problem. Two women commented that;

'My family supported me because they knew that I had an operation before and they thought it might be good to my health'.

'I had cancer before and always had the fear that it would come back again. Therefore, my family encouraged me to go for the health tour'.

Some families had a positive point of view about healthy lifestyles. Therefore, all of the health activities are considered to be the good activities. One woman said;

'My family supported me to go for it. My family love to lead the healthy lifestyle. So, anything which will be good to the health is considered to be a good investment'.

In some cases, the family expected the participants to go for the health tour in order to learn something new so that they can adapt this knowledge to the family lifestyle for the sake of the whole family.

'My family wanted me to join the tour. They wanted me to learn about the food and the exercise. My mom got a stick a long time ago but never exercises because she did not have the knowledge to do. So, she hoped that I would teach her how to do the stick exercise properly and we would do it together'.

'My family knew that I was very interested in health matters. And they know that I always wanted to give the best thing to them. If I know something new which is considered to be good to life, I am ready to let my children practice it. They knew that if I learnt new good thing from the tour, they would gain benefit too'.

Friends of the participants also supported them in attending the health tour and were themselves interested in the health tour and wanted to join the tour but faced some obstacles such as constraints of time and money. Two women said that;

'When my friends knew that I would go for a health tour, they were jealous of me but they could not go because the tour was quite expensive for them and it was so hard to find the time to go'.

'They were happy for me. Some friends wanted to go but had no chance because the problem of time available. And they said that if I gained some new knowledge, they would like to know about it too'.

Negative

A few participants got some negative comment from the family member such as;

'Some of my relatives thought that I was too panicky about health. They thought that I was ill so often because I was too clean and didn't have an immune system for beating the viruses'.

'My relatives think that it was a waste of money but I did not care. They did not know anything about it. So, that's fine'.

'My family complained that it was too expensive to go. They thought that if I could control myself in term of eating and drinking, I did not need the health tour at all'.

'Some people said that I am strange. I have a lot of money but why do I have to torture myself with the strict eating habit. They think that I should use my money to buy very delicious food to eat. They think that eating fruits and vegetables is some kind of torture'.

There were a number of peers who had a negative attitude towards health tour participation, the main reason being the cost of the tour. Peers liked to compare the health tour with general sightseeing tours and they considered it to be very expensive. They thought that they could buy the very luxury and comfortable sightseeing tour without any restriction of food or requirements for undertaking exercise. One woman explained about her friends' comment as;

'My friends thought that it was expensive and they perceived that I was strange to go for this. I asked many friends to go with me but nobody wanted to go. They said that it would not be fun to go for eating vegetables. Some people said that it sounded good but too expensive'.

7.2.6. Time available for health tour participation

More than half of the participants declared that they did not have any problem about the time needed to attend a health tour. They could go anytime they wanted. The two main reasons for this were having their own business or being retired. Nearly half of the participants have their own business and one quarter of them are retired. Therefore, as for these two groups, time is not considered a major factor for their decision making. Some of the participants who have their own business mentioned;

'I have my own business. So, I can work as I want. I also have the very reliable staff to work for me'.

'I can go to the tour whenever I want because my husband takes care of the businesses.'

However, there are a lot of women working outside home. This group needs to go for the weekend or take a long holiday health tour. They cannot go for the weekday tour unless they take holiday, which they were not prepared to do. They would prefer to take a holiday with their family rather than going to the health tour alone. Some women stated;

'The period of the tour is important to me because I work in office hour. So, setting the tour at weekend would be much better for me'.

'I want the tour to be set in the weekend or long public holiday because it is so hard for me to ask for leaving from my office unless I will take the time as part of my annual holiday'.

7.2.7. Cost of health tour

A large proportion of the participants accepted that the cost of the health tour was quite expensive. However, they had the reasons for joining it. Some thought that the health tour cost was reasonable and only few considered it to be cheap.

Expensive

The expression of the health tour as being expensive can be divided into two main groups, which are the health tour, are unreasonably expensive and expensive but worthwhile.

- Unreasonably expensive

As for this group, they accepted that they would not go for it unless someone paid the cost of the tour for them. For example;

'As for the price of the tour, I think that it is very expensive. If my mom did not pay for me, I would not go or I would rather go for the meditation tour instead'.

'I accept that if I have to pay by myself, I will not go for it. It is too expensive for me and I think that I may buy the book and learn how to do it by myself at home. Or I may not even think about doing it. I think that now, my life is fine. I am taking care of myself quite well. I think that in fact, the detoxification is not so important to me. However, getting a free health tour and travelling is irresistible'.

- Expensive but worthwhile

A variety of reasons were mentioned upon the high cost health tour as;

'The fact that health tour is very expensive is true but I think that it is worth going for it because you will know a lot more about health from it and it is for your health. You need to keep your body as healthy as you can. Having illness is such a big nightmare'.

'I think that the Balavi tour is quite expensive but I understand that it is not the normal tour. It is the health tour with the doctor'.

'It is quite expensive but I understand why. Sometimes they have to use a lot of expensive materials'.

Some participants at first perceived the health tour as an expensive tour but changed their opinion after attending the health tour. Two of the examples of their expression are as shown below;

'Before I went to the health tour, I thought that the price of the tour was quite expensive. At that moment, I did not know exactly what I would get from the tour. After the tour, I did not think that the price is too high at all comparing to what I got from the tour. It is worthy'.

'In the beginning, I thought that it was very expensive but after the tour, I thought that it was very worth of money. I earned a lot of things from it and the food there was very good'.

Reasonable

Some perceived that the price of the health tour was reasonable to the reason that it was worthwhile to pay to get good health and the knowledge to maintain the healthy lifestyle for their whole life. Most of the participants in this group stated that they never thought twice about the price of the tour. They went for it without calculating about the price. Some of the examples of their statement are;

'As for the price, I think that it is ok. I spent more in term of beauty concerns'..

'I think that the price is reasonable because I gained a lot of knowledge from the tour. I think that it is the price to learn how to protect myself. If I do not know how to take care of myself, I may have to pay even more for the doctor cost in curing myself if I am seriously ill.

Cheap

Only a minority of the participants considered the health tour as a cheap tour. One woman made a comment that the health tour was too cheap to gain profit. Some elderly participants considered it was worth paying for the health tour in the hope that they could be healthy like in the past. For example;

'The cost of the tour is cheap. I can say that I never thought about the money matter. I could do everything to have a healthy body back to me. I want to walk nicely again'.

'The price of the tour is a bit cheap comparing to the food. Brown rice is not cheap at all. I wonder if they can get the profit from the tour'.

'I compare the price of health tour with my normal spending in holidays. Health tour is even cheaper than my holiday cost'.

7.2.8. Regime of health tour

When being asked about the regime of the health tour, participants explained about the practice and gave the opinion about it. The level of difficulties of the regime can be divided into three main sections, which are not difficult, partly difficult and difficult.

Not difficult

The majority of the health tour participants considered the regimes in the health tour as not difficult for them with many reasons given such as;

- Fully committed to the practice

They are highly motivated to attend the health tour. Therefore, they had a strong intention to go on the health tour regime. Two of this group said;

'The regimes in the tour were not difficult for me. I think that it was because I had a strong intention to follow the practice. I thought that if I intended to go for it, I had to do everything doctor taught us'.

'The regimes in the tour were not difficult at all. I really had a strong intention for it. I wanted to learn as much as I could from the tour so that I can adapt it with my life '.

- Not sufficiently demanding

Regarding to the Balavi health tour participants, they did not find the regime difficult because the health tour was not strict enough. It was like the general sightseeing tour adding some health activities rather than the real health tour or detoxification tour. Two participants commented that;

'The practices in the tour were not difficult at all because it seemed that the staff did not place much emphasis on health matter. It was not the strict health tour. Dr.Banchop told me that it was not the detoxification tour. Therefore, the activities in the tour were variety from water therapy to visiting the tourist attractions'.

'The regime in the health tour was not difficult for me. I think that it was not as strict as I expected. In the beginning, I thought that we had to eat the very healthy food every meal and we had to do the very healthy activities all the time but it was like we spent lots of

time in travelling to the tourist attractions. So, it is like the general tour but with the healthy food and some water therapy activities'.

According to this result, the level of health tour should be differentiated clearly such as the strict detoxification tour, the health tour, the health tour with sightseeing or the sightseeing tour with some health aspects.

- Choose not to follow the regimes

Interestingly, one claimed that the health tour regime was not difficult because she did not follow the practice strictly. She joined the tour only for relaxation.

'As I told you, I always take care of myself. My brother asked me so many times to go for the health tour and I said yes and I postponed it again and again. So, I thought that I would just go and relax. I did not follow the practice strictly like other tour members. So, I do not think that the regimes were difficult'.

- Regular practice

There are some participants who have been practicing the healthy lifestyle for a long time already. The regimes of the tour were more or less like their daily practice. Therefore, they considered the regimes easy for them.

'I think that the regimes of health tour were not difficult for me. I always get up at 3 am everyday and I am vegetarian. So, everything is fine for me'.

'The regimes in the tour were not difficult for me because they were the same as I did when I was at home. One thing which was added is the regular exercise'.

'When I went to the tour, there was nothing new for me. I have been practising as the doctor suggested for a long time already. I did the detoxification by myself at home. I ate papaya and drank the water with lemon drop and salt. However, I felt happy from attending the tour'.

- Comparison with past tour experience

The comparison of the health tour with some other tours they had experienced in the past was made among the health tour participants. Some of the tours in the past were harder than health tour. Therefore, they considered health tour easy. For example;

'The regimes of the tour were not difficult at all. When I went to yoga tour, I had to get up at 4 am as well. I love getting up early because the weather is very fresh and nice'.

'I do not think that the practice in the tour is difficult. I think that going for the meditation tour is even harder. As for the meditation tour, we had to get up 3.30 am to pray and did a lot of religious activities'.

Partly difficult

The idea of the health tour regimes being difficult in some part was expressed. However, the participants were all willing to follow the practice because they knew that these would cause the good effect to their health. The examples are expressed as;

'The regimes in the tour were a bit difficult for me. I do not like to get up early. However, I tried to do every activity because I wanted to see effective results from it'.

'The regimes of health tour were partly difficult for me, especially the wake up time. We had to get up at 4.30 am'.

'Some of the regimes of the tour were so difficult for me. I do not like doing the coffee detoxification and I cannot stand eating a small portion of meal'.

'The regimes in the tour were not difficult for me but only forbidding drinking coffee made me feel so frustrated. I am addicted to the coffee'.

Difficult

Few participants thought that health tour regimes were difficult. The reason was they hardly practice this kind of lifestyle before. Two participants said;

'I think that the regimes in the tour were very difficult. I had to eat only papaya for a whole day. I had to do the message and water aerobic. I had to drink two litres of water with lemonade and salt every morning. I had to do the coffee detoxification. I felt so scared of doing it. However, I did it'.

'The regimes of the tour were so difficult for me. I never eat only fruit for a whole day like this before. I felt so hungry all the time '.

'The regimes of the health tour were so hard for me. After I did the stick exercise, my muscle was so damaged that I could not walk for a while. I had to be at home and take a rest'.

One woman accepted that the regimes were so difficult but she could go on doing it because of peer pressure.

'It is quite hard for me. However, seeing people practicing it make me feel that I will be able to do it too'.

7.2.9. Satisfaction and post tour experience

In this stage, the satisfaction of the participants will be explored beginning with the rate of satisfaction followed by a comparison of what was expected in relation to knowledge gained. The participants were also asked about their perception towards themselves after attending the health tour compared to the pre health tour period. As for those who were satisfied with the health tour, they were asked about the benefits they gained from their participation. The last

section portrayed the lifestyle of participants six months after attending the health tour. The findings of this section were obtained from interviewing fifty experienced health tour participants.

The majority of the health tour participants gave a rate of satisfaction between 8 -10 on a scale where 10 points represented full marks. A large number of people stated the mark without any reason however a few gave the reasons.

Some of the reasons for the marks are;

'I will say 9. I love the food and I think that the practice is very effective. There are many cancer patients who get better from the Cheewajit practice'.

'If 10 is the full mark, I think that I will give it 10. I was very happy with everything in the tour'.

'I will give 10 out of 10 for the tour. I love the location of the tour. One time, it was in the valley of the mountain and another one time at a seaside resort. The sea was so beautiful there. I had a chance to breathe the very fresh air. And I had a chance to do the detoxification. I felt light and clean in my body'.

Even though some of the participants gave a high mark of 8 points or over, they still have some complaints and comments about some aspects of the tour. The fact that the health tour period was too short was raised.

'I will give 9 because the period of the tour is too short for me. It will be better if they set the longer period'.

'I will give 10 out of 10 from it even though I think that the time of the tour is too short. That's why I came back to continue the 10 days detoxification at the Balavi centre'.

Some people complained about the facilities as;

'I will give 8 out of 10 for the tour. I think that the food is not so perfect'.

'I will give 8 out of 10 for the Spatan tour. I do not like the room. The sun shone into the room all day so it is so hot'.

The large number of the health tour members can cause the problem in terms of the insufficient staffs and services.

'I will give 8 out of 10 for the tour. The staffs are nice but sometimes they could not take care all of the tour members'.

'I will give 8 out of 10. I have a complaint in term of the amount of tour members. There were too many people. So, the service and activities were insufficient'.

Two participants complained about the ill-organised tour.

'If the full mark is 10, I will give the tour 8. I have the comment on the organisation. It did not run smoothly as I thought. I expected that it should be better because they set the health tour for many courses already'.

'I want to complain about the organisation. It was not well prepared. It was a big mess when tour members stepped out from the train. The worse thing is that there was no bus from hotel coming to pick us up. So, we had to go by taxi. And we had to carry our belonging by ourselves. I really hate this part'.

In one point, an inquiry of the differentiation between the real health tour and the half health tour half-sightseeing tour is asked.

'I have a comment for the tour that the doctor should make it clear whether he wanted to do the serious health tour or the health tour with some fun. Some people expected to have some fun in the trip. So, they hated to listen to the lecture at the night time. Some expected the full health tour. So, they hated to go out for fun at the tourist attractions'.

Only few people gave the low mark as 5-7 from the full mark of 10. A variety of complaints were made by these people. The majority of this group is the Balavi health tour participants. Only a few are from the Cheewajit health tour. Most of the Cheewajit tour participants in this category complained about the facilities such as the accommodation and water system, which did not meet their expectation or their standard. One unusual comment is one participant said that she would give only 7 for the Cheewajit tour because she thought that Dr. Satis was so egotistical.

As for the Balavi tour, the complaints were made about the activities, the accommodation and the doctors. In term of the activities, many people thought that there were too many unrelated health activities. Half of the time was devoted to travelling. Therefore, as mentioned above, there should be the clear differentiation of the type of health tour. The examples of the complaint are shown below;

'I will give 7 out of 10 for the tour. I have a complaint about some activities which are not related to health matter'.

'They did not emphasise the health activities that much. It is like general sightseeing tour rather than a serious health tour'.

The organisation of the tour was complained as well.

'The organisation is not good. They are not professional. For example, they gave us the T shirt but they did not tell us when we should wear it. And there is no reserved seat on the train. So, people just fight to get the good seat'.

One participant complained about the doctors of the tour.

'I got complains. One doctor was so strict. She said something very strongly to the elderly. It is good that she forced the elderly to follow the practice but she should say something nicer'.

Also, the facilities such as the transportation, accommodation and meal are commented as;

'I want to complain about the hotel. It is so dirty. And the transportation is dirty too'.

'Before I went, I expected to eat something like healthy food but it turned out to be only one meal from the trip. As for the other meals, the hotel set for us and it is not healthy at all'.

One participant complained about every aspect of the health tour.

'I will give only 5 out of 10 for this tour. I think that Dr.Banchop is more selfish than in the past. He is more businesslike. And he also kept the good things or good seats on the train for his relatives and himself. It seemed that he did not pay much attention to the tour members. The activities were not good and the staffs were not professional at all. And before the tour, the programme stated that we would have a chance to eat healthy food every meal but we didn't. The accommodation was bad too. And there were insufficient staff. So, we had to take care of ourselves'

7.2.10. Expectation and knowledge gaining

The expectation of the participants towards the health tour participation arises from the attitude towards the health tour which was partly encouraged by the media promotion. Three levels of expectation were identified. These are expressed as low, medium and high degrees of expectation.

Low degree of expectation

A low degree of expectation was expressed from some of the participants when asked about their expectation before coming to the health tour. The fact that the concept and the main activities of the health tour were advertised in media channels meant that the participants got the brief idea about it. Thus, their expectation levels were not high. Two of the comments made were;

'Before I went to the tour, I knew from the leaflet of how the tour would be like from the leaflet. So, I got the idea about what I would gain from the tour'.

'I did not expect anything before going to the tour because I knew what would be going on in the tour. I followed Dr.Satis for so long already and knew everything about it'.

Having been taken care of themselves for a long time, some participants did not have a high degree of expectation in term of getting a better health status. For example;

'I did not expect much from the tour because I have been taking care of myself for a long time. I wanted to go for it because of the lecture and some new practice'.

'I did not expect anything from the tour because I think that I know everything already. So, I just join the tour for my relaxation.'

In contrast, one of the main reasons for participants having a low level of expectation was the lack of information about health tour. Some comments were made as;

'I did not expect anything from the tour because I did not have any idea about it'.

'To tell you the truth, at that time, I really had no idea about the alternative medicine and the health tour. I just knew that it was the way to prevent the illness from the lifestyle change practice'.

Without any interest in health matter, some participants accepted that they went for the health tour with the expectation of travelling to the tourist attractions. This group of participants were all the Balavi health tour members because the Balavi tour brought their members to a number of very attractive places while the Cheewajit tour urged their members to stay in the same place all the tour period to have the very strict health activities. A lot of comments were indicated;

'I always take care of myself. So, I went to the health tour only for fun'.

'I went to the tour because I would like to have fun with friends'.

'I did not expect anything from the tour because I thought that I knew everything already. So, I just join the tour for my relaxation'.

Medium degree of expectation

Although the low level of expectation was widely expressed with various reasons, there were some respondents who expected to gain more knowledge in term of the practice, food and nutrition, stick exercise, the coffee detoxification and the water aerobic. They stated that;

'I expected to gain knowledge from the tour'.

'I expected to learn how to do exercise in water and wanted to try bathing in mineral water. I know about it from the tour programme. They are something I was looking forward to'.

Most of these had the intention to use the knowledge obtaining from the tour to adapt to their lifestyle. They would like to change their old unhealthy habit to the healthy one.

High degree of expectation

Some perceived that health tour was the alternative way to cure their illnesses. Two of the participants said that;

I had a very strong confidence that I would gain a lot of knowledge from the tour and I would get some tips for curing my cancer. I believe that Dr.Satis intended to help people without thinking of any benefit'.

'I can say that my expectation towards this tour was quite high. I expected to learn more about the alternative medicine and the way to practice the healthy lifestyle. I hope to get some new knowledge and idea'.

7.2.11. Post health tour perception of themselves

After the participants finished the health tour, they were asked about their perception towards themselves comparing the pre and post health tour participation. Two kinds of answers were expressed, which are seeing change and no change. The reasons for these two answers will be discussed.

Change

The participants could see the changes in both physical and mental aspects.

Physical changes

- Light and clean

Most of the participants accepted that they felt very light and clean in their body, which could be affected from the food controlling, the exercise, sauna and the coffee detoxification. For example;

'I can see the changes after the tour. My body is so clean and light'.

'I fell light and clean in my body causing by the coffee detoxification, sauna and healthy food'.

'After the tour, I felt so light and so comfortable with my body. I think that coffee detoxification gave the very effective effect'.

- See differences in their body

Some could see the differences in their body, especially their stomach. Two participants stated that;

'After the tour, I felt more active and I could notice that my tummy was smaller'.

'After the tour, I felt better about my body especially my stomach. I can go more easily to the toilet than in the past'.

- Better from long term pain

Some even could notice that they were better from their long term pain.

'After the tour, I felt so good about my body and my knees were much better than before'.

'I feel fresh after the tour. And my knee ache disappeared too'.

However, one participant said that she was fatter after the tour with the reason that the food in the tour was so delicious that she could not stop eating it although she was full.

Mental changes

- Determine to change lifestyle

The participants accepted that after the tour, they were so determined to change into the healthy lifestyle because they knew that it would be very beneficial to them.

'After the tour, I got a very strong intention to change my lifestyle'.

'I feel that I have a lot of motivations to do continuous exercise. I want to eat the healthy food. I will reduce my meat eating habit. And I want to eat more vegetable'.

- Changing attitudes

Many participants stated that they learned a lot from the table talk section. It changed their attitude to life.

'I felt so great after the tour. There was the table talk section which would let the tour member to share the health experiences. That made me realise that I should be more careful in term of my health practice. I mean, I should make myself as healthiest as I can. We cannot know the future'.

'After the tour, I did not feel the change in my body that much but I absolutely changed my attitudes towards life. I would like to change my lifestyle'.

'I was happy. And I learn to care people more. In the past, I thought that I could be alone and could do anything by myself. In fact, we need to care people and sometimes we need help from others'.

- Calmer

Apart from changing attitudes and determining to continue the healthy lifestyle after the tour, some of the participants felt that they were calmer than in the past from the meditation practice. Two of the participants stated that;

'My mind is so peaceful from the meditation practice'.

'I feel better in term of my mind. I know how to beat the stress. I learn how to avoid the feeling of attaching to the material things'.

- **Pride**

The feeling of pride occurred among the health tour participants, especially the participants of the Spartan Cheewajit health tour. It is the strict course to test the body and mind of those who have been practicing the Cheawajit way. One woman from the Spartan health tour said proudly that;

'I was over the moon. I could win over myself. I could practice like others. Even though it might be influence from the group force, I still feel good about myself'.

No change

As mentioned above, there is group of participants who could not see the difference after the health tour participation. Two main reasons were stated as their regular healthy practice and the short period of health tour.

- **Long time healthy practice**

As for this group, most of them were people who were interested in health and have practiced healthy lifestyle for a long time. Also, some of them experienced health tour before and knew everything. They came to the health tour again just only for stimulating themselves or social reason. For example;

'After the tour, I felt the same as before. I have been practicing Cheewajit way for a while already. I went to Spartan just to test my health and I wanted to chart my battery also. AS for my husband, he had a chance to meet a lot of new people. He rarely go out for relaxing himself'.

- **Short period of health tour**

Apart from the reason of regular practice, the short period of the health tour is another cause the participants gave for not feeling the difference between pre and post health tour participation. Two of the participants said;

'I think that I could not see much of the results from the tour because it is only the three days course. The lecturers gave the lecture in most of the time. In my opinion, I think that the lecture part is not necessary because I can read it from the books or listen from the cassettes. I think that they should have more real practice because the practice will help in term of the memory'.

'The health tour period was too short to see the differences. I think that it is the guideline to let us continue practices by ourselves when we went back home'.

7.2.12. Benefit of health tour participation

Regarding to the benefit the participants gained from the health tour, respondents mentioned two main aspects, namely physical benefits and mental benefits.

Physical benefits

Physical benefit is the major benefit that the participants gained from health tour participation. They could see the positive results in their body after finishing the health tour. For example;

'I think that the coffee detoxification is really effective. I can feel the cleanness of my body and I feel lighter also'.

'What I gained from the tour are the losing weight, the better knees and the lifestyle changes'.

Mental benefits

- **Psychological**

The health tour gave many psychological benefits to the participants. According to the interview, a large number of participants accepted that they could see the positive results in term of their feelings and state of mind. For example;

'The benefit I got from the tour was the fresh feeling. Also, I felt clean in my body and my mind'.

'I feel so much better in term of my mental part after the tour'.

Meditation was the activity which encouraged the feeling of happiness and calm among the participants. One said;

'I did the detoxification to clean up my body and meditation to clean up my mind'.

- **Educational**

More than half of the health tour participants expected to gain knowledge which could be adapted for their future life and all of them gained what they expected. The main benefit for them is the knowledge of how to take care of themselves, how to lead a healthy lifestyle and

how to avoid illness. The idea of learning the healthy lifestyle was emphasized repeatedly by these participants. For example;

'The benefit that I gained from this health tour is I have a lot more knowledge about how to take care of myself, how to choose to eat the healthy food and how to beat the stress'.

'What I gained from the health tour is the knowledge of how to lead the healthy lifestyle and living a long life without getting the serious illness. I also know how to eat properly to my age'.

Also, knowledge about illness was mentioned, especially cancer, which is a very serious illness that cannot always be cured by modern medicine.

'From the tour, I gained more knowledge about the cancer. I know that cancer can be caused by the bad eating habit. I know how to choose the right food and the learn more about kind of exercise such as the stick exercise'.

The health tour also encouraged participants to be aware of the illness around them so that they would lead their lives more carefully than in the past. One of the participants mentioned this point as;

'From the tour, I learned more about health and illness from the experience of the tour member. Their illnesses motivated me to change my lifestyle'.

Apart from the overall health practice, some participants commented that they could gain knowledge about specific activities that they cannot learn from general tour or from some institutes. For example, coffee detoxification and some special exercises were emphasized. One participant made a comment about coffee detoxification as;

'What I gained from the tour is coffee detoxification. Normally, I always have a toilet problem. I have to spend such a long time in there. After I know how to do the coffee detoxification, my problem is solved'.

Also, various exercises from the tour have been referred to. For example;

'What I really got from the tour was the Tai Chi and Chi-Kong'.

'What I gained from health tour is that I see the benefit for doing exercise and I can continue doing the stick exercise by myself at home'.

'I realised of how good it is for doing exercise. In the past, I had no time for it and now I think that I am too old to do the exercise. However, from the tour, I got some idea about the soft exercise which is more proper to me than the hard one'.

Knowledge of meditation and the ideas of Buddhism were mentioned widely by the participants. Even though Buddhism is the national religion and meditation the general practice for the Buddhists, the pace of city life does not allow the participants to practice it as they would wish. The only group in the tour who regularly practice Buddhism are the elderly. Therefore, the idea of getting benefit in terms of meditation came mostly from the young to middle aged adults rather than the elderly.

- Social

There are some people who came for the health tour with the aim of socialisation for example;

'I and my husband are getting older. We feel bored of travelling abroad. So, we think that we better join the activities that we can find people who share the same interest with us. I gained more new friends from each tour. And my husband is the representative of some group also. And now, he is the leader of the stick exercise at the park everyday in the morning'.

'The benefits that I got from the tour is having a chance to meet new people and listening to their opinion and experience about health. This helped me to widen my point of view'.

'I had a chance to meet a variety of new friends. I still keep in touch with some people from the tour'.

'I met many new people. I had a chance to share the experience with them. There were some ill people in the tour and they told us about their experience also. And now, we still keep in touch. We always made appointment to visit our ill friends'.

A few participants claimed other benefits from the tour. The first benefit involved with Dr.Satis himself. The Cheewajit health tour participants considered that it was a great honour to have a chance to meet Dr.Satis.

'One benefit is I had a chance to know Dr. Satis. I like him very much. I think that he is the one who I am happy to be with. I want to work with him and help him. He is so good to mankind'.

'What I gained from the health tour is I know the new circle of friends. I also have a chance to get to know Dr.Satis in person. He is such a great person'.

Another benefit from the health tour participation is the chance to travel.

'I have a chance to travel in the different place'.

'The thing I got from tour is the experience of travelling'.

7.2.13. Post tour practice

One of the aims of this research is to see if the health tour participants adopt a healthy lifestyle after attending the health tour. Therefore, from the 100 participants, 50 participants were interviewed immediately after finishing the health tour while another 50 participants who had attended a health tour six months previously were also interviewed. The additional questions to this second group were questions about lifestyle change.

Effects upon the participants

It is found that some participants were able to change their lifestyle having attended the tour while others could not. The explanation and the reasons for these two types of responses will be discussed.

Lifestyle change

Concerning the participants who changed their lifestyle, it is accepted that some completely changed their lifestyle while some only partly changed and some changed only temporally.

- Completely change

The first group admitted that they now fully practiced the healthy lifestyle in terms of food, exercise, coffee detoxification and meditation. Some examples are as given below;

'After the tour, I absolutely changed my lifestyle. Since then, I started to eat more vegetables and fruits. I did the fruit juice enzyme by the juicer. And I started to go for regular exercise. I did the RC water(water contain with variety of wheat) for my husband. And I and my husband go for exercise together'.

'After I finished the tour, I started doing exercise regularly. Apart from exercise, I started making the RC water by myself. I also eat the Cheewajit food. Since I started eating Cheewajit food, I do not want to eat out anymore because there are a lot of monosodium glutamate and a lot of chemical in food'.

'After attending the health tour, I still follow the practice. I do the coffee detoxification. I take more care in food selection and do regular exercise. I bought the Cheewajit cook book to learn how to cook the healthy food and how to make it delicious and beautiful'.

'After the tour, I took more care in term of food. The best thing is I started doing exercise since then. I went to the park and joined the Tai Chi group. It is like Chinese soft exercise suited for the elderly. However, a lot of adult go for it. It is such a good exercise. It helps your concentration and blood circulation. I feel like doing the meditation at the same time of exercise'.

- Partly changed

This group is the health tour participants changed their lifestyle only in some aspects. They made comments which included;

'After I came back, I did not do stick exercise at all. I did the detoxification. I try to eat healthy food'.

'After I came out, I ate less in meat and more in vegetables. I still do the stick exercise till now. However, I did not go on the detoxification'.

Temporary lifestyle change

As for this group, in the beginning, they had a strong intention to change their lifestyle. However, later on, for a variety of reasons, they found they could not continue practicing a healthy lifestyle.

One woman said that under some circumstances, she could not choose the food she wanted to eat. Therefore, she had to give up the practice. She said;

'After I first came back from the health tour, I was quite strict with my lifestyle. I changed a lot. I took more care of food. I did the RC. I did the coffee detoxification. As for the meditation and exercise, I do it as my daily routine before going to health tour. However, today, I am less strict with food than the past because sometimes I am in the situation that I cannot choose the food I want to eat. And I drink less of RC because I have no time for that'.

Some tried to be strict in term of exercise but finally gave up for the reason that they did not have time.

'After the tour, I did the regular exercise but I did not continue it because I had no time for that'.

No change

Some participants claimed that they did not change their lifestyle after the tour. The first reason is that they had been taking care of themselves before the health tour participation. Therefore, they still go on with their healthy lifestyle as the same. The health tour did not have any effect in terms of practice but in terms of social and educational aspects.

'I did not change my lifestyle after the tour because I always practice when I am home. I do exercise, yoga, stick exercise, walking around 2-5 kilometres. When I am home, I like swimming. Also, I do meditation and I eat the very healthy food'.

'After the tour, I still maintain my healthy lifestyle as I did before the health tour. I take care of food. I do exercise. I do the coffee detoxification and I also do a frequent meditation'.

'After the tour, I did not change my life that much. The thing is I am vegetarian and I do exercise regularly. So, I still keep on my practice which is more or less the same as the practice of the doctor'.

'After the tour, I did not change my life at all because I always take care of myself. The thing from the tour that I adapt to my daily life is the food. I know more about the local vegetables and herb. So, I have more varieties in food and I know which kind of food suit to some situation'

Another reason for not changing their lifestyle is their own personal inclination. They did not have a healthy lifestyle before joining the tour and they did not want to change to a very strict life. Some said that they were too busy. For example;

'When I am back, I still have the same lifestyle. I am not strict in term of food because sometimes it is difficult to do so. I hardly do the stick exercise when I am back because I am so busy with my life. I even have no time for watching TV. I have tons of work waiting for me'.

Effects upon the participants attitudes towards others

As frequently reported in the literature and observed in real life practice, women are seen as having a caring role. Therefore, this idea was investigated by enquiring if health tour participation and practising a healthy lifestyle influenced their attitudes towards others.

Encouraging others to participate in health tours

Two kinds of responses arose when the participants were asked about encouraging others to participate in health tours. The first response was that they did and the second response was that they did not.

- Encourage

After the health tour participation, these participants persuaded their family and friends to go for a health tour. However, generally they were not successful. The main reason is the price of the tour. Most of their friends and family thought that the price of the tour was too high. Another reason is that their peers do not want to adopt a strict lifestyle.

'My younger brother is very fat and has the liver problem. I persuaded him to go for health tour but he never wanted to go. He

told me that he did not want to be so strict like me in term of lifestyle'.

'I could not persuade my family member and friends to go for the health tour. They said that they could not do the practice'.

Some of their peers thought that it was just a fashion and people followed the practice because of media promotion.

'I also persuaded friends to go for it but no one was interested in it. They complained that I just follow the fashion. Some people were very annoyed when I started talking about it. They did not want to listen to me. So, I always kept my mouth shut'.

There are other health tour participants who had encouraged their friends and family to go on a health tour but had not seen the results yet. They explained why they would like to persuade their peers to go.

'I persuaded people to come for health tour because it can change their life attitude. I cannot believe myself that I would change too'.

'I encouraged my friends and family to come for the tour. I think that they should learn how to take care of themselves in the proper way. It is the necessary thing for life. There are so many toxins in the environment. We should learn about it so that we can avoid it'.

- Not encourage

Some of participants admitted that they did not have any intention of persuading their family and friends to go for a health tour.

'I did not persuade my friends to go for health tour. I think that it is quite expensive. I think that they better read books or I can teach them how to do it'.

Some did not persuade their peers because they knew that their peers were not interested in this kind of practice.

'I did not persuade any friends to go because they do not like this kind of food'.

'I did not encourage my friends to go for it because I know that they are not interested in it. When they asked me about the tour, I said it was good'.

Personal interest is another reason which made the health tour participants felt reluctant to encourage their friends to go.

'I persuaded my family members to be more careful in term of food. I did not persuade them for coming to the tour because they have

their own health activities such as yoga and aerobic. I think that health tour is really a personal interest'.

From the point of view of some a health tour is not essential. Therefore, the idea of encouraging health tour participation was skipped.

'I think that it is not necessary to go for the health tour. I did not tell my friends to go for it. I think that if they read books about health, they can practice by themselves at home. It really depends on them whether they can do it at home or not. Health tour only guides us what we should do for our health. If we go to the tour but do not practice regularly, it is useless to go for it'.

'I did not tell anyone to go for the health tour. I think that it is not the necessary thing in life'.

Healthy lifestyle encouragement to others

The majority of health tour participants claimed that they encouraged their family and friends to adopt a healthier lifestyle. They told their peers about their knowledge from the tour. Also, some practiced and asked their family members to practice with them. However, there are some people who tried to encourage their peers but failed.

- Encourage and succeed.

This group of women encouraged their peers to practice the healthy lifestyle and they were successful in it. Most of the women in this group are married women who can control the food in the family.

'All of us practice the Cheewajit way. I even persuaded all the staff in my shop to do so. I have a chef in the shop to cook for us. I told my staffs to eat more vegetables and eat the brown rice. They do so in term of food but they do not do exercise. My family goes for the stick exercise together in the morning. We are doing the detoxification'.

'My daughter and I were so eager to persuade our family member to have a healthy lifestyle. And now, our family follows the practice'.

Some women can change only some part of their families' lifestyle. For example, some can change only the food or some can only change the exercise regime.

'I asked my family to change their lifestyle. I took care of them in term of food. However, they are too busy for the exercise'.

'After the tour, I tried to take more care in term of food. I told my kids to follow the practice but they do not like it. However, at least, they do some exercise. They like to play basketball'.

- Encourage but fail

Some of the participants admitted that they tried to hard to persuade their family and friends to have a healthier lifestyle but they failed to do so.

'Sometimes I cooked the Cheewajit food to all of my family members. However, some of them did not like it. So, I have to cook the normal food'.

'I asked my family members to do the healthy activities but they were not interested in them'.

'I tried to persuade my family member to follow the practice but they did not want to do so. So, I let them think about it by themselves. It depends on the personal interest'.

'I encouraged my family to practice it since I came back from the health tour but they did not pay attention in it. They thought that I was crazy'.

- Not encourage

Apart from the participants who encouraged their peers to have a healthy lifestyle, there is another group of women who did not persuade their peers to adopt a healthy lifestyle. The first reason of this is they respected their peers' interest.

'I never forced anyone in my family to follow me. It depends on them'.

Another reason is their peers have been leading the healthy lifestyle for a long time already.

'I did not persuade my family to practice the healthy lifestyle because they are even healthier than me. They really take care of themselves in term of food and exercise'.

'I did not encourage my family member to practice the Cheewajit way because my mom does not cook. We always use the delivery service. Their food is clean and without the monosodium glutamate. I do not need to tell my parents in term of exercise because they do it regularly too. My mom goes for aerobic while my dad goes for golf'.

'I did not tell my family members about the Cheewajit because I think that their everyday life practices are exactly the same as the Cheewajit practice. They live in natural way. They do exercise regularly and they eat very healthy food'.

Some gave the reason that they did not encourage their family members about the healthy lifestyle because they were single. They live alone. Therefore, they just take care of themselves.

'I am still single. So, I have no chance to tell family member about it. I did not encourage people whom I know to go for the tour. I think that it is depended on the personal interest'.

'I had no other family member in my house. So, I just took care of myself and I let my housemaid to eat healthy food too. I told her to buy the fresh food from the reliable place and let her cook the very healthy food'.

7.2.14. Future health tour participation

Finally, the participants were asked about their plan if they would like to go for the health tour again. Various answers were given which included;

- Once a year

The majority of participants considered going on a health tour once a year enough for their health. Going once a year tour was stimulating enough for them to maintain the healthy practice life they continue doing after learning from the tour. The aim of the health tour is to teach the participants how to lead a healthy lifestyle and after the tour, the participants are expected to practice by themselves at home. Therefore, the important point is how the participants lead their lifestyle after the tour, not the frequency of the tour they attend. Some examples of the comments are as given below;

'I want to go to the health tour about once a year. I do not think that I will go so often like some people do. I want to go just to update myself about health and inspire myself in practicing the Cheewajit way'.

'I think that I may go the health tour only once a year. I know about it already. So, it is not necessary to go so often'.

Some know everything about health tour already but they still insist on going again in order to listen to the other participants' experience about their health.

'I want to go again in order to listen to others' experience about their health. I love the 'table talk' activity. It gives the chance for us to learn more about sickness or some useful point about health matter'.

- Less than once a year

Some commented that they would go for the health tour less than once a year. They thought that it was not necessary to go so often. One of woman in this group gave the reason that;

'I do not plan to go to the health tour often. I think that we can gain knowledge from books or magazines'.

- Go again under some conditions

Some participants wanted to go for the health tour again given the condition that there were new practices to adopt;

'In the future, if there are some different things in health tour, I would love to go again. If the practice is still the same, I do not see any point to go again because I think that I know everything already. I can manage to have a healthy lifestyle by myself at home'.

'In the future, I do not think that I will go for the health tour so often. I may go again if there is something new in the health circle'.

On the contrary, some wanted to go again, not because of the new practice but with the new team. For example;

'I may go to the health tour again but I may try a new team'.

'I will go to the health tour again but with another organiser. I will go with the Cheewajit magazine next time'.

- Not sure

Some people could not make a decision if they would like to go for the health tour again or not. They said that it depended on the situation such as time, money, location, team, programme or the companion. One said that she would go again if she had a companion. It seems that most of the Balavi health tour members were more concerned with the location for the next tour rather than the Cheewajit tour member. It is because the Balavi centre likes to set the tour in the tourist attraction to attract the member while Cheewajit tour set the tour in the natural resort and let member stay there for a whole period of tour. Some Balavi health tour commented that;

'In the future, I will go for the health tour again surely. However, my first consideration is the location. I want to go to the new place'.

'I cannot say how often I want to go for health tour. It depends on the location. If the location is attractive, I will go again'.

- Those who want to go again but have constraints

This group of the participant desperately wanted to go for the health tour again but have the constraints in term of time and money. The examples are;

'I want to go for the tour at least once a month but I really have no time for it'.

'I want to go for a health tour about twice a year. The money is the big obstacle for me. I will go to the tour again surely but I have to wait for a while'.

'I want to go to health tour again but not so often because it is expensive. If I have a lot of money, I may go as often as I can such as once in two months'.

- Enough

Participating in a health tour the once was enough for some of the participants. They considered they had a chance to learn how to lead the healthy lifestyle from the tour. The next stage would depend on them. The practice could be done at home regularly. Therefore, repeating of health tour is not essential. Two of the reasons given are;

'As for the health tour, I think that it should be enough for me. I learned a lot about health and healthy lifestyle and now I know how to do it. So, there is no point to go again'.

'I don't think that I will go for a health tour again. I think that one time is enough. I had a chance to learn how to lead a healthy life. And later on, it was my duty to practice it at home. I see no point to go again while I know all the theory'.

7.3. Five groups of health tour participants emerging from the qualitative analysis

One of the aims of this research was to categorise health tour participants. From the qualitative analysis, five groups of health tour participants were determined basing on their behavioural changes in healthy lifestyle adopting in relation to their health tour participation. The first three groups emerge from the experienced health tour participants, who had participated in a tour six months before the interview. The latter two groups were from the current health tour participants, who were interviewed immediately after they finished their health tour. After separating group basing on above criteria, the characteristic of each group were illustrated with the help of the cluster analysis.

The five groups are composed of;

- Group N 1 'The completely adopted' group
- Group N 2 'The partly adopted' group
- Group N 3 'The no adoption' group
- Group N 4 'The determined' group
- Group N 5 'The stable group' group

Table 0:1 Summary of characteristics of each group

Group	Name	Characteristic
N1	Completely adopted group	<ul style="list-style-type: none"> ○ Experienced health tour participants ○ Hardly led healthy lifestyle before joining health tour. ○ Viewed health tour as starting point to lead healthy lifestyle. ○ Experienced positive results from the tour and then completely changed their lifestyle into very healthy ones.
N2	Partly adopted group	<ul style="list-style-type: none"> ○ Experienced health tour participants ○ Led healthy lifestyle in certain degree before joining health tour. ○ Learned new health regimes from the tour. ○ Maintained former health regimes and added new regimes into their lifestyle
N3	No adoption group	<ul style="list-style-type: none"> ○ Experienced health tour participants ○ Led their own way of healthy lifestyle before joining health tour ○ Joined health tour with different purposes exempt of lifestyle changing. ○ After the tour, insisted to maintain their former healthy lifestyle.
N4	Determined group	<ul style="list-style-type: none"> ○ Current health tour participants ○ Never led healthy lifestyle ○ Viewed health tour as stimulator to change lifestyle into healthier one ○ Plan to lead healthy lifestyle as learned from the tour
N5	Stable group	<ul style="list-style-type: none"> ○ Current health tour participants ○ Lead healthy lifestyle before joining the health tour. ○ Joined health tour for educational benefits. ○ Planned not to change their lifestyle after joining tour.

7.3.1. Group N1 – The Completely Adopted group

This group of women are those who experienced a health tour six months before the interview took place. They admitted that after joining the tour, they completely adopted the healthy lifestyle they learned from the health tour. They would like to practice a healthy lifestyle but there was compelling motivation for them doing so. They joined the tour mainly to improve their general fitness and level of illness protection. Some expected to gain knowledge about how to lead a healthy lifestyle so that they could do it after the tour end.

The majority of them considered the health tour as a starting point for changing their lifestyle to a healthier one because they could not control themselves to lead a healthy lifestyle. They expected that the health tour would help them to start and encourage them to continue doing it. More than half of them expected the health tour could help them to overcome their illnesses.

Due to the lack of a healthy lifestyle, after the tour ended, the majority of them could feel the differences in their body, especially feeling lighter and cleaner in their body. Right after the tour ended, sixty percent of these women in this group were determined to change their lifestyle and it was demonstrated that one hundred percent of them could completely change their lifestyle into the healthier ones. They also encouraged their family and friends both to join the health tour and to lead a healthy lifestyle.

Slightly more than half of women in this group are below 50. Half of them graduated abroad and were employed with a reasonable salary. Two thirds live in houses and condominiums. However, only 30 percent claimed that they owned the accommodation. Slightly more than half of them have a car.

7.3.2. Group N2 – The Partly Adopted group

Women in this group partly adopted the healthy lifestyle they learned from health tour they joined six month before they were interviewed. All of them claimed that they led a healthy lifestyle to a certain degree before joining the tour due to their past experience of fitness and illness cures. Their main motivation for joining the tour is illness protection followed by the need to gain more knowledge about how to lead a healthy lifestyle. About half of these women perceived the health tour as an activity to change their lifestyle into a healthier one and one third of them thought the health tour may help them cure an illness.

As said earlier, they had been practicing a healthy lifestyle to some extent. Therefore, they could not notice much change physically after the tour ended. However, they adapted some knowledge they gained from the tour into their lifestyles. Some partly changed in term of their food and some in terms of their exercise habits. Some added colonic irrigation and meditation to their lives and some paid more attention to massage and saunas. The majority of them claimed that the most benefit they gained from health the tour is educational while half of them mentioned about physical benefits. These women agreed that they would rather encourage their friends to lead a healthy lifestyle rather than suggesting that they join a health tour. The women in this group are of mixed ages and marital status. Most of them have a degree of which half graduated abroad. The majority are employed and two third of them lived in houses and condominium while the rest live in flat and terraced accommodation. Only one third claimed that they owned the accommodation. Eighty percent of women in this group have a car.

7.3.3. Group N3 – No Adoption group

This is the last group arising from the experienced health tour participants. They regularly do exercise in their leisure time. They have plenty of free time for their own leisure and for taking care of themselves. Women in this group considered a healthy lifestyle as a life without illness or 'seriousness'. In the past, more than half of them had experienced illness. Therefore, they turned to leading a healthy lifestyle. Now, they are stronger and healthier and still continue leading a healthy lifestyle. They even considered themselves healthier than their friends due to their care for their physical and mental wellbeing.

They joined the health tour because they would like to improve their general fitness and gain some more knowledge about healthy lifestyles plus the opportunity to socialise with people who share the same interests. Nearly all of them regarded the regimes in health tour as not difficult due to their long term practice of a healthy lifestyle. For the same reason, they hardly see any changes in their body after the health tour. However, nearly ninety percent of them claimed that they gained educational benefits from health tour.

Although they have very positive attitudes towards health tours, they claimed that they encouraged friends to lead healthy lifestyle rather than to join a tour. These women stated that they did not adopt the healthy lifestyle they learnt from the health tour due to the satisfaction with their long term healthy practice. Neither did they did not plan to change their lifestyle in the future.

Women in this group are over fifty years old. The proportion of single and married women is more or less equal. Most of them gained a university degree from Thailand and are employed. They mainly live in houses and most of them claimed that they owned the accommodation. The majority of them have cars.

7.3.4. Group N4 –The Determined group

Women in this group are those who joined the tour a very short time before the interview took place. These women have some similar characteristics with the Completely Adopted (N1) group. For example, they had hardly led a healthy lifestyle previously and joined the tour to gain more knowledge about how to lead a healthy lifestyle. The majority of them also viewed health tour as an activity to help change their lives into healthier ones.

Nearly half of these women did not have any idea about health tour before they participated for the first time they stated that they knew about the tour from their peers. However, once

they had heard about it, they had very positive attitudes about the tour and set their mind to join it. Apart from the intention of gaining more knowledge about how to lead a healthy lifestyle, they also wanted to improve their general fitness and protect themselves from illnesses.

Slightly more than half of women in this group considered the health tour regimes not difficult due to their commitments to participate in all activities. After the tour, about seventy percent felt lighter and cleaner in their body. All of them were determined to change their lifestyle into a healthier one. The majority of them claimed that they mainly gained educational benefits from health tour followed by the physical benefits and psychological benefits respectively. After the tour, the majority of them encouraged friends both to join a tour and lead a healthy lifestyle.

They are under fifty years old. The proportions of single and married women are more or less equal. Most of them graduated from Thai universities. They are employed and cannot choose the free time as they want. They are only free at the weekend. More than half of them live in houses. However, only thirty percent of them owned the accommodation. Around seventy percent have car.

7.3.5. Group N5 – The Stable group

This group of women have the same characteristics as the No Adoption group (N3) in the sense that they do not want to change their lifestyles following their health tour participation. They are women who joined the health tour just before the interview while the No Adoption group joined the tour six months before the interview. In their free time, these women like to do exercise and other activities which give them educational benefits such as reading or joining a part time class. They have plenty of free time for their leisure activities because most of them are retired. They have been leading healthy lifestyle due to their experience of fitness and preventative medicine.

The joined the health tour mainly to gain knowledge. Surprisingly, although this group did not want to change their lifestyle, ninety percent of them perceived that the health tour could help them change their lifestyle if they choose. Ninety percent did not find the health tour regimes difficult due to their long term healthy practice. They claimed that they gained educational benefit from the health tour. These women are over 50 years old and approximately 50% are married. They graduated from Thai universities and are employed with a high salary. They live in houses and half of them owned the accommodation. Most of them have car.

In summary, this chapter presents the background of domestic health tours in Thailand and the findings from participant observation gives an insight as to how the domestic health tours function. The findings from semi-structured interviews illustrate the motivations of the participants for joining the health tour, their decision making process and their actual health tour participation and post tour practice. As a result of the post tour inquiries, health tour participants are divided into five groups according to their adoption of healthy lifestyle following health tour participation. Three groups were derived from the health tour participants who had joined a tour six months before the interview. They are the 'completely adopted' group, the, 'partly adopted' group and the 'no adoption' group. The other two groups are derived from e those health tour participants who joined the tour just before the interviews took place. They are the 'determined group' and the 'stable group'. It can be noted that the latter two groups gave the opinion of their intention to lead the healthier lifestyle or not to do so.

7.4. The Investigation of relationship between participation in health tour and the adoption of a healthy lifestyle

This research incorporated a method in seeking to investigate the relationship between participation in health tour and the adoption of healthy lifestyle over the course of three years. Two interviews were conducted, the first in 2002 and the second in 2005. These two series of interviews were carried out to compare and evaluate the results of lifestyle adoption in relation to health tour participation. In the first survey, the participants were equally divided into two groups, those regarded as experienced health tour participants and current health tour participants. The experienced health tour participants were women who had attended a health tour six months before the current participants. These two groups were chosen in order that the pattern of healthy lifestyle adoption in the short term could be investigated so that it could be compared with the findings from the second survey three years later.

The first interview demonstrated how health tour participation could influence healthy lifestyle adoption among the participants over a period of six months and groupings of the respondents were determined. In order to investigate healthy lifestyle adoption over time, a second interview was conducted three years after the first interview. Twenty-five percent of the participants in each of the five qualitatively determined groups were interviewed by telephone.

The five groups derived from qualitative analysis were chosen as the sampling frame for the second series of interviews and 25 percent of participants in each group were sampled at

random. As opposed to the original five qualitative groupings, analysis of the responses from the second series of interviews indicates four distinct groupings which are;

- 1. those who adopted a healthy lifestyle influenced by their health tour participation (F1)
- 2. those who led a healthy life style and were not influenced by health tour participation (F2)
- 3. those who claimed not to adopt the healthy lifestyle learnt from the tour but three years later, they lead a healthier lifestyle (F3)
- 4. those who changed from a healthy to a unhealthy lifestyle three years after the tour (F4)

Table 7:2 The change of members from qualitative groups from the first survey into groups from the second survey

Qualitative Groups from firsts survey	Qualitative	groups	from	secon d	survey
		F1	F2	F3	F4
N1	10, 13, 38, 44, 47	10, 13, 38, 44, 47			
N2	41,46,48	41,46, 48,			
N3	8, 32, 39, 45		32, 39,45		8
N4	54, 60, 63, 67, 70, 71, 82,98	60, 67, 70, 82,	54,63	71	98
N5	73, 81, 87, 89, 94		73,81,87,89, 94		

7.4.1. Those who adopt the healthy lifestyle Influenced by the health tour participation

This group is the largest group composed of 48 percent from the sampling of the second interview. The majority of this group are consisted of members from group N1, N2 and N4, the characteristics of women in these groups are given in Table 9.2 above. Three years on, combining these groups demonstrates that eighty six percent from these three groups adopted a healthy lifestyle following their participation in a health tour. For example, Number 38 classified in N1 the completely adopted group has been interested in health for five years and enjoys watching health programmes on cable television. Although she had been interested in health, she never led a healthy lifestyle until she attended the health tour. From the health tour, she learned more about healthy food and the soft exercises for the elderly such as yoga, Tai Chi group and Xi Gong. After participating in a health tour, she joined Tai Chi exercise at

the park, she also practices meditation. Three years later, she still leads the healthy lifestyle she learnt from the health tour and adds more from the learning from Natural Therapy. She has also learnt more about Buddhism teaching and meditation.

In the morning, we will use the water to clean our eyes. Then, we clean our noses with water with lemonade. Then, we clean our throat with water with lemonade too. And we eat a lot of fresh fruits. I got a knee joint problem. So, the doctor asked me to eat fruits in the morning and evening. At noon, I can eat rice. In the beginning, I could not eat a lot of fruits. So, it was quite difficult for me but now it is very easy and I can eat more fruits now. For example, in the beginning, I could eat only one banana but now I can eat at least 4 bananas and eat some other fruits too. However, sometimes, I ate rice both lunch and dinner... I am interested in Buddhism's teaching. I read more about life and the change in life. The change happens every moment of life. We need to learn about change and accept it. We need to understand the cycle. It is like something happen and then it is gone such as your word, your thought or what you see from your eyes. And now, I am practicing to control my mind.

Another example is Number 44 from the N1 group, who has suffered from diabetes and migraine for a long time. In the past, she worked really hard and had no time to take care of herself in terms of food and exercise. She always had a quick unhealthy meal at work and worked until late night. She never controlled her food even though she really needed to do it for the sake of her health. She became interested in health more seriously because her body was weaker and she joined the health tour as a starting point for leading healthy lifestyle. She completely changed her lifestyle by eating the right food, doing regular exercise and colonic irrigation and practicing meditation to beat the stress of work. Three years after the tour, she still maintains all these activities because they have cured her migraine and lessened her diabetes problem. She does not need injections anymore. The meditation also makes her feel peaceful and calm.

I still take care of my food because I still have diabetic but I do not need any insulin injection anymore. My migraine is getting better from regular exercise. I never feel tired of taking care of myself. It is part of my life now. If I don't do it, I feel like I am missing something... Meditation is really good. I do not know how to explain. I can say that it will be good for you. You need to try it by yourself. And please do not feel bored. If you give up before you see the result, you will not know how good it is.

Number 13 from the N1 group was never interested in health tour from the first place. She thought that her life is fine. She joined the health tour following encouragement from her mother, who had joined the tour earlier. She learnt from the health tour that she had a problem of fatigue when she fainted while doing the stick exercise during the health tour. The Doctor on the tour suggested she change her lifestyle and gave her 14 days formula to get into

the healthy life as a starting kit. After that, she changed her diet and did exercise regularly. She also encouraged her mother and sister to lead healthy lifestyle and was successful. Three years later, she got married but still lives with her mother and sister. They always eat healthy food because her mother sets a healthy menu everyday that the chef cooks for them. Her husband changed his eating habit to be healthier one as well. She also does fasting one day a week as a detoxification. She, her mother and her sister regularly go to the gym together. They spent quite a lot of money to hire their personal trainer so that they would have the motivation to go to the gym and it works. They go to the gym 3-5 days a week and spend at least 2 hours in the gym. In the beginning, she did exercise because it was good for her health and it helped to beat the stress. Now, she realises one more benefit which is the improvement of her personality. In the past, she was too thin and lacked of self-confidence. She is now gaining weight and has more muscle. She has more confident in her appearance.

As for food, at my house, we will not eat big dinner. We eat only fruits in the evening. I do not even have salad. The dinner meal will be only fruits or sometimes the homemade soya milk. Sometimes, we cooked pumpkin soup. We emphasized big breakfast, medium lunch and less dinner. At lunch, we do not feel hungry that much because we are full from the big breakfast... I go to the gym 3- 5 days a week. I am so addicted to exercise. I feel good after getting sweat. I spent at least 2 hours per session in a gym I feel stronger after going to the gym regularly. I think that I have more muscle and am not too thin like in the past. I gained weight... I think that exercise helps a lot in term of beating the stress. Also, I think that it helps me in term of personality. I feel that I have more self-confident and better personality. In the past, I dare not to wear the sleeveless top because my arms are too small and ugly to show for public. My body looks so big comparing to my arms. Now, I feel more confident because I have bigger arms with nice muscles. I dare to wear sleeveless top.

7.4.2. Those who were not influenced by health tour

This group refers to those who have been leading a specific kind of lifestyle and did not adopt the lifestyle they learned from health tour. Two kinds of lifestyles were portrayed, which are the healthy lifestyle and the relaxed one. This group marks forty percent from the sampling population. Eighty percent of this group is mainly composed of members from the no adoption group and the stable group (N3 and N5). Another twenty percent comes from the determined group.

Those who led healthy lifestyle before joining the tour and still lead a healthy lifestyle

Women in this group have been practicing a healthy lifestyle for a long time even before joining the tour for many reasons. They joined the tour mainly for gaining knowledge about

healthy lifestyles and in relation to illness protection. After the tour ended, they claimed that they would not change their lifestyle and three years later, they still lead their same lifestyle without any influence from health tour participation. One example is number 32. She is originally in the no adoption group (N3). She has been vegetarian for more than 20 years and has always taken care of herself physically and mentally by eating healthily, doing yoga and practicing meditation. Three years later, she is leading the same healthy lifestyle. She loves travelling. She is 76 years old but can still travel, even the adventurous tour like rafting and canoeing. She joined various kinds of health tours and meditation tours because she would like to gain more knowledge about health. She learned many different things from different tours but she insisted to continue her own way of a healthy lifestyle. She claimed that it would be nice to learn more about health but she would lead the lifestyle which suited her most.

I think that I take care of my body and my mind very well. I am 76 years old now but I can travel to anywhere I want without any health problem. This year, I went abroad for three times. In September, I went to Australia for 9 days. In October, I went for meditation tour at India 16 days with Lecturer Sujin... I adapt the suitable thing in my life...I think that I have different life with other older women. Most of them do not like to travel. They like to save money. And some are not in a good condition. Some need to take care of their husbands who are ill. Some still have to take care of their business or help their children to take care of their grandchildren, etc.

Number 39 from the no adoption group has also been interested in health for 30 years because her father had a heart disease when she was 35 years old and had to strictly control his food. From this incident, her family members realised how important it was for the healthy diet and exercise. Since then, she changed her eating habit into a healthier diet. She also started going to aerobic classes. She believed in eating for the purpose of protecting herself from illness. She knew about the tour from the health lecture and she joined it because the doctor on the tour had the same policy as her about leading a healthy lifestyle to prevent illness. Three years on, she is still leading the same healthy lifestyle and she is very strong. She also participated in health activities.

I still follow the health programmes and health news. I like to watch tv for the health programme. I also like to read about health from newspaper and magazines too. I also go for health lecture. I chose to go for the one I am interested. I will not go for the same topic. I always go for the listening to the new topic which I am really interested. They also gave me the leaflet from the lecture. And I gave them to friends, family or my customers. I go for the lecture with my children, sometimes my husband or my friends.

She is also the very strict healthy eater. She said,

Sometimes I put pork and chicken in my food but we do not eat it. We put pork or chicken to make my food sweet. We will eat all the

vegetables and leave pork for the dogs. And as I said, we may eat only 2 bites for pork and chicken. We prefer to eat fish. If I really want to eat meat, I will eat a little bit to feel the taste of meat and then stop. Then, I will eat more of fruits and vegetables to clean up my body after eating meat.

The last example concerns a respondent who leads a healthy lifestyle due to her experience of illness. She was diagnosed at stage 1 breast cancer 10 years ago and underwent an operation. Since then, she started searching for information about health from the health books, magazines, television, radio and health lecture. After the operation, she changed her eating habit into the macrobiotic style and exercised regularly by walking 4 times a week and swimming once a week. She did not change her lifestyle after joining the tour because she considered herself being healthy by her way of lifestyle. Three years later, she does not intend to join a health tour again with the same reason. She claimed that she had enough knowledge about health. On the other hand, she goes to health lectures from time to time. She has no specific health interest. She can listen to any subjects, which can give her more knowledge about health and illnesses. She is still leading the same very strict healthy lifestyle.

Those who had a relaxed lifestyle before joining the tour and continue to lead the same lifestyle

One woman in this group has led the relaxed lifestyle for long and does not want to change her lifestyle. She is number 73 from group N4. She loves passive activities because she does not want to be tired. She has been interested in health for two years before joining the tour for the reason that she wants to live until 80 years old without illnesses. She started searching for information about health, health supplements and health tours. She took a lot of vitamins and supplements. However, she did not take care of her food and do exercise. After she finished the tour, she insisted that she could not change her lifestyle into a healthier with the reason that her career was the main obstacle for leading healthy lifestyle. She is a business woman who always has business meal and she eats unhealthily all the time. Besides, she would prefer to take the vitamin supplements rather than live a healthy lifestyle. It is the quick fix for her without making any effort. Three years later, she cannot eat healthily or do exercise regularly due to nature of her job. She said she could not eat healthily because she had to eat out with clients and she could not exercise because she had no time. However, she fairly admitted that it might be an excuse for the lazy woman like her. She claimed that the healthy lifestyle for her in this moment depended on the vitamin supplements and the colonic irrigation. She could not do anything with healthy diet or exercise.

*If I have more free time, I want to take more care of myself.
Actually, I think that it is just the excuse of the lazy person like me. I*

like to say that I do not have time. I want to join the health tour again but I still have to work. I am the elderly who still has to work while others can retire. As I said; I may not have a chance to eat the real healthy food. However, I take a lot of vitamin supplement. I got a lot of vitamins and the vegetable capsule to make sure that I gain enough nutrition per day.

Some of women in this group had a strong intention to change their lifestyle after attending the health tour into the healthier ones. However, they failed to do so in a long run with various reasons. These women are from the determined group. For example, number 54 has been interested in health for a long time because her aunt was a nurse and had very large collections of health magazines and books. She read them all. She also liked to read the health section in women magazines or newspapers. However, she never followed the health regimes she learnt from those materials. She liked to eat out and drink with friends. After attending the health tour, she gained more knowledge and saw the examples of illnesses causing by the careless lifestyle. The moment after the tour, she was determined to change her lifestyle. She applied for the gym, tried to eat healthier and cut down her social habit. However, this habit did not go on for long. Three years later, she still likes to read about health from many sources but hardly practice healthy lifestyle. She stated that it was really hard to change her social habit. She still loves to eat out and drink with friends as before.

I have been taking care of myself by doing frequent exercise. I like to go to the gym. I also cook for myself. I cook only vegetables and fish. I hardly eat chicken, pork or beef. However, if I have to go for party, I will eat anything I want because I think that it is like reward to myself. Also, I still drink and smoke sometimes when going out with friends.

Number 63 faces the same problem. She did regular exercise before joining health tour. Nevertheless, going to the gym seems to be the activity for socialization at the same time. She went to the gym in the afternoon and had a chat with her friends there. Then, they would go out for a very big dinner afterwards. They felt like they did a lot of exercise so that they deserved to eat nice food. She hardly thought about the healthy food in the past. After attending health tour, she learned more about the healthy diet. Since then, she told herself she would lead the healthy lifestyle. However, according to the second interview three years after attending the health tour, she admitted that she could not change her eating habit. She still goes to the gym and goes out for a big meal with her gym friends.

I do not take care of my food that much. I cannot be strict and eat only the healthy food because it is really hard to find. I do not cook for myself. I need to buy food from outside or go to the restaurant. Actually, I eat a lot of fruits and vegetables but I do not eat a lot like I did when I joined the tour. I still have the same habit. I like to go to the gym for exercise and socialise. After finishing the gym, we like to go out and have meal together. We like to go seek for the

delicious meal together. Sometimes, we buy meal to eat together at the gym. I am not serious with myself about food.

7.4.3. Those who claimed not to adopt the healthy lifestyle learnt from the tour but three years later, they lead a healthier lifestyle

There is one woman in this group. She claimed immediately afterwards that participating in a health tour did not have any influence on their lifestyle and she did not plan to adopt a healthy lifestyle. However, three years later she leads a healthier lifestyle. She changed because of her aging process and illnesses. Before joining the tour, she ate healthily and she was satisfied with her lifestyle. However, she did not do any exercise and insisted that she would not do it after the tour ended even though she knew it would be good for her. She just hated the exercise so much. Nevertheless, three years later, she does exercise regularly due to her bone problem.

7.4.4. Those who negatively changed into the unhealthy lifestyle three years after the tour

There are two women in this group, which makes only eight percent from the sampling population. Number 98 from group N5 experienced the stage one cancer and led healthy lifestyle before joining the tour. She went for the tour to learn more about health. She announced that she was satisfied with her healthy lifestyle and would continue this kind of lifestyle regardless of health tour participation. However, three years later, she stopped leading healthy lifestyle due to the reason that she was diagnosed as clear from cancer while at the same time, she had her new granddaughter.

Number 8 from the no change group (N3) also changed her lifestyle negatively into an unhealthy one due to her further study. Before joining the tour, she was a sports woman who liked to do various kinds of exercises and active activities. She also ate healthily. She has been interested in health since she was teenager. She claimed not to change her lifestyle after finishing the tour with the reason that she has led the suitable healthy lifestyle already. However, in the past two years, she has studied for her further degree. She needed to stay up till late night to read. She had to drink coffee every night and she always drinks it with food, especially the junk food such as cookies, cakes, instant noodles or pizza. Sometimes, she drove into the main street and bought food from the street vendors. She has gained a lot of weight in the past three years. She has no time for exercise she complained that she even had no time for girlie activities like going shopping or going to a spa for a massage. She promises

to herself that after she finishes course work, she will get back to her healthy life again, starting with yoga class.

In the past, I went for exercise 3 times a week but now it is only 2-3 times in a month. I am quite worried about my health and my weight. I gained 5 kilogram. I sleep late at night because I need to read. Then, I feel sleepy. So, I need to drink coffee and I need to eat something with coffee too. Therefore, I ended up eating a lot at the late night. I hope that this kind of life will end soon because I will finish the course work in this February. After that, I will get back to my old routine. I started looking for fitness now.

In summary, the follow up interviews, which were conducted three years after the first series, investigated the longer term effects that participation in a health tour has upon the participants' commitment to and practice of a healthy lifestyle. As a result of these follow up interviews, it was possible to identify women who had adopted a healthy life style as a result of attending the tour and who continue to practice this lifestyle, women who felt that they had been practicing a healthy life style and for whom the tour offered other benefits such as increased knowledge and awareness of health topics and opportunities for socialisation. In addition, there were two minority groups, the first who having completed the tour stated they would not be adopting a healthy lifestyle but who subsequently did adopt a healthy lifestyle and the reverse i.e. women who said after the tour that they would adopt a healthy lifestyle but subsequently abandoned this.

Next chapter presents the findings from the quantitative analysis consisting of the relationship of the findings from initial qualitative findings and the demographic variables.

CHAPTER 8

QUANTITATIVE FINDINGS

This chapter describes the relationship between the findings from initial open-ended questions, which were transcribed and texturally analysed, with the demographic profiles of the health tour participants. Ten individual demographic variables were identified, which were analysed quantitatively along side the initial qualitative findings, namely age, marital status, educational attainment, subject studied, educational institution, career, income, accommodation type, accommodation ownership, car ownership. This chapter is composed of three main sections. The first looks at the relationship of women and leisure, the second women and healthy lifestyles, while the third explores women and health tour participation. With the categorising of health tour participants quantitatively by cluster analysis, three groups emerge. They have been termed the 'intended group', the 'peer pressure' group and the 'illness' group. The women in these three groups originate from the same population as those categorised qualitatively. The different groups result from differences in the categorisation techniques employed.

8.1. The relationship between psychographic and demographic variables

This study adopted the pragmatism paradigm in undertaking a socio-cultural analysis of the participation of Thai women in health tours. Semi-structure interviews with 100 female health tour participants were conducted in Thailand in the Winter 2002/Spring 2003. All the interviews were recorded, transcribed, and translated before being coded for input into N Vivo software that facilitates the analysis and categorisation of qualitative data sets.

For purposes of profiling, SPSS was used as a quantitative vehicle to determine the relationships between the demographic profile of interview respondents and those themes identifying the key determinants of health tour participation that emerged out of the N Vivo analysis. The ultimate purpose of this stage of analysis was to identify, wherever possible, groupings of women that share similar patterns of health tour participation and that demonstrate similar patterns of leisure behaviour. The remainder of this chapter explores a range of variables thought to impact on participation.

Individual variables

A number of demographic variables were selected for purposes of profiling. The variables which were investigated are: age, marital status, educational attainment, subject studied, educational institution Career, income, and accommodation type, accommodation ownership and, car ownership.

The first variable chosen, age, is recognised to be a major determinant of leisure participation generally and health tour participation in particular. A study by Robinson and Godbey (1997) provides the necessary evidence to highlight the inclusion of age as a key determinant of leisure behaviour. Their study demonstrates that the youngest and eldest populations have the most leisure time compared to other age ranges.

In another study, younger women were found to do more 'active' leisure activities than older women. In terms of travel, age clearly a major form of leisure time behaviour. Age was found to influence the vacation sub-decisions such as vacation style, accompaniment, organisation mode and travel purchase (De Crop, 2000).

In view of the above studies, the ideal breakdown for the age variable would be to subdivide into decades i.e.: 20-30, 31-40, 41-50, 51-60 and women over 60. However, due to the small sample size of the exploratory interviews, the age range has been aggregated into two main subdivisions: those above and those below the age of 50.

The second variable, marital status, can affect the pattern of leisure activities and health tour participation. For example, being married and having a family can serve as severe constraints for women wishing to participate in leisure generally and health tours in particular. In view of the above, marital status has been broken down into four categories, namely: single, married, divorced and widow.

The third variable that of educational attainment level has been used as Hoyer and MacInnis (1997) among other authors have demonstrated that education is the one of the key determinants of one's occupation and therefore social class. According to the study, educational attainment is considered the most reliable determinant of consumers' income potential and spending patterns. Educational level is assigned to one of three main categories of attainment, which are sub degree, bachelor (graduate) and postgraduate. Similarly, as for subject studies, the fourth variables, three main fields of study are recognised these are science, business and others.

The fifth variable identified is the institution where these women studied, a variable which may signify the respondents' social status. For example, women who graduated abroad commonly reflect a higher economic status than women who graduated in Thailand. Equally women who studied abroad may be more aware of women rights than those who studied in Thailand.

The sixth variable is that of occupation. Hoyer and MacInnis (1997) stated that some occupations, especially those that require higher levels of education, skill or training were viewed as higher in status than some others. Furthermore, individuals with the same occupation tend to share similar income, lifestyles, knowledge and values. From the study of De Crop (2000), occupation is related to motivation and the nature of leisure activities. For example, the housewife may need to have leisure activities that are not related to the household or caring tasks. Conversely women who work in day to day repetitive jobs may need something adventurous in their free time. Careers are classified in this research into self-employed, employed and other careers, e.g. housewife, students and retired.

Income is the seventh variable, which has a direct influence on the vacation and travel experience. Lower income people tend to have a limited vacation experience (De Crop, 2000). In this research, income was divided into the individual income of all respondents and the income for the women who have spouses. Four types of income level were grouped as less than 600 Euro per month, 601-1400 Euro per month, over 1400 Euro per month and others, which refers to women who did not want to reveal their income.

The eighth variable is accommodation type. This can be used to represent ideas of status and lifestyle. For example, women who live in a condominium tend to have higher economic status than the ones who live in flats. The types of accommodation recognised in this research are house, townhouse, flat, condominium, detached house and others. Accommodation ownership is the ninth variable analysed. It can be divided into five types as the respondent themselves, their husbands, their parents, rent and others.

The last of the ten variables, car ownership, represents mobility. It influences motivation and constraints upon leisure participation. Godbey (1991) argued that mobility is one of the structural constraints upon leisure participation.

8.2. Review of women and lelsure

Table 0:1 summary of the relationships between the variables and the lelsure patterns of Thai women

Individual Variables	Leisure patterns
Age	<ul style="list-style-type: none">• Free time• Choice of free time
Marital Status	<ul style="list-style-type: none">• Free time• Importance of individual leisure• Belief in patriarchal society
Educational subject	<ul style="list-style-type: none">• Free time• Belief in patriarchal society
Accommodation ownership	<ul style="list-style-type: none">• Importance of individual leisure
Car ownership	<ul style="list-style-type: none">• Importance of individual leisure

Table 8.1 represents the summary of the relationships between the variables and the leisure patterns of Thai women in that it highlights those relationships that are valid at the 95% and 99% confidence limits, instances where no relationships exist and finally, instances where it is not possible to calculate statistical significance. The table reveals that age and marital status are those variables that most readily explain the leisure patterns of Thai women in that both are valid at the 95% level of confidence when conducting chi-squared analysis.

The variable age represents a key behavioural determinant vis-à-vis the relationship between free time and leisure participation in that it is valid at the 95% level of confidence for those respondents expressing how they spend their free time (Chi-squared value = 5.561, d.f. = 1, p = 0.018). This finding suggests that the older the respondent, the more likely they are to have free time to pursue their leisure interests.

The majority of older respondents are retired which gives them a larger amount of free time when compared to other members of the family. The pursuit of leisure activities is a mean for the occupation of their free time and also, their avoidance of loneliness (Chi-squared value = 3.614, d.f. = 1, p = 0.057).

One participant stated that;

‘Leisure can occupy my free time. If I am too free, I may think too much’.

In some cases, leisure is viewed as a social activity for older respondents. They belong to a club or society in order to make friends with people of the same age and those who share the same interests. This can be supported by the statements such as;

'When talking about leisure, I am thinking of the activities that I do with my friends, such as watching movies, listening to music in the hotel lobby, eating out and playing cards'.

Age is clearly important with regard to the ability of older women to choose those times they consider as truly 'free time' (Chi-squared value = 7.173, d.f. = 1, $p = 0.007$). Three-quarters (76%) of women over the age of 50 stated that they could choose those times they considered as truly 'free' time in which they are able to do 'their own thing'. This is due to the fact that most of them are retired. Interestingly, over half of the older respondents considered that they had more leisure time than men argue that the nature of men's careers does not allow them to have leisure time as they grow older (Chi-squared value = 5.025, d.f. = 2, $p = 0.081$). Hence, older women are able to enjoy plenty of leisure time while older men still have to deal with their businesses or their careers. This finding receives some support in that the majority of men still have higher status jobs than women in Thai society.

One of the older respondents mentioned about the difference of free time created by the nature of jobs as;

I think that I have more free time than my husband because he has more responsibility in business. His work is continuous. As for me, I still have time for myself'.

This finding is in contrast to the research of Firestone and Shelton (1994) whose study suggested that women in general would feel that they had less free time than men due to their having to take responsibility for home and family in addition in many cases to having a full time job. Conversely less than half of respondents under the age of 50 agreed that they had more free time than men. The reason is that the women in the sample who are 50 or below still have to work. Therefore, they have dual work from the career and household tasks.

As the above analysis concludes, marital status is also a key determinant of leisure patterns of Thai women and their undertaking of leisure activities as free time activities (Chi-squared value = 7.361, d.f. = 2, $p = 0.019$). For example, widows are the largest group of respondents that use leisure as an activity to occupy their free time and to avoid loneliness. Most of the women who have been widowed are the elderly. Leisure activities are ways of occupying their free time in order to minimise their grief.

In contrast, this is not the case for single women and women who find themselves divorced. Due to the fact that single women get used to being alone, loneliness does not seem to be an issue in their life. As for the divorced, they are busy with earning money to raise their children. One single mother accepted that she had to do double the work to earn more while

another single mother invests in the stock market in addition to her full-time job. Therefore, they hardly have time for leisure activities. For example;

'I had a full time job but I also had a part time job as an insurance sale representative. I was so busy and always came back home at 9 pm everyday. I had to take care of my kids by myself because I was divorced'.

'I rarely have my own leisure time. I devote my life to the family because I am divorced and raise up the kids by myself.'

When comparing the individual leisure and family leisure behaviour of respondents, it is suggested that marital status plays a significant role (Chi-squared value = 43.682, d.f. = 2, $p = 0.000$). As predicted, ninety percent of single women considered their individual leisure activities far more important than the family leisure activities while only one quarter of married women agreed this to be the case. Married women gave more weight to family-oriented leisure activities. They could postpone their own leisure to do some other times so that they could join the family leisure.

A similar pattern appears when focusing on the relationship between marital status and the belief in patriarchal society of the respondents (Chi-Squared value = 7.134, d.f. = 2, $p = 0.028$). With regard to viewpoints on Thailand's patriarchal system, married women are found to believe in it more than the others with divorced women tending to be the group who are least in agreement with this analysis. One married women stated;

'I think that we have patriarchal system in Thai society. The closest example is my family. I am always happy to be the hind leg of the elephant and let my husband lead me'.

Even though full-time jobs heighten women's role in society, the burden of housework still makes the married women think that they are inferior to men. One statement apparently supporting this view was;

'I think that our society is still the patriarchal society because both I and my husband work out of home but it is only me who does all the housework. I think that it happens in most families. Some family may have maid to help but the duty to take care of housework still mainly belongs to wife'.

In addition to the two major determinants of patterns of leisure behaviour, age and marital status, which are shown to be significant in the relationship between women and their leisure patterns, accommodation ownership is also an important determinant. For example, accommodation ownership is a key determinant when making a comparison between individual leisure and family-oriented leisure activities (Chi-Square valued = 12.707, d.f. = 4,

$p = 0.013$). Predictably, married women (living in their husband's accommodation) are the largest group who place emphasis on family rather than individual leisure.

Accommodation ownership also affects the respondents' choice of free time (Chi-Squared value = 11.121, d.f. = 4, $p = 0.025$). Accordingly, the two largest groups of women who can select their free time are women who owned the accommodation themselves and those who rent. In contrast, women who have the least free time are women who live with their parents. The reason is those who own accommodation and who rent are mostly the older women who retired from work while those who live with their parents are younger ones.

The subject studied by the respondents also appears to influence women's leisure patterns. The idea of performing leisure activities as free time activities is represented differently according to the subject studied (Chi-Squared value= 5.348, d.f. = 2, $p = 0.069$).The results suggests that women who studied sciences tend to use their leisure activities for the purpose of occupying their free time more than those who studied other subjects.

The belief in a patriarchal system is also differentiated among the respondents who studied different subjects (Chi-Squared value = 7.560, d.f = 2, $p = 0.023$). It is demonstrated that the respondents who studied science hardly believe in the patriarchal system comparing to the respondents who studied business and other realms. The reason is maybe because they became more objective in their approach to life and rather less subjective.

These results also suggest that car ownership affects the relationship between women and their leisure pattern in term of the comparison between individual leisure and family leisure (Chi-squared value = 4.791, d.f. = 1, $p = 0.029$). It is found that nearly half of women without a car considered their leisure activities as free time activities, while less than one third of women with a car agreed this to be the case.

8.3. Review of women and healthy lifestyle

Table 0:2 Summary of the relationships between the variables and healthy lifestyle of Thai women

Individual Variables	Health lifestyle
Age	<ul style="list-style-type: none">• Perception of health status
Educational Level	<ul style="list-style-type: none">• Perception of healthy lifestyle as life without illness combined minor aspects• Attitude towards healthy lifestyle as practicing healthy life
Car ownership	<ul style="list-style-type: none">• Perception of healthy lifestyle as life without seriousness

The relationship between the respondents and a healthy lifestyle is reviewed in this section. The health tour respondents were requested to express their opinion about their attitude towards the phrase 'healthy lifestyle' and the motivation for them to practice a healthy lifestyle. Also, the perception of the respondents towards their own health status was discussed.

Considering the concept of a 'healthy lifestyle', it can refer to both physical aspects, such as a life without illness, practicing a healthy life style, an active life or a 'nature pursuit' life; and mental aspects, which refer to a life of religious practice, a non-serious life and a life without loneliness. Similarly the motivations given by the respondents for practicing a healthy lifestyle can be divided into two main aspects, these are physical and mental.

When the respondents were asked about their perceptions of their own health, three types of perceptions were mentioned, which were; better than women of the same age, worse than them, the same status as them, and depended on the nature of their health since they were born.

However, applying the Chi-square test to the relationship between the different variables and the healthy lifestyle behaviours of the health tour respondents, demonstrates that not all the patterns are determined by all the variables. The variables which are found to have some effects upon behaviour in respect to a healthy lifestyle are age, educational attainment and car ownership.

The variable age represents a key behavioural determinant of one of the motivation for the respondents to practice the healthy lifestyle, which is physical motivation, (valid at the 95 % level Chi-squared value = 5.953, d.f. = 1, $p = 0.015$). More than half of women above 50 practice healthy activities as their physical leisure activity while less than one third of women who are below 50 do so.

Age is important with regard to the perception of the respondents towards their own health in this survey more than 70 percent of women who are over 50 perceived themselves as having a better health status than people who are of the same age due to their physical care (Chi-squared value = 13.091, d.f = 1, $p = 0.000$). By comparison only one third of younger women stated this.

The older women perceive that their friends face a lot of illnesses while they are strong without any major or even minor illnesses. Some participants claim that their healthy

conditions result from their strict eating habits and others from regular exercise. The idea of having strict eating habits is expressed as;

'Comparing myself to friends, I think that I am in a better health condition because I stopped eating hot an spicy food, meat and a lot of bad stuffs. I eat only fish, vegetables and fruits'.

Regular exercise is another reason which ensures that health tour participants think that they have a better health than their friends.

'Comparing to friends, I think that I am in a better health status because I have been doing regular exercise for 2 years already. I can notice the difference of my body before and after the exercise period. I feel more active'.

Moreover, some of the women who are below 50 perceive themselves as having a worse health status than people who are of the same age due to their illness, both major ones such as cancer and minor ones such as asthma and migraine (Chi-squared value = 3.183 , d.f. = 1, p = 0.074). The experience of previous operations also discouraged the participants from thinking that they were strong. It may be the fact that in some cases, the operation left the patients feeling weak afterwards no matter how long ago it occurred;

'I think that I am in a worse health condition than my friends because I had a hysterctomy.

Insomnia can be the reason for the participants to perceive themselves as a weak person comparing to their friends. One of the women under 50 said;

'Comparing myself to my friend, I think that they are in a better health condition than me because they have a chance have enough sleep. If I had enough sleep, I believe that I would have the same health status as them or even better.'

The educational attainment is also shown to influence healthy lifestyle patterns among the respondents. It is found that the higher levels of education have the greatest effect upon the attitudes of the respondents towards a healthy lifestyle as a life without any illness combined with 'minor' aspects such as an independent life, a natural life and a happy life (valid at the 95% level Chi-squared value = 7.832 , d.f.= 2, p=0.020). More than 80 percent of women who either gained sub degree and post graduate degree qualifications considered a healthy lifestyle as life without illness while less than two third of the graduated women stated so. One of the comments is shown below:

'Healthy lifestyle is life without illness. It is a life that you can depend on yourself. You do not have to ask somebody to help you.

The level attained in higher education is also a determinant for the attitudes towards practicing a healthy life (Chi-squared value = 5.529, d.f. = 2, $p = 0.063$). It is found that the women with sub-degree qualifications pay less attention to this than do the graduates and the post graduates. Less than one quarter of them stated this while about half of the other two groups of women did so.

The idea of 'healthy lifestyle' is one that combines healthy food and regular exercise. In some cases, healthy food consumption and regular exercise had been practiced a long time before attending the health tour. In other cases, these activities have been encouraged by health tour participation. Many respondents who gained qualifications than higher sub degree diplomas accepted that they never thought of either taking regular exercise or eating healthy food until they attended the health tour. Doctors on the health tour gave examples of the results of having an unhealthy lifestyle, which led them to realise the importance of good food and regular exercise. Therefore, when being asked about the healthy lifestyle, these two activities were widely mentioned. For example;

'Concerning the phrase 'healthy lifestyle', I am thinking of the right way of eating. You have to eat non-chemical food and emphasise a lot of vegetables. I also think of doing exercise, travelling, relaxing, reading the books which can give me the knowledge about health, taking care of my health, reading religious book and doing meditation'.

The last aspect of healthy lifestyle patterns which is affected by educational attainment is the motivation for having a healthy lifestyle relates to the need to consider preventative medicine rather than curative medicine (Chi-squared value = 4.847, d.f. = 2, $p = 0.089$). It is suggested that practicing healthy lifestyle can be regarded as a form of preventative medicine. The largest group of women who give importance to this point where the women whose highest qualification is at sub-degree level. More than two thirds of these view practicing a healthy lifestyle as preventative medicine while only slightly more than one third of the graduates and postgraduates agree with this point.

Preventative medicine has been paid more attention to recently than has curative medicine because of the rise of 'new' illness from new viruses. Moreover, modern medicine cannot apparently find ways to cure some of these new illnesses. Therefore, more and more people believe that it is better to take care of themselves and become stronger so that they will not fall ill. Apart from new illnesses, there are still some old illnesses that cannot be cured by modern medicine such as cancer, diabetes and heart attacks. Thus, preventative medicines have become more popular (Shealy, 1996).

Apart from the fear of severe illness, the apparent failure of modern medicine to cure their illness leads to the interest in the preventative medicine for the participants. Some of the participants had had body weaknesses before and had tried modern day medicine to cure their weakness but it seemed not to be very efficient. As an alternative, they turned to practice preventative medicine by changing their lifestyle, which had proved very successful. Thus, they have been continuing this practice until the present day.

Apart from the two major determinants of patterns of healthy lifestyle behaviour, age and educational attainment, car ownership is also an apparent determinant. For example, car ownership is a key determinant for the idea of attitudes towards the word 'healthy lifestyle' of the respondents in term of enjoying a life without seriousness (Chi-squared value = 4.827, d.f. = 2, $p = 0.089$). Only half of the women who have a car perceive that a healthy lifestyle is life without any seriousness while about seventy percent of women who have no car stated this.

'In my opinion, the healthy lifestyle means the happy life without any seriousness and headaches'.

8.4. Review of women and health tour

Table 0:3 Summary of the relationships between the variables and health tour participation of Thai women

Individual variables	Health tour participation
Age	<ul style="list-style-type: none">• Motivation of joining the tour as improving quality of life• Motivation of joining the tour as socialisation• Information obtaining about health tour• The results after the tour ended• Benefits from health tour
Educational Level	<ul style="list-style-type: none">• Motivation of joining the tour as preventative medicine• Motivation of joining the tour as improving quality of life• Motivation of joining the tour for gaining knowledge• Motivation of joining the tour by curiosity• The encouragement towards their peers to join the health tour
Educational Subject	<ul style="list-style-type: none">• Motivation of joining the tour as socialisation• Motivation of joining the tour to please the persuader• Information obtaining about health tour• The results after the tour ended
Educational Institute	<ul style="list-style-type: none">• The encouragement towards their peers to join the health tour
Career	<ul style="list-style-type: none">• Motivation of joining the tour for relax• Motivation of joining the tour to meet famous doctor
Accommodation owner	<ul style="list-style-type: none">• Motivation of joining the tour for improving quality of life• Benefits from health tour
Car ownership	<ul style="list-style-type: none">• Information obtaining about the tour

Table 8.3 presents a summary of the relationships between the variables and the participation in health tours by Thai women.

Based upon the interviews, the motivations for health tour participation will be discussed, beginning with the decision making process which starts with the pre purchase search which is influenced by and participants' attitudes towards the health tour which are affected by information obtained during the search. As part of the process of decision making, information about health tours is available from many sources such as books, magazines, newspapers, television, radio, peers, lectures, websites and direct experience. After gaining some ideas about health tours from the information sources, the participants were shown to

have a range of attitudes towards health tours such as health tours will help in changing lifestyles, overcoming illness, etc. Practical details about health tours such as price, time, place, the regimes, the compliments and complaints were also discussed with the respondents. The views of the women about the health tour regimes are reviewed as is their perception towards themselves after the tour and the level of satisfaction they gained from having participated in the tour. The final topic investigated what the benefits of the health tour were. Finally the idea of future health tours and whether the respondents join other health tours in the future and whether participation in the health tour would change the lifestyle of participants is reviewed.

The motivations of health tour participations have been shown to include: health and well being, the need to improve their general fitness; protection against illness, a need to improve the quality of life, to improve knowledge; to relax; as a beauty therapy; socialisation; the opportunity to meet 'famous' doctors; general curiosity about health tours and to please those who had persuaded the respondent to participate in the health tour.

Relationship between different variables and health tour participation

The relationship between the variables and health tour participation behavioural patterns was tested by the Chi-square test to confirm the significant of the differences. According to the test, it is indicated that not all the variables can affect the behavioural pattern of health tour participation.

It is found that only seven variables are significant as determined by the Chi-squared tests. They are age, educational attainment, educational subjects, ownership of accommodation, occupation, Higher education and car ownership. These variables have been ordered in relation to the number of behavioural patterns in which they played an important role.

Age greatly affects the significance of health and well being as an aspect of the need to improve the quality of life as a motivator of health tour participation. (Chi-squared value = 3.561, d.f. = 1, $p = 0.061$). Less than 30 percent of women above 50 expected that health tour would help them to improve their quality of life while twice that percentage of women below 50 believed health tour participation would improve their quality of life. The reason may be that some older women have been practicing a healthy lifestyle for a longer time due to their having plenty of free time and as a result they were satisfied with their lifestyle and quality of life. Conversely women below 50 are still busy with their family and work, which prevents them from reaching their expected quality of life. For example, one woman stated;

'Two main reasons to go for the health tour are that I want to encourage myself to take up to exercise again. Also, I have no time to practice healthy lifestyle in my daily life. Therefore, at least, I had a chance to do so in the health tour. And I hope that I will maintain a healthy lifestyle in the future'.

Socialisation is another of the motivations for health tour participation of the respondents which is affected by the variable age in that it is valid at the 95% level of confidence (Chi-squared value = 4.675, d.f. = 1, p = 0.031). It is suggested that older women seek more for socialisation than do women in the younger age groups. It appears that nearly half of women over 50 years old give importance to having a chance to socialise with new groups of friends from the health tours while only 20 percent of women below 50 give this reason. One health tour participant frequently participate in health tour for the reason that;

'You may wonder why I like to join the health tour so often. The reason is I and my husbands are getting older. We feel bored of travelling abroad. So, we think that we better join the activities that we can find people who share the same interest with us. I gain more new friends from each tour. And my husband is the representative of some health tour group also. And now, he is the leader of the stick exercise at the park everyday in the morning'.

Age also appears significant in relation to the method of obtaining data about health tour from books and magazines with the validity of confidence as 95 % (Chi-squared value = 5.818, d.f. = 1, p = 0.016). It is suggested that women who are below 50 are more likely to read books and magazines about health more often than women of an older age. More than half of them stated that they knew about health tour from the magazines and books while only one third of women in older age category referred to these sources.

This research involve two health tour organizations, Cheewajit and Balavi. The Cheewajit organization produces a monthly magazines and Dr. Satis, the leader of the organization has written many books about the Chewajit practice. Therefore, Cheewajit practice was well known by the younger women who like to read books and magazines. Some of the respondents mentioned their information sources and their ideas towards the health tour obtaining from these sources.

'I have been interested in health for 2 years already. I have read a lot of magazines about health and the Cheewajit practice. I tried to follow the books. However, I think that I should learn directly by taking a health tour'.

'I wanted to go to the health tour because I read a lot about healthy lifestyle practice but I was not sure if I practiced in the right way as suggested in the book. So, I wanted to assure myself by attending a health tour'.

On the other hand, Dr. Banchop's tour does not produce a magazine even though Dr Banchop has written a lot of books about the practice. Some of the Balavi tour members knew about the Balavi centre from information Dr.Banchop mentioned at the end of his books. Therefore, they went to the Balavi centre or called the office to ask about the schedule of the health tour. Some applied for membership of the centre so that they could get the monthly leaflet about the latest health news and the health tour schedule.

Considering changes among the respondents after health tour participation; age affects three types of change, which are physical change, mental change and no change.

Physically, some of the respondents argued that they could see differences in their bodies (Chi-squared value = 6.889, d.f. = 1, $p = 0.012$). More than one third of the women below 50 stated that they could feel that their bodies were different compared to the pre-health tour period while less than 15 percent of women above 50 stated this. The reason may be that many of the women over 50 have been practicing a healthy lifestyle for a long time while younger women hardly found time to lead healthy lifestyle. Nearly half of women above 50 stated that they could not see any difference between the pre and post health tour practice. This idea appears to be at a 99% level of confidence (Chi squared value = 10.340, d.f. = 1, $p = 0.001$).

Mentally, more than half of women under 50 stated that as a result of participating in the health tour they were determined to change their lifestyle to a healthier one while only 20 percent of women above 50 stated this. This idea is strongly supported by the Chi-squared test in that it is 99 % level of the confidence (Chi-squared value = 12.267, d.f. =1, $p = 0.000$). As mentioned earlier, women above 50 have been practicing the healthy lifestyle for a long time. Therefore, they were not motivated to change their lifestyle.

Lastly, age is the key determinant in terms of respondents saying that they gained physical benefit from health tour at the 99% level of the confidence (chi-squared value = 11.864, d.f. = 1 , $p = 0.001$). According to the statistic, women below 50 gained more physical benefits, twice that of women above 50.

Educational attainment is also a key determinant for the relationship between women and health tour participation. For example, the highest degree of education can affect three of the motivations for health tour participation by the respondents. Firstly, is the idea of health and well-being in terms of improving the quality of life of the respondents (95% level of confidence Chi-squared value = 8.646, d.f. = 2, $p = 0.013$). Nearly half of the graduates long for an improvement in their quality of life as a result of health tour participation while only 6

percent and 20 percent respectively of women who held sub degree qualifications or were post graduates stated this. Most of the graduates seem to have less time for themselves to practice healthy lifestyle compared to other women interviewed. Therefore, they need to be encouraged by the doctors who ran the health tours to improve their quality of life.

Secondly, the health and well being motive is further emphasised in the sense of gaining knowledge from health tour so that the respondents could adapt this knowledge to their daily life (Chi squared value = 5.790, d.f. = 2, $p = 0.055$). It is found that the graduates are the largest group (78%) seeking for knowledge from the health tour participation while the smallest groups are women who earned sub degree with less than 50 percentage interested in gaining knowledge.

'The main motivation for me to attend the health tour is wanting to gain more knowledge about health matters'.

The specific knowledge which can be obtained by health tour participation was discussed such as the food, the stick exercise, water therapy, meditation and coffee detoxification. Some of the examples are;

'I wanted to see how they cooked healthy food so that I could do it at home'.

'I wanted to go to the tour because I wanted to learn how to do the coffee detoxification, eat the healthy food and do the stick exercise.

I have heard that stick exercise is the best exercise because it helps us in term of our flexibility and strength'.

The last motivation for health tour participation which is affected by the educational attainment is curiosity (95% level of confidence Chi-squared value = 7.668, d.f. = 2, $p = 0.022$). The post graduates appear to be the largest group (47%) who joined the tour because they would like to know what in practice would go on on the tour while the graduates are the smallest group (17%). Some of the post graduates stated;

'I read Cheewajit magazine and learnt a lot of new things but I had never tried it. Therefore, I would like to try it and see if it is efficient as the magazine said'.

Besides this, educational attainment is also the key determinant for the relationship between the respondents and the encouragement of the health tour participation among their friends (Chi-squared value = 5.159, d.f. = 2, $p = 0.076$). It is found that only half of the post graduates would encourage their peers to join the tour while three quarters of the graduates and women who got the sub degree did so.

Some of the post graduates gave the reasons that they could tell their peers about the healthy lifestyle practice so that their peer did not have to go for the health tour.

'I did not tell them to go to health tour but I told them: how to lead a healthy lifestyle'.

Personal interest is another reason which made the health tour participants felt reluctance to encourage their friends to go for it.

'I think that health tour is very interesting but I did not think that I should tell everyone about it. I told only friends who seem to be interested in health matter unless those who were not interested in health tour might feel annoyed of me'.

Apart from the age and educational attainment, educational subjects appear to be significant for the relationship between women and health tour participation. For example, two motivations of health tour participation are highly affected by the academic subjects studied by the health tour respondents. The first one is socialisation (Chi-squared value = 8.398, d.f. = 2, $p = 0.015$). Nearly half of women who studied business and science aimed to socialise with people who share the same interest from the health tour. On the other hand, women who studied other subjects did not pay much interest in socialisation with the other health tour participants.

The second motivation for the health tour participation of the respondents is the intention to please those who persuaded them to go on the health tour (Chi-squared value = 4.695, d.f. = 2, $p = 0.096$). It is found that women who studied science tend to care more of the persuaders than women who studied business and other subjects.

The educational subject studied also affects the source of information about health tour used by the respondents. In the case of obtaining information about health tour from television (95 % level of confidence, Chi-squared value = 8.690, d.f. = 2, $p = 0.013$), it appears that women who studied business are the largest group (32%) who knew about health tour from the cable television. The programme about health tour is shown in the afternoon. Therefore, it may be that this group of women may have their own business or have an afternoon free so that they can watch the programme. In contradiction, none of women who studied sciences got information about health tour from the television.

After the health tour participation, some of the respondents could see the changes, physically and mentally and some could not. Subjects of study are key determinant for the physical change in term of feeling light and clean of the respondents (95 % level of confidence Chi-squared value = 7.265, d.f. = 2, $p = 0.026$). It is indicated that two third of women who studied

other subjects could feel a physical change while only one third of women who studied business felt the same.

The ownership of accommodation is one of the variables which affect the relationship between women and health tour participation. For instance, one of the motivations for health tour participation, the improvement of quality of life, is affected by ownership of accommodation. For example only around one quarter of women who live in their own house or their husband's house give importance to the idea of improving their quality of life through health tour participation. Conversely between half and three quarters of women who live in other types of accommodation regard improving their quality of life as an important outcome of health tour participation (Chi-squared value = 10.493, d.f. = 4, $p = 0.033$). The reason may be that women who live in their own accommodation are mainly single women over 60 who always practice the healthy lifestyle and are satisfied with their quality of life. Therefore, improvement of quality of life is not a benefit they sought from health tour participation. As for the other, often younger women, they still long for an improvement in their quality of life which they expected to get from the health tour participation. For example;

'I wanted to learn how to eat healthily. I thought that health tour could force me to eat healthy food. If I am in the everyday circumstance, it is so hard to control myself to avoid the junk food.'

'I knew how the health tour would be like before I joined it. I thought that health tour would help me to put myself under the condition for exercise. I wanted to start exercise again'.

The respondents were asked to comment on changes after their health tour participation. The three answers given were physical changes, mental changes and no change. All three answers appear to be influenced by the ownership of the accommodation they live in. Physically, the respondents felt light and clean in their body after the health tour participation (95% level of confidence, Chi-squared value = 10.721, d.f. = 4, $p = 0.030$). More than half of women who live in other accommodation owner types felt light and clean in their body while only one third of women who live in their own accommodation felt so. The reason is that most of the women who live in their own accommodation are single, divorced or widow age above 50. They have more time for themselves compared to the married younger women who stay in their husbands', parents' or other types of accommodation. It is indicated that more than fifty percent of women who live in their own accommodation have practiced a healthy lifestyle for a long time before participating in a health tour while less than one quarter of the other women have done so. Therefore, they could not see any changes after the health tour participation (95 % level of confidence, Chi-squared value = 11.837, d.f. = 4, $p = 0.019$).

'After the tour, I could not see the difference of myself. I think that it is because I always practice healthy lifestyle when I am home. I do exercise, yoga and stick exercise, walking around 2-5 kilometres. When I am home, I like swimming. And as you know, we eat the very healthy food. I also do the meditation. So, I cannot see the very obvious effect from the health tour'.

Mentally, some of the respondents stated that they were determined to change their lifestyle to a healthier one (99% level of confidence Chi-squared value = 13.321, d.f. = 4, $p = 0.010$). It is found that one hundred percent of women who rent their house could feel the mental change and more than half of women who live in accommodation owned by the others felt the same. On the other hand, less than one third of women who live in their own house wished to change their life style. A possible reason mentioned above is that the women who live in their own accommodations are mostly single women over 50 who have been practicing healthy lifestyle for a long time. Therefore, they did not have the same determination to change their lifestyle.

The career of the respondents is clearly important with regard to the relationship between women and health tour participation. Two of the health tour motivations are affected by the career of the respondents. They are, the need to relax, (Chi-squared value = 8.779, d.f. = 2, $p = 0.012$) and an interest in meeting the famous doctors who are the key leaders of the health tours (Chi-squared value = 5.636, d.f. = 2, $p = 0.060$). One third of self-employed women considered relaxation as a motivation for health tour participation while none of women in other careers thought about this. The nature of the occupations for self-employed women may be more demanding than with other types of occupation.

Also, none of women in other occupations mentioned about wanting to meet the famous doctors as one of their motivations while one third of employed women expected to meet the

Considering changes in the respondents after health tour participation, it is found that the occupation of the respondents has a great effect upon the idea that health tour participation did not affect any physical or mental changes due to the short period of the tour; (95% level of confidence Chi-squared test = 6.070, d.f. = 2, $p = 0.048$). Women with other careers are the largest group which commented that the period of health tour was too short to notice physical or mental changes while employed women were the smallest group who commented of this aspect.

The institute of the higher education the respondents attended also appears to influence the relationship between women and health tour participation in the sense of the encouragement by the respondents to their friends about the health tour participation (95 % level of

confidence Chi-squared value = 6.084, d.f. = 2, $p = 0.048$). It appears that only one third of women who graduated abroad encouraged their friends and relatives to join the health tour while more than seventy percent of women who graduated from institutes in Thailand encouraged their peers to attend the tour.

Seventy percent of women who graduated from Thai universities accepted that they encouraged their peers for the health tour participation for reasons such as;

'I encouraged my friends to go for the tour so that they would have a chance to clean their body and mind, learn more about health and get some motivation for practice the healthy lifestyle'.

'I want them to learn how to eat more of vegetables. And if they have the problem of their stomach, they will learn how to do the detoxification'.

However, women who graduated abroad consider health tours as something which are not essential for life. Some of the comments are;

'I think that it is not necessary to go for the health tour. I did not tell my friends to go for it. I think that if they read books about health, they can practice by themselves at home. It really depends on them whether they can do it at home or not. Health tour only guides us what we should do for our health. If we go to the tour but do not practice regularly, it is useless to go for it'.

It is likely that those women who graduated abroad would prefer to encourage their friends and families to practice a healthy lifestyle rather than participating in health tours.

'I tried to persuade my family members to practice the healthy lifestyle. I cooked for them. I told them about how to take care of themselves'.

'I learned how to cook the healthy food from the Cheewajit cook book. I eat healthier food and so do my family member because I take care of them. I also encouraged them to go for exercise together'.

The last variable which appears to be significant for the relationship of women and health tour participation is the relationship between car ownership and the use of books and magazines as sources of information about health tours (Chi-squared value = 6.464, d.f. =1, $p = 0.011$). It is found that more than half of women who have a car knew about health tour from health books and magazines while only one quarter of women who have no car knew about health tours from these sources.

Apart from investigating the relationship between the initial findings and profiles of the participants, this study aims to categorise health tour participants. The classification reviews

in the previous chapter categorised health tour participants based on the qualitative data analysis. In contrast, this chapter categorises health tour participants on the basis of quantitative data analysis. Three groups of health tour participants are determined with the help of cluster analysis. The characteristics of these three groups are explained in the next section.

8.5. Three groups determining by the Cluster analysis

To begin with, the profiles of women in each group are illustrated followed by their shared characteristics in relation to leisure, healthy lifestyle and health tour participation.

8.5.1. Group C1 – The Intended group

This group is the biggest group among three categories of health tour participants, composing of 48 % from all participants. Two thirds of women in this group are under 50 years old and half of them are married while forty percent stay single. The rest are divorced or widowed.

The majority of them graduated and one third of them graduated from abroad. This indicates that at least one third of them are from well-to-do families which can support overseas education. The majority of them are employed with good salaries. The majority of this group live in houses or condominiums but only one quarter claimed that they owned their accommodation. The reason is because as for the married women, it is likely that the accommodation belongs to their husbands. As for the single women, they tend to live with their parents. Most of the women who own accommodation are likely to be the older ones. In this group, only one third of participants are over 50 years old. The majority of this group owns a car, which gives them mobility and freedom.

Two thirds of the women in this group claim that leisure activities were important to their lives because they could give physical benefit. It can be said that these women do exercise as their leisure activities. About half of women in this group stated that they could gain more knowledge from their leisure. Reading is the main activity for these women. Only the minority of this group considered leisure as an activity to occupy free time, avoid loneliness or for escapism.

When talking about healthy lifestyle, two main attitudes were equally illustrated among women in this group. The first view perceives healthy lifestyle as a life without illness and seriousness while the second view perceives it as healthy practice life. More than half of them claimed that they took good care of themselves physically and twenty percent mentioned

about mental care. Few of them mentioned about their illness or non physical and mental care, which results in poor health. Women in this group aim to lead a healthier lifestyle because of their experience of fitness. They experienced illness in the past or saw their friends and families being ill. Preventative medicine is another focus so that they will not experience illness in the future. The majority of them joined health tour with the aim of gaining knowledge from the tour lectures and practice so that they can use it in the future. Besides, they also aim to improve their general fitness from the practice in the tour. Around two third of them claimed that they joined the tour for illness protection and half of them would like to improve their quality of life.

This group of women are interested in health matters but they need to know more about healthy practice, which led them to join the health tour. It was evident that half of the women in this group know about health tour from health books and magazines. The attitude of the majority of women in this group towards health tour is that the health tour will help them to change their lifestyle into the healthier one. Around one quarter of them mentioned about overcoming illness.

After the tour ended, the majority of them said they could see changes in their bodies. They also felt lighter and cleaner. Half of them felt calmer and were determined to change their lifestyle it healthier ones. Only a few of them could not see the changes due to their long time healthy lifestyle and the short period of health tour. Educational and physical benefit from health tour participation were the benefits most often mentioned by the health tour participants.

To sum up, some of women in this group do exercise as their leisure activity. However, they do not consider themselves leading a fully healthy lifestyle. The health tour is their answer. They join the tour with the aim of gaining educational benefit about how to lead a healthy lifestyle. Statistically, this group is the biggest group which notice physical and mental changes after joining the tour. They are also determined to lead the healthy lifestyle which they learnt from the health tour.

8.5.2. Group C2 – The Peer Pressure group

This group is the smallest group of the three groups emerging from the cluster analysis. It is composed of twenty women. The age of women in this group divides equally between those below 50 and those over 50 years old. Nearly half of them are single while one third are married and the rest divorced. Two thirds of them graduated while the rest held sub-degree

qualifications. Half of them graduated from Thailand while the other half graduated from abroad.

The majority of them are employed by government or both public and private company while the rest are self-employed. They and their families earn a reasonable salary. The majority of them live in either a house or a condominium but only one quarter claimed that they owned their accommodation. As with group C1, it is likely that women have less chance to own accommodation than men.

Leisure is important to women in this group in the sense that it can give them knowledge. Physical benefit is another point which these women focus on. Contrary to group C1, nearly half of women in this group use their leisure to occupy their free time and avoid loneliness while only a few women from group C1 stated the same thing. The reasons maybe because it is only one third of women in this group are married. Composed mainly of single women, divorcees and widows this group considers individual leisure more important than family leisure.

The majority of women in this group consider a healthy lifestyle as life without illness and seriousness. Nearly half of them mentioned about active and healthy practice lifestyles. Twenty percent of this group mentioned about religious practice life as part of a healthy lifestyle. This group of women lead healthy lifestyle to some extent. More than half of them experienced illness in the past. Therefore, they lead a healthy lifestyle to protect themselves from illness as a form of preventative medicine. One third of them also consider leading healthy lifestyle as their physical leisure activity. Slightly less than half of women in this group view themselves as in a good health when comparing themselves to their friends in the same age due to their physical care. As for the rest, they view themselves have normal health status. Few consider themselves as having a worse health status than friends due to their past illnesses.

This group of women are satisfied with their lifestyle and had never considered participating in a health tour before. All of them claimed that they joined the tour to please their friends and families who persuaded them to join a health tour. Nearly half of them stated that they would join the tour for socialisation and illness protection while only one third of them aim to gain knowledge about how to lead a healthy lifestyle.

Since they know about health tour from their peers, their attitudes towards health tour are positively encouraged. Half of them perceived health tour as a starting point for changing

their lifestyle into healthier ones. Twenty percent thought about joining the tour to help them overcome illness.

Although these women did not intend to join a health tour in the first place and considered the price of health tour expensive, they show the highest rate of satisfaction. About two third of them stated that they felt lighter and cleaner in their bodies while the rest could not feel any changes due to their long time healthy practise and short period of time in health tour. About one third of these women stated that they felt determined to change their lifestyle to a healthier one. Nearly all of them claimed that they gained educational benefits from the health tour participation and about two third of them mentioned about physical benefits. Although they are highly satisfied with health tour participation, only sixty percent of them will encourage their family and friends to join the health tour but nearly all claimed that they would encourage their peers to lead a healthy lifestyle.

In summary, this group is mixed with various ages as well as different levels of marital status. They are well-educated and have a proper career. They spend their leisure time gaining some knowledge and physical benefit. They practice a healthy lifestyle as one of their leisure activities and as preventative medicine. Considering to health tour, all of them knew about it from their peers and they joined the tour to please their peers. They prefer encouraging peers to lead healthy lifestyle to joining the health tour.

8.5.3. Group C3 – The illness group

This group is composed of thirty two participants. More than seventy percent of them are over 50 years old. Nearly half of them are married while thirty eight percent are single and the rest are widow and divorces. The majority of them have graduated from Thai universities. Half of the women in this group are employed while the others include those who are retired and housewives. Half of them earn a reasonable salary while the other half earns less. The majority of women in this group live in houses and condominiums and, in contrast to the two groups above, they claimed that they are the owners of their accommodation, and the majority have a car.

Three quarters of the respondents do exercise in their leisure time to gain physical benefit and some do activities which can give them knowledge such as reading or joining short course courses. The rest of the women in this group claimed that they used their leisure activities to occupy their free time and avoid loneliness. Most of these women are the divorces and the widows.

The majority of these women perceived 'healthy lifestyle' as a life without illness and featuring healthy practice. They experienced illnesses in the past and some still have illnesses. Therefore, life without illness is an ideal for them. They started taking care of themselves since they experienced illnesses in the past. They lead a healthy lifestyle to lessen their former illnesses and prevent new ones. Although some of women in this group experienced illnesses, they still consider themselves having a better health status than their friends in the same age due to the physical care they take of themselves

They knew about the health tour from books and magazines. Also, they watched health programmes on television. From initial knowledge about health tour, their perceptions about health tour is that it can help them to change their lifestyle into a healthier one even though they consider themselves leading healthy lifestyle already. Also, some expect health tour to cure their illness.

After the health tour participation, only a few respondents could see the change because they have been practicing healthy lifestyle for a long time already. When talking about the benefits from the participation in health tour, an educational benefit is the main benefit that the respondents gained from the tour. The next one is social benefit. Nearly half of the them mentioned about this benefit while one third talked about physical and psychological benefits.

In summary, the majorities of women in this group is over 50 years old and own both their accommodation and a car. Due to their past experiences about illnesses, they have been practicing healthy lifestyle for a long time as both their physical leisure and as their preventative medicine. They joined the health tour for illness protection and general improvement. Due to their long time healthy practice, after the health tour participation, they could not see any changes and only a few of them mentioned about physical benefits arising from health tour participation. Most of them considered educational and social benefits as the most important.

To conclude this chapter, age is a key determinant to three of the main aspects of this study, which are leisure and lifestyle, healthy lifestyle and health tour participation of Thai women. Regarding leisure time, as predicted, older women have more leisure time and freedom to choose their free time than younger ones. Also, the older women are the biggest group who claimed that they did leisure activities to occupy free time and avoid loneliness. They do individual leisure to serve these purposes or they join a club or society as socialisation. It is also found that women who are above 50 years old lead their healthy lifestyle as their physical leisure activities. They claimed to have physical benefits and mental benefits from

this healthy practice. The older women also view themselves as having a better health status than friends who are in the same age due to their healthy lifestyle.

With regard to health tour participation, when compared to younger women, older women hardly consider attending health tours to improve their quality of life. One of their main motivations for joining a health tour is socialisation. They aim to meet new people who share the same interest. Another prominent result from the analysis is that older women could not see the differences in themselves after joining the tour. The main reason is they have been practicing healthy lifestyles for a long time. So, the strict healthy regimes in health tour could not affect to their body.

The next chapter provides the discussion of the qualitative and quantitative findings in relation to the literature reviews basing on the aim and objectives.

CHAPTER 9

DISCUSSION AND EVALUATION

This chapter provides the discussion of the relationship between the findings of the primary research and the theoretical underpinning emerging from the literature review. The order of the discussion is based upon the aim and objectives of this research. The main aim of this research is to explore the participation of Thai women in health tours in relation to their leisure patterns and lifestyles. Various objectives were set to achieve the aims beginning with the examination of the concept of leisure and lifestyle of Thai women. In this part, the leisure pattern of the health tour participants is explored starting from the importance of leisure, the types of leisure activities undertaken, leisure time, leisure choice and future leisure. The next section looks at the concept and development of health tourism in Thailand. This is based in part on secondary data but also reflects the attitudes towards health tours by health tour participants. Next, the identification of factors affecting the health tour participation by Thai women is clarified and the motivations for attending health tours are explored. The penultimate section of this chapter discusses the approaches used to determine if there are distinct and demonstrable categories of health tour participants. Then, the benefits of health tour participations are reviewed. The last part is the evaluation of this study.

9.1. Concept of leisure and lifestyle

One of the purposes of this research is to discover if the participants share the same leisure motivations as women in western societies. However, it is necessary to emphasise that it is not appropriate to generalise the findings of this research to all Thai women because the research populations are a very specific group namely Thai women who participate in health tours and it appears that the majority of the participants are urban women in the middle to upper middle socio-economic class and do not therefore represent Thai women in general. Examples of the occupations for upper middle class are professors, leading business women, and writers. As for the middle class, they are government officers, lawyers and lecturers. Many are graduates and post graduates who studied at overseas universities. However, both groups also include housewives who stay at home and help take care of children. These housewives live in well-to-do families which do not require them to earn for the family.

From the initial findings, it is suggested that the motivations of participants in engaging in leisure activities are similar to those of Western women. The urbanisation and the westernisation of Thai society may help to explain this result. Also, the urban middle class in

Thailand demonstrates similarities with the urban middle class in other countries. The concepts of urban middle class and Westernisation will be discussed in detail in the section concerning the characteristics of the health tour participants.

9.1.1. Importance of leisure

To begin with, the important of leisure activities for the health tour participants is discussed in comparison with the concept of leisure discussed in the literature. In the study of Henderson and Bialeschki (1991), almost all the women said that they were entitled to leisure and that leisure was important even though it was not a priority in their life. It was clearly stated by the participants in this research that leisure activities were very important in their lives because leisure activities can bring happiness, physical benefits, knowledge and they can also be considered as an activity for occupying free time and avoiding loneliness.

Considering the relationship of leisure and physical benefits, leisure is described as 'therapeutic' and 'remedial' and associated with health and fitness indicating that leisure and physical benefits are connected. Equally, physical leisure can be associated with Maslow's Hierarchy of Needs at the basic physical stage, in which human beings perform any activity for physical benefit. Physical leisure can also be portrayed at the safety needs stage in the sense that physical leisure may lead the participants to have better health, protecting them from illness. According to this study, older women gave greater emphasis on gaining physical benefit from their leisure activities than the younger women. In the study of Parry and Shaw (1999) of leisure in women's experience of menopause and middle age, it is suggested that older women can be aware of their aging process. Hence, they do exercise as a physical leisure activity to improve their health and lessen their risk of illness.

Apart from giving physical benefits, leisure activities can give knowledge to the participants as evidenced by the fact that reading is one of their three favourite leisure activities for all participants. Tillman (cited from Tolkinsen, 1983) argues that needs are not necessarily set in hierarchical order. Needs can be overlapping and occur simultaneously. He identifies ten aspects of human being's needs and mental activity is one of his ten needs. Mental activity can be referred to any activity that one aims to perceive and understand. As a result, reading can be one of the examples for Tillman's mental activity.

Leisure is also viewed as occupying free time, avoiding loneliness and providing opportunity for socialisation. This research has demonstrated that, these leisure functions are more relevant to the participants who are over 50 years old than to the younger women. Life-cycle changes are factors affecting leisure participation in the sense that participation may increase

with increased age with the result of children leaving home or a person retiring from work (Tolkinsen, 1983). These reasons create the time available for the participants. This study demonstrates that the behaviour of the participants accords to Tolkinsen's theory. The older retired women have more free time than the younger ones. *Therefore, their leisure activities help them to have something to do at a stage when they have plenty of free time. In the past in Thai society, older women would not have had much free time due to the traditional family pattern, that of the extended family. Traditionally, even though a daughter gets married, the couple still live with their parents. When they have their own children, their parents would help taking care of grandchildren. Therefore, older women had little opportunity to feel bored and lonely. Equally, older parents are cared for by their daughter when they get older.*

Leisure can also encourage the participants to meet people who share the same interest. Leisure functions as socialisation as Haywood (1989, p.4) mentions '...with social cohesion through the sharing of common interest; and with community development through collective action and sociability'. Unsurprisingly, widows turned to their leisure activities to eliminate their grief from the loss of their husbands.

9.1.2. Leisure time

When discussing the relationship of leisure time and age, it appears, as predicted, that women over 50 years old have more free time than the younger ones due to their being retired. This finding is related the proposition of Tolkinsen (1983) who suggests that the amount of free time is greatest for adolescents and the retired rather than for the middle aged group who live under significant time pressure. Life-cycle changes is another factor affecting leisure participation which may increase with increased age with the result of children leaving home or a person retiring from work. Also, when people get older, the reductions in family and work responsibilities influence considerably leisure participation. Most of older women claimed that they had more free leisure time after their children left home and after the death of their husbands. Also, over half of the older respondents considered that they had more leisure time than men using the argument that the nature of men's careers did not allow them to have leisure time as they grew older. When men are older, they still have to deal with their businesses or their careers.

Clearly, it can be claimed that younger participants have less free time than the older ones due to the family restrictions and careers. The younger women in this research claimed that they hardly found free time for their leisure due to their careers. The demographic and economic changes in Thai society have given more opportunities to Thai women for career development beginning from women have more chance to study, which leads to the increase of females in

the workforce and to their achieving higher rank in the public and private sector (Paraniramai, 1997). Some of the women encountered in this study work very hard and some even have dual careers in order to provide financial support for their families. It can be seen that the participants in this study can represent the transformation of women in Thai society. However, this transformation in term of the career can and does lessen the leisure participation time of the participants.

Another factor preventing the participants having free time for leisure is housework. Henderson and Bialeschki (1991) claim that household obligations and family commitment are one of the largest constraints on women in participating in leisure activities. These aspects are related to societal expectations about women's role in the family. Women are expected to accept domestic responsibilities, even if they are employed outside the home. In a study of Thai society by Komin (1991), it is found that Thai women are more concerned about family happiness and security and peacefulness than they are about equality and freedom. Although today, Thai women are more individual, the idea of putting family's happiness in the first place still remains strong. Through socialisation Thai women are encouraged to adopt a traditional role which is how to take care of home, husband and children. From this study, those younger women stated that they had less leisure time as they should have when compared to men for the reason of the dual role of career and housework. Willming and Gibson (2000) call this practice as 'superwomen syndrome' which women try to do both her work and unpaid domestic work. Although some participants in this study were assisted by maids or their parents, they still considered themselves having responsibilities for the state of their family. Only one woman from this study claimed that she was assisted by her husband in doing housework.

Housework is not only one of the factors affecting the leisure participation of the participants. It is also representative of the patriarchal system in Thai society. Today, both men and women have careers outside home. Nevertheless, it is only women's duty to do housework while men can relax after work.

9.1.3. Leisure choices

When asked about their leisure choice, the participants claimed that they had freedom to choose their own leisure activities. This confirms the study of Henderson and Bialeschki (1991), which state that the definition of leisure by their participants is having their own choice. However, as anticipated, ninety percent of single women consider their individual leisure activities far more important than the family leisure activities while only one quarter of married women agreed this to be the case. The majority of married women give more

weight to family-oriented leisure activities. They are prepared to postpone their own leisure so that they can join family leisure activities. Again, this finding is relevant to the study of value of Thai women by Komin (1991) who found that Thai women are more concerned about family happiness, security and peacefulness. Stokowski and Lee (1991) also claim that individuals who have the strong bond with the family are likely to do their leisure activities with their family members. Orthner et al. (1994) suggest that sharing leisure time within families' influences personal and social development and may define the nature of the relationship. Some participants in this research claimed that *both they and their husband* play an important part in determining leisure activities. Their husband can influence them to do some certain activities and vice versa. Besides, the couples encourage their children to have the same leisure activities, mostly exercise the types of exercise varying from family to family.

9.1.4. Types of leisure activities

The participants in this study participate in both home and out of home leisure. The out of home leisure activities are claimed to be their favourite ones. However, these activities cannot be performed as often as many of them desire due to financial restrictions. It is apparent that income is related to leisure participation. Higher amounts of income lead to a rise in leisure participation. As Godbey (1999) mentions, an increase in discretionary income gives rise to the leisure spending and the potential to participate in many activities. However, many participants claimed that they have financial constraints upon their leisure. Financial constraint is one of the interpersonal constraints, which include constraints that are results of relationships with others such as inability to find partner for their desirable leisure, money and time unavailability or family obligations (Crawford and Godbey, 1987). They also mention about the other two constraints. They are intrapersonal constraints and structural constraints. The first one includes perceptions of oneself that primarily shape the expression of preferences such as attitudes and perception towards leisure activity while the latter one involves resources and reasons that intervene between leisure preferences and activity participation such as transportation, facility availability, and the availability of opportunity.

Regarding the future of the leisure activities of the participants, activities which give educational and mental benefits were the ones mentioned most frequently such as devoting more time to Buddhism and to meditation, studying short courses and doing charity work. This can be related to the last stage of Maslow's theory of needs, the self-actualisation needs, realizing one's full potential and self-fulfilment. Most of the participants aimed to do the things which can lift up their spirit or fulfil their dreams. In relation to Buddhism, it is noticed

that participants from this study aim to enter the Dharma world when they become older. This accords with the study of Komin (1991) who demonstrates not only that rural Thais are more attached to Buddhism and merit making than the urban Thais but also suggests that as Thai people age, they have a higher sense of a comfortable life with high social recognition and inner peace. They attach importance to religious-spiritual leaning and philosophical contemplation in search of wisdom.

It is not surprising that younger urban participants neglect Buddhism and wait until they become older. This is caused by the rapid pace of urban life. They know about the doctrine of Buddhism and merit making but few of them maintain this habit. As they age, they start to think about death, karma and the rebirth. Therefore, older people tend to attend the temple and adhere more to Buddhism practice rather than younger ones.

To sum up, leisure participation of Thai women can be motivated by many factors such as; the search for happiness, physical benefits, educational and social benefits. In relation to the amount of free time available for leisure participation the women's life cycle plays an important part. It appears that the older women have more free time than the younger ones due to the reduction in family and work responsibilities. Leisure activities are freely chosen by Thai women. However, for married women, they prefer to engage in family leisure activities in preference to their individual leisure activities.

9.2. Concept and development of health tourism in Thailand

Generally, Thailand is famous for its range of health tourism facilities developed to attract international inbound health tourists. For example, amenity resorts, hotels with spas, day spas destination spas and health resorts and the medically orientated destinations. Health tourism services vary from relaxation at the spas to major plastic surgery in the hospital. Therefore, the concept of health tourism for the international tourists is a diverse one. The domestic health tour concept is similar to the concept of health tourism and health farm defined by Medlik (1993, p.83) in the Dictionary of Travel, Tourism and Hospitality as 'trips and visits to health resorts and other destinations whose main purpose is health treatment, ranging from therapeutic treatments for various diseases to fitness and relaxation programmes. Some of these services are also offered by many hotels and cruise lines and by such establishments as health farms'. He also defined health farms as 'a residential clinic in the countryside where people stay with a view to improve their health and appearance by dieting, exercise and relaxation' (Medlik, 1993).

The activities in health tours which are the focus of this research include natural therapy using food as medicine mixing this with the integrated and alternative medicines, which are Holistic, Macrobiotic, Chinese, Acupuncture, Ayurveda, Yoga and Reflexology. In addition, exercise and coffee detoxification are integral activities. This is consistent with the factors affecting the growth in health tourism. Alternative medicine is one of those factors influencing on the growth of health tours. Ross (2001) claims that in 1997, 42 percent of Americans spent \$ 21 billion on non-traditional medical therapies and products. Shealy (1996) in discussing the principles of alternative medicine identifies a mixture of different beliefs and techniques. The principle ideas are that the body has a natural ability to heal itself and health and healing reflect a state of emotional, mental, spiritual and physical balance.

From the point of view of some of the health tour participants, a health tour is a lifestyle changing activity. No matter the participants aim to adopt a healthy lifestyle or not, a health tour is still seen as an activity which can help them to change their lifestyle into a healthier one. Apart from the attitude that participating in a health tour could change lifestyles, more than half of the participants believed that health tour participation could help in protecting themselves against illness but less than thirty percent expected that it could cure illnesses. It suggests that the participants believe in the preventative aspect of health tour rather than curative ones. Those who believe that a health tour could help cure their illnesses, referred to alternative medicine. Kuhn (1999) talks about seven specific fields of alternative medicine stating that diet and nutrition are one of the seven elements. Additionally, the idea of mind and body interventions are mentioned in the sense that individuals can it is argued, influence disease by our mind. Even though curing illnesses is not the main aim of the health tour, these practices were performed in the tours.

The majority of Thai health tour participants are urban middle to upper middle class and their lifestyles are influenced by Westernisation, in regard to fashion, sports, cultural activities and food. For example, in relation to pattern of food consumption, the Thailand Health Profile (2002) in Bangkok revealed that 42% of those over 15 years consumed fast foods and only about 25% took exercise. Consumption of alcohol and tobacco were on the increase, with 22.8% of the population aged 15 years and over being regular smokers. Suicide in the metropolis of Bangkok has increased due to the stress of the city life. According to Harmsworth (1990), the increased stress plays the essential part for the growth of health tourism.

9.3. The characteristics of health tour participants

One of the objectives of this research was to characterise and categorise the health tour participants and investigate if they are different from the Western health tour participants. In terms of the characteristics of health tour participants, there are a number of earlier studies which gave diverse average ages of health tour participants as 40-60 years old with 50% over 55 (Viceriat, 1984), 35-50 years old (Becheri, 1989; Stanton, 1992) and 39 years old (Goodrich and Goodrich, 1987). Most of those featuring in previous studies were professionals or were working in middle and higher management with relatively high incomes.

Compared to those statistics, the health tour participants in this study appear to be different in the sense that they were of various age from twenty to over sixty years old. Four percent of the participants were between 20-30 years old while 23% were 31-40 years old and another 23% of women were 41-50 years old. Women in the age of 51-60 years old made up a further 22 percent and women over 60 a further 28%. The ratio of women who are below 50 and above 50 was 50:50.

The characteristic of health tour participation of this study does not accord to the more generally accepted market trends in regard to the age profile of the respondents. It is said that the increasing number of the elderly will affect the demand of health tourism and most of the health tour participants will be people in the older ages, especially women due to the reason that women live longer than men (Harmswoth, 1990), whereas in this study there was a fairly even age distribution suggesting age was only one of the factors affecting health tour participation. Considering marital status, single women were the biggest group of participants, 40%, however married women with children at home represented a similar proportion of the participants 38%. It can be seen that the participants are well-educated, slightly more than half of them had gained a Bachelor degree and nearly one quarter had a Masters degree. Tolkinsen (1983) claims that the type of education, the length of education and the education attainment have great impact to the leisure participation as they are related to upbringing, class, occupation, income and other factors. It is found that the higher the qualification, the greater the degree of participation.

Reviews of the health tour literature suggest it is possible to categorise health tourists into four types; leisure health holiday tourists, pampered tourists, well being tourists and medical tourists. This categorisation is based on the relative importance of health starting from travelling for relaxation to the extreme case such as travelling for the medical purpose. The leisure health holiday tourists are tourists who engage in health activities but health is not

their main motive. They relax at the destination using the health facilities at the hotel. The pampered tourists are those who travel with the aim to receive 'feel good' treatments at the destination. The well-being tourists are those who travel for improving their minds and bodies. Lastly, the medical tourists are those who travel to obtain medical treatment at the destinations.

Regarding the health tour participants in this research, it appears that they share the characteristics of the well-being tourists whose aims of travelling are to improve their minds and bodies. However, other motivations were mentioned apart from health related matters. To begin with, health and well-being motivation is the main concern for health tour participants. This motivation can vary from an improvement in general fitness, illness protection, and knowledge about leading a healthy lifestyle and improvements in quality of life. These reasons can be connected to Maslow's theory of needs, which are the physiological needs and the safety needs. The physiological need refer to hunger, thirst, rest, exercise etc. while the safety need refers to the protection from danger; the need to exist under the system of rules and boundaries and the freedom from fear and anxiety.

An interest in participating in a health tour can also be interpreted as a way of attempting to satisfy one's safety needs in the sense that the participants long for protecting and assuring their longevity by taking care of their body and mind (Mill, 1992) Horner and Swarbrooke (1998) suggest that the postmodern movement encourages a growing interest in health and media heavily promote the idea of inner and outer health and well-being. Equally, health tourism can be fitted in at the fourth and fifth level of Maslow's hierarchy in the sense that some people travel to health tourism destinations in order to be accepted by society or to fulfil their personal needs. This is related to the factors affecting in the increase of health tourism. One of the factors is the shifting consumer values from material things to experiences. Pollock and Williams (2000) state that human beings seek for meaning, self-fulfilment and self-autonomy, which lead to the higher quality of life and participating in health tour can provide 'space and place' allowing participants to seek harmony, balance and permanent lifestyle with the healing atmosphere.

Improvement in quality of life is widely mentioned among the health tour participants. It is found that two third of the younger women joined the health tour with this aim. Most of them are career women who have a hectic lifestyle in the city. Therefore, a balanced lifestyle is desirable for the city populations and participating in a health tour is one of the alternatives available for the urban Thai population. Interestingly, compared to the women who live in other styles of accommodation, fewer of the women who live in *their own houses* or their

husbands' house joined health tour for the improvement of the quality of life. This suggests that those who own their own accommodation or live with their husbands consider themselves having a balanced quality of life. They also viewed themselves as having a better health status than their friends due to their physical and mental care. The majority of them joined the health tour for educational benefit.

Apart from the attitude that participating in a health tour could change lifestyles, more than half of the participants believed that health tour participation could help in protecting themselves against illness but less than thirty percent expected that it could cure illnesses. It suggested that the participants believe in the preventative aspect of health tour rather than curative ones. Those who believe that a health tour could help cure their illnesses, referred to alternative medicine. Kuhn (1999) talk about seven specific fields of alternative medicine stating that diet and nutrition are one of the seven elements.

A number of the respondents did not have any previous ideas about health tours before they were encouraged to participate by their friends. It can be said that they never considered joining the health tour in the past. Some even had never heard about health tours before. However, through the persuasion of their family and friends, they agreed to join the tour. This shows the characteristic of Thai people. From the study of Komin (1991) about Thai society, it is claimed that Thais tend to have smooth, kind and no conflict interactions by being polite, humble, non-assertive and appearing relaxed by smiling and being friendly. The core value of Thais is the care and consideration. Participants in this group joined the tour to satisfy their peers rather than for any other motivation.

Comparing the characteristics of these health tour participants to the class structure of Thai society proposed by Supap (1991), the participants mainly belong to the urban middle and upper middle class, which refers to general government officers, merchants, graduates and post graduates from abroad, lawyers, lecturers while upper middle class refers to intellectuals, senior lecturers, professors, leading business men, writers and scholars. As for the occupations of participants, they are mainly freelance and business women who can choose when to have free time. They earn quite high salaries. Nearly half of these women have their own accommodation and more than one third of them have car. Though paid work can create an impact of dual jobs, which means working both outside and inside home, work can provide them with the feelings of self-respect and an independence identity separate from being someone's wife or mother (Green, et al, 1990). Also, paid work encourages them to feel they are entitled to have their personal leisure. It is obviously seen in this research that only a few people joined the tour with their own family members. Most of them joined the tour with

friends or their parents. Most of them consider joining a health tour as their own leisure activities giving them various benefits, which can be adapt to practice in their family.

Comparison to the study of Savage and his colleagues (1992) demonstrates that their study population had similar characteristics of the participants in this research. Their study was conducted in Britain to investigate the spending and activity patterns of the upper middle classes using data from a market survey. Three large groups were distinguished. These were public sector professionals, managers and bureaucrats and a post modern group. The characteristic of the health tour participants in this research share similarities with the public sector professionals group, which have an ascetic lifestyle characterised by sport, healthy living and high culture pursuits. Health tour participants of this research clearly show their interest in sport and healthy living. While nearly two third of the participants considered the price of the health tour expensive, they still participated and claimed that it was worth the money. It obviously shows their commitment to health matters. Some compared the cost of health tour with their annual holiday cost and considered health tour to be much cheaper. Some never thought about the price if the activities could give them health related benefits. This reflects the study of Maguire (2002) in which he argues that the main the main concern of the middle class is the performance of body such as experience of exertion, illness, aging and body function.

Bourdieu(1984) states that body can represent social class because different groups and classes cultivate different types of body and also engage in different type of body practices. The middle classes engage in the health-related concern activities such as the controlled diet and healthy lifestyle. This middle class is called 'the petite bourgeoisie'. They do not feel at ease and confidence in their body. They feel uneasy with their body, constantly self-consciously checking, watching and correcting themselves. Therefore, they are attracted to the body maintenance techniques, the new forms of exercise, cosmetics and health food. Their bodies are treated as a sign for others because they search for the self-expression, fascination with identity, presentation and appearance.

Featherstone (1987) comments on the role of education which encourages the middle class educational view of life. He states 'the new petit bourgeois...adopts a learning mode to life; he is consciously educating himself in the field of taste, style, lifestyle' (p.65).

In summary, through the eyes of the participants of *this research*, a health tour is a tour on which they can relax in the natural environment and at the same time take care of *their health* by diet and nutrition control plus mind and body exercises. A health tour is also seen by some

as an activity which helps the participants adopt a healthy lifestyle after the tour ends whereas some participants are concerned about an illness cure.

9.4. Expressions of benefits of health tour participation

After attending health tour, the participants expressed their benefits they gained from the tour in two types, physical benefits and mental ones. As for the physical benefits, the participants could see the positive results in their body. For example, they could feel lighter and cleaner. In regards to mental benefits, they mentioned about psychological benefits, educational benefits and social benefits. With these two types of benefits, it is noted that the majority of health tour participants emphasised on the feeling of their body. They expressed themselves in term of their body. This can be called the embodied experience. This is linked to the embodiment concept. Game (1991) stated that leisure and tourism provided the space to explore the role of expressive, sensual and elusory faculties of the body. Another example was given by Cloke and Perkins (1998 cited in Pons, 2003). They argued that the relationship of tourism and embodiment could be seen in adventure tourism which required the physical challenge. This created the thrills and heightened new sensory experience of the participants. They put their bodies into the test. The experience of the health tour participants can be compared to those who pursued the adventure tourism. The activities in health tour required the physical challenges such as the early get up, the strict diet, the long distance walk and the stick exercise. Some of the participants revealed that they joined the tour to test their bodies after they have been leading healthy lifestyle for a while. Some would like to conquer their unhealthy life and started the new healthy life. Some were ill and would like to try if they could manage to get through this health tour.

This experience can also be compared to those of *the female fire fighters* in the research of Yarnal et.al. (2006). The activities in the female fire fighter camp encouraged *the participants* to increase the sense of body control and competence. This gave confidence to the participants who had more understanding about their body potentials. The health tour participants felt the same way with their bodies. After finishing the tour, they felt proud that they could endure all the strict activities in health tour and they were determined to continue their healthy lifestyle. This suggests their aims to control their body and have the sense of achievement towards their own bodies.

9.5. Evaluation of this research study

On balance it can be argued that this research study has been successful that the main aim and all the objectives were achieved. The secondary research undertaken explored two objectives which were to examine the factors that determine women's leisure and lifestyle and the general concept and development of health tourism. As a result, it was possible to present a general overview of Thai society to provide necessary background knowledge for the case study. In regard to the leisure patterns and habits of Thai women and to health tourism in Thailand, these were reviewed in as much detail as possible given the limited range of secondary material available both in English Language academic journals and in the relevant Thai publications. As had been anticipated there was very little information about domestic health tourism, this led subsequently to an exploration through primary research of the participation in domestic health tours by Thai women

The other two objectives; a detailed examination of the concept of leisure and lifestyle of Thai women and the identification of factors affecting the participation in health tourism by Thai women, were achieved by conducting primary research through participant observation of a health tour and semi-structured interviews with female health tour participants. Both qualitative and quantitative analytical approaches were employed to analyse this primary data. Qualitative analytical approach provided insights into the leisure practices and lifestyles of Thai women and indicated some of the factors that affect the participation in health tourism by Thai women. This qualitative analysis also suggested the existence of a number of categories of health tour participant in terms of their adoption of a 'healthy lifestyle'. Quantitative analysis confirmed both the nature of the relationships between various demographic variables and leisure and lifestyle characteristics and gave an alternative objectively determined classification of the respondents.

In order to achieve the last objective, to investigate the relationship between participation in health tour and the adoption of a *healthy lifestyle*, a second phase primary data collection, telephone interview were conducted three years after the first series of interviews. *As a result*, new groups of health tour participants, based on their adoption of a healthy lifestyle, were determined. Given that it was possible to achieve all the objectives, it is argued that the main aim of this study to explore the participation of Thai women in health tours in relation both to their patterns leisure and lifestyles and to their adoption of a healthy lifestyle was successfully accomplished.

A more detailed evaluation of the study can be considered from two perspectives, theoretical and methodological.

9.5.1. Theoretical

This study is a study of the participation of Thai women in health tour in relation to their leisure and lifestyles. Theoretically, three main concepts of background knowledge were reviewed. They are leisure and lifestyle, health tourism and Thai society. Throughout this study, the researcher believed that the choice of these three main concepts was the right one. This study is about health tour participation of Thai women. Therefore, the background knowledge about Thai society has to be reviewed. There was the explanation of the generic value of Thai society in relation to their gender, age, income, education, occupation and religion. Also, national characteristics of Thais were presented. Those values and characteristics provided the essential background for more understanding of the participants in the primary research and analysis stage. For example, from the findings, some of the participants hardly have their own leisure time due to the gender and traditional value in Thai society.

Due to the majority of participants of this study are middle class from Bangkok, the overview of urban population was discussed. Lastly, two key factors, demographic changes and economic changes, affecting the changes in Thai society and their impacts on contemporary life of Thailand were reviewed. This part helped to understand more about the changing way of life of modern day women, whose lives are far from traditional ideas in the past and more of Westernised. For example, it is found out that younger urban women tended to neglect going to temple due to the pace of urban lifestyle. However, they would like to have more time for Buddhism practice for their future leisure. The review about generic values and characteristics of Thai people are relevant to the latter comment.

The second main concept of background knowledge is part of leisure and lifestyle. Health tour is one of leisure pursuits. Therefore, the relevant leisure literature needed to be reviewed starting from various definitions of leisure, factors contributing to an increase of leisure, various theories of motivations and needs for leisure. These reviews are appropriate because the findings from primary research are related to the literature. For example, the participants talked about physical leisure, which can be related to Maslow's Hierarchy of needs while mental leisure activities can be relate to Tillman's theory. Also, findings demonstrated that the reviews about leisure demand, leisure participation, leisure socialisation and leisure constraints are relevant. For example, according to the study, leisure demand and leisure participation are increasing when participants getting older. Concerning about leisure constraints, it is found out that financial constraints forbade the participants not to pursuit out of home leisure as often as they wanted.

The relationship of women and leisure were also presented such as leisure opportunities and leisure constraints of women. Apart from that, the increasing individualisation of women and the transformative idea of women and leisure were reviewed. This part about women and leisure are essential because the majority of participants became more individual and do not follow the traditional way of life. Therefore, the contrasting concepts about leisure constraints and individualisation of women are very supportive. After the researcher reviewed literature about this part, it was expected that Thai women might have lower leisure and more leisure constraints than men. However, from the findings, it is clearly seen that the participants of this study are educated middle class working women who could afford to have their own leisure time and activities.

The last section of this second main concept is about lifestyle. Concept of lifestyle was reviewed followed by the theory of consumerism and the relationship of consumption, class, social status and lifestyle. Factors affecting the popularity of lifestyle were mentioned along with Pierre Bourdieu's Distinction theory. Lastly, the relationship of leisure, lifestyle and health was discussed. This section is appropriate because Westernisation superficially influence Thai society. The review of social class and status helped to understand Thai society. Also, this part is appropriate for identifying characteristics of health tour participants.

The last main concept of background knowledge is the part about health tourism. This study is about health tour participation. Health tour is part of health tourism. Therefore, it is relevant to review literature about health tourism. Health tourism is also one form of special interest tourism which aims to participate, learn about and experience the place they visit. Tourists are in pursuit of more meaningful experiences, which will teach them something about themselves and about life. This motivation was reflected in findings that health tour participants joined the tour for learning how to lead healthy lifestyle. They did not just join the tour for one time practice. They would like to learn the practice for lives. Apart from that, former researches about health tourism and health tour participants are very useful in categorising health tour participants of this study.

9.5.2. Methodological

With the choice of methodological approach, this study is explanatory study over the course of six years which aims to investigate the participation in health tours by Thai women in relation to their leisure pattern and lifestyles. The choice of using this kind of study is the appropriate decision because the researcher needed to see the leisure and lifestyle pattern of participants over certain period of time whether they changed their lifestyle in accordance to the participation of health tour. The advantage is the researcher could measure the pattern of

change through period of time. However, at the same time, this kind of study can be very time consuming. The pragmatic paradigm is well chosen because this study uses the mix of qualitative and quantitative approach. Pragmatic paradigm supports the use of both approaches in a single study.

In regard to choices of data collection techniques, they are considered to be the proper ones. They are semi-structure interview and the participant observation in phase one. The participant observation helps to gain the insight knowledge and understanding about health tour through the participant's eyes. The semi-structure interview is proper in the sense that the detail of the health tour participants is comfortably and flexibly reviewed with the open-ended questions. Also, not like focus group, the face to face interview focuses with only one interviewee encouraging the in depth detail of the story. Due to the time and money restriction, the telephone interview was chosen for the second phase of data collection. The difficulty in using telephone interview is the participants were not that eager to talk in detail comparing to the face to face semi- structure interview. This might cause by the fact that some of participants are not the telephone person. They tend not to talk long on the phone.

Considering to the data collection technique, health tour organisers were very helpful in providing the contact information of health tour participants for the researcher under the condition that it was only for the educational purpose. The researcher made phone call to talk to the participants before making an appointment for the interview. The difficult part was persuading the participants to give some time for the interview. However, in the interview session, everything ran smoothly. The data collection process was a concurrent one because this research is a longitudinal one and there were two periods of data collections over three years.

Concerning to the sampling of this research, it is considered to be the appropriate sampling because the study is about the participation of Thai women in health tour. Therefore, the samplings are the female health tour participants. Approximately, there were about 2000 people. There are 100 participants in this study. Therefore, it is 5 % of the whole population. They are the convenient sampling. It is noticeably that most of the women who joined the tour are middle class women. Inevitably, the sampling is a specific type of population and this sampling cannot be generalised and applied into the bigger size of the population.

Methodologically, in term of the design of questions to be used for the semi-structured interviews, it is considered proper in helping to fulfil the research aim. It is the open-ended free elicitation questions which encourage the participants to feel free to answer the questions and explain more of their opinion. The outcome from this kind of question is the very rich data. Besides, the semi-structured questions are flexible for probing after the participants gave

answers to the interviewer. The demographic part of the questionnaire is the close-ended questions so that they can be pre coded and categorised. The question topics are based on the review of the literature, which provides the knowledge about the underlying theory for this study.

Regarding to the administration of the interview, the most important factor influencing the success of this act is the understanding of the researcher about the activities in health tour because the research took part in the participant observation and this built up the quick bonding among the participants. But sharing the same experiences, the interview ran very smoothly.

In term of the analytical approach, the use of the QSR Nu*dist N6 software is a suitable choice for helping in organizing the theme emerging from the initial finding. This helps achieving the main aim of the research, which is exploring the participation of Thai women in health tour in relation to their leisure and lifestyle. Also, from this analysis, five groups of health tour participants were determined. One of the objectives of this research is to identify factors affecting the participation of health tour by Thai women. Quantitative SPSS software with cross tab analysis and chi-square test were applied to achieve this aim. Lastly, the cluster analysis was applied to categorise the health tour participants. One main problem of the analysis part is the use of time scale for this part. Due to the unfamiliar skill of the researcher towards the software, it took longer time than expected in analysis part.

The overall strategy for the data collection was successful because the research questions were answered. The most demanding aspect was the analysis qualitative using QSR Nu*dist N6 software and quantitative using SPSS software due to the researchers initially low level of understanding of these analytical programmes. As a result, more than a year was devoted to the analysis of the primary data.

This chapter discussed the connection between findings from primary research and the underpinning theory from the reviews of the literature. The discussion is based on the aim and objectives of the research study. Also, there is the evaluation of the way of this study was undertaken theoretically and methodologically. The next chapter is the conclusion chapter wrapping up the main thought of this study.

CHAPTER 10

CONCLUSION

This chapter provides an overview of the entire study in accord with the main findings. This chapter also suggests future related research topics which would further develop our understanding of health-related leisure activities.

10.1 Conclusive overview

At the outset of this research there is an underlying assumption namely that Thai society has its own particular culture and associated values and these were subsequently reviewed and form the basis of Chapter 4. The question arose as to whether these cultural and value differences would be manifest in differences in the leisure patterns and practices of Thai women in comparison to what we know of the leisure and lifestyle practices of women in the 'Western / developed world where for example the fundamental ethical tradition is Judeo – Christian whereas in Thailand the underlying ethical tradition is based upon Buddhism. What this research has clearly demonstrated is that rather than there being notable differences there are considerable similarities with regard to those factors that determine women's leisure in Thai society with those operating in Western societies. With regard to lifestyle considerations, particularly in terms of interests in health-related issues there are again many similarities some of which may be due to the so-called 'westernisation' of Thai society.

The findings of the study have clearly shown that the factors that are instrumental in determining women's leisure in Thailand are as they are in many western societies. It might be argued that these findings and the conclusions drawn from them are unsafe as the women who were the focus of this study live in an urban environment and that as a result they have been more exposed to western values than Thai women living in rural areas. Such a criticism overlooks the fact that women living in rural areas have different experiences from those living in urban areas in all countries and whilst leisure opportunities may differ between urban and rural locations the underlying factors determining a woman's leisure are the same in both situations.

The analysis clearly demonstrates that biological age is a major factor for some Thai women in determining their pro-active engagement with concerns relating to their own diet, health and experience of illness and their consequent participation in health tours. These findings supports both the theory proposed and articulated by Tolkildsen (1983) that people's choice

of leisure is circumscribed by a number of acknowledged conditions which include age, stage in life-cycle etc. and that of Maslow's Hierarchy of Needs which postulates that at the basic physical stage human beings perform any activity for physical benefit. Physical leisure can also be portrayed at the safety needs stage of Maslow's hierarchy in the sense that physical leisure may lead the participants to have better health which may protect them from illness.

Clearly the women interviewed for this study come from the upper-middle and upper socio-economic classes of Thai society and what this study suggests is that the leisure patterns of women in these socio-economic groups are more or less alike in every society so that in effect what is being observed and recorded is a convergence of leisure related behaviours and choice. For example the findings support Pierre Bourdieu's theory of consumption and consumer lifestyles based on his French research study, especially, the observation of the group who have a high volume of capital culture. He argued that intellectual capital could be obtained from the educational systems of modern society. The group which earn the cultural capital through education is called the *petite bourgeoisie*. This group of people are likely to pay attention to their body and tend to search for the attraction of body maintenance techniques, and the associated new forms of exercise, cosmetics, and an interest in healthy food. Equally they share some similarities with those studied by Savage and his colleagues in 1992 with regard to the spending and activity patterns of the upper-middle classes. As with the respondents in Savage's study the participants in Thai health tours also have aesthetic lifestyle characterised concerns with healthy living and with interests in a range of cultural pursuits. Some of the Thai women questioned also demonstrated that they were empowered in their leisure lives as a result of out-of-home employment; a feature that has been widely commented on in studies on women and leisure in western society by Deem (1986), Pahl (1989), and Prassek and Bloks (1991).

At a practical investigative level previous research concerning women and leisure employed a variety of methodological approaches which led to the findings regarding women's leisure that were extensively reviewed as part of this investigation. This research, whilst remaining essentially quantitative in approach, also employed more than one data collection technique and the results obtained indicate that the combination of participant observation and interviews were appropriate and robust.

10.2. Contribution of the research

For social benefits, the findings of this study clearly identified a range of factors that play an important role in terms of the relationship between Thai women and healthy lifestyle and health tour participation. It was found that younger women seek help to improve their quality

of life and their general fitness by participating in health tours. In contrast, older women pay more attention to their health than the younger ones. Therefore, it is clearly seen that the organisation of public health promotion should focus more on younger women who lead unhealthy lifestyles and encourage them to seek help.

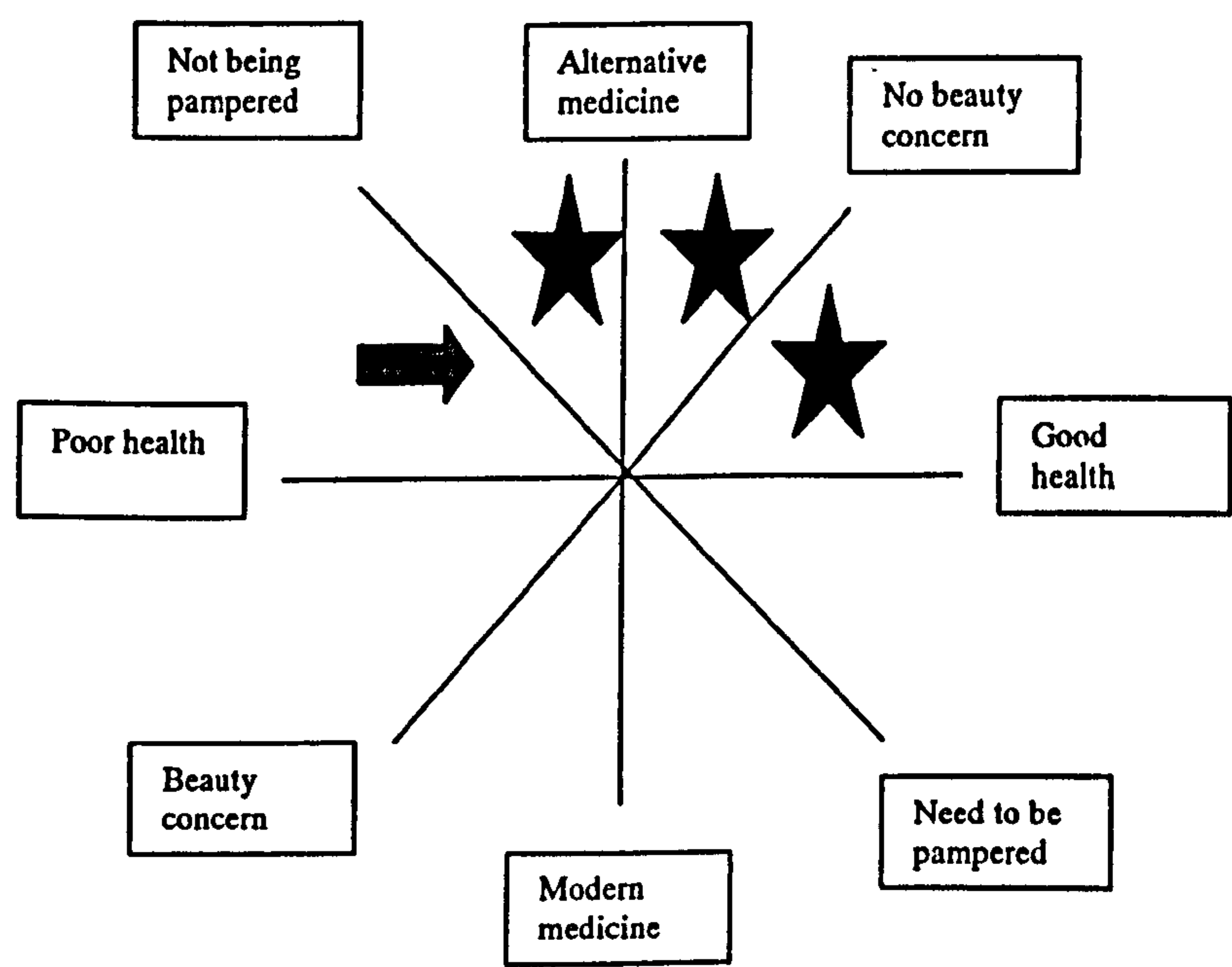
Apart from that, the findings also clearly demonstrate that significant numbers of health tour participants adopt a healthy lifestyle in the long run. The Ministry of Public Health can reinforce the same practices into the wider public by promoting the private and public workplaces to reinforce the health lecture or health tour for preventative medicine in order to lessen the cost of health insurance in the long term.

This study revealed a number of cases of participants who have been ill attending a health tour and by adopting the practices recommended during the health tour practice lessened and even cured some illnesses. These findings suggest the opportunity for further alternative medicine research in reviewing healthy lifestyles as an alternative way of curing illnesses. For example, conducting a longitudinal research study following ill people who join health tours and exploring the effects of health tour participation over time.

In term of marketing benefits, the categorisation of health tour participants should enable health tour providing organisations to better understand their market leading to the opportunity to develop evidence-based marketing strategies.

This research explores the well-being health tour in which the tour encourages the participants to lead the healthy lifestyle in the long run by teaching them the core of the practice. This kind of health tour is not related to beauty, cosmetic surgery, spa or modern medicine. Therefore, there are still varieties of areas which can be explored for future with the use of the same kind of study. For example, in Diagram 1, the characteristic of the health tour in this study are the three blue stars. The red arrow presents that there are some of people who are poor health participate in health tour. Therefore, the future research can explore the rest of the area.

Diagram 1: The four continuums of characteristic of health tour



The overriding conclusion of this study is that there exists evidence for the convergence of behaviour. The health tour participants in Thai society context share some similarity to observation of those in Western society. Therefore further studies in different cultures to further explore the apparent commonality of the underlying determinants of women's leisure would seem timely and appropriate. For example, the study in some other religion contexts such as exploring general issues of women, leisure, lifestyle and attitudes of women in relation to health tour participation in Middle East countries or the same study with people in rural area where there is different economic dimension.

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