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Chapter 12

Vulnerable Populations in Thailand: Giving Voice to Women Living With HIV/AIDS

Adeline Nyamathi, Chandice Covington,
and Malaika Mutere

ABSTRACT

Thailand was the first Asian country hit by the AIDS epidemic, and in the 1990s reported the fastest spread of HIV/AIDS in the world. According to Thailand's Ministry of Public Health, women, primarily between the child-bearing ages of 15 and 49, are increasingly becoming infected with HIV. A number of factors contribute to the increasing AIDS epidemic, including the rise of the commercial sex industry in Thailand; social disparities that have existed between men and women throughout Thailand's history; and the gender-expectations faced by Thai women toward family and society.

Thailand enjoys one of the oldest, reputedly successful primary health care delivery systems in the world; one that relies on community health workers to reach the most rural of populations. In the mid-1990s, day care centers were established

at district hospitals by the Thai government to provide medical, psychological, and social care to people living with HIV/AIDS (PWA). Buddhist temples also provide a source of alternative care for PWAs. However, the AIDS policy of the Thai government relies on families to care for the country's sick.

Although poor women are a vulnerable population in Thailand, they are changing the paradigm of AIDS stigma while providing a significant cost-savings to the Thai government in their caregiving activities. Based on existing nursing studies on Thailand, this chapter gives voice to poor Thai women living with HIV/AIDS, and examines how they make sense of their gendered contract with society and religion while being HIV/AIDS caregivers, patients, or both.

Keywords: HIV/AIDS; Thailand; commercial sex industry; vulnerable populations; women

INTRODUCTION

Thailand, a population of 62 million, was the first Asian country hit by the AIDS pandemic; this country also reported the fastest spread of HIV/AIDS in the world by the 1990s. Thailand's Ministry of Public Health indicates that women are increasingly becoming infected with HIV, with the proportion of men to women infected with HIV increasing from 97:3 in 1988 to approximately 60:40 in 2005. The HIV/AIDS epidemic in Thailand has emanated from both the high-risk sexual behaviors of men who visit the numerous commercial sex workers (CSWs) in Thailand (Wawer, Podhisita, Kanungsukkasem, Pramualtrana, & McNamara, 1996) and the increased use of illegal injection drugs (Mastro et al. 1994). Although prostitution is frowned upon in Thailand, CSWs generate significant foreign income to society while helping to support the financial obligations of their families. The majority (86%) of Thai women infected with HIV are between the ages of 15 and 49, with an increasing prevalence among pregnant women in some areas (Songwathana, 2001).

In Thailand, HIV in women has been associated with dirt, danger, and death. These associations have led to a profound stigma for infected mothers in seeking care and support. Moreover, as part of the Buddhist view that AIDS is a disease of Karma (*rok khong khon mee k am*), in that infected persons deserved their fate, HIV-infected Thai women have had to carry the dual demands of survival and maternal caregiving single-handedly. HIV-positive Thai mothers are often overwhelmed by feelings of guilt, grief, emotional pain, and exhaustion; all of which effect their emotional responses to already stressful situations complicated by poverty (Andrews, Williams, & Neil, 1993; Weiler, 1995). Desperate for support from family, friends, and community, poor HIV-positive mothers

often experience a profound sense of isolation (Shayne & Kaplan, 1991) and powerlessness over the disease and the associated social stigma, which in turn effects their maternal role-taking process. Coming from a vulnerable population framework where poor outcomes are associated with limited resources and such populations are at high risk for morbidity and premature mortality (Flaskerud & Winslow, 1998), the experiences of poor HIV-infected Thai women need to be better understood by health care providers.

The purpose of this chapter is to highlight some of the key nursing studies conducted from 1990 to 2005 in Thailand, a developing country plagued with a high HIV/AIDS prevalence. A computerized literature retrieval was conducted with Entrez PubMed and CINAHL database searches using keywords HIV/AIDS, Thailand, and nursing. The search resulted in 198 articles published between 1988 and November 2005. PubMed provides access to bibliographic information that includes Medline and OldMedline, covering over 4,800 journals published in the United States and more than 70 other countries primarily from pre-1966 to the present. Citations in Medline are from journals selected for inclusion in the database. CINAHL is a literature resource for nursing and allied health professionals that provides indexing for 2,719 journals from the fields of nursing and allied health. The database contains more than 1 million records dating back to 1982.

From this search, a specific review for those articles where primarily nursing professionals conducted qualitative studies and the essence of the investigation focused on nursing phenomena revealed 10 articles for review. Our focus on qualitative studies was based on the fact that an understanding of the cultural and social context of HIV/AIDS and of women in Thailand is foundational and critical to ongoing studies of caregiving and survival. Those selected articles, as shown in a Table 12.1, were published between 1992 and 2004, and form the set for review.

Social Status of Poor HIV-Infected Women in Thailand

Numerous studies characterize a main feature of Thailand's social structure as giving second class status to women, particularly those who are poor and vulnerable. In an analysis of the growth of prostitution in Thailand, Muecke (1992) concludes that Thai ideologies of family and religion are being prostituted for material rewards as is evident in the country's economic progress. Muecke (1992) examines the heterosexual transmission of AIDS through female prostitution in contemporary lowland, village-level Buddhist Thai society as a socio-cultural phenomenon. Although illegal, prostitution enables women to fulfill traditional cultural functions of daughters through remittances provided to the families at home and as merit-making activities, all of which paradoxically helps conserve

TABLE 12.1 Selected Research Studies Reviewed

References	Sample / Setting	Study Design	Recommendations
Bechtel & Apakapakal, 1999	<ul style="list-style-type: none"> • 5, HIV+, mean age 27 + 5 years • Buddhist temple in Southern Thailand 	Narrative study over 2 months; four 90-minute sessions per informant; unstructured telling of their story	A systematic effort by nursing organizations encouraging <i>krongjai</i> is needed to promote culturally holistic interventions
Boonpongmanee et al., 2003	<ul style="list-style-type: none"> • 77 HIV- / 79 HIV+ pregnant women; mean age 29 / 26 • Bangkok & Nonthaburi 	Predictive model testing design included comparison group of HIV- pregnant women to help interpret findings	Findings on the relationships of depression, resourcefulness, & prenatal self-care can help nurses provide more effective services & counseling
Jirapaet, 2001	<ul style="list-style-type: none"> • 39 low-income HIV+ mothers representing each month of infant age from 1-12 months; 18-40 age range • Bangkok & suburbs 	Qualitative, unstructured, in-depth phenomenological 2-hour interviews over 8 months; two per mother; concluded with negative sentence to authenticate data	HIV+ mothers need more access to private consultation, a regular provider, confidentiality, & respectful treatment in health care settings
Kauffman & Myers, 1997	<ul style="list-style-type: none"> • Seven VHV's & villagers • Northeast Thailand 	Ethnographic field study over 2 weeks: participant observation; focus groups; semi-structured interviews; informal interviews	While still a vital part of Thailand's PHC system, the VHV role needs to adapt to the needs of an increasingly urbanized community
Kespichayawattana & VanLandingham, 2003	<ul style="list-style-type: none"> • 394 HIV+ household parents / 376 HIV- household parents • Chiang Mai, Phichit, & Rayong provinces 	Comparison of health outcomes between affected & matched nonaffected parents using survey data; & between principal & nonprincipal care-givers (18 interviews of affected parents)	Adverse health outcomes of affected parents/caregivers call for management of pain, sleep, anxiety, & other forms of palliative care; need health care training & financial assistance

Muecke, 1992	<ul style="list-style-type: none"> • Unspecified • Chiang Mai Province, Northern Thailand 	Case studies, some from 5 years of longitudinal anthropological study; participant observation; review of media & texts	Concludes that ideologies of family & religion are being proscribed for material rewards in Thailand in the form of increasing CSWs
Muecke, 2001	<ul style="list-style-type: none"> • Non-clinical mothers & children from larger ongoing study • Chiang Mai Province, Northern Thailand 	Semi-structured & open-ended interviews; supplementary data obtained from HCPs, NGOS, AIDS organizations, & Health Ministry officials	The progress of AIDS in Chiang Mai reconfirms gender & class biases by Thai society at large
Nilmanat & Street, 2004	<ul style="list-style-type: none"> • Eight caregivers, 2 HIV+, 27-61 age range • Songkhla Province, Southern Thailand 	Longitudinal narrative study over 8 months; interviews-conversations; participant observation; & field notes	Dominant care-giver theme: "search for a cure" aimed to reunify & balance fragmented lives with a more holistic & paliative AIDS care approach
Songwathana, 2001	<ul style="list-style-type: none"> • 15 caregivers, 9 HIV+ 6 HIV, 21-50 age range • Southern Thailand 	Narrative study; in-depth interviews; participant observation; qualitative analysis following Spradley	Research is needed on role of men in sharing care-giving. Interventions are needed to address the needs of HIV+ care-giving women
Tsunekawa et al., 2004	<ul style="list-style-type: none"> • 271 DCC members at 9 district hospitals • 29.5% • Chiang Mai Province, Northern Thailand 	Cross-sectional survey using DCC-employed research nurses to conduct interviewer-administered questionnaire: 47 multiple choice questions & verbal clarifications as needed	PWA benefit from DCC services; services would be enhanced by physical exams & administration of meds; Thailand's expansion of ART should define DCC role & address access barriers for PWA

institutions of the government, which benefits from the lucrative, tourist-fueled sex industry, the family, and Buddhism.

Muecke (1992) draws from Thailand's history to connect this particular aspect to current social norms and their health implications. From the 15th century, Thai laws codified male authority over women and, until the late 19th century, men could legally sell or give wives or daughters away without their consent as a gift to a superior or as debt payment. Men could also purchase slave women as so-called lesser or minor wives; traditional Thai polygamy was an acceptable custom, which provided men access to more than one woman. These customs and laws collectively set a precedent for the current practice where family members, especially daughters, are sold for economic gain. It is conservatively estimated that no fewer than 1 million of Thailand's population are female prostitutes, over 20,000 of whom are under the age of 15.

Research Methodologies

Until the mid-1970s, the major ethnographies of Thai society were conducted almost exclusively by foreign male ethnographers (Muecke, 1992); thus the earlier literature tended to overlook social disparities for females. Much of the data in this chapter derives from ethnographic nursing studies, where data were gathered through qualitative systematic inquiry using the researcher as instrument. Progressive in-depth interviews were conducted (e.g., structured demographic data, semi-structured interviews, focused conversations, and mutual dialogue or casual conversations); participant observations and extensive field notes were made; and qualitative analyses were applied to the data that included extensive Thai-English and English-Thai translations to ensure fidelity to original intent and participant meaning. Jirapaet (2001) employed Patton's (1980) phenomenological method of interviewing, which began with an open-ended question and elicited storytelling by informants through unstructured, in-depth interviews. Songwathana (2001) employed a constant comparative method following Spradley (1979) in performing a qualitative analysis of data.

Boonpongmanee, Zauszniewski, and Morris (2003) tested Rosenbaum's theory of learned resourcefulness, a predictive model testing design, in their examination of self-care in HIV-positive pregnant women with evident depression. Among other findings, they suggest that a qualitative study would be helpful to gain more insight into cultural meanings of learned resourcefulness in Thailand. As many argue, modern medicine splits the diseased body from the ill person's life and daily experiences, which is why Nilmanat and Street (2004) advocate that health care professionals pay attention to their clients' stories, referred to as illness narratives. These narratives offer patients the opportunity to reframe their experiences, construct new contexts, and fit their so-called illness (disruption of an ongoing life)

into a temporary framework. In Nilmanat and Street's study (2004) their key informants (primary care-givers) are aware that health professionals hold different views of sickness, and therefore would often withhold information on their participation in spiritual or traditional healing rites during medical visits.

Impact of Culture on HIV/AIDS in Thailand

The cultural concept of *krengjai*, consistent with the concepts of Buddhism, describes and governs family and social order through the maintenance of harmonious relationships. To fully understand the HIV/AIDS experience of women in Thailand, it is important to understand how the concept of *krengjai* works within Thai society (Bechtel & Apakupakul, 1999). Illness, along with a pervasive sense of isolation, creates chaos for a Thai families' sense of harmony, and harshly threatens their social support system or *krengjai*. To make matters worse, the stigma of HIV/AIDS, which is profound in Thailand, akin to leprosy, requires the physically debilitated and infected person to be isolated from family and society. Thus, the impact on caregiving activities is profound.

Vichit-Vadakan's (1994) review of Thai women in social changes notes that opportunities for wage labor in cities created distances that altered the traditional Thai family structure. The Thai family has typically been a modified extended structure based around a matrilineal residence, to which married daughters bring husbands to work and live until the daughter's family grows large and breaks away to form a new family unit. Although women are the center of the Thai family and the major agents of socialization in their children's lives, they are still second class to men in society, providing supporting and subservient roles, which are never direct or overt.

Studies of the Health Care System in Thailand

Thailand enjoys a government-supported primary health care (PHC) system that is reputed to be one of the world's oldest successful health care delivery systems. PHC began in Chiang Mai in 1966 as a successful pilot project to develop a model of community participation in resolving health issues. This system was implemented through partnerships of community residents, health workers, and health care professionals using a combination of appropriate technology, local resources, and government support to provide culturally appropriate interventions for the communities' health-priorities.

Kauffman and Myers (1997) performed an ethnographic field study in 1994 to look at the role of the Community Health Worker (CHW) or, as Thai's commonly refer to him or her, Village Health Volunteer (VHV), as the backbone of the PHC system in Thailand. Through systematic inquiry over a 2-week period

in Thailand's largest, poorest, least developed region, these authors explored the implementation and acceptance of the role of VHV to determine whether current PHC methods effectively lead to universal health care. Areas of assessment included how the VHV role was implemented and how their role was understood and accepted by villagers. This study was designed to provide information for evaluation and revision of the existing PHC model, and to help other planners avoid hurdles to community acceptance and utilization of VHV.

Through qualitative analysis of their ethnographic data, Kauffman and Myers conclude that rapid urbanization and increased technology provided greater access for villagers to secondary and tertiary services. Therefore, use of VHV services and the importance of their role, as outlined by Thailand's PHC model, diminished exponentially as an entrée into the PHC system. VHVs themselves expressed difficulty in obtaining continuing education to remain current on treatment practices. Villagers reported minimal use of VHV services and most were unable to identify who the VHVs were, opting instead for self-treatment and self-referral for health concerns based on information obtained from radio and television. Kauffman and Myers suggest that the VHV role needs to be adapted accordingly with help from, and in collaboration between, U.S. nurses and those in Thailand's urban centers.

In another evaluation of how Thailand's health care system is addressing the needs of the sick, in particular people living with HIV/AIDS (PWA), Tsunekawa et al. (2004) studied day care centers (DCCs) which, as a result of Thai government policy, were established at district hospitals in 1995 to provide medical, psychological, and social care to PWA. This cross-sectional study of 271 DCC members at nine well-established hospitals in the Chiang Mai province, attempted to assess the psychosocial and economic impact of DCC services to PWA, and to determine the extent to which DCCs were making a difference in the lives of PWA.

Tsunekawa et al. (2004) evaluated the socioeconomic and demographic background data of PWA and their reasons for attending DCCs, their use of the medical services, the cost of attending DCCs, and how DCCs changed their lives. Registration at DCCs is voluntary for people who are diagnosed as HIV positive. Monthly meetings at DCCs included activities such as breathing exercises, massage, group sharing of experiences, counseling, and Buddhist teachings. These authors concluded that the services provided by DCCs benefited PWA, particularly in areas of educational and mutual psychological support. However, barriers preventing PWA access to utilize DCCs were apparent, some of which included economic and geographic issues. Tsunekawa and colleagues suggest that these issues call for a more comprehensive examination on the role of DCCs, and that the role of DCCs needs to be clearly defined within the planned expansion of antiretroviral therapy in Thailand. They recommend enhancing DCC's

medical services by including physical examinations and administering medications such as IPT-cotrimoxazole and antiretroviral therapy.

Voices of the Thai Poor: Living With HIV/AIDS as Caregivers, Patients, or Both

The Thai government's AIDS policy relies on families to care for the country's sick (Muecke, 2001), validating the premise made by Kespichayawattana and VanLandingham (2003) that "the economic, social, and familial context in which this caregiving occurs in Thailand and in other developing countries is vastly different from the situation in the developing world" (p. 217). Muecke (2001) similarly acknowledges the role of wealth in Thai women's health: "Although wealth probably is not protecting Thai women from receiving the HIV from their husbands, it can protect them from the stigmatizing label of HIV/AIDS, and it can buy them care to promote the quality and duration of their lives" (p. 36). A number of nursing studies exist that reflect the voice of the Thai poor as they experience living with HIV/AIDS, as patients, caregivers, or both.

In an exploratory ethnographic study, Muecke (1992) examined the experiences of AIDS caregivers, very poor to lower middle class, non-clinical urban informants drawn from Chiang Mai, Thailand's province of highest AIDS mortality. Data were obtained from mothers and children by semi structured interviews, in the informant's home or workplace, followed by a varying number of open-ended interviews. Supplementary data were obtained by open-ended interviews with health care providers, AIDS nongovernmental organizations (NGOs), and Ministry of Health officials. Muecke translated Thai recordings into English and field researchers checked translations for accuracy of interpretation.

The research questions raised were the following: (a) Who are the home and community caregivers for PWAs? (b) What kind of care do they give? and (c) What is the impact of caregiving on the caregiver(s)? Findings revealed that among caregivers, parents, overwhelmingly mothers—followed by wives, then grandmothers, and then sisters—considered it their place and duty to care for adult children or husbands sick with AIDS. They also believed that caring for their ailing family members provided moral and spiritual benefit in the form of building positive karma for themselves. The most intimate and physical care for PWA came from women, who were also most likely to sacrifice their jobs and food-obtaining activities in order to care for the men in the family who are dying of AIDS. In addressing the question of who will care for women when they get AIDS, Muecke (2001) notes:

It is not clear how families will cope financially, emotionally or socially as more AIDS widows and children become sick, but it is likely that the burdens will be

even heavier on families who have already witnessed the suffering of the disease and spent their emotional and financial resources in caring for one who died from it. (p. 33)

Women, in particular those who are poor, were changing the paradigm of AIDS stigma while providing significant cost-savings to the Thai government in their caregiving activities. Motivating factors for women as AIDS caregivers included social, cultural, and moral predisposition; family ties (mother to son or daughter, daughter to parent, sister to brother/sister, and wife to husband); and lack of other support for PWA who are poor.

Bechtel and Apakupakul (1999) conducted a qualitative study of the experiences of five individuals experiencing HIV disease in rural southern Thailand. Isolated from family and social networks, each participant told their story over a 2-month period in an average of four 90-minute sessions, and explored their tenuous relationship with *krengjai*, a sense of order which is essential to Thai's sense of harmony for family and society. All participants lived in a Buddhist *wat* or temple, as a source of alternative care. Each conversation began with the researcher asking the participants their feelings about having AIDS.

Findings of the study, which incorporated additional data from the subject's family and friends, revealed the significant loss of identity these persons experienced within their families and society, and the subsequent isolation and partial reconnection with society, either through their original families or new emerging families in the *wat*. Clearly, HIV disease was found to interrupt economic and social patterns, to cause chaos and mistrust, and to limit adaptability and adjustment to family crisis as separation ensued, with loss of *krengjai*. Inability to cope with this disintegration increased utilization of already scarce resources and aggravated the cycle of poverty and despair.

Re-establishing *krengjai* was a consistent focus. All participants felt the need to incorporate into their social networks and fulfill a social purpose; they returned part of their earnings from work in the *wat* (as health permitted) back to family to make things right. Men expressed a strong desire to return to birth family. Women adapted by connecting with new familial groupings, relationships made in the *wats*, and as a result of their shared situations, enabled a new sense of *krengjai*. As a profession, nursing is focused on enhancing a holistic environment within the family and community by encouraging *krengjai*.

In a longitudinal narrative case study, Nilmanat and Street (2004) examined the experiences of family members caring for a relative with AIDS in rural southern Thailand's Songkhla Province. The study explored the construction of health-seeking behaviors: how caregivers made sense of illness episodes and how they chose and evaluated particular treatments and care. By means of illness narratives, eight female caregivers (two of whom were unemployed and HIV-positive from spousal contact), ranging in age from 27 to 61, were offered the opportunity

to reframe their experiences, construct new contexts, and fit their so-called illness (disruption of an ongoing life) into a temporary framework. Qualitative data collection via semi structured and structured interviews, focused conversations, mutual dialogue, and participant observation captured their social world of being a caregiver; the support system they created to support their beliefs about health, life and death; how they managed and cared for their patients; and what medicines and remedies they provided for their loved one.

The dominant theme of the caregivers' illness narratives was the search for a cure. As caregivers became aware that available medicines and therapies were palliative and not directed at a cure, they sought other sources of cure and adopted alternative remedies and religious practices. Families held a holistic view (mind-body-spirit) of illness and suffering, and believed that illness might be affected by various causes such as pathogens, supernatural affliction, or karma. They made sense of their experiences by combining medical, supernatural, and traditional therapeutic means. Some sought secondary forms of treatment to support medical therapies, and others focused on addressing religious or supernatural causes that might hinder the efficacy of medical treatments. Early health seeking behaviors were dominated by the view that modern medicine held the best hope for a family member with AIDS, and the caregivers' subsequent search for a cure was aimed to heal, bring unity and balance to the fragmented parts of life, and establish a more holistic approach towards AIDS care.

In another ethnographic study, Songwathana (2001) examined the role of women in traditional Thai families, concentrating on personal, kinship, and social obligations of women. Specifically she assessed under what circumstances women take on the caregiver role, and how they cope with this function; particularly if they themselves are HIV-infected. In-depth interviews, participant observations, and qualitative analyses were conducted on 15 women afflicted or affected by HIV/AIDS in southern Thailand, all but one of whom were Buddhist, and six of whom were employed.

The research findings showed that women with HIV/AIDS had multiple roles, in part because the expectation and experience of their caring role remains, even if they are employed. In answer to the research question of how a woman lives with HIV, manages her family, and provides meaningful care for herself, her family, or both, the following narrative themes were elicited:

- (1) with HIV, I become patient but miserable; (2) when the income earner is sick, care is my responsibility; (3) when the income earner recovers, I care for the children; (4) when the child is sick, care is our karma; (5) when the income earner is sick again and terminally ill, continuing care keeps my morale high; (6) when the income earner is dead, care is for survival; (7) when I myself am sick, I *khit maak* [worry very much] with greater suffering; (8) when I am dead, care will be transferred to my mother. (Songwathana, 2001, p. 267)

In Thai culture, women are required to fulfill the expectations of other people's needs because being a woman means to nurture, even if it is at the expense of her own health. The emphasis is on giving (*hai*) and sacrificing (*siasala*). Buddhist beliefs in karma reinforce this sense of responsibility for women, particularly those who were infected by their husbands or those who were taking care of HIV/AIDS patients. The belief that AIDS is the result of their karma made acceptance of responsibility to give care in this life in order to have happiness in a future life, according to Buddhist principles of transmigration and reincarnation. Women's sexuality, vulnerability, responsibility, and caregiving are adversely affected by traditional, persistent gender imbalances and inequalities.

In another study, Kespichayawattana and VanLandingham (2003) explored the potential health effects on older parents (over age 50) caused by living with and caring for their adult HIV-infected children. In Thailand, as in other developing countries with modest health care budgets and high rates of infection, multiple generations live in the same household including PWAs. The researchers compare the health outcomes between affected and matched non-affected parents, and between principal and non-principal caregivers in Thailand to determine whether and to what extent the physical and mental health of older parents declined from close contact and providing care to their ill children.

Village clusters (*tambon*) were chosen within the three provinces of Chiang Mai (AIDS epidemic characterized by relatively high prevalence and long duration); Phichit (maintained low levels of AIDS prevalence); and Rayong (relatively high prevalence and short duration). VHVs acted as intermediaries and helped identify the 394 AIDS-affected families based on AIDS deaths that had occurred 6 months to 3 years prior to the interview period, as well as 376 control households, matched by age, marital, and socioeconomic status of the parent(s), that had not experienced an AIDS death within the same timeframe.

The range of caregiving tasks performed by AIDS-affected parents included: shopping; food preparation; feeding; dishwashing; bathing; helping with toileting; dressing; laundry; watching over; lifting and moving (e.g., from bed to chair); preparing and giving medicines; cleaning wounds; providing transportation to the clinic or hospital; consulting with health care providers; and helping to apply for welfare benefits. The more physically strenuous and time-consuming tasks were carried out by significantly more parents, mostly mothers, who co-resided with PWAs than by those who did not. This extensive output of care directly resulted in older parents suffering adverse health outcomes. Conversely, the suffering of PWAs would be much worse without these massive inputs of time, energy, and money by their parents.

Lower levels of overall happiness were reported by parents who had an adult child die from AIDS, compared to the control households. During the period of caregiving, parents of children with AIDS reported high levels of anxiety,

insomnia, fatigue, muscle strain, and head and stomach aches. To address the needs found in this study, Kespichayawattana and VanLandingham (2003) recommended a variety of programs, such as: anxiety, pain and sleep management programs for parents; accessing social support networks; government and private financial assistance for PWAs and their families; training workshops on cleaning wounds and administering medications for caregivers; and training local health personnel to identify and treat older people who are suffering from caregiving strains.

Pregnant Thai women constitute the fastest-growing segment of people diagnosed with HIV/AIDS (Boonpongmanee et al., 2003). HIV infection with pregnancy increases a woman's risk for depression due to changes in maternal identity, tasks, as well as the physical alterations (Rubin, 1984). Poor health-related behaviors such as smoking, consumption of alcohol and cocaine, and poor weight gain help give rise to symptoms of depression during pregnancy (Walker, Cooney, & Riggs, 1999). In a study of pregnant HIV-positive Thai women, Panuwatsuk (1998) found that women reported no condom use with partners, no exercise during pregnancy, and over-the-counter drug use.

Using Rosenbaum's theory of learned resourcefulness, Boonpongmanee et al. (2003) revealed the direct effects of depression and resourcefulness on prenatal self-care as well as the mediating effects of resourcefulness on depression and self-care. Resourcefulness is learned through experience, instruction, and modeling and, for HIV-positive pregnant women, may serve as a repertoire of coping skills to help manage symptoms of depression and perform self-care. Research findings indicate direct effects of depression and resourcefulness on prenatal self-care. The effect of depression on prenatal self-care was mediated by resourcefulness. HIV status did not predict prenatal self-care.

These findings support the usefulness of learned resourcefulness theory (Rosenbaum, 1990) for studying depression and prenatal self-care among pregnant women who are either HIV-positive or HIV-negative. Boonpongmanee and associates (2003) suggest that these findings can help nurses provide effective services to pregnant Thai women, including teaching resourcefulness to enhance prenatal self-care. The authors also suggest that formative studies involving in-depth interviews can significantly help in gaining more insight into the meanings of learned resourcefulness in Thai culture.

Recently, the influence of HIV on Thai women after childbirth has been addressed in several studies. Jirapaet (2001) explored factors affecting maternal role attainment of HIV-infected Thai women. Maternal role attainment is a process by which the mother achieves competence in the maternal role and comfort with her identity as a mother through integrating the mothering behaviors into her established role set (Mercer, 1985). Most mothers attain this role completely by well before the end of the first postpartum year (Grace, 1993; Mercer, 1985; Mercer & Ferketich, 1995).

In Jirapaet's sample of 39 informants, aged 18–40, heterosexual transmission was identified as the factor for HIV infection. Seventy-four percent were infected by their husbands, and 26% had a history of prostitution. From the informants' storytelling, Jirapaet identified the following six essential themes or descriptive factors that commonly fuel HIV-positive mothers to attain competency in their maternal roles while surviving with the infection:

1. Setting a purpose for life to raise an infant: Over 50% of mothers attempted suicide after first being identified as HIV-positive, but found motivation to live after aiming their life goals toward responsibility for their infants' well-being. When presented with the choice of therapeutic abortion, all chose to continue their pregnancies and have sterilization after the labor—a decision that was strongly influenced by a husband or grandmother.
2. Keeping secrets from others: All the women identified that secrecy was necessary to ensure safety for their infants and themselves. Informants feared rejection or expulsion from home and community, as well as the negative associations and unpleasant consequences that would follow disclosure through family members, such as stigmatizing the infants.
3. Normalization: Normalization was described by informants as the need to feel and live as if nothing has happened. This occurred through partial denial wherein mothers, if they were symptom free, could easily maintain verbal denial. However, behaviorally, their actions showed considerable regard to protecting their infants from infection. Alternatively, the women could achieve normalization by possessing a positive attitude toward life.
4. Quality of support from others: More significant than the number of supportive persons in their support networks is the quality of support the women receive. Most common true companions were an HIV-infected husband, a parent (especially the mother), or a sister.
5. Having hope for an HIV cure: One hundred percent of mothers were Buddhist and believed in the process of karma. Herbal remedies also provided hope for a cure.
6. Health services environment: Even in the presence of benefits, 98% of the HIV-positive mothers avoided using health services, even though they described health care providers as important and reliable sources of information, and potential aids to preserving their physical and mental health and meeting their infants' needs. The avoidance of health services was due to lack of accessible and pleasant health services, and the failure on the health services part to protect the anonymity of the women. Low income mothers with no health coverage

had to use government health care agencies, which the majority felt provided unpleasant service (e.g., "impolite talk," "scolding and acting sarcastic"), lacked a stable care provider, and personal privacy. In addition, hospital regulations required notation of the mother's HIV status on her infant's immunization record, which carried the risk of being disclosed to other family members, thus creating a continual source of worry (Jirapaet, 2001, pp. 28-30).

The implications of this study are that in order to encourage low-income HIV-positive mothers to access health care, providers need to ease the HIV-positive mothers' transition to maternal role attainment through providing more understanding of her struggle and needs; by creating accessibility to a regular provider and private consultation; by being more cordial and constructive in outreach activities; by including the mothers' most trusted people in the caring system; and by demonstrating an ethical concern for the mothers' confidentiality.

Design and Methodological Limitations

Nilmanat and Street (2004) argue that modern medicine splits the diseased body from the ill person's life and daily experiences, and note that Thai caregivers are aware that health professionals hold different views of sickness than they do, even though the search for a cure is a shared concern of both. Perceptions of illness, hospitalization, isolation, and adaptation between both groups differ in significant ways, largely along cultural lines. These differences in perception play out adversely in therapeutic settings. Existing instruments dealing with coping and adaptation are Western oriented, and are seen by some as inappropriate in Thailand. Boonpongmanee et al. (2003) attempt a predictive model testing design using Rosenbaum's theory of learned resourcefulness, and among other things, conclude that qualitative studies are needed to gain more insight into the cultural meanings of learned resourcefulness in Thailand.

SUMMARY

Thailand's HIV/AIDS crisis presents some interesting challenges to the nursing profession, in terms of how it views itself; its role in non-Western cultures; and how it would operate within existing health policies. Although the Ministry of Public Health in Thailand established DCCs at district hospitals to provide services to PWAs, the Thai government AIDS policy nevertheless relies on families to care for the country's sick, in part because of a lack of inpatient beds. Cultural factors dictate that women bear the burden of caregiving for those families unable to afford professional nursing and medical care. Poor women living with HIV/AIDS

provide a tremendous cost-savings to the Thai government but their numbers and caregiving activities are often overlooked within the professional ranks of health-care providers, even in terms of providing them much-needed basic health care training as advised by Kespichayawattana and VanLandingham (2003).

Most of the highlighted studies in this chapter, as presented in Table 12.1, were based on qualitative data and provided important cultural insights which challenge Western sciences to be more inclusive and holistic. Indeed non-Western knowledge systems have much to offer the healing profession. As Muecke (2001) suggests, poor Thai women are changing the paradigm of AIDS stigma, and as Bechtel and Apakupakul (1999) suggest, "A holistic and systematic effort by professional nursing organizations to promote family and community strengths by encouraging *krengjai* should be undertaken" (p. 474). In Bechtel and Apakupakul's view, this mechanism will effectively reduce patterns of morbidity and mortality from AIDS, and will enhance women's and children's health worldwide.

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