Motherhood and infant feeding practices: The lived experience of HIV- positive women in southern Thailand

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January 2017

Contract No. TRG5780266

Report

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The project granted by Thai Research Foundation and Research and Development Institute Thaksin University

ACKNOWLEDGEMENTS

I would like to give my grateful thank to The Thailand Research Fund (TRF) and Research and Development Institute Thaksin University (RDITSU) Thailand who provided financial support for me to conduct this project. I also would like to thank all infected HIV women for participating in my study.

บทคัดย่อ

Project Code: TRG5780266

Project Title : ความเป็นมารดากับการให้นมบุตร: ประสบการณ์ของผู้หญิงที่ติดเชื้อเอดส์ในภาคใต้

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Project Period : 15 กรกฎาคม 2557-14 กรกฎาคม 2559

บทคัดย่อ: มารดาติดเชื้อไวรัสเอดส์ต้องเผชิญกับการไม่สามารถให้นมตนเองแก่ลูกได้เนื่องจากการให้นมลูกเป็นช่องการผ่านเชื้อสู่ลูก อย่างไรก็ตามยังมีเรื่องราวที่เรายังรู้เพียงเล็กน้อยเกี่ยวกับการรับรู้และประสบการณ์ของการให้นมลูกของแม่ที่ติดเชื้อ โครงการนี้มีวัตถุประสงค์เพื่อศึกษาประสบการณ์การให้นมบุตรของหญิงไทยติดเชื้อเอดส์ในภาคใต้ โดยการสัมภาษณ์แบบกึ่งมีโครงสร้างและการวาดรูปในกลุ่มแม่ติดเชื้อ 30 คน ที่อาศัยในชุมชนชนบทของภาคใต้ประเทศไทย วิเคราะห์ข้อมูลด้วยวิธีการวิเคราะห์แก่นสาระ ผลพบว่าแม่ติดเชื้อเอดส์มีความรู้สึกปั่นป่วนเนื่องมาจากการที่ตนไม่สามารถให้นมบุตรได้ มองตนเองเหมือนเป็นแม่ที่ปนเปื้อนจากสิ่งสกปรก สถานบริการสาธารณสุขในท้องถิ่นเองมีการจัดสรรนมผงฟรีให้แม่กลุ่มนี้เป็นการทดแทนการให้นมตนเองจนบุตรอายุถึง 1 ปี 6 เดือน แต่แม่ติดเชื้อหลายคนยังพบกับความยากลำบาก เนื่องจากเด็กบางคนมีอาการแพ้นมผงที่ทางสถานบริการจัดให้ บ้างประสบกับปัญหานมที่จัดให้ไม่พอเพียงกับความต้องการของเด็ก แม่เหล่านี้ต้องหาวิธีการอื่นเพื่อให้ลูกได้รับสารอาหารเพียงพอ หลายคนหันมาใช้นมข้นหวานบ้างบดกล้วยให้ลูกรับประทาน การแสวงหาแนวทางต่าง ๆ เหล่านี้เพื่อเติมเต็มความเป็นแม่ที่ดีและเป็นแม่ที่มีความรับผิดชอบ ดังนั้นการศึกษานี้ส่งเสริมให้เกิดความเข้าใจถึงประสบการณ์ชีวิตเกี่ยวกับการให้นมลูกของแม่ติดเชื้อในภาคใต้ ผลครั้งนี้มีประโยชน์ต่อการผดุงครรภ์และนโยบายสุขภาพในการที่ควรมีการเตรียมทางเลือกที่หลายหลายเกี่ยวกับการให้อาหารทารกและสามารถเข้าถึงได้ขนานไปกับการให้การสนับสนุนและคำแนะนำอย่างมืออาชีพ

คำสำคัญ: แม่ติดเชื้อ HIV, นมแม่, การให้นมทารก, การเป็นแม่ที่ดีและมีความรับผิดชอบ, การวิจัยเชิงคุณภาพ

ABSTRACT

Project Code: TRG5780266

Project Title : Motherhood and infant feeding practices: The lived experience of HIV-positive women in Southern Thailand

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Project Period : 15 July 2014 - 14 July 2016

Abstract: Mothers living with HIV are encouraged not to breastfeed as it can transmit HIV to their infants. However, there is little known about how women with HIV perceive and experience their infant feeding practices. This paper explores the breastfeeding experiences among Thai women living with HIV in southern Thailand. Semi-structured interviews and drawing methods were used with 30 HIV-positive women in rural communities of southern Thailand. Thematic analysis was used for data analysis. HIV-positive mothers had ambivalent feelings about not being able to breastfeed their infants. They perceived themselves as a 'contaminated mother'. Healthcare centres and hospitals supply free infant formula for HIV-positive mothers up to one and a half years. Despite this, many mothers had to deal with some difficulties. Some infants developed an allergy to the infant formula. The free infant formula was not sufficient for some infants and the mothers had to find alternative means for the well-being of their infants: many mothers relied on condensed milk whereas some fed mashed banana. The women made every effort to fulfill their ideology of being a good and responsible mother. Thus, my study contributes a conceptual understanding about the lived experiences of breastfeeding among women living with HIV in southern Thailand. The findings have implications for midwifery care and health policy. The provision of different options of feeding should be made available to infants along with accessible resources and professional support and guidance.

Keywords: HIV-positive mothers, breast milk, infant feeding, good and responsible motherhood, qualitative research

EXECUTIVE SUMMARY

Mothers who are living with HIV/AIDS have to face many burdens. They have to not only care for their children but also their HIV-positive partner. However, there has been little study examining the meanings and experiences of motherhood among HIV- positive women in southern part of Thailand. In this project, I investigated the experiences of being a mother and living with HIV/AIDS among Thai Women in this region, examined their perceptions and experiences of infant feeding practices and developed theoretical understandings of motherhood and infant feeding practices among women living with HIV/AIDS.

I anticipated that the findings of this study will provide many benefits to individual women, health care workers and health policy makers. This research offers the first empirical and comprehensive data regarding the meanings and experiences of motherhood and infant feeding practices among women living with HIV/AIDS in southern Thailand. Also, it produces new knowledge concerning Thai women's understanding of motherhood, infant feeding practices and living with such disease which has received little attention thus far. This study aimed to 1) investigate the meanings of motherhood among women living with HIV/AIDS in southern Thailand, 2) examine the lived experiences of being a mother and living with HIV/AIDS among Thai Women in southern Thailand, 3) examine the perceptions and experiences of infant feeding practices among mothers living with HIV/AIDS in southern Thailand, 4) produce data for the development of effective and culturally appropriate policies for providing sensitive care for women living with HIV/AIDS and their newborn infants in southern Thailand and 5) enhance theoretical understandings of motherhood and infant feeding practices among women living with HIV/AIDS.

I employed qualitative approach as it allows the researcher to learn about individuals' lives and their stories in depth detail. In-depth interviews and the drawing methods were used to gain insights into the perceptions and practices of mother who had HIV/AIDS. All interviews were conducted in local Thai language and digital voice recorded was used to record the conversation. Thematic analysis was used to analyse the data.

HIV-positive mothers had ambivalent feelings about not being able to breastfeed their infant. They perceived themselves as a 'contaminated mother'. Healthcare centres

and hospitals supply free infant formula for HIV-positive mothers up to one and a half years. Despite this, many mothers had to deal with some difficulties. Some infants developed an allergy to the infant formula. Free infant formula was not sufficient for some infants and mothers had to find alternative means for the well-being of their infants. Many relied on condensed milk whereas some fed mashed banana. Women made every effort to fulfill their ideology of being a good and responsible mother. Thus, my study contributes to a conceptual understanding about the lived experiences of breastfeeding among women living with HIV in southern Thailand. The findings have implications for midwifery care and health policy. The provision of different options of feeding should be made available to infants along with accessible resources and professional support and guidance.

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GLOSSARY TERMS

The terms given below of lay expressions and indigenous terms include cultural meaning as this study has involved a cross-cultural study. Most of the expression terms are in the southern dialect, which can be different from other parts of Thailand.

Phu ying mai dee	Bad women
Sumseon	Promiscuous
Huaw ok deaw kun	In the same boat
Rung keit	Disgust
Kum lung jai	Encouragement
Tum jai	Accept
Mae	Mother

Chapter One

Introduction

Why mothers with HIV-positive?

There are an increasing number of mothers who are living with HIV/AIDS around the globe. Thailand is one of the Asian countries and there are about half a million (530,000) of Thai people living with HIV/AIDS (UNAIDS, 2014). In 2015, UNAIDS (2012) reported that there were about 180,000 women aged 15 and over living with HIV in Thailand. Many of these women are mothers with young infants (Kourtis, Lee, Abrams, Jamieson, & Bulterys, 2006). It reported that nearly all Thai women contracted HIV from sexual intercourse within monogamous relationships with partners who engaged in high risk behaviour (Liamputtong, Haritavorn, & Kiatying-Angsulee, 2012).

Because of the HIV infection, mother cannot provide breastfeed their babies. It is often found that most mothers are from poor family and background. Their poverty living has impact on the feeding practices. Many could not afford formula milk because of high cost formulation. The transmission of HIV through breast milk created huge dilemma to the individuals mother. This is because the individuals would consider and balance between the benefits of breastfeeding and the risks of not breastfeeding. They felt guilty if they cannot breastfeed but if they do breastfeed, they baby will have higher chance of getting HIV. Public or child health specialists and health care workers in many resource-poor settings are challenged by the infant feeding dilemma posed by HIV status. Whereas previously breastfeeding practice, especially exclusive breastfeeding, was a key strategy for child survival, the finding that HIV is present in breast milk has led to a re-assessment of the benefits of breastfeeding and avoiding breastfeeding is recommended to eliminate breast milk transmission of HIV (Liamputtong, 2013). This public health issue is also confronted by many women living with HIV/AIDS in southern Thailand.

Research concerning the lived experiences of motherhood among women from Thailand has been very few, especially in the southern region. The limitation of literature on motherhood among Thai women in northern part, it has been suggested that the process of becoming a mother depletes health of women and

well-beings (Liamputtong & Naksook, 2003a; Liamputtong, Yimyam, Parisunyakul, Baosoung, & Sansiriphun (2005); Liamputtong, 2007a), and women endure multiple burdens of motherhood (Liamputtong & Naksook, 2003b). More importantly, the question of what it means to be a mother as well as living with HIV/AIDS among Thai women has been neglected. Due to high rates of women living with HIV/AIDS in Thailand, I contend that this particular issue should deserve urgent attention. How would Thai mothers in southern Thailand see themselves as mothers while living with HIV/AIDS? What are the impacts of HIV/AIDS on motherhood? What are the impacts of HIV/AIDS on how they manage infant feeding practices, especially when they are not able to give breast feeding their infants? Thus, I should examine these issues in this research project.

Objectives

1. investigate the meanings of motherhood among women living with HIV/AIDS in southern Thailand.

2. examine the lived experiences of being a mother and living with HIV/AIDS among Thai Women in southern Thailand.

3. examine the perceptions and experiences of infant feeding practices among mothers living with HIV/AIDS in southern Thailand.

4. produce data for the development of effective and culturally appropriate policies for providing sensitive care for women living with HIV/AIDS and their newborn infants in southern Thailand.

5. enhance theoretical understandings of motherhood and infant feeding practices among women living with HIV/AIDS.

To understand these research questions and meet the study aims, a qualitative approach was chosen. This qualitative methodology is descriptive and exploratory in nature and relies on various sources. Its emphasis on anthropology and sociology encourages an understanding of the dynamic nature of people's worlds and their experiences. This approach also supported the use of combined qualitative methods.

The evidence was gathered through in-depth interviews and drawing technique with HIV-positive mothers. It was expected that these triangulated methods would result in data which could provide a deep understanding of experiences of Motherhood and infant feeding practices among HIV-positive women in Southern Thailand. Thematic

analysis, where the researcher takes part in the process of interpretation and induction, was employed to analyse the fieldwork data. This is consistent with qualitative studies where theories are developed by the emerging information, rather than testing existing theories per se (Suwankhong & Liamputtong, 2016).

Chapter Two
Experiences of HIV-positive mothers

This chapter illustrated the conceptual framework. The first part focuses on the concept of "moral career". Stigma theory is also used to illustrate phenomena under investigation. Why these both have been increasing attached health and academic professions are discussed. In applying this conceptual framework, it is anticipated that they will guide the collection of useful data, and assist in its analysis and interpretation better.

Moral career as a conceptual framework

In this study, I will situate my discussions within Goffman (1963)'s theoretical framework of "moral career"; in the case of this particular proposal, women and a moral career of motherhood. Goffman refers "moral" to the experience of the self or self-conceptions. Goffman (1963: 45) suggests that individuals who have "similar changes in conceptions of self" share a "moral career", which in turn may be "both cause and effect of commitment to a similar sequence of personal adjustments". The women share similar changes in their self-perceptions of being a mother, and hence motherhood becomes a "moral career" for these women as they mother their children. McMahon (1995: 154) suggests that "women see themselves as having achieved the characteristically feminine moral attributes of giving and caring through motherhood", and that this shared perception constitutes their moral career. In this proposal, I also refer to the moral career of mothers as not only changes in their self-perception, but also changes that occur in relation with the "female value system or ethic of care and responsibility" (McMahon, 1995: 153); here I refer to their responsibility as mothers and how they practise about infant feeding.

Goffman's conceptual framework of "moral career" is related to the concept of "identity". Identity, according to symbolic interactionists, is formed through shared social interaction. People make sense of their experiences through a common set of symbols and these symbols are developed and find meaning through an interaction (Brubaker & Cooper, 2000). Identity, according to Brubaker and Cooper (2000: 4), is conceptualised as a "category of practice". Identity, as a category of practice, is "used by 'lay' actors in some everyday settings to make sense of themselves, of their activities, of what they share with,

and how they differ from, others". In this proposal, I contend that identity as the category of practice may be adopted by the women to make sense of themselves as mothers and their mothering roles including infant feeding practices. As well, their identity as women living with HIV/AIDS and their changing social situations may make them conceptualise themselves as different from other "normal" mothers who are not affected by HIV/AIDS.

The concept of identity represents self as a social object. Therefore, identity places the self in social terms. Identity refers to the social meaning of the self. McMahon (1995: 29) argues that since identities are upheld through interaction, when individuals embark on different social relationships, pertinent identities must be formed. The social relationship of mothering a child, for example, is the social meaning of how women care for their children. Thus, this is the social identity of motherhood. Motherhood, in this sense, has the potential to carry "shadow images of immoral mother or bad mother". For this study, I contend that this is the image of mothers who do not conform to societal expectation of a good motherhood identity due to their HIV/AIDS status.

Goffman (1963: 130-131) maintains that individuals who fail to "acquire (the) identity standards" norm of the society will inevitably feel some ambivalence about their own selves. If women who are living with HIV/AIDS and becoming mothers feel that they cannot perform their motherhood career according to societal expectations (in this case they are mothers who cannot breastfeed their infants), they will inevitably feel ambivalent about their motherhood career and self-identity as mothers. McMahon (1995: 20-21) suggests that "children have become social objects of great cultural worth. Children carry the symbolic power to transform women's identities". Children thus become important to women's self-conceptions. Mothers usually connect with their newborn infants through the act of breastfeeding. Being able to do so can impact greatly on women's moral career as mothers. On the contrary, being unable to connect with their infants through the act of breastfeeding, women may have ambivalent feelings toward their mothering roles. And this will have great ramifications on their emotional well-being as well. Apart from "moral career" concept, diagnosed HIV/AIDS mother can be illustrated as common features of stigma.

The matter of stigma theory

Erving conceptualised stigma theory as a socially constructed labelling process used to distinguish persons based on possession of personal characteristics, resulting in

stereotypical beliefs about those who are labelled. Goffman (1968) defines stigmatising characteristics as "an attribute that is deeply discrediting" (p. 13) or as "blemishes of individual character" (p. 14). According to Goffman, stigma theory is constructed in order to give reason for the stigmatised person's inferiority and to justify perceptions of the stigmatised as a threat or to be feared by others. The outcome of this process is that stigmatised individuals experience a lack of acceptance and subsequent discrimination by others (Goffman, 1968). Stigma negatively impacts on those who experience it because an individual's perceptions of themselves is largely dependent on how they are treated and responded to by others (Goffman, 1968).

The concept of stigma can be said to be more than just possessing differences, rather, both Arboleda-Flórez (2008) and following Link and Phelan (2001) suggest that differences which are stigmatised are socially selected. Arboleda-Flórez (2008) states that these socially selected differences often develop through an association between the difference and a reason for fear being created. In order for stigma to exist, Arboleda-Flórez (2008) theorises that there must be two types of people. The first being those who perceive and recognise the point of difference, and the second being those who possess this attribute and thus are degraded as a result. Link and Phelan (2001), mentioned that stigma is also dependent on either social, economical, or political power being exercised.

Having said that, the concept of stigma has attached health care professionals and other professional groups in recent decades. This is because stigma contributes to various types of chronic health illnesses and health problems elsewhere. In many health conditions, in particular, it becomes a priority interest of public health and a matter of particular culture, society or even broader world (Greene & Banerjee, 2006; Heijnders & Meij, 2006).

Stigma is described as undesirable attribute reducing status of individual in the view of society and people around. Stigma thus tends to bring about discrimination and social inequality. It creates the social boundaries as it borders between normal and outsiders, between us and them. Thornicroft, Rose, Kassam, and Sartorius (2007, p. 192) contend that: "Stigma is a mark or sign of disgrace usually eliciting negative attitudes to its bearer". Following Link and Phelan (2001, p. 377), stigma will continue when "…elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them". Although each might define 'stigma'

similarly, substantial number of researcher related it in different fields of public health conditions (Merriam et al., 2001; Thornicroft et al., 2007).

There are problems of three components that involve in causing stigmatisation of individuals including knowledge (ignorance), attitude (prejudice) and behaviour (discrimination). Individuals somehow have no knowledge about what might lead them to stigmatisation (Thornicroft et al., 2007). Stigma gives the sense of discrimination which attaches to individual persons for life. Person who are stigmatised statuses are mostly brought about negative affects to their lives in many ways. It could destroy personal relationships, exclude or separate person from social contacts and networks, disregard individual rights, decrease potential roles of individuals. Thus, the final benefit of thinking about stigmatization among chronic ill health can call more attention to the ways in which stigmatised people could cope with the stress they are suffering (Frank, 1995; Heijnders & Meij, 2006; Pescosolido, Martin, Lang, & Olafsdottir, 2008; Sprung et al., 2011; Thornicroft et al., 2007; Wilson & Luker, 2006).

Motherhood with HIV/AIDS and stigma

Although many infectious diseases including HIV/AIDS are illustrated as common features of stigma, HIV/AIDS considered as communicable disease related stigma. Stigma has much impact on lived experience of motherhood, seeking for health and searching for treatment in many ways.

Goffman (1963) recognises the impact of stigma in the construction of a spoiled identity with a more contemporary thinking about identity. Parker and Aggleton (2003, p. 19) suggest that this enables us to ‘‘theorize changing constructions of identity’’ not only in relation to the experience of stigma, but more importantly ‘‘resistance to it’’ (Castells, 1997, p. 8). This is aligned with Castells (1997) who contends that there are three identities. First, legitimizing identities are ‘‘introduced by the dominant institution visa `-vis social actor’’. Second, resistance identities are ‘‘generated by those factors that are in positions/conditions devalued and/or stigmatised by the logic of domination’’. Last, project identities are formed ‘‘when social actors, on the basis of whatever cultural materials are available to them, build a new identity that redefines their position in society and, by so doing, seek the transformation of overall social structure’’ (Parker & Aggleton, 2003, p. 19). Indeed, it is on the latter two identities that my focus. In my

study, I will show that some women attempt to deal with stigma and discrimination by going public as a collective identity.

Mother with HIV/AIDS survival is seen as dynamic changing from the time that begins diagnose and continues for life (Liamputtong, 2013). Stigma occurs when society labels someone as tainted, less desirable, or handicapped. This negative evaluation may be "felt" or "enacted." A felt negative evaluation refers to the shame associated with having a condition and to the fear of being discriminated against on the grounds of imputed inferiority or social unacceptability. An enacted negative evaluation refers tactual discrimination of this kind. Stigma can lead to feelings of guilt, shame, and spoiled identity. It may increase the stress associated with illness and contribute to psychological and social morbidity. Stigma may also threaten personal identity, social life, and economic opportunities and can profoundly affect families and significant others (Wilson & Luker, 2006; Sprung et al., 2011).

The stigma associated with disease depends on whether or not the patient is held responsible for the disease and whether the disease leads to serious disability, disfigurement, lack of control, or disruption of social interactions. Some research suggests that stigma ascribed to controllable factors elicits a greater negative reaction than stigma ascribed to uncontrollable factors (Liamputtong, 2013).

Social support as buffering resources

Bloom, Stewart, Johnston, Banks, and Fobair (2001) describe that there are two distinct concepts of social support that most researchers have agreed upon. Structural support refers to the network of relationships which is in place between individuals and others including the relatives, friends, neighbours, and so on (p. 1513). The later aspect of social support is functional support. According to Mbekenga, Christensson, Lugina, and Olsson (2011), functional support comprise tangible assistance, emotional support and availability of information. Tangible or instrumental support refers to the specific assistance that other people provide to the individual: financial assistance, household chores, childcare, or the provision of transport to medical appointments and so forth. The emotional support includes messages which signify that the individual is cared for, loved, and valued. It has been suggested that the perception of the availability of tangible and emotional support is more critical than its actual occurrence (Drageset, Lindstrøm, Giske,

& Underlid, 2012). Informational support means the provision of knowledge that is relevant to the situation that the individual is encountering (Bloom et al., 2001).

Cohen, Gottlieb, and Underwood (2000) state that each type of support has its own function but they play integrative roles in meeting the needs of individuals. Different social support can be obtained from different sources and may become essentially important at different stages and trajectories of the person's illness. Landmark, Strandmark, and Wahl (2002) point to some typical sources of social support that a person may have: from family members, close friends, peers and health care professionals. Different sources of social support offer different levels of the support needed.

HIV-positive and motherhood

Women discover that they are afflicted by this disease in different stages of being mother. Some find out during their pregnancies and many becoming mother after diagnosed illness. Most HIV-positive women fear that they may die soon without having children. In some other societies, women are blamed if they are childlessness and they are assigned to play a salient role in childbearing (Liamputtong, 2013).

A lot of HIV-positive women with childbearing age wish to have children. They have high intention to live longer in order to look after their children. This desire is recognised as the role of motherhood as well as femininity attribute. For almost all HIV-positive women, despite living with serious illness and its condition, becoming motherhood allows them to "come back to life". Motherhood enables them to "reclaim their social identity" (Liamputtong, 2013, p. 5) and women can say that they are women like other women.

The advance of biomedical medicine in recent years provides better quality of life of mother with HIV-positive. Antiretroviral treatment (ARV) becomes the possible choice to reduce the transmission of HIV. This development can change the expectation of these women about having children. Although women have their own rights to have children, it is not an easy matter for those who are HIV-positive (Liamputtong, 2013). According to chronic illness condition (Suwankhong & Liampupttong, 2016), they not only take specific biomedicine package, but they have to manage and deal with physical, psychological and cultural issues related to the disease.

Having a child is significant mean for many women that drive them to manage the hostile social impacts for living with HIV-positive mother According to Liamputtong

(2013), many HIV-positive women used discourse of motherhood to negotiate individual identity. Apart from this, it can reduce deviant conditions and increase motherhood role act. However, women have to work very hard toward motherhood. Social support can be a buffering source for all HIV-positive mothers. The appropriate social support source is crucial factor to promote health of mother living with HIV-positive. It also can help them to live in the community better.

Motherhood and responsibility: A conceptual framework

Motherhood is a moral enterprise (Murphy, 2000), and becoming a mother is internalised in the sense of responsibility and care for their children (Liamputtong, 2006). The actions of mothers which are seen as a potential risk to their infant's health and well-being will invite blame. Infant feeding practices have also been bound up with moral judgements of mothers (Murphy, 2000: 296). In relation to infant feeding practices, the presence of children who are seen to be healthy and well has culturally constructed a new identity for women (Murphy, 2000). It is the identity of women as 'responsible' and 'moral' mothers.

Based on this premise, mothers who neglect to protect the health and well-being of their children, such as not practice breastfeeding, will render them morally accountable (Murphy, 2000: 298). However, for HIV-positive mothers who ignore certain potential risk reducing practices such as breastfeeding for their newborn infants against the advice of health care professionals will find themselves in potential 'moral danger' (Lupton, 1995: 425) as breastfeeding can transmit HIV to their infants (Coutsoudis, 2005; Kourtis et al., 2006). Individual mothers who fail to ensure the health and well-being of children are at risk of being seen as persons who failed to act responsibly (Murphy, 2000: 298). Consequently, mothers' identities as moral and responsible persons will be threatened.

Motherhood and responsibility are the main issues that many HIV-positive women have to deal with. As these women are advised not to practise breastfeeding, their sense of motherhood and responsibility can be questioned. To defend themselves as a good mother, I shall show in this paper that HIV-positive mothers in this study are caught in this cycle of good motherhood and responsibility. As such, these mothers set about doing many things in order to establish that they are responsible and good mothers.

HIV infected mother and infant feeding practice

There newborn babies are infected HIV every day. These babies are born in low income or poor country. Most cannot live longer than five days after born. It reports that about 40 per cent of newborn baby are infected through breastfeeding (Liamputtong, 2013). HIV-positive mothers are discouraged to feed their baby and this is a key strategies used as a part of prevention mother to child transmission of HIV (WHO, 2016; Coutsoudis, 2005). Rather they have two options to select about feeding their infant; exclusive breast feeding with early weaning or replacement feeding. Many HIV-positive mothers cannot afford to do so because of economic, cultural and social concern. Replacement feeding can be a problematic among these mothers (Liamputtong, 2013).

All HIV-positive mothers are advised not to give breastfeed to infants (Kourtis, et al. 2006; Liamputtong, 2013). But most mothers reside in developing countries and are from poor background and this has a great impact on their feeding practices (Desclaux and Alfieri, 2009). Mothers have to confront with alternative breastfeeding methods which mainly go for formula feeding. This increases further risk of health problems especially malnutrition, respiratory tract infection and diarrhoeal disease among infants group (Liamputtong, 2013).

The result of HIV-positive leads to exclusive breastfeeding as it found that HIV presents in breast milk. Although exclusive breastfeeding strategy can against the mother to child transmission of disease and increase survival rate among infants, it creates dilemma issue for HIV-positive mothers (Desclaux & Alfieri, 2009; Doherty, 2011). Because of this, the health policymakers elsewhere strongly promote eliminating the transmission of HIV through breast milk. It suggests that HIV-positive mothers should receive sufficient information. They can have guidance for appropriate practice later on (Doherty, 2011).

Conclusion

Motherhood has huge meaning to women who are living with HIV-positive. In recent years, they are provided advance biomedical care making this vulnerable people chance to lead their normal life as woman being. ARV can increase the quality of life of women as it can reduce the severity consequences of disease as it eases risk of mother to child transmission. Thus they also offered opportunity to have children with good health. However, to meet the study aims, a qualitative approach was chosen. The qualitative methodology is descriptive and exploratory in nature and relies on various sources. Its emphasis on understanding of the dynamic nature of people's worlds.

Chapter Three
Qualitative approach: Understanding phenomenon being studied

This chapter outlines qualitative research paradigm and methods available for use in this study. Ethical considerations that can arise in research on human lives are noted. The process by which the researcher collects the data is described. In the light of the context and circumstances, decisions about the research strategies to be used in the study are discussed.

Methodology

I adopted a qualitative approach for the proposed research since the approach allows the researcher to learn about "persons' lives, stories, [and] behaviour" (Strauss & Corbin, 1990: 17). This qualitative approach is suitable due to qualitative researchers accept that, in order to understand people's behaviour, I must attempt to understand the meanings and interpretations that people give to their behaviour. Qualitative approach allows us to closely examine the meanings and interpretations of motherhood, infant feeding beliefs and practices, and living with HIV/AIDS within the perspectives of Thai woman.

The strength of using qualitative methodology is that it has a holistic focus, allows for flexibility and also allows the participants to raise issues and topics which may not have been included by the researcher, hence, adding to the quality of the data collected. This methodology is most appropriate when the researcher has little knowledge of the research participants and their world views (Liamputtong, 2013) and when the researcher wishes to work with marginalised and vulnerable people (Liamputtong, 2007b).

A story of study site

Southern Thailand is divided into 14 provinces with a total population of about nine. The area has a distinct geography because it not only is surrounded by a range of mountains and hills but also operates as a gateway for trade with other countries because of its position on the peninsula. Because of its geography, southern Thailand has been influenced by multi cultures. People have close ties with one another, and networks within the communities are strong. Those living in the hills rely on hunting and gathering forest products for subsistence while residents of the lower lands maintain their lifestyles

by growing rice and fishing. They barter with each other and are self-reliant. The traditional occupations supporting economic growth are agriculture, hunting and fishing. The rubber tree is the main economic plant in this region. The southern region, however, differs from other Thai regions because Buddhism and Islam lead people to have different lifestyles, beliefs, languages and cultures. Buddhists communicate using the local Thai dialect while the Muslims use Yawi. Each group follows its own customary practices (Nartsupa & Lertvicha, 1994).

From my observation, the provinces are fast developing into a modern society. It has an increasing number of modern supermarkets, department stores, shopping centres, local markets and other facilities to support people in a contemporary urban lifestyle. Most of the local policy-making bodies, namely the business sector and the government bureaucracy, are located in urban zones.

Community lifestyle is typically traditional and peaceful. People follow practices related to their religious beliefs and this reinforces community solidarity. Most community members give alms to monks every morning to gain merit and receive good fortune. There are three Buddhist temples for the ten villages. In Thailand, the temple is recognised as a central location or heartland of the community. The temple is the place used for religious activities and for communal gatherings. This community and its people uphold traditional beliefs and religious practices by visiting the temple, moque and the monks on important religious days.

Methodology

I adopted qualitative approach as it allows the researcher to learn about the lives of individuals (Creswell, 2014). The qualitative approach permitted us to closely examine the meanings and lived experiences of motherhood, infant feeding beliefs and practices, and their perspectives of living with HIV/AIDS. Descriptive phenomenology was adopted as the methodological framework as I attempted to understand the women from their own lived experience as an HIV-positive mother (Carpenter, 2017).

This study has combined several methods to gain deeper understanding the phenomenon under investigation: in-depth interview and drawing method.

In-depth interviews

In-depth interviews (Minichiello et al., 2008) and some participant observations (Liamputtong, 2007b, 2013) will be conducted with a number of Thai women in southern Thailand. The number of participants will be determined by Strauss's sampling technique (1987), which is to stop recruiting when little new data emerge. My previous experiences indicate that saturation tends to occur around the 30th interviews. In this study, I continued to recruit at least 30 participants. Purposive sampling technique (Liamputtong, 2013; Suwankhong & Liamputtong, 2016) was adopted; that is only Thai women who are mothers and living with HIV/AIDS will be approached to participate in the study. The participants will be recruited through personal contacts that I have made in my previous research. In conducting research related to women, motherhood and living with HIV/AIDS, the recruitment process needs to be highly sensitive to the needs of the participants (Liamputtong, 2007b). The sensitivity of this research will guide how I would approach the women and invite them to take part in this research.

The interviews will be conducted in the local Thai language to maintain as much as possible the subtlety and any hidden meaning of the participant's statements (Liamputtong, 2010, Suwankhong & Liamputtong, 2016). Prior to the study being conducted, ethical approval was obtained from Thaksin University Ethic Committees. Before appointment for interviewing, the participant's consent to participate in making an the study will be sought. After a full explanation of the study, the length of interviewing time and the scope of questions have been explained, the participants will be asked to sign a consent form. Each interview can take from one to two hours.

Each participant was paid 300 baht as a compensation for their time in participating in this study. This incentive is necessary for a sensitive research like this as it is a way to show that research participants are respected for their time and knowledge (Liamputtong, 2007b, 2013). I have adopted this approach with my previous researches in rural community of Thailand (Liamputtong, 2007b, 2010, 2013).

Drawing method

Situated within the feminist framework, I used an innovative method involving drawing technique. Drawing is "about how people see the world in both its simplicities and its complexities" (Guillemin, 2004, p. 275). Drawing method is a form of visual imagery which has started to be widely used with vulnerable people and for sensitive topics (Guillemin, 2004; Liamputtong, 2007). According to Guillemin (2004: 272), drawing methodology provides "a rich and insightful research method to explore how people make sense of their world" and hence, it is suitable for conducting research with vulnerable people (including women living with breast cancer and women from ethnic minority groups). It is argued that vulnerable people tend to have difficulty expressing their emotions and understanding of phenomenon through conversations or written words. Drawing could better assist them to express their feelings and tell others about the meanings of their illness conditions. This method is often used to complement other methods such as in-depth interviews to obtain insight understanding of the participant's world

In this study, the drawing method was employed after the in-depth interviews. Participants will be given a packet of 12 coloured pens and blank flip-chart papers for the drawing session. The HIV/AIDS mothers who have children aged under five years old were invited to draw the meaning of motherhood, infant feeding practices and while living with HIV/AIDS. When they finish drawing, they were asked to describe the image they have drawn. The descriptions will be tape-recorded.

With permission from the participants, all interviews will be tape-recorded. The tapes will be then transcribed for data analysis. The theoretical framework guiding this study is situated within a phenomenological approach. The in-depth data was analysed using a thematic method guided by phenomenology (Liamputtong, 2013; Suwankhong & Liamputtong, 2016). Phenomenology, as Becker (1992: 7) argues, aims to interpret "situations in the everyday world from the viewpoint of the experiencing person". Phenomenology attempts to "determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it" (Moustakas, 1994: 13).

In this proposed study, the interview transcripts were used to interpret how the participants describe their meanings of motherhood, infant feeding practices and living with HIV/AIDS in their everyday lives. The focus of this analytical approach was on

identifying not only themes and patterns that emerged from the participants' accounts of their lived experience, but also "contradictions, ambivalence and paradoxes" of their narratives (Lupton, 2000: 53; Liamputtong, 2013).

Participant profiles

Considering the aims of this study, the key participant groups in my theoretical sampling approach included HIV-positive mother who have children aged up to five years old. My previous experiences indicated that saturation tends to occur between the 20^{th} and the 30^{th} interview in each location. It is then anticipated that about 30 participants were obtained by a purposive sampling technique. This method was used to select key informants who meet the study criteria and could provide rich data relevant to the study purposes (Bernard, 2006; Patton, 2002; Silverman, 2010). The number of participants was determined by theoretical sampling technique, which is to stop recruiting when little new data emerges (Liamputtong, 2013).

Recruitment was carried out through a personal network of the researchers who are members of the Thai community in southern Thailand. In Southern Thailand, I initially contacted health care providers at the primary health centre. Snowball sampling technique was used to expand the number of participants (Biernacki & Waldorf, 1981). Snowball sampling requires the researchers to initially select another community that reported HIV-positive mother (Liamputtong, 2007, 2010).

Ethical considerations

Ethical considerations involve both the requirements of Human Research Ethics Committees and it is the researcher's responsibility to the participants who are being studied. Ethical consideration is a necessary concern for the research that is involved in people's life. Researchers should be careful that their data gathering does not impinge on the well-being of the participants (Hansen, 2006; Liamputtong, 2010). This study conducted among Thai women in Thailand. Thus it has approved by the Thaksin University Human Ethics Committees.

Data management and analysis

Almost all information and data were managed and analysed during the period of the fieldwork. Glaser (1978, p. 56), depicts data analysis as generating "an emergent set of categories and their properties which fit, work and are relevant for integrating into a theory." Transcriptions of in-depth interviews was transcribed and downloaded electronically into the researcher's personal laptop. The in-depth interview data were analysed using thematic analysis (Liamputtong & Suwankhong, 2016). I analysed these data using a manual coding technique. Grounded theory, using open coding, axial coding and selective coding guided the process of data analysis.

Transcriptions of each in-depth interview were transcribed by the researchers in Thai. Analysis of the findings occurred during the data collection period to ensure saturation of the data. I began with the process of open coding, which involves identifying any codes that exist within the participant transcripts. Once the codes had been identified, axial coding was undertaken. This step allowed the researcher to reconceptualise the research material by making new and different connections whereby patterns and more specific categories begin to emerge from the findings. Axial coding ensured that the themes had been completely elaborated upon. It must be noted that as both author are Thai native speakers, I analysed the data in the Thai language. This allowed us to maintain any subtleties of the data. I only translated verbatim examples that presented in my findings. To ensure the correct meanings of the translation, the first author did the first translation and this was cross-checked by the second author (Liamputtong & Suwankhong, 2016).

Conclusion

I have outlined in this chapter the qualitative approach. This methodology is used to describe and understand social world. The qualitative study requires combination of methods to gain insight phenomena being investigation. This study employed in-depth interview and drawing to explore all aspects of the study objectives.

Chapter Four

Motherhood as career

This chapter outlines the findings from a qualitative study among HIV-positive mother in southern Thailand. The possible themes emerged from initial data analysis are presented here.

Socio-economic of study participants

There 30 mothers living with HIV-positive participated in this study. Their profiles showed that most HIV-positive mothers aged between 19 and 45. The educational levels are varied from primary to secondary school level. HIV-positive participants predominantly are married and unemployed. Two third are housekeepers. Monthly income ranged from 900-12,000 baht. The number of children is between one and four with the youngest is about one month and the oldest is 18 years old. However, nearly all have no family history diagnosed HIV-positive whereas three participants have relative diagnosed HIV-positive. The socio-demographic characteristics of HIV-positive mothers are presented in Table 1.

Table 1: Socio-demographic characteristics of the participants (n=30)

Socio-demographic characteristics	n (%)
Age (Years)	
≤ 25	5(16.7)
26-30	4(13.3)
31-35	8(26.7)
35-39	8(26.7)
40-44	4(13.3)
≥ 45	1(3.3)
Education level	
Primary school	15(50.0)
Secondary school	15(50.0)
Marital status	
Married	26(86.7)
Divorce	1(3.3)
Widow	3(10.0)

Table 1: Socio-demographic characteristics of the participants (n=30) (Cont'd)

Socio-demographic characteristics	n (%)
Occupational	
Housewife	16(53.3)
Agriculture	4(13.3)
Employee	8(26.7)
Trade	2(6.7)
Monthly income (Baht)	
<1,000	2(6.7)
1,000-5,000	7(23.3)
5,001- 10,000	15(50.0)
10,001-15,000	6(20.0)
Number of children	
1	7(23.3)
2	10(33.3)
3	9(30.0)
4	3(10.0)
5	0(0.0)
6	1(3.3)
Period of diagnosed (Years)	
< 1	3(10.0)
1-5	10(33.3)
6-10	14(46.7)
>10	3(10.0)

Perceptions of HIV/AIDS

All mothers living with HIV participating in my study viewed HIV/AIDS infection similar. They described overwhelmed anxiety and uncertainty about their future life and motherhood status after diagnosed. HIV positive is perceived as life threatening and it is a frightening disease which creates stress and destroy their lives because they experienced that this particular disease is not only uncured disease, it is stigmatised. No one accepted a person who is infected. The individuals have to face with physical, mental and social sufferings. All participants in this study thought of death after being diagnosed with HIV/AIDS. Malai shared her story when she diagnosed HIV:

> [I] thought of walking to the street to get crash…but afraid [to do so]…walking along the street and crying…cannot change anything…don't know what to do next… want to suicide…HIV is death disease and no cure.

Kampang added her view:

> it is something like thunderbolt…never thought…still questioning is it true… is it real…am I infected? It remains in my deep heart…

Lahn added her description of HIV/AIDS through drawing:

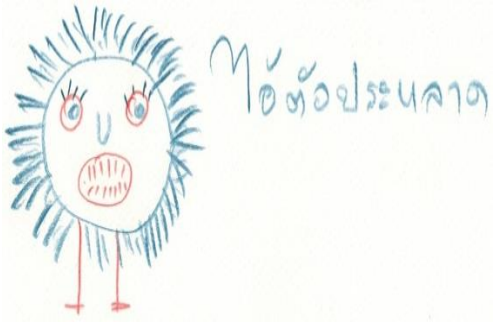

Figure 1: HIV as monster

Most often, the emotional reaction was the result of being diagnosed with HIV/AIDS. They expressed the first moment as something that was very hard for them to go through as feeling no future life. These women would encounter many losses and difficulties for the rest of their life. They also imagined that they will face with many negative side-effects of HIV treatment as well as social consequences of HIV-positive. All women concerned that HIV/AIDS was burdensome and have to deal with their

unfortunate life alone. Somsri illustrated her account: "…[I] was shock…feeling stuck and overwhelmed…don't have anything left in my life…no hope…" Songkean also expressed similar notion about HIV-positive person here:

Figure 2: HIV as a killer

Diagnosis of HIV-positive

The vast majority of HIV infected mothers interviewed found out about their serological identification during the pregnancy. Many found out the disease in previous pregnancy when visiting doctors while some decided to visit the hospital for blood check-up when their husband got sick or passed away. Karan expressed her deep thought through the drawing here:

Figure 3: Unfortunate and fortunate

All women interviewed accepted the diagnosis without much consideration as to their partners or themselves. Many women participated in this study reported that their partner knew about their HIV status before getting married. Although these women recognised that they are vulnerable person, husbands showed empathy and gave best support as much as they could, expecting to reduce the difficulties and sufferings their wife would encounter.

Apart from this, all mothers with HIV-positive give first priority to their own health. They paid attention to medical management for HIV- infection because the patients will face death sentence sooner if they fail to follow medical prescription. Many women experienced that the more they miss good medical management, the more they could get advanced HIV and face severe condition. Thus, different mothers with HIV-positive in this study manage antiretroviral therapy treatment in different ways, hoping to prolong their life. I found that the vast majority of mother with HIV-positive participating in this study preferred setting alarm as to help reminding them taking antiretroviral tablets on its schedule. Suree said: "We have to look after ourselves…taking drug on time… have to stick with it…I then can stay longer for my kid…".

HIV positive and fertility

Diagnosed HIV-positive does not eliminate the desire of women from having children because it signifies to reserve for the womanhood being. I found that some HIV-positive mothers involved in my study was very keen to have baby although they are infected HIV. They were confident that their baby have high chance of survival and have less possibility for HIV infection because of advanced modern medical care and its facility. They were confident that they will receive sufficient information from health professionals including appropriate practice throughout pregnant period. This support can ensure them that they can continue the pregnancy. Suree, 34 years old mother, shared her wish:

> …the doctor said that don't need to abort the baby…will attend ANC clinic as it has high chance that not infected through baby…doctor provide information emphasizing on how I can live long…what I should do, something like that…

Amrine expressed her wish of having a baby although she is a HIV-positive mother through drawing:

Figure 4: HIV-positive mother and baby

Many mothers with HIV-positive would not want to have further baby, if they have choice. The reason of not having children varied. About two third stated that they did not plan to have more kids while some stopped the opportunity for further pregnant. Most mothers left the decision of having further baby to their partners. They would if their partner said so. Several partners intended to have baby and did not worry much if there chance of transmission from mother to child because of the advanced medical care provision. Mother can receive close care from health care provider to prevent the transmission HIV to the baby. Mother herself also takes antiviral medicine continually, so it could reduce the risk of transmission from mother to child.

Stigma and disclosure

Women diagnosed HIV-positive is commonly labeled as suspicious and often blamed as *phu ying mai dee* (bad women). Because of their HIV status, many women experienced violence from people in their community. Stigma has painful consequences for mothers living with HIV-positive. If their HIV status becomes known to public, family members as well as children may be stigmatised. They thus do not disclose their health status to anyone including their family members. Many tried to isolate themselves from their friends and social network to hind HIV illness. Their HIV status then can be

protected from being stigma. Pang disclosed her negative experience of being HIV-positive mother:

> At the beginning [I] cannot *tumjai* (accept)…relatives and neighbor caused me thinking too much…my kids went to their home. They not allowed my kid to go inside their house. They said to my kid that "you go back to your home…don't come to my house. You brought disease here…

Sopee also has experienced discrimination from her neighbor because they doubted that she was HIV-positive mothers and illustrated such negative experiences by sketching design here:

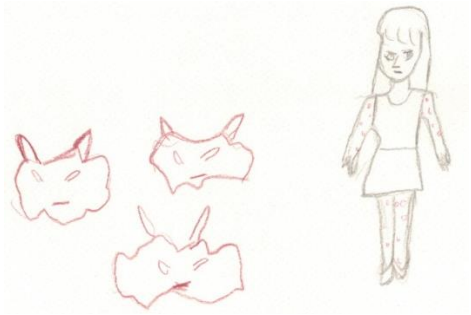

Figure 5: Being disgusted by others

There obvious signs that people can recognise if a person is infected HIV. Many women with HIV-positive in this study described that a person with HIV-positive usually shows such symptom as skin rashes and appears bumps. This typical symptom is a common presentation of HIV/AIDS person and is one of symptoms that can use to detect the disease. All participants perceived these symptoms can be signified of HIV patient. Its symptom creates shame and stigma to the individual persons. Flow stated:

> This disease absolutely appears skin rashes all body…other people can know if I am infected… it is noticeable symptoms of this disease…very shameful…".

She also emerged her worry through drawing

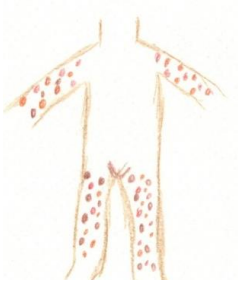

Figure 6: Noticeable signs of HIV-positive

However, the stigmatisation is not quite a big issue for many mothers living with HIV infection participating in this study. They experienced that in some societies seem to understand and accept mother with HIV-positive better. It is because the policy makers and healthcare providers kept informing their people about cause of such disease and promoted giving positive support to HIV-positive patients. Sunee ensured: "In the past, if one infected, absolutely die…no cure…now organizations and nurses give us knowledge and information…lots of campaigns…then individuals are less stigmatised…". Suree also stated:

> They not join meal…no talking… gossip…in the north part [of Thailand], if died, no one will participate in dead ceremony of HIV-positive person. But after the information about HIV was promoted, this picture has decreased. Recently, I visited home I feel good because when having meal, they show not *rung keit* me (disgusting) … encouraging me *kum lung jai* (encouragement).

Side effects of anti HIV medicine

Many mothers with HIV-positive experienced negative side effects of anti HIV medicine provided by modern medical service system. Anti HIV medicine has a negative impact on women's general appearance, body image and psychological function. Often, the treatment causes these women to suffer. They also continue to endure the illness and treatment processes for a long period of time. These traumatic experiences reduce the quality of their lives. All HIV-positive mothers agreed to follow the prescription as to live long. Keen articulated that: "why I have to take this medicine for the rest of my life…now I feel ok as it gives me life and can do many things…". She further explained: "have to take tablets for my kid…will do my best for them and as long as I can…they are most important for me now…let forget partner…".

Some HIV infected women participating in my study experienced anti HIV medicine dreadfully. The side effect of this medical group changed their body image and identity, leading to lose the feminine appearances amongst these women. A number of HIV-positive mothers are far less likely womanhood after taking such treatment option. Oranee complained: "Top part of my body looks big …low part is very thin…looking weird…not like woman" She further said: "Everyone who takes this kind of medicine look like monster…awful… like a man". Some types of antiretroviral drugs effects blood

circulation system. It causes pale, loss energy and frail reducing the individual's capacity to do works and perform various social roles.

Being a mother living with HIV-positive and social support

Mothers with HIV-positive in my study encountered life threatening. They suffered from fear, poor social relation as well as live in a state of uncertainty for the rest of their life. Some may not be able to cope with changes, and this results in stress and feeling of isolation. The intensity of stress and anxiety experiences lead to low level of general well-beings amongst these vulnerable mothers. Kong illustrated her deep loneliness feeling over this sketch:

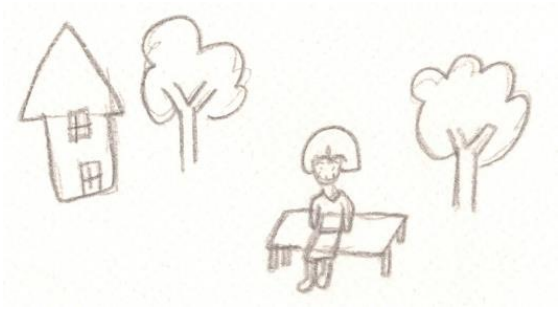

Figure 7: Depression and isolation moment

Often mothers with HIV infection do not have sufficient social support. Most received support from several sources. More than half of these women received support from their husband or partner whereas small number received discouragement from these people. One third decided to join the support group provided by health care professional. The main aim of this group is to provide as much as support for susceptible mothers to promote their health and well-being. The one who attended the group could feel that she is not alone in the world. She rather has chance to meet other mothers who are HIV infection. Suree shared her view:

> This group is for people who diagnosed HIV-positive…so feeling good to share difficulties and things with people who are in same situation…*huaw ok deaw kun* (in the same boat) able to talk with everything.

About one third of mother participated in my study preferred to join the support group organised by health care centre. They hoped that meeting with mothers who experience similarly could provide them many advantages and support. Attending such

group could empower these vulnerable mothers for further hope, so that they could live longer. Songkean stated:

> Good to join [support group] as we can see that not only us that ill but there are others…we have friends who are like us. We also have chance to talk and listen to their story and practice…so [we] can adapt and use in [our] life.

Many mothers with HIV-positive were reluctant to join support group provided by health care providers at the local health centres. They worried if they will expose themselves to others but want to keep their story secret as long as possible of throughout their life. Joining the group could create stress as they might be prejudged by society more. Some mothers with HIV-positive interviewed were not willing to participate in the support group available at the local hospitals because the service was not suited their lifestyle and need. They considered that joining support group possibly not able to bring any benefits to their life enough but shame.

Buddhist beliefs play the important part in dealing with emotional sufferings among mothers living with HIV-positive. Although there are various ways to manage emotional problem, many desired making merits while some opted to go for meditation practices, depending on their convenient and lifestyle. Common way to relieve tension and stress were pray and meditation. Meditation practice was a common practice to calming the feeling of loss and grief. These options have integrated in individuals' daily life as these practices are perceived as encouraging factors to promote them to more peaceful life. I found in this study that almost all HIV-positive mothers followed these techniques to cope with sufferings and difficulties.

Another strength factor encouraging these women staying strong is child bonding and their loves one. The vast majority of study participants proudly described a powerful support they received is from this source. Husband and children presented supportive during diagnose and throughout treatment stages. They shared all responsibilities and provided special care when encountered emotional and physical difficulties. This aspect brought them best support which can increase them hope and can live with this evil disease. Songkean described about the support she received from her loves one:

> Very pleased that my kid concerns about my illness…the older one always takes medicine for me…he knows how many tabs I have to take. For the younger one is just kindergarten student sees me taking tablet… also remembers how many tablets I have to take…he then prepares for me …

Experiencing breastfeeding

Three main themes emerged from the interviews: 1) To breastfeed or not to breastfeed: Infant feeding practices, 2) Infant feeding practices and the notion of a good mother, and 3) I will do everything I can to replace the loss. In presenting the women's verbatim quotes, I used pseudonyms so that their true identity remained anonymous.

To breastfeed or not to breastfeed: Infant feeding practices

All participants believed that breast milk was the best option for their infant and was seen as a primary source of nutrition as opposed to formula or other kinds of milk. The women believed that since breast milk was produced from their breast it could boost the immune system of the infant and prevent or reduce the risk of illnesses. Many also suggested that breastfed babies would provide better growth development and boost immunization.

> Breast milk provided by the mother is the best nutrient for a baby. Milk from the mother's breast contains better nutrients. Because of this, it is much better than formula milk. (Jaru)

All participants in this study said that breastfeeding was an expected role of being mother. But they made a decision not to breastfeed their baby due to the health advice given by health professionals. These mothers understood that breastfeeding would be a main route of HIV transmission to their babies, although they are taking AZT. One participant shared her perceptions and experiences of why she did not breastfeed her child:

> No…I don't breastfeed as the doctors told us that we should not do so. The doctors would not allow us to breastfeed. They provided formula milk for free. Doctors told us to give babies this kind of formula provided by the hospital only. (Sirin)

Naree also expressed her experience:

> The doctors told me that I cannot breastfeed my baby. The (doctor) quickly said this after I gave birth that I have to bottle-feed my baby. For mothers living with HIV, breastfeeding is not recommended.

No exception, mother perceived that HIV positive caused them to not breastfeeding. They considerably regret and some cases showed anger although they received this information about breastfeeding as it is possible transmission route at the

earlier stage. Many mothers interviewed felt that they cannot be a good mother like normal one because they were not allowed to give breastfeed. But the health policymakers provided formula milk to their baby from birth to one and half years old. All mothers blamed themselves and recognised that they are deviant mother. Take the case of Flow whose son now aged 5 years old: “very upset…keep thinking why I cannot give my milk to my baby…very hurt…cannot [breastfeed]”. Because they cannot give breastfeed, HIV-positive mothers intend to compensate by many means. Keen articulated that: “This is because mom can do everything for kid… it doesn’t matter you are HIV-positive mom or uninfected one…mom can die for kid...for kid mom can do all…”. Suree who faced same experienced further stated her intention:

> No it makes me think that we have to compensate more than just feeding food, water…not much worry…only thing that I think is that will I should have enough money to buy formula milk for my kid? That’s it…because cannot give breastmilk…

The risk of HIV transmission through breast milk created difficulty for mothers with HIV-positive. All mothers with HIV-positive that milk is only one substance nourishing their baby’s health. But as they are infected HIV, all have to accept the condition with no giving breastfeed to the baby. Otherwise, it increases high chance of disease transmission to their baby. A part from this, health care providers always give guidance in choosing the suitable options and safe for child. Malai explicated her difficulty and her appropriate choice for her child: “ It is upset. I wanted my baby to impress with breastfeed. I supposed that why I cannot…I can reassured the benefit of breastfeed…but because I am infected, so I cannot…”. She added further details: “It is better not to give disease to my baby… still have other mothers who are in good health but not do breastfeeding…”.

The participants were also advised by their health professionals not to practise breastfeeding because they were on Highly Active Antiretroviral Therapy (HAART). Their health professionals suggested that if they (the mothers) loved and cared for the future of their infants, they should not breastfeed their infants.

> We knew that we cannot feed our breast milk to our baby. If we love them, just don't breastfeed them…just don't. We don’t want them to be exposed to the disease, do we? (Suree)

Formula feeding was acknowledged by the women in this study as the best supplement diet for infants who were at risk of HIV infection. Infant formula is provided for HIV-positive mothers with free of charge during hospital stay and by local healthcare centres across Thailand until the infant turns one and a half years old. Although infant formula could fulfill nutrient requirements of the infants, some infants developed allergies from drinking infant formula. These mothers had to seek alternative means for feeding their infants. Many searched for different brands available in the community. Some used pasteurised milk products to ensure a safe option of infant feeding. Sirin stated:

> If my baby was allergic to a formula, I had to look for other choices. It is what we have to do as our baby needs sufficient nutrients. I have to look for other types of formula for my baby, but it is very costly.

Each HIV infected mother received about four packs of infant formula per month from the health care centre and hospital at the locality. Nearly all mothers in this study claimed that this amount was insufficient for their infants. They had to buy extra formula and it became a burden for them and their family. Many said that infant formula feeding was very costly and they could not afford the cost in the long term.

The majority of HIV participants in this study came from low- to middle-income families. Because of the high cost of infant formula, many mothers could not afford to obtain formula that contained the recommended amount of nutrients that infants need. They went for the one that they could afford and are available in the community even it contained lower nutrients. Kanok said that “four packs a month are not sufficient for my babies. I instead gave him pasteurised milk or something like that as supplements…to reduce cost”. Jira further added: “I gave powdered milk at that time. But when I did not have enough money, I gave the baby sweetened condensed milk. I thought it was better than not giving him anything. It is a lot cheaper”.

Poor mothers, in particular, faced a dilemma in terms of not being able to afford good infant formula for their infants. Although many felt anxious that cheap feeding choices could lead to an unhealthy life of their infants, later on, it was the only choice they could have. Sri, a widowed mother, said “by giving my son cheap milk, he might not get sufficient nutrients or he can get diarrhea. But I have no choice”. She added:

> I have to give condensed milk although I don't want to do. I have three children. I don't have much money to buy formula milk for the third one because it is too expensive. I gave him condensed milk instead as I have to save money for other necessary things and for his future too. It is a pity that I have to do this.

Infant feeding practices and the notion of a good mother

The majority of mothers felt very guilty because they were unable to breastfeed their infants. Even though they wanted to breastfeed their infants, their breast milk was considered as 'poisonous' to their baby. Thus, they saw themselves as an irresponsible mother or a useless mother. Jira expressed her feelings:

> I felt very upset as I think I am not being a 100% *mae* [mother]. I saw others can breastfeed but I cannot do it…It's a pity that I cannot breastfeed my baby. I became a useless and worthless mother. It is so sad. I was crying, especially when I have to feed him with formula. I did not know what I could do.

In her drawing, Daran illustrated her disappointment:

Figure 8: Feeling guilty and upset

The women often inquired about breastfeeding practices from other people which increased their anxieties for fear of being seen as a bad mother. Because breastfeeding was a common practice among mothers in the local area and if a mother did not practise breastfeeding, it would be seen as unusual. People can doubt if they might be afflicted by communicable disease. The women also pointed out that in rural communities in particular people tended to observe such behaviour and assume negatively if mothers did not breastfeed. Many told us that they felt guilty for having HIV. This created an

emotional burden among the women. Lumyai stated: “The relative of the mother next to my bed asked me why I didn’t breastfeed. I felt very upset. She asked me if I had a serious illness”. Due to situations like this, the women had to lie to avoid being despised or disparaged.

> After I was discharged from hospital, my relatives visited me at home. They asked how often I breastfed my baby. I told them that I cannot breastfeed because of my flat nipples. I didn’t know what to tell them. I do not feel good about it. (Keen)

Although the women felt ambivalent about not being able to breastfeed, many tried to think in positive ways. They suggested that many HIV-positive mothers did not breastfeed their infants and bottle-feeding had become more common in Thailand nowadays. The women believed that this could lessen suspicion from others in their local communities. Nha commented:

> Many healthy mothers in my community bottle-feed their child straightaway after they are discharged from the hospital. They only do this [breastfeeding] when they are at the hospital because the doctors force them to do so. This practice is normal among mothers. Thus, if I do so, neighbours and others would not have doubt about me or ask why I do not breastfeed as a mother should do.

Some women tried to find reasons to deal with the feelings of failure, which could decrease their emotional dilemma. Some women suggested that formula feeding could offer their infants many good nutrients. Lumyong, for example, remarked: “I use powder milk a lot nowadays as it contains lots of good nutrients. I can see many children grow up faster than those who are breastfed.” Other women tried to find the negative aspects of breast milk to reduce their feeling of disappointment from not being able to breastfeed.

> The babies often get hungry if they are given breast milk. They cannot sleep long. Nowadays, there is powder formula that contains high protein and lots of nutrients available for babies. It can be used to replace breast milk, I am sure. In fact, if the mother does not eat well, she cannot produce good milk for her child and the child may be at risk of malnutrition. (Nha)

Importantly, the fact that they did not breastfeed in order to prevent HIV transmission to their infants was seen as an act of a good and responsible mother. In Nuree's view, "Not being able to breastfeed doesn't mean we are bad mothers. If we do not breastfeed, our baby won't get the infection, right". Suree explained her feeling through her drawing:

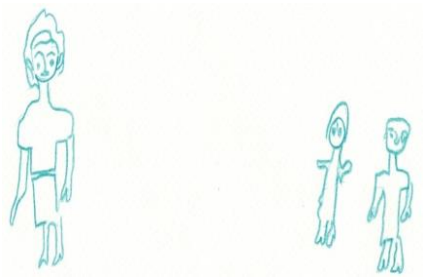

Figure 9: Keeping infants away from breast milk to prevent them from getting HIV

I will do everything I can to replace the loss

Because HIV-positive mothers are recommended to avoid breastfeeding, and they had accepted this reality, they looked for alternative means to promote the health of their infants. Some mothers introduced other diets although the infants were still under six months old. Many gave rice porridge in addition to infant formula while some fed their babies mashed banana for sufficient diet replacement as rice and bananas are an abundant and low-cost food in Thailand. The women believed that this helped to promote a normal weight and avoid malnutrition. Naree said:

> If I could choose, I would feed my baby myself [breastfeed] up to six months at least. I feel sorry for them. If mothers are living with HIV, breastfeeding is an impossible practice because the babies will be infected. My poor baby. I gave him mashed banana instead as it contains good sources of nutrients.

Apart from concerning about food consumption, mothers expressed their concerns toward the well-being of their infants through physical contact. Most mothers made special attempts to stay close to their infants with lots of hugging, kissing and babbling them. They spent most of their time with their infants and kids and encouraged child to touch their breasts. Many mothers also put their infants on their laps and hold their hands when bottle-feeding. This provided the mothers a sense of having a physical

contact similar to the act of breastfeeding. All the women remarked that through these physical contacts, it provided them with a sense of being a good mother and replaced what they were unable to do with breastfeeding. Karn shared her practical strategies:

> I accepted that I cannot breastfeed like other women because of my condition. From my heart, I will try my best to provide good care and spend most time of the day with my baby. I have never left my baby with others when I have to go out and I will not in the future either. Wherever I go, I always take him with me. I never leave him alone. I have to ensure that he is safe and well.

Many HIV-positive mothers emphasised good nurturing pathways. Some women paid more attention to building a clean environment, hoping that their child would live in healthy surroundings which would reduce the risk of disease susceptibility. They perceived that such means could promote the health and wellbeing of the child. Karnda, for example, pointed out that she always cleans the floor twice a day and reorganised the garden and grew different types of trees around the house to create fresh air.

> Thinking about my child future, I have to plan for him in advance and give it as first the priority in my life. I hope to see him happy and wish him grows beautifully. I build a good environment around the house, so he can get fresh air which will keep him in good health and reduce the risk of disease. My husband understands and helps me creating the clean environment for our boy.

Conclusion

This study was based on the qualitative approach and my findings cannot be used to generalised to other women in Thailand. However, the findings of my study provide a conceptual understanding about the perceptions and experiences of infant feeding among mothers living with HIV in southern Thailand that I thus far know little about. The findings also offer some implications for midwifery care for Thai mothers living with HIV and health policy in Thailand. Midwives need to appreciate that HIV-positive mothers see breast milk as the best feeding option for their infants and they wish to be able to do so as other mothers do. Due to their HIV status, healthcare providers advise them to not breastfeeding. Due to their ideology of good and responsible mother, they decide to follow the advice of their healthcare providers.

The advice given to mothers that they should avoid breastfeeding and use infant formula as an alternative means may be problematic for some women. For example,

despite the fact that Thailand has provided free infant formula to infants of HIV-positive mothers up to 18 months, the provided amount may not be sufficient for some infants. This can impact on the living situation of some families, particularly poor families who have financial difficulty in obtaining sufficient infant formula for their infants and kids. I conclude that this policy may need to be revised so that the needs of poor families can be better taken into account. Second, women should be provided sufficient guidance relating to the benefits and risks of infant feeding options so that they can make an "informed choice" (Desclaux and Alfieri, 2009). The guidance should also be appropriate for their living situation (Desclaux and Alfieri, 2009; Doherty, 2011).

Chapter Five

Infant feeding practices amongst HIV-positive women

This discussion is associated with the aims of study, which are to 1) investigate the meanings of motherhood among women living with HIV/AIDS in southern Thailand, 2) examine the lived experiences of being a mother and living with HIV/AIDS among Thai Women in southern Thailand, 3) examine the perceptions and experiences of infant feeding practices among mothers living with HIV/AIDS in southern Thailand, and 4) produce data for the development of effective and culturally appropriate policies for providing sensitive care for women living with HIV/AIDS and their newborn infants in southern Thailand.

This findings suggest that infant feeding practices were inextricably linked with the notion of good motherhood. The transmission of HIV through breast milk created a dilemma for mothers living with HIV in my study. Previously, HIV-positive mothers would be discouraged to breastfeed their infants as it is the main route of mother-to-child transmission (Coutsoudis, 2005; Coovadia, et al. 2007; World Health Organization, 2016). Although World Health Organization has now recommended that HIV-positive mothers can practise exclusive breastfeeding for six months if they are on antiretroviral therapy, current Thai health policy adopted the old World Health Organization's priority to reduce transmission risk by discouraging breastfeeding and providing free infant formula for an infant up to one and a half year. During 1993-2009, the Ministry of Public Health of Thailand recommended that formula feeding was provided for HIV-exposed infants for 12 months. But since 2009, it has been increased to 18 months (Department of Health, 2016).

In this study, all HIV-positive mothers were on antiretroviral therapy (ART). ART has been formally included in the universal health care system known as the 30 Baht health care scheme in Thailand since 2002 (Bureau of AIDS, TB and STIS, 2012; National Health Security Office, 2015). Current National Thai health policy has commenced the Getting to Zero policy; HIV-positive mothers are thus treated with HAART as this could reduce the amount of active virus better. Thai health policy has recommended that exclusive breastfeeding should not be done at all although the mother is on HAART. It is still perceived as the best means to reduce HIV transmission to

newborn infants (National Health Security Office, 2015). To assist HIV-positive mother with infant feeding, all mothers are provided with free formula for their infants.

HIV-positive mothers in my study also chose not to breastfeed their infants because they perceived that their breast milk would be harmful to their infants. The women were knowledgeable that breastfeeding would render their infants at risk of HIV transmission. As a moral and responsible mother, they should not breastfeed their infants although they would like to be able to do so as other mothers do. Murphy (2000) theorises that the responsibility and care for a child is the common sense of a good mother. This notion of good motherhood has also been evidenced among Southeast Asian mothers (Liamputtong, 2006). The notion of good motherhood made the women find appropriate means which would not attract risk to their children.

Free infant formula that was given to all HIV-positive mothers up to one and a half years was helpful for many mothers because they could ensure that their infants would have milk for survival. In reality, the free formula did not serve the actual needs of all infants. Some infants could not tolerate such formula milk. These mothers then encountered more burdens in life as they had to seek other feeding means for the well-being of their infants.

I found that not being able to breastfeed their babies presented some difficulties and anxieties for the women. Breastfeeding has been a cultural norm in Thailand for centuries. Most women from lower socio-economic backgrounds tend to breastfeed their newborns (Liamputtong, 2006). When a new mother does not breastfeed her child, this can cause suspicion from other family members and neighbours. This suspicion by others made it more difficult for women living with HIV in my study as often they had not disclosed their HIV status to others. HIV-positive mothers tended to encounter social stigma and were suspected of being a promiscuous mother or mothers afflicted with bad disease, especially HIV/AIDS (Liamputtong & Naksook, 2003a; Liamputtong, 2012). My findings confirm previous studies which suggested that within a society where breastfeeding is socially accepted and HIV stigma is prevalent, formula feeding may be seen as a way of revealing one's HIV status to others (Leshabari, Blystad, & Moland, 2007; Liamputtong, 2012; Liamputtong, 2016).

This study also suggested that HIV-positive mothers had great concerns about being a good and responsible mother (Murphy, 2000). They perceived that breastfeeding was the practice of a woman who becomes a mother. But they saw themselves as a

‘contaminated mother’ as they could transmit HIV to their babies through breastfeeding. Thus, replacement formula feeding became their best option. Apart from this practice, they showed their sense of good motherhood through physical contacts. They perceived that not being able to breastfeed their infant was not a sole determinant of being a good or bad mother. Ingram (1999) and Suwankhong and Liamputtong (2016) contend that mothers would try to defend their notion of good motherhood through such diverse approaches.

In many societies, good motherhood is determined through the practice of breastfeeding and this is also a norm within the Thai society (Liamputtong, 2007b). Thus, the sense of guilt as a consequence of being unable to breastfeed was prevalent in my study, although they understood the high risk of transmitting HIV to their infants through breastfeeding. This is congruent with the previous study of Omari and associates (2003) among HIV-positive mothers in Lusaka, Zambia. They found that the majority of HIV-positive women in their study expressed negative views on their inability to breastfeed. Such negative responses were shown through painful, upset and guilty feelings.

Leshabari and colleagues (2007) contend that breastfeeding practice is both socially and culturally embedded in societies. Coutsoudis (2005) supports this notion by suggesting that cultural and social acceptance is jeopardised if a mother does not breastfeed her infant. Mothers living with HIV in this study expressed negative attitudes with regard to not being able to breastfeed. Most mothers felt that people would have doubt about their health if they did not breastfeed. Their responses confirm the findings in the study of Suwankhong and Liamputtong (2016) among mothers with HIV/AIDS who did not breastfeed in central Thailand.

For many resource-poor nations, where prolonged breastfeeding is the norm for social, cultural or economic reasons, encouraging HIV-positive mothers to adopt replacement feeding is a challenging task. This assertion was also reflected in this study. The majority of HIV-positive mothers in my study came from low- to middle-income families. Although they accepted their inability to breastfeed, these mothers looked for alternative and affordable means to provide sufficient food for their infants. Because of the high cost of infant formula, many mothers could not afford to obtain formulas that contained the recommended amount of nutrients that infants need. They bought the products that they could afford at the cost of having lower nutrients. Some introduced

supplementary food early in the infant's life whereas many bought cheaper formula to ensure that their infant would remain healthy.

Conclusion and implications for midwifery care and health policy

This study was based on the qualitative approach and my findings cannot be used to generalised to other women in Thailand. However, the findings of my study provide a conceptual understanding about the perceptions and experiences of infant feeding among mothers living with HIV in southern Thailand that I thus far know little about. The findings also offer some implications for midwifery care for Thai mothers living with HIV and health policy in Thailand. Midwives need to appreciate that HIV-positive mothers see breast milk as the best feeding option for their infants and they wish to be able to do so as other mothers do. Due to their HIV status, healthcare providers advise them to not breastfeeding. Due to their ideology of good and responsible mother, they decide to follow the advice of their healthcare providers.

The advice given to mothers that they should avoid breastfeeding and use infant formula as an alternative means may be problematic for some women. For example, despite the fact that Thailand has provided free infant formula to infants of HIV-positive mothers up to 18 months, the provided amount may not be sufficient for some infants. This can impact on the living situation of some families, particularly poor families who have financial difficulty in obtaining sufficient infant formula for their infants. I conclude that this policy may need to be revised so that the needs of poor families can be better taken into account. Second, women should be provided sufficient guidance relating to the benefits and risks of infant feeding options so that they can make an “informed choice” (Desclaux and Alfieri, 2009). The guidance should also be appropriate for their living situation (Desclaux and Alfieri, 2009; Doherty, 2011).

Appendices

Ethics approval

มหาวิทยาลัยทักษิณ
ใบรับรองจริยธรรมการวิจัยในมนุษย์

เลขที่ E ๐๐๖/๒๕๕๘

โครงการวิจัยเรื่อง :

(ภาษาไทย) ความเป็นมารดากับการให้นมบุตร: ประสบการณ์ของผู้หญิงที่ติดเชื้อเอดส์ในภาคใต้

(ภาษาอังกฤษ) Motherhood and infant feeding practices: The lived experience of HIV-positive women in Southern Thailand

ผู้รับผิดชอบโครงการ : อาจารย์ ดร.ดุษณีย์ สุวรรณคง
หน่วยงานที่สังกัด (คณะ) คณะวิทยาการสุขภาพและการกีฬา
(มหาวิทยาลัย) มหาวิทยาลัยทักษิณ

ได้ผ่านการพิจารณาและได้รับความเห็นชอบจากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ (Ethics Committee) มหาวิทยาลัยทักษิณ เรียบร้อยแล้ว

ลงนาม

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วันที่ ๑๒ พฤศจิกายน ๒๕๕๗

คณะกรรมการจริยธรรมการวิจัยในมนุษย์ สถาบันวิจัยและพัฒนา มหาวิทยาลัยทักษิณ
๒๒๒ หมู่ที่.๒ ตำบลพร้าว อำเภอป่าพะยอม จังหวัดพัทลุง
โทรศัพท์/โทรสาร (๐๗๔) ๖๗๓๒๒๗, ๐๘๑-๕๔๐๗๓๐๔, E-mail: research.tsu@gmail.com

Interview guides

General information

1. Age ……years
2. Religion.....
3. Education level.....
4. Marital status……
5. Occupation…….. monthly income.....baht
6. Number of child.....
7. Number of infected child.....
8. Family member.....
9. History of HIV positive person in your family
   - ☐ No
   - ☐ Yes, please specify the relationship .....

History Illness

1. Year of diagnosed HIV.....
2. Causes of infection……
3. Do you currently attend treatment?
   ☐ No ☐ Yes
4. Kind of treatment you are receiving.....……
5. Places you go for treatment.....……
6. Treatment period.....years
7. Telephone number (If possible) .....

Semi-structured in-depth interviews guide

1. How did you know if you get the disease?
2. How did you feel when knowing you diagnosed HIV?
3. What did you do when you knew you diagnosed HIV? Where did you go for treatment? Why?
4. How did you respond to the treatment and when you have to take medicine?
5. In case of treating with tablets
    5.1 What your experiences were?
    5.2 What are barriers from taking tablets to daily activity?
    5.3 What made you taking tablets continually?
6. In your opinion, is HIV infection a barrier of breastfeeding? Why? How?
7. When you diagnosed HIV positive, what are your practices about breastfeeding? What are the barriers?
8. How do you think about breast milk and formula one? Why?
9. Can the condition of HIV positive affect motherhoods' role? How?
10. When you faced with problems, who gave you support? In what forms? How do you feel about that?
11. How do you care for yourself?
12. How do you care for your child? How do you plan for his/ her future?
13. Did you know if your child was infected? How did you find out? How did you feel?
14. In your opinion, what mothers mean?
15. What make a good mother?
16. Can HIV infected mother be good mother?
17. In future, will you tell your child about your infection? Why?
18. Does HIV infection affect couple relationship? How?
19. Do you prevent transmission to your husband? How?
20. How public health profession can help? Are current support suited your need? Why?
21.What support do you need form health professionals? How?
22. What else would like to share?

Drawing section

1. As mother, how would you explain HIV?
2. How did you feel when you first diagnosed?

References

Arboleda-Flórez, J. (2008). The rights of a powerless legion. In J. Arboleda-Flórez &N. Sartorius (Eds.), *Understanding the Stigma of Mental Illness: Theory and Interventions* (pp. 1-17). West Sussex, UK: John Wiley & Sons Ltd.

Becker, C. (1992). *Living and relating: An introduction to phenomenology*. Sage: Newbury Park.

Bernard, H. R. (2006). *Research methods in anthropology: Qualitative and quantitative approaches* (4th ed.). Lanham: AltaMira Press.

Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research, 10*(2), 141-163.

Bloom, J. R., Stewart, S. L., Johnston, M., Banks, P., & Fobair, P. (2001). Sources of support and the physical and mental well-being of young women with breast cancer. *Social Science & Medicine, 53*(11), 1513-1524.

Brubaker, R., & Cooper, P. (2000). Beyond "identity". *Theory & Society, 29*, 1-47.

Bureau of AIDS, TB and STIS. (2012). Health care coverage for HIV and AIDS patients. 2012. Retrieved December 24, 2016, from: http://aidssti.ddc.moph.go.th/contents/view/222

Carpenter, C. (2017). Phenomenology and rehabilitation research. In P. Liamputtong (ed.), Research methods in health: Foundations for evidence-based practice, 3rd edn. Oxford University Press, Melbourne.

Castells, M. (1997). *The power of identity*. USA: A John Wiley & Sons.

Cohen, S., Gottlieb, B., & Underwood, L. (2000). Social relationships and health. In S. Cohen, L. Underwood, & B. Gottlieb (Eds.), *Social support measurement and intervention* (pp. 3-28). New York, NY: Oxford University Press.

Coutsoudis, A. (2005). Breastfeeding and the HIV positive mother: The debate continues. *Early Human Development, 81*, 87-93.

Coovadia, H.M., Rollins, N.C., Bland, R.M., et al. (2007). Mother-to- child transmission of HIV-1 infection during exclusive breastfeeding in the first 6 months of life: An intervention cohort study. Lancet, *369*, 1107-1116.

Creswell, J.W. (2014). Research design: Qualitative, quantitative and mixed methods approaches, 4th edn. Sage, Thousand Oaks.

Drageset, S., Lindstrøm, T. C., Giske, T., & Underlid, K. (2012). "The support I need": Women's experiences of social support after having received breast cancer diagnosis and awaiting surgery. *Cancer Nursing*, *35*(6), E39-E47.

Department of Health. (2016). Countdown to zero "elimination mother to child HIV transmission. Retrieved August 8,2016, from: http://www.anamai.moph.go.th/mobile_detail.php?cid=76&nid=6759

Desclaux, A., Alfieri, C. (2009). Counseling and choosing between infant-feeding options: Overall limits and local interpretations by health care providers and women living with HIV in resources-poor countries (Burkina Faso, Cambodia, Cameroon). Social Science & Medicine, 69, 821-829.

Doherty, P. (2011). Infant feeding in the era of HIV: Challenges and opportunities. In Liamputtong, P. (Ed.), Infant Feeding Practices: A Cross-Cultural Perspective. Springer, New York, pp. 175-193.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley: Sociology Press.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice Hall: Englewood Cliffs, New Jersey.

Greene, K., & Banerjee, S. C. (2006). Disease-related stigma. *Journal of Homosexuality*, *50*(4), 185-209.

Guillemin, M. (2004). Understanding illness: Using drawings as a research method. *Qualitative Health Research, 14*, 272-289.

Hansen, E. C. (2006). *Successful qualitative health research: A practical introduction*. Crows Nest: Allen & Unwin.

Heijnders, M., & Meij, S. V. D. (2006). The fight against stigma: An overview of stigma-reduction strategies and intervention. *Psychology, Health & Medicine*, *11*(3), 353-363.

Ingram, D., 1999. Defensive mothering in HIV-positive mothers. *Qualitative Health Research, 9, 243-258.*

Kourtis, A. P., Lee, F. K., Abrams, E. J., Jamieson, D. J., & Bulterys, M. (2006). Mother-to-child transmission of HIV-1: timing and implications for prevention. *The Lancet*, *6*(11), 726-732.

Landmark, B. T., Strandmark, M., & Wahl, A. (2002). Breast cancer and experiences of social support: In-depth interviews of 10 women with newly diagnosed breast cancer. *Scandinavian Journal of Caring Sciences*, *16*(3), 216-223.

Leshabari, S.C., Blystad, A., Moland, K.M., 2007. Difficult choices: Infant feeding experiences of HIV positive mothers in northern Tanzania. Journal of Social Aspects of HIV/AIDS 4, 544-555.

Liamputtong, P., & Naksook, C. (2003a). Life as mothers in a new land: The experience of motherhood among Thai women in Melbourne. *Health Care for Women International*, *24*(7), 650-668.

Liamputtong, P., & Naksook, C. (2003b). Perceptions and experiences of motherhood, health and the husband's roles among Thai women in Australia. *Midwifery*, *19*(1), 27-36.

Liamputtong, P., Yimyam, S, Parisunyakul, S., Baosoung, C., & Sansiriphun, N. (2005). Traditional beliefs about pregnancy and child birth among women from Chiang Mai, Northern Thailand. *Midwifery*, 21(2), 139-153.

Liamputtong, P. (2006). Motherhood and "moral career": Discourses of good motherhood among Southeast Asian immigrant women in Australia. *Qualitative Sociology*, 29, 25-52.

Liamputtong, P. (2007). *Researching the vulnerable: A guide to sensitive research methods*. London: Sage Publications.

Liamputtong, P. (2007a). *The journey of becoming a mother amongst women in northern Thailand*. Lexington Books: Lanham, MD.

Liamputtong, P. (2007b). *Researching vulnerable people: A guide to sensitive research methods*. Sage: London.

Liamputtong, P. (2010). *Performing qualitative cross-cultural research*. Cambridge: Cambridge University Press.

Liamputtong, P. (ed.) (2012). *Infant feeding practices: A cross-cultural perspective*. Springer: New York.

Liamputtong, P., Haritavorn, N., & Kiatying-Angsulee, N. (2012). Living positively: The experiences of Thai women in central Thailand. *Qualitative Health Research, 22*(4), 441-451.

Liamputtong, P. (2013). *Qualitative research methods*, 4th edn. Oxford University Press: Melbourne.

Liamputtong, P. (2016). My life as *mae tid chua* [mothers who contracted HIV disease]: Motherhood and women living with HIV/AIDS in central Thailand. Midwifery, *30*,1166-1172.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363-385.

Lupton, D. (1995). Medicine as Culture, Illness, Disease and the Body in Western Societies. London, Sage.

Lupton, D. (2000). 'A love/hate relationship': The ideals and experiences of first-time others. *Journal of Sociology*, *36*, 50-63.

Mbekenga, C. K., Christensson, K., Lugina, H., & Olsson, P. (2011). Joy, struggle and support: Postpartum experiences of first-time mothers in a Tanzanian suburb. *Women and Birth*, *24*(1), 24-31. doi:10.1016/j.wombi.2010.06.004

McMahon, M. (1995). *Engendering motherhood: Identity and self-transformation in women's lives*. The Guildford Press: New York.

Merriam, S. B., Johnson-Bailey, J., Lee, M.-Y., Kee, Y., Ntseane, G., & Muhamad, M. (2001). Power and positionality: Negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education, 20*(5), 405-416.

Minichiello, V., Aroni, R., & Hays, T. (2008). *In-depth interviewing: Principles ,techniques, analysis, 3rd edition.* Pearson Education Australia: Frenchs Forest.

Moustakas, C. (1994). *Phenomenological research methods*. Sage: Thousand Oaks, CA.

Murphy, E. (2000). Risk, responsibility, and rhetoric in infant feeding. *Journal of Contemporary Ethnography, 29,* 291-325.

Nartsupa, C., & Lertvicha, P. (1994). *Thai village culture*. Bangkok: Athita Printing.

National Health Security Office. (2015). Manual of health care coverage fund 2016: Budget management service for HIV and AIDS patients and budget management for TB patients. Bangkok: Sangchan.

Omari, A.A., Luo, C., Kankasa, C., et al., 2003. Infant-feeding practices of mothers of known HIV status in Lusaka, Zambia. *Health Policy Plan,* 18, 156-162.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine, 57,* 13-24.

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks: Sage Publications.

Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A framework integrating normative influences on stigma (FINIS). *Social Science & Medicine, 67,* 431-440.

Silverman, D. (2010). *Doing qualitative research: A practical handbook* (3rd ed.). London: Sage Publications.

Sprung, B. R., Janotha, B. L., & Steckel, A. J. (2011). The lived experience of breast cancer patients and couple distress. *Journal of American Academy of Nurse Practioners, 23,* 619-627.

Strauss, A.L., & Corbin, (1990). *Basics of Qualitative Research: Grounded Theory,*

Procedures and Techniques. Sage: Newsbury Park, CA.

Suwankhong, D., & Liamputtong, P. (2016). Breast cancer treatment: Experiences of changes and social stigma among Thai women in Southern Thailand. *Cancer Nursing, 36*(3), 213-220.

Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: Ignorance, prejudice or discrimination? *British Journal of Phychiatry, 190*, 192-193.

UNAIDS. (2012). *HIV and AIDS estimates (2015)*. Retrieved June 12, 2016, http://www.unaids.org/en/regionscountries/countries/thailand/ (12.06.16).

UNAIDS. (2014). *2014 progress report on the Global Plan* .Retrieved Jaunaury 7, 2017 from: http://www.unaids.org/sites/default/files/documents/JC2681_2014-Global-Plan- progress_en.pdf

Wilson, K., & Luker, K. A. (2006). At home in hospital? Interaction and stigma in people affected by cancer. *Social Science & Medicine, 62*, 1616-1627.

World Health Organization. (2016). *Mother-to-child transmission of HIV*. Retrieved January 17, 2016, from http://www.who.int/hiv/topics/mtct/en/